Board of Directors - Public meeting

Wed 06 December 2023, 13:45 - 16:15

Boardroom, Trust Headquaters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

13:45 - 13:47
2 min

13. Declarations of Interest

Information *Mark Jones*

Verbal item

13:47 - 13:50
3 min

14. Minutes of Previous Meeting

Approval *Mark Jones*

14. Minutes_Board of Directors - Public Meeting_04 10 23.pdf (6 pages)
14a. Public Board Action Log - Oct 2023.pdf (1 pages)

13:50 - 14:00
10 min

15. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

14:00 - 14:20
20 min

16. Chief Executive's report

Information *Silas Nicholls*

16. Board Report_CEO_December_2023 FINAL.pdf (3 pages)

14:20 - 14:50
30 min

17. Committee chairs' reports

Information *Non Executive Directors*

17.1. Finance and Performance

Information *Julie Gill*

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

17.2. People

Information *Lynne Lobley*

17.2. AAA People - November 23.pdf (2 pages)

17.3. Audit

Information *Ian Haythornthwaite*

17.3 AAA - Audit Committee - 15 Nov 2023.pdf (2 pages)

17.4. Quality and Safety

Information *Francine Thorpe*

17.4. AAAQSOct23.pdf (3 pages)

17.5. Research

Information *Clare Austin*

Verbal update

14:50 - 15:05
15 min

18. Board assurance framework

Discussion *Paul Howard*

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

15:05 - 15:20
15 min

19. University teaching hospital update

Discussion *Richard Mundon*

19. University Hospital Status AAA November 2023.pdf (5 pages)

15:20 - 15:35
15 min

20. Biannual staffing review

Decision *Rabina Tindale*

20. Bi-annual staffing Review for Board Dec 2023 Final 28 11 23.pdf (18 pages)

15:35 - 15:45
10 min

21. Maternity

21.1. CNST presentation

Cathy Stanford

21.1. CNST BOARD REPORT UPDATE DECEMBER 2023.pdf (16 pages)

21.2. Maternity incentives scheme

21.2. Maternity Incentive Scheme Year 5 update report Dec 2023.pdf (9 pages)

21.3. Bi-annual maternity staffing

21.3. Maternity Staffing Paper November 2023.pdf (15 pages)

21.4. Board declaration form

21.4. MIS_SafetyAction_2024_V8.pdf (26 pages)

15:45 - 15:55
10 min

22. Finance Report

Information

22. Trust Financial Report 23-24 October Month 7 Board.pdf (14 pages)

15:55 - 16:00
5 min

23. Balanced Scorecard

Information *Christos Zipitis/Juliette Tait/Mary Fleming/ Rabina Tindale*

23. M7 Board of Directors Balanced Scorecard Report FINAL.pdf (6 pages)

16:00 - 16:05
5 min

24. EPRR core standards

Approval *Mary Fleming*

24. EPRR Core Standards Board Report 2023.pdf (6 pages)

Consent Agenda

16:05 - 16:05
0 min

25. Agenda item not used.

16:05 - 16:07
2 min

26. Equality, diversity and inclusion annual report

Information

26. EDI Annual Report 2022-23.pdf (39 pages)

16:07 - 16:12
5 min

27. Workforce Race Equality Standard and Workforce Disability Equality Standard report

Information

27. People Committee WRES and WDES Report Nov 2023.pdf (26 pages)

27.1. Workforce Race Equality Standard - Action plan

Endorsement *Juliette Tait*

27.1 Draft WRES Action Plan 2023 until Board approval with success indicators.pdf (2 pages)

27.2. Workforce Disability Equality Standard - Action plan

Endorsement *Juliette Tait*

27.2 Draft WDES Action Plan 2023 until Board approval with success indicators.pdf (2 pages)

16:12 - 16:14
2 min

28. Committee effectiveness review findings

Endorsement *Nina Guymer*

28. Board report - Committee Effectiveness Review - findings and recommendations.pdf (6 pages)

16:14 - 16:15
1 min

29. Maternity Dashboards and Neonatal action plan

Information

29. Maternity Dashboard report Nov 23.pdf (7 pages)
29a. Maternity and Neonatal Safety Dashboard November 2023.pdf (10 pages)
29b.Copy of November 2023 Perinatal Monthly Surveillance Dashboard.pdf (3 pages)
29c. NWNODN Workforce Action Plan 2021- 2023.docx November 2023 update.pdf (11 pages)

16:15 - 16:15
0 min

30. Date, time and venue of the next meeting

Information

Wednesday 07 February 2024, 12:15 to 4:15pm, Boardroom, Trust HQ

Board of Directors - Public Meeting

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

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Board members

Mark Jones (Chair), Sanjay Arya (Medical Director), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Mary Fleming (Deputy Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Terence Hankin (Non-Executive Director), Lynne Lobley (Non-Executive Director), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Richard Mundon (Director of Strategy and Planning), Silas Nicholls (Chief Executive), Juliette Tait (Chief People Officer), Rabina Tindale (Chief Nurse)

In attendance

Nina Guymer (Deputy Company Secretary (Minutes)), Member of the public

Meeting minutes

11. Declarations of Interest

Information

Mark Jones

No declarations of interest were made.

12. Minutes of Previous Meeting

Approval

Mark Jones

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

13. Chair's Opening remarks

Information

Mark Jones

The Chair began by noting the recent news of Mr S Nicholls's new appointment, as the Chief Executive Officer of Lancashire Teaching Hospitals. He advised that further information around the interim appointment covering this position would be forthcoming shortly. Key areas of focus for the person taking up the position were noted to be elective recovery and discharge. He noted that the Chief Nurse position would not be appointed to until the new Chief Executive has taken up post.

The Chief Executive thanked the Board for the support which they had provided during his tenure.

He went on to acknowledge the current pressures faced by the executive team and that the non-executives had agreed that whilst they will continue to seek thorough assurance, they will strive to work with the data and information already available to resolve their queries, thereby not increasing the burden on teams in carrying out additional work.

He provided a positive account of the Mayor of Greater Manchester, Andy Burnham's recent visit to WWL's Leigh site.

The Board received and noted the update provided.

14. Chief Executive's report

Information

Silas Nicholls

The Chief Executive provided a summary of the report which had been shared in advance of the meeting. In particular, he highlighted that, whilst the continuing doctors' strikes do create additional pressures for the trust, WWL's Board understand the position of those on strike and that WWL have not had any internal conflict relating to the strike action. He implore the government to engage in meaningful negotiations at the earliest opportunity.

The Board received and noted the update provided.

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

Information

Sanjay Arya

The Chair invited the Medical Director to present the paper which had been shared prior to the meeting and set out the policies and processes which WWL has in place to enable staff to raise concerns without fear of reprisal . He added that the newly implemented Patient Safety Incident Response Framework will allow the trust to talk about incidents in a more transparent way. He highlighted that WWL was one of the first within the North West to launch its medical examiner service - meaning that any non coronial death is reviewed by the medical examiner and resulting learning shared with the organisation, with any issues of concern escalated to the Executive Scrutiny Group. Further, WWL are one of the only organisations to carry out a weekly audit of deaths and regularly share learning which is taken from this.

The Chief Nurse noted that WWL also introduced provision of human factors training and carry out after action reviews where incidents take place.

Mrs L Lobley expressed support for the need for an open culture and to ensure that staff feel able to speak up to their colleagues, she went on to highlight importance of triangulation and integrated governance, which builds robust assurance.

The Deputy Chief Executive noted how helpful it can be to hear from those with lived experience such as Ms S Talbot who had spoken to the Board during the preceding private meeting.

Lady R Bradley appreciated that Ms S Talbot felt safe enough to express her concerns to the organisation and what this illustrates about the nature of WWL's cultures and values

Prof C Austin asked whether the recent verdict and news coverage around the Lucy Letby case may be impacting on the way that staff feel when carrying out their roles and whether there is any additional support which needs to be offered.

The Chief Nurse reiterated the importance of giving staff support to speak up, learn from incidents and undertake training and explained that from her personal point of view, staff feel comfortable with what the organisation offers in that regard.

Mr T Hankin noted that despite the robust processes evidenced as being in place and the positive progress made in respect of culture, criminality can be very difficult to detect.

The Board noted the assurance provided by the report and further, that the Chair and lead Non-Executive Director for Freedom to Speak Up, Prof C Austin, will both be consulted throughout the process for the appointment of WWL's new Freedom to Speak Up Guardian.

16. Committee chairs' reports

Information

Non Executive Directors

The respective Committee Chairs presented the reports provided.

16.1. Finance and Performance

Information

Julie Gill

Lady R Bradley asked whether discussions around the board assurance framework (BAF) need to reflect further detail around the assurance of the delivery of financial commitments which WWL has recently made at system level.

It was noted that the corporate objectives would need to be realigned in that case, since the BAF monitors risks to delivery of corporate objectives, rather than wider organisational risks. However, there would be an opportunity to consider the relationship between system commitments and WWL's corporate objectives at the next annual review.

16.2. People

Information

Lynne Lobley

Following presentation of the report, concerns were expressed around the potential for middle grade doctors to also strike.

The Deputy Chief Officer noted that the Greater Manchester Chief Operating Officers' Group will make a daily statement around cancellations and waiting list growth moving forwards.

16.3. Research

Information

Clare Austin

It was noted that an action had been taken for the establishment of a forum to support better engagement with external partner organisations, which would report up to the Research Committee moving forwards.

16.4. Audit

Although Mr I Haythornthwaite was not present, Lady R Bradley, who had been present at the meeting to which the report pertained, highlighted good assurance around the follow-up to the previous safeguarding audit, which had been requested at the previous meeting.

16.5. Quality and Safety

Terrance Hankin

The Board received and noted the reports and additional updates provided.

17. Board assurance framework

Discussion

Paul Howard

The Chair invited the lead executive directors for each of the four corporate pillars to provide respective comments.

The Medical Director added that in respect of the risk to CO1, being ID 3805, that a Sepsis Nurse has now been appointed.

The Chief People Officer advised that work around the People Dashboard refresh had now begun and recommended that this risk therefore be closed.

The Director of Strategy and Planning advised that there would be a forthcoming recommendation of an increase to risk PR12 in respect of CCG changes, due to a lack of advice centrally around how commissioning will be handled moving forwards. The board acknowledged that this creates a risk for most trusts. In respect of sustainability, risk PR13 should be reduced subject to the approval of the executive team and following the installation of more LED lighting, with much progress made across this area.

Prof C Austin raised a query around the risk on widening access to employment risk, PR11 and whether this needs review by the People Committee.

The Director of Strategy and Planning advised that WWL has identified 41 placements and would increase that in the current year, however outlined the risk that filling these would not be possible due to the additional resource required to do this. He was agreeable to providing a separate report for the Committee, if required.

The Board received the report and noted its content.

18. Integrated performance report

Discussion

Sanjay Arya/James Baker/Mary Fleming/Mary Fleming

The Chair invited the lead executive directors for each of the four quadrants to provide respective comments.

The Chief Nurse noted the marked improvement in respect of complaint responses and the Medical Director highlighted the satisfactory figures for the current summary hospital-level mortality indicator and hospital standardised mortality ratios.

The Deputy Chief Executive highlighted the positive position in respect of elective long waits. She provided a positive update in respect of a recent visit from Prof T Briggs, to the Wrightington and Leigh sites, noting that WWL would now submit a bid for funding for theatre 12 at the Wrightington.

The Chair noted WWL's confidence in the system wide transformation plans described within the performance section of the scorecard and asked when the results of the two pieces of work will be available.

The Deputy Chief Executive advised that between October and November, Newton Europe will carry out an intense diagnostic exercise, reporting the findings in November, including suggested opportunities and interventions. The report will be disseminated to local leads but that at that point funding for the further stage will need to be considered collectively and will be dependant on the resource required, as dictated by the findings. The Emergency Care Improvement Support Team (ECIST) will evaluate their work December. She concluded by advising the both the executive team and the Finance and Performance Committee will keep a focus on this work.

The Chief People Officer advised that she will soon carry out work to review and refresh the metrics included in respect of the 'People' quadrant. She outlined several areas in which changes may be recommended.

A delay in the Workforce Race Equality Standard and the Workforce Disability Equality Standard data was noted to be due to a delay in the results being benchmarked centrally and she advised that this is expected imminently.

It was noted that the staff survey is now running and that there is a circa 8 week period in which staff may complete this, allowing time for further communications to be issues to increase uptake if required.

Mrs L Lobley expressed concerns around the issue of non attendance at mandatory training sessions, noting the decrease in those completing the resus training and recalling that this had been a problem for the Trust previously.

The Deputy Chief Executive noted feedback from divisions around how current pressures hinder the availability of staff to attend training but it was noted that improvement is required here to ensure that this does not have a negative impact on patient safety or finance and resource.

The Chair requested that he meet the newly appointed Equality Diversity and Inclusion Lead once the member of staff begins in post.

The Board received and noted the report.

19. Finance Report

Discussion

Tabitha Gardner

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

Dr T Hankin asked if the team are confident that all of the additional costs associated with industrial action are being captured and if any feedback has been provided on what has been outlined as a resulting funding gap.

The Chief Finance Officer advised that this is estimated and reported to PwC, although there has been no feedback, she supposed that if there were any associated issues, these would be communicated back to the Trust.

The Chair noted that the largest percentage of cost improvement programme (CIP) savings is not yet realised and asked whether the schemes which will deliver later in the year have been factored into the financial forecast accordingly.

The Chief Finance Officer advised that this is tracked both in terms of forecast and delivery.

The Chair reminded the Board that all staff are responsible for CIP, adding that NHSE have asked him to provide a paper for the Integrated Care Board and turnaround teams at the same time as WWL's board, around the five areas where WWL has been asked to ensure a focus to improve its financial position.

The Board received and noted that paper.

20. Maternity

Information

Rabina Tindale

The Chief Nurse presented the report which had been shared in advance of the meeting. She highlighted that medical examiners have now begun examining all non-coronial neonatal deaths.

20.1. Maternity and Neonatal Dashboard

20.2. Perinatal quality surveillance report (Q4)

It was noted the next iteration of the report provided will come to the Board in December, so that Board are kept informed but the last cut of the data will be signed off by the Chief Executive and his Deputy following this, to ensure that national reporting timescales can be adhered to.

The Board received and noted the reports.

21. Winter Planning

Information

Mary Fleming

The Deputy Chief Executive summarised the content of the paper which had been shared in advance of the meeting.

The Chair asked whether the Trust are likely to be in a better position than usual this year.

The Deputy Chief Executive noted that the two transformation plans led by ECIST and Newton Europe will make the biggest difference within the current year. She added that targets of 55 discharges per day and a length of stay of 7.5 days must be met to ensure that WWL delivers the plans in place.

The Chief Executive emphasised the importance of demand management and ensuring that patients do not need to be admitted in to beds. He noted that when consultants do more of this at the 'front door' to the emergency department, as they have needed to during periods of industrial action, it is always effective. He suggested therefore that a change in model is required.

The Board noted and received the update.

22. Item no longer required

Consent Agenda

23. Review of changes to Standing Financial instructions

Approval

The Board received and noted the paper and **APPROVED** the changes outlined therein.

24. Maternity Papers

Information

The Board received and noted the papers which had been shared in advance of the meeting.

24.1. CNST update

24.2. CQC maternity action plan

24.3. Saving babies lives compliance update

25. Date, time and venue of next meeting

Information

Wednesday 6 December 2023, 1:15 - 4.15pm

Mark Jones

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
7 Jun 2023	81.3/23	Review of well-led action plan	Identify a well-led KLOE to undertake a deep dive into	Executive team	Feb 2024	A deep dive into KLOE7 has been agreed for early 2024.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	06/12/23
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

WWL was very busy again throughout the months of October and November and I want to thank all our staff for their collective efforts to ensure we continue to deliver high quality and safe care for our patients.

Our Urgent and Emergency Care services continued to experience high attendances, with patients of high acuity, which regretfully has meant that many of our patients have experienced longer waits than we want. We are actively working with our system partners on improvement plans to enable better flow within our hospitals and improving discharges out of hospital. Part of this is an improvement collaboration with the Emergency Care and Improvement Support Team (ECIST) and Newton Europe to help us with patient flow, as at WWL we truly believe that the best place for our patients to continue their recovery is in the place that they call home. Unfortunately, while we aim to get our patients safely back home as quickly as possible, the increasing pressures across the health and social care system can mean that some patients will end up staying in hospital longer than they need to. However, together with our system partners, we are committed to continuing to safely increase discharges and all work towards a “Home First” approach for our patients when safe to do so.

All of this activity is maintained against a backdrop of safely addressing our financial challenges and there continues to be considerable scrutiny on the Greater Manchester (GM) system financial position. As a result, an external turnaround director is supporting GM and all NHS providers including WWL, to move into a more financially sustainable position, with an expectation that we recover to a stronger financial footing. We are all working hard Trust wide to stabilise the financial position and get ourselves into a more resilient position going forwards.

I am really pleased to share the news of WWL colleagues and services continuing to gain significant peer and sector recognition, with colleagues at Wrightington Hospital celebrating two National Orthopaedic Alliance (NOA) Excellence in Orthopaedic Awards, for the work around our Paediatric Hip Arthroplasty Service. WWL’s joint work with the GM Orthopaedic Alliance also won the Innovation in Orthopaedics award for the trauma and orthopaedic care pathway optimisation using a digital platform. Our Research colleagues also celebrated at the GM Health and Care Research Awards, while Dr Anthony Short was named as the winner of the Exceptional Research Delivery Leadership, and the GM Research Van Collaboration (WWL & MFT) - Best Public Engagement were awarded a Highly Commended accolade. WWL’s Patient Research Advisory Group were also runners up at the Inclusive Involvement Excellence. Further recognition must also be given to our Emergency Care Team, who were named as finalists at the national Nursing Times Awards for their work on the Electronic SBAR in the Critical and Emergency Care category. Trainee Nursing Associate Neelesh Patel also won 'Positive Contribution - Community Award' at the University of Bolton Apprenticeship Awards last month. To be nominated, and to then go on to win such prestigious national and regional awards, is a great achievement, and truly is testament to the hard work and innovation of our colleagues and their dedication to our patients.

October saw the second ever Staff Thanks And Recognition (STAR) Awards return to WWL, an evening to shine a spotlight on the work our colleagues carry out on a daily basis within the Trust. This year’s fully sponsored event proved to be yet another unforgettable evening for all, and it was great to see colleagues come together to celebrate each other’s accomplishments over the past 12 months. 12 teams and individuals were award winners on the night, after more than 600 nominations were received – it was incredibly tough for the judging panels to whittle them down to the 30 finalists, all of whom would be worthy winners. Events like the STAR Awards are so important, to be able to recognise the incredible work our colleagues are doing, and make sure they know how much we all appreciate them.

In early November, we held our 2023 Annual Members’ Meeting. Members of the Trust, along with the public, joined the Board of Directors and Council of Governors to find out the latest about the Trust, our sites and our achievements during 2022/23. The meeting provided an opportunity for our local community to engage with us, ask any questions they have, meet the staff who work here and

learn more about the service improvements that have taken place over the last year. Presentations also included a summary of our accounts, the results of the recent elections to the Council of Governors and a keynote presentation on research and innovation at the Trust.

We were also honoured to be visited by Professor Chris Brookes, Chief Medical Officer for the Rugby Football League and England Rugby League, and Chairman Elect of Wigan Warriors Rugby League, in early November, as he officially opened the new Macmillan Supportive and Palliative Care Hub at the Royal Albert Edward Infirmary (RAEI). The hub is a former ward that has been transformed into a space of peace and privacy for patients and staff and is set to change the way in which end-of-life care and support is delivered. The integrated unit includes outpatient facilities to allow for an increase in clinic capacity and the opportunity to further develop hot clinics, to support patient concerns and reduce some attendances in our Emergency Department. The space truly is a much-welcomed and much-needed addition to RAEI.

In mid-November, our Continuous Improvement Team hosted the WWL Continuous Improvement Conference. Returning after a three-year break due to the COVID-19 Pandemic, the conference was bigger and bolder than ever before. I had the pleasure of welcoming over 150 participants to hear from five external speakers and five internal speakers, as well as our Silver, Gold and Platinum awards presentation, and a varied marketplace. The external speakers gave an insight into national work taking place across deterioration, investigations and improvement, whilst our internal speakers shared the incredible work they have been undertaking to improve services across our Trust. Our Staff Networks were also well represented at the conference. A huge thank you goes to the incredible team of staff who helped to make the day such a success

Finally, this is my last Board of Directors meeting, and I would like to take this opportunity to say thank you to everyone at WWL and our system partners for being great colleagues to lead and work with. I know that as we are now into the winter period, WWL will still have challenges both operationally and financially, but as I leave WWL, I leave knowing that patient safety and high-quality care is paramount, and that colleagues are committed to supporting each other, night and day. Thank you.

Committee report

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

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

ALERT

- The Committee noted deterioration with the progress previously made in terms of the work to improve equality, diversity and inclusion, as reported in the previous Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and gender pay gap reports. A Board Development Workshop has been scheduled for January 2024 focussing specifically on Equality, Diversity & Inclusion.
- A comprehensive update was received from the Chair of the Culture Programme (OFOFOF) and the Committee felt that the Board would benefit from further information and engagement in this regard.

ASSURE

- The Staff Story was provided by a colleague who had secured a permanent position with WWL after having completed the Princes' Trust scheme.
- The corporate divisional dashboards will now contribute to the people dashboard moving forwards, which will strengthen reporting from divisional level.
- Turnover levels have improved, and sickness levels remain below the Trust target.
- The revised induction programme has now been launched and will see a face-to-face Welcome Day held for new starters with effect from 20th November 2023.
- The Committee noted that two distinct establishment control panels, one for medical and one for non-medical, had been set up to take forwards work to ensure grip and control in the filling of any vacancies. Both panels are Executive led. AAA reports will be provided by these groups for the Committee's review.
- *Following the meeting, the Committee Chair received and reviewed the Establishment Control Group AAA.*

ADVISE

- The Committee welcomed the Trust's new Equality Diversity and Inclusion (ED&I) Lead.
- The ED&I Steering Group has now been re-established and will begin reporting to the Committee at its next meeting.
- The National Staff Survey results were reviewed and triangulated with the findings from the Culture Programme.
- The Committee endorsed WWL's signing up to the NHSE Sexual Safety Charter and becoming and pledging to become an anti-racist organisation.
- The Committee noted positive progress through early indications of reductions in nursing agency usage.
- WWL's staff network Chairs attended the meeting and provided some advice around

the work that they have done and how this links to discussions following from papers that were being considered by the Committee. ▪ The Committee received the usual audit and risk report.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ ED&I related risks have now been included within the board assurance framework to ensure that there is ongoing oversight and monitoring of these.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Audit Committee
Date of meeting:	15 November 2023
Chair:	Ian Haythornthwaite

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

ALERT

- A number of limited assurance internal audit reports were presented to the Committee:
  - SAS/LED job planning
  - Data quality – community
  - Discharge planning

  The Committee noted that these audits had been proactively commissioned by management to identify issues and that focused work is now ongoing to address the recommendations made. The executive lead (or deputy) for each of these audits attended the meeting to provide an update to the Committee.
- It was noted that there remained a high number of follow-up reports outstanding and that the process for following these up will be reviewed before the next meeting, with more executive attention given to the process for moving previously agreed dates.

ASSURE

- The Committee received one internal audit report with high assurance (risk management – core controls); one with substantial assurance (Empactis absence management); and one with moderate assurance (research and development sponsorships). The Committee passed on its thanks to all involved with these audits.
- Continuing strong performance in counter-fraud was noted.
- The Committee received a report which provided an analysis of the effectiveness of the foundation trust's board assurance framework and confirmed that it is fit for purpose.
- The Committee reviewed the corporate risk register and confirmed that it was confident in the arrangements for management oversight of risk via Risk Management Group which is chaired by the Chief Executive and attended by a number of executive directors.

ADVISE

- The Committee noted that a collaborative arrangement with NHS Greater Manchester is currently being pursued for the Freedom to Speak up Guardian, noting the benefits of independence and cross cover available from other guardians working in that service. A report will be provided to the People Committee meeting once this external contract is formally in place and then to the Board through that AAA report.
- The Committee received an update on medical e-rostering and pharmacy staffing and noted that the risks discussed previously have been reduced accordingly.
- The Committee received a review of the risk register.
- The Chief Finance Officer provided a verbal update on a potential 'off balance sheet' capital build. KPMG have been consulted and have provided advice on key lines of enquiry to be resolved by the Trust with the potential partner, prior to any formal agreement being made. The project is still in early stages will be brought to both non-executives and the Board of Directors once further progress had been made.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- As noted within the risk register review.

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	11 October 2023
Chair:	Francine Thorpe

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

ALERT

- An updated AAA report was received from the Deteriorating Patients Group that provided an overview of a range of actions being taken to address issues relating to this theme. Measures agreed to track progress around sepsis, whilst still below target, showed improvement. Measures to track progress around other workstreams are being finalised.
- The specialist services divisional deep dive report highlighted risks scored at 15 in terms of gaps in junior doctor rotas in trauma & orthopaedics and lack of capacity in non-medical prescribing within the rheumatology service. Mitigating actions were discussed.
- This report also highlighted an increasing trend in incidents relating to missing or damaged instrument packs from the sterile services decontamination unit. The division agreed to provide an update for the next meeting and to escalate this issue to secure a resolution if necessary. Serious incidents were highlighted in relation to unplanned transfers due to patient deterioration and a delay in reporting CT scan findings. It was confirmed that these issues were being considered within the established sub-groups.
- The Lost to Follow-up Group has not yet finalised actions and measures being used to secure and monitor progress. Information will be presented at the next meeting. The committee requested that this includes information on any quality and safety issues relating to patients on the waiting list.

ASSURE

- The specialist services divisional deep dive provided assurance on a range of programmes contributing to achievement of Trust objectives including:
  - 95% of complaints responded to within the agreed timescales with thematic reviews being undertaken and action plans in place to address key themes;
  - Actions to improve pre-operative access, theatre utilisation and reduce length of stay;
  - Regular review and engagement with harm free care initiatives particularly in relation to pressure ulcers and falls.
- The committee received a report from the Mortality Group that provided assurance on the level of scrutiny in terms of mortality data. Our summary hospital level indicator

(SHMI) has shown an improving trend for seven successive months and is now within the expected range. Our Hospital standardised mortality ratio (HSMR) also shows an improving trend and is below (better than) the national benchmark.

- A report was received on progress with the Locality Diabetes Improvement Programme that provided assurance on:
  - The current baseline on a range of performance measures;
  - The indicators being used to track progress;
  - The level of engagement from WWL services within this improvement work;
  - Progress in the establishment of a multi-disciplinary foot service;

  It was agreed that maternity services need to be linked into this work.
- An update is scheduled for a future meeting so that the committee can retain oversight of corporate objective C03.
- A sepsis progress report was received that provided a baseline on the advancing quality indicators being tracked to measure progress in the management of sepsis, in line with corporate objective C01. A range of actions were outlined to drive improvement. The most recent data highlighted improvement in all of the measures.
- A medications incident annual report was received that provided assurance:
  - That medication incidents are reported at an appropriate rate for an organisation the size and diversity of WWL;
  - Medication incident reporting is thoroughly scrutinised and thematically analysed to ensure issues are identified, actions taken and lessons learned;
  - Over 98% of incidents are listed as no harm providing evidence of a good reporting culture;
  - Information is fed back through divisional assurance meetings to secure appropriate engagement in any improvement work;
- The biannual quality and safety impact assessment report provided assurance on the clinical oversight and scrutiny of any service changes.
- The AAA report from the Clinical Audit and Effectiveness Group provided assurance on the Trust's process for seeking assurance on compliance with National Institute of Health and Care Excellence guidelines.

ADVISE

- The committee approved the recommendations made following completion of its annual effectiveness review.
- The committee approved a recommendation to formally step down the CQC Stakeholder Group as there is significant assurance that all areas that the CQC review are being assessed within the current governance assurance meeting structure.
- The committee received a Patient Incident Response Framework (PSIRF) process assurance report and approved the PSIRF policy and plan. It was noted that the five local priorities identified were consistent with the information presented and discussed at the Quality & Safety Committee.
- A range of reports were received from maternity services including:
  - The Clinical Negligence Scheme for Trusts (CNST) 5 year progress plan;
  - The CQC Action Plan that addresses the issues identified around staff training;
  - The Maternity Incentive Scheme 2023 (Safety Action 8 Training Plan);
  - Saving Babies Lives Compliance Update.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the board assurance framework were reviewed.

- The Specialist Services divisional risks were discussed as part of the Deep Dive

Title of report:	Board Assurance Framework (BAF)
Presented to:	The Board
On:	6 December 2023
Presented by:	Director of Corporate Affairs
Prepared by:	Head of Risk Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

The latest assessment of the trust's fifteen key strategic risks is presented here for approval by the Board. Two new risks have been escalated to the BAF and one risk has been accepted and de-escalated since the last Board meeting in October 2023.

Link to strategy

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

Risks associated with this report and proposed mitigations.

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

Financial implications

There are three financial performance risks within this report.

Legal implications

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

People implications

There are two people risks within this report.

Wider implications

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

Recommendation(s)

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

1. Introduction

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

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

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

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

2. BAF Review

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

2.2 **Patients:** Five patient focussed BAF risks were presented at the Quality and Safety Committee meeting on 11 October 2023. One patient focussed BAF risk has been escalated to the BAF, one risk has been closed and three risks have been reviewed and updated since the last Board meeting in October 2023. The following risk scores have been amended:-

- ID 3805 - Sepsis Recognition, Screening and Management – risk reduced from 20 to 16.
- ID 3676 - Complaint response rates - risk reduced from 10 to 8.

2.3 **People:** Two people focussed BAF risk were presented at the People Committee on 12 September 2023. One new people risk has been added to the BAF since the last Board meeting in October 2023.

2.4 **Performance:** The five performance focussed BAF risks were reviewed and updated for presentation at the Finance and Performance Committee meeting on 29 November 2023. No finance and performance risks have been added or removed from the BAF since the October Board meeting and the risk scores for the five existing risks remain the same.

2.5 **Partnership:** The four partnership focussed BAF risks have been reviewed and updated for presentation at the Board meeting. No partnership risks have been added or removed from the BAF since the last Board meeting in October 2023 and the risk scores for the four existing risks remain the same.

3. New Risks Recommended for Inclusion in the BAF

3.1 ID 3647 - Preferred Place of Death. This patient focussed risk has been updated and escalated to the BAF.

3.2 ID 3871 – Staff Engagement. This people focussed risk has been added to the BAF and is linked to corporate objective 9 - to ensure we improve experience at work by actively listening to our people and turning into positive action.

4. Risks Accepted and De-escalated from the BAF

4.1 ID 3507 - Ward accreditation programme - patient focussed risk reduced from 6 to 3 (target score achieved).

5. Review Date

5.1 The BAF is reviewed bi-monthly by the Board. The next review is scheduled for February 2024.

6. Recommendations

6.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

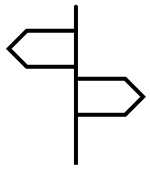
2023/24

The content of this report was last reviewed as follows:

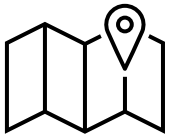
Board of Directors	October 2023
Quality and Safety Committee:	October 2023
Finance and Performance Committee:	November 2023
People Committee:	November 2023
Executive Team:	November 2023

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

How the Board Assurance Framework fits in

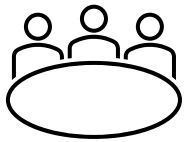


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

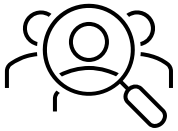


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

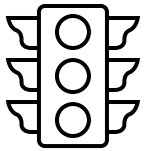
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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



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



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



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

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

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
↑ Likelihood	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Critical 5**
	Impact →				

DIRECTOR LEADS

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

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

Our approach at a glance

Our Strategy 2030

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

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

FY023/24 Corporate Objectives

Patients

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

People

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

Performance

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

Partnerships

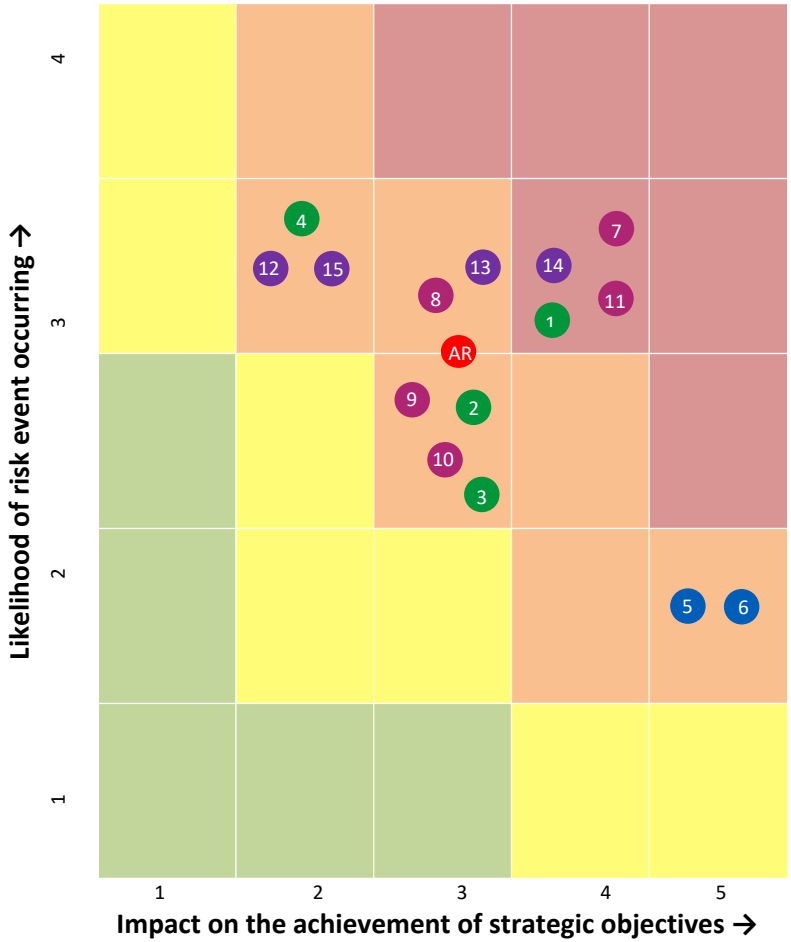
We will…
- Improve the health and wellbeing of the population we serve
- Develop effective partnerships within the new statutory environment
- Make progress towards becoming a Net Zero healthcare provider
- To increase research capacity and capability at WWL and in collaboration with EHU plan to make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

Risk management

Our risk appetite position is summarised in the following table:

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

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



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

Patients

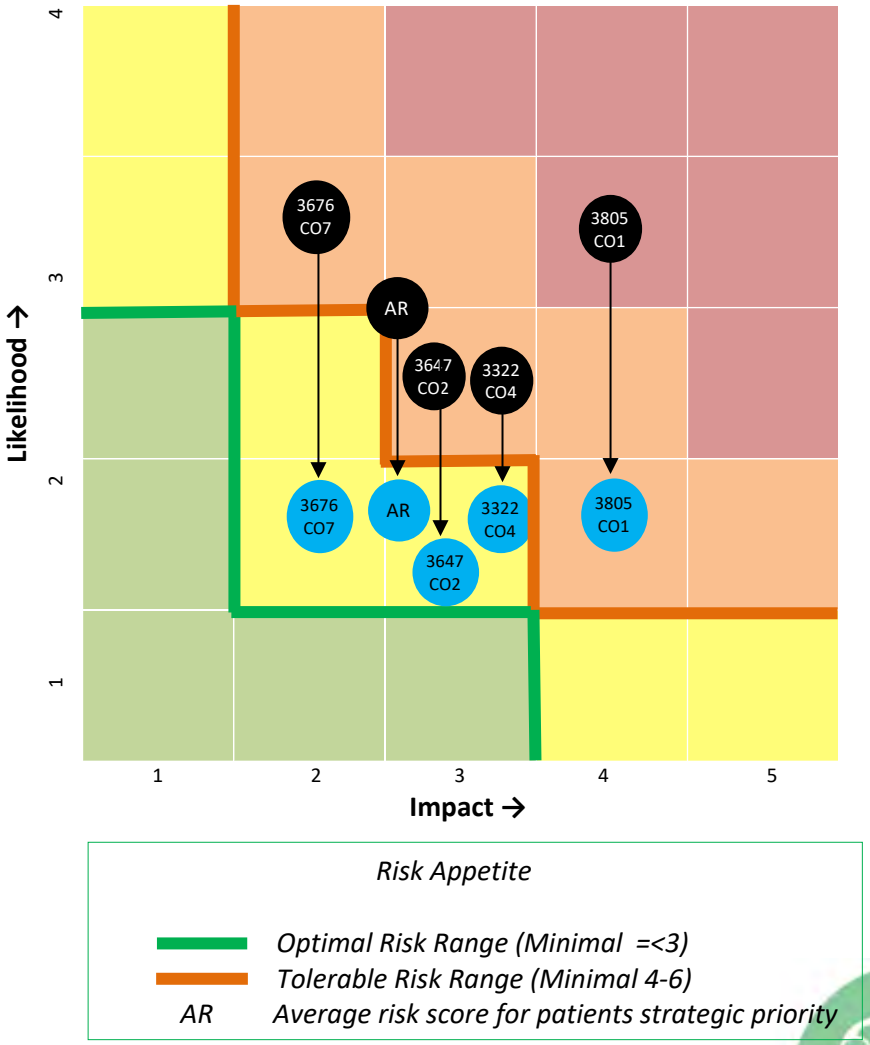
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

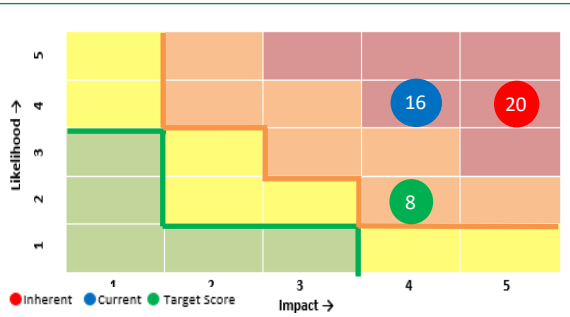
Monitoring: Quality and Safety Committee

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

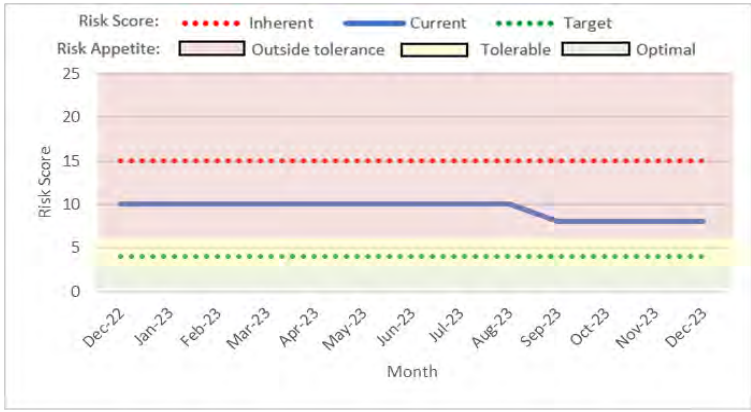
Ref.	Purpose of the objective	Scope and focus of objective
CO1	To improve the safety and quality of clinical services	To improve the compliance of Sepsis-6 care bundle as per Advancing Quality Audit, with aim to reduce mortality from sepsis.
CO2	To ensure patients and their families receive personalised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

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

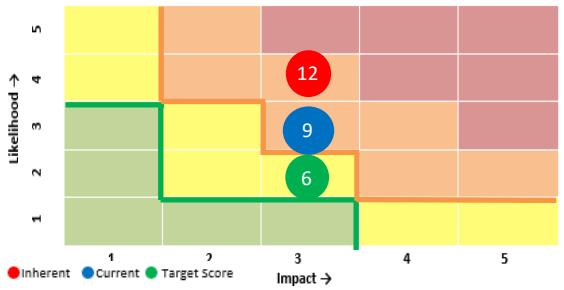


Corporate Objective: **CO1** To improve the safety and quality of clinical services					**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 1: Sepsis Recognition, Screening and Management**				
	Risk Statement:	There is a risk of the under diagnosing of patients with Sepsis, due to Health Care Professionals failing to recognise Sepsis in the deteriorating patient, which may result in patients not receiving Sepsis 6 treatment within one hour of triggering for Sepsis.				
Lead Committee	**Quality and Safety**		**Risk Appetite**	Minimal		
Lead Director	**MD**		**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**19.07.23**		**Linked risks**	-		
Date of last review	**11.10.23**		**Risk treatment**	Treat		

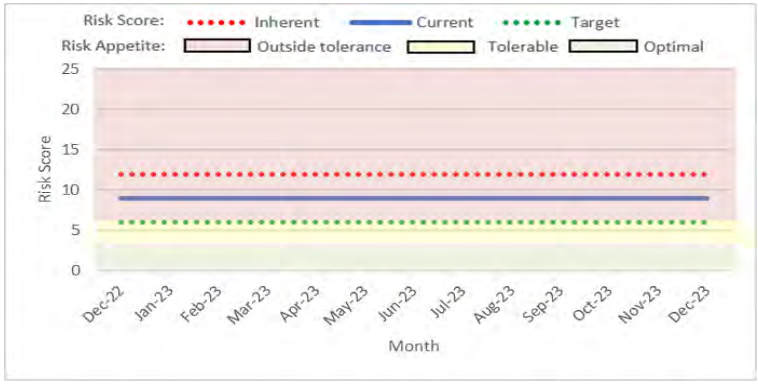
Risk Score Timeline



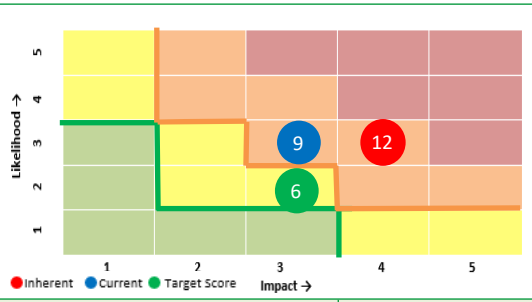
Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **(ID 3805)**	• Sepsis Nurse = High Visibility, Ward walk rounds. Recommenced by current Sepsis Lead Nurse. • Link Nursing in all wards and department have been reinstated. • Training and Education = Corporate Induction, E-learning Sepsis currently being updated, Sepsis in HIS to be made mandatory. Bespoke training for clinical areas and ECC. • Recommenced reviewing Datix's specifically related to Sepsis. Learning from incidents, information sharing. • QI project ongoing in. Supported by Sepsis Lead Nurse and Consultant. • Monthly Sepsis coding review in which Sepsis Deaths are reviewed and accurately coded. Sepsis Discharges are also reviewed. • Sepsis Improvement Plan developed alongside the MIAA Sepsis action plan. • ED Patient Group Directive for IV Antibiotics re-established in ED. • Blood culture training is being recommenced by Sepsis. Initial training commenced in ED. • Sepsis Nurse to attend AQ Sepsis Clinical Expert Group (CEG)	• Sepsis/AKI Specialist Nurse has been appointment at a band 6 level. • Room booking and releasing staff due to operational pressures • Appropriate Care Score objective may not be achieved due to the lack of data available from 2022/23. • Blood culture training is only currently available to ED staff. • HIS sepsis flags are currently over sensitive and do not differentiate between sepsis and a differential diagnosis.	**2nd Line:** • Quality & Safety Committee August 2023	**2nd Line:** • Sepsis Group to be established reporting into Deteriorating Patient Group.	1. Review Sepsis Policy and Sepsis SOP – Live on the Intranet 2. To recommence Sepsis training 3. Sepsis E-Learning review 4. AQ Audit – Recommence 5. ECC Red Flag Sepsis Audit – Recommence 6. Community SOP for Adults 7. Community SOP for Paediatrics	Aug 2023 Completed July 2023 Completed Nov 2023 Sepsis Lead Mar 2023 Completed June2023 Completed Oct 2023 Sepsis Lead Oct 2023 Sepsis Lead

Corporate Objective: **CO2:** To ensure patients and their families receive personalised care in the last days of life					**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 2: Preferred Place of Death**				
	Risk Statement:	There is a risk that patients under the care of the district nursing caseload will not die at their preferred place of death.				
Lead Committee	**Quality and Safety**			**Risk Appetite**	Minimal	
Lead Director	**MD**			**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**13.12.22**			**Linked risks**	-	
Date of last review	**11.10.23**			**Risk treatment**	Treat	

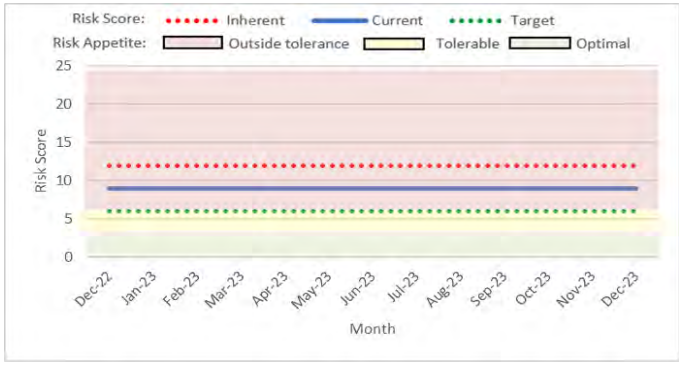
Risk Score Timeline



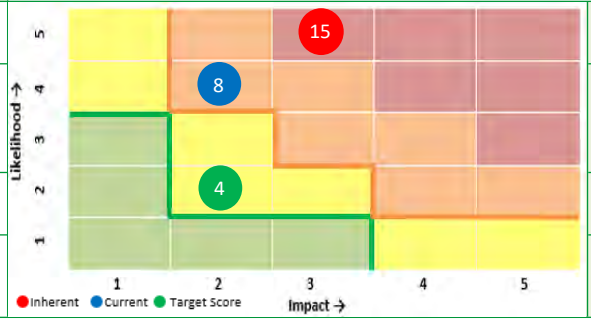
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3647)**	• Monthly audit on preferred place of death undertaken on any deaths that occurred whilst patients are under the DN service. • Weekly inpatient death audit which also reviews all hospital deaths. • EPaCCS / Advanced Care Plan records highlighting preferred place of death. • Training on EPaCCS ongoing across the Borough covering all services. • Mayfly Advanced care plan accredited training programme ongoing across the trust. • Hospice Practice development team delivering training within the borough, including residential and nursing homes to identify deteriorating patients and the correct action to take.	• Data capture from SystemOne – currently inputting data and auditing manually. • Single nurse lead currently leading within the District Nursing Service. • Reduced numbers of Healthcare professionals at advance care plan and EPACS training due to pressures. • Not all patients who have a palliative diagnosis are known to the district nurse services • Very limited overnight provision in community / acute for overnight rapid discharges	**2nd Line:** • Monthly audit reviewed within trust Mortality and End of Life meeting. • District nurse palliative care lead reports to End of Life Borough Strategy Group.	**2nd Line:** • None currently identified.	1. Further development of the review of EPACS and this will be included within the monthly audit 2. Nominated district nurse palliative care lead who attends daily multidisciplinary single point of access meeting to discuss any potential discharges or admissions for palliative patients. 3. Community and acute setting to share information to review patients who die in hospital and to identify if they were under the district nurse caseload and if not, would a referral have been appropriate. 4. Deep dive of all patients on the district nurse caseload who die in hospital to identify any trends or issues. 5. Liaising with community services such as Community React Team / virtual ward to identify their input with palliative patients being cared for in the community setting.	Ongoing – district nurse palliative care lead

Corporate Objective: CO4 To improve the delivery of harm-free care					**Overall Assurance level**	**Medium**
Principal risk	**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 Appetite**	Minimal		
Lead Director	**CN**		**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**19.10.21**		**Linked risks**	3323		
Date of last review	**11.10.23**		**Risk treatment**	Treat		

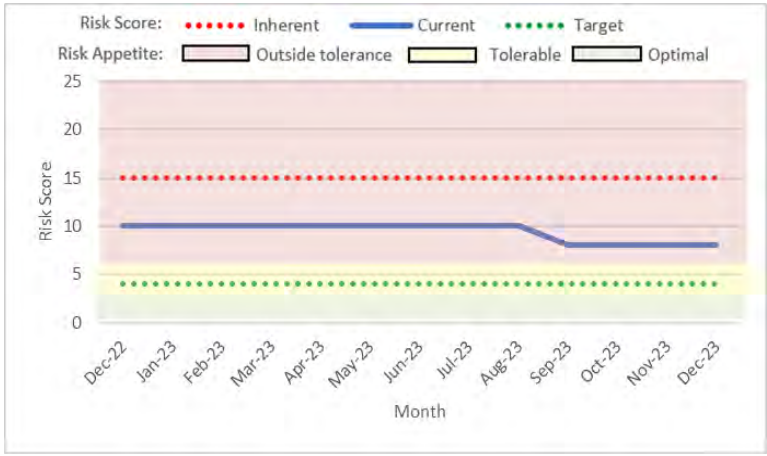
Risk Score Timeline



Strategic Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3322)** **Linked risk:** 3323 – Tissue viability team capacity	• Pressure ulcer link nurses trained within all areas and extended to community care homes. • Human factors training to continue to be embedded within the organisation building on success of 2022/23. • Category 2/DTI Pressure Ulcer Low Harm Review Panels (PURP) in place. • Category 3/4 & Unstageable Pressure ulcer panels Moderate& Severe Review Panels (PURP) in place. • Pressure ulcer policy and SOPs embedded. • PU prevention training in place and monitored via the Learning Hub. • Quarterly reports submitted to HFC group, Patient Safety group, NMAHP body and Q&S committee to provide assurance. • Data captured re incidence of moisture associated skin damage (MASD) • 2022/23 MIAA PU audit report evidenced substantial assurance and all actions required where completed by Q4. • ED improvement plan in plan and monitored by PU steering group. • Use of AAR to create opportunities for learning cross divisions. • First contact data now captured.	• Staff being able to be released to undergo training. • Junior workforce. • High use of bank and agency staff. • Escalated areas continue beyond winter. • Number of increased ED attendances, with the capacity demands continuing beyond its current footprint • Large number of patients on the no right to reside list contribute to compromised patient flow which results in continued long waits to be seen and delays in patients being admitted to an inpatient area. • Ongoing Industrial action (IA) • Equipment issues. • Beds owned by individual Divisions. • Under resourcing of Tissue Viability Team. • Due to the Trust financial situation, further investment into patient safety and the HFC Business case (BC) is on hold.	**2nd Line:** Quality & Safety Committee August 2023	No gaps currently identified	1. Continue the roll out of human factor training. 2. Implement governance changes in managing the low-level harm panels to align to the Patient Safety Incident Response Framework (PSIRF framework). 3. Implement the utilisation of the revised Datix PU reporting form. 4. Further work and interrogation of data to be undertaken regarding relationship between end of life skin changes and pressure damage. 5. Explore a system wide response to pressure ulcer development utilising 'on first contact" data. 6. Commence Pioneer pilot in 3 clinical areas: Pemberton ward, Shevington ward and BWN. 7. Implementation of the Repose Wedges. 8. Roll of out the revised MASD pathway to acute and community services. 9. Commence differential diagnosis training as part of the verification training to enhance the verification process. 10. Review the Purpose T training package to prepare for implementation in the Trust as an alternative to using the waterlow risk assessment tool. 11. Total bed management project progressing to BC stage. 12. Development of Care Consortium commenced beginning with Pressure Ulcers and Recognition of Deteriorating Patient.	PU steering group March 2024

Corporate Objective: **CO7** Listening to our patients to improve their experience					**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 4: Complaint response rates**				
	Risk Statement:	There is a risk that complaints received may not be responded to and acted upon within our agreed timeframes, due to operational pressures, resulting in missed targets, unresolved complaints and adverse publicity.				
Lead Committee	**Quality and Safety**			**Risk Appetite**	Minimal	
Lead Director	**CN**			**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**24.01.23**			**Linked risks**	-	
Date of last review	**11.10.23**			**Risk treatment**	Treat	

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3676)**	• Complaints SOP in place with defined roles, processes and timescales. • How to respond to a complaint training is being delivered with further sessions planned for November. • Training time has been reduced from 6.5 to 4 hours. • Patient relations team provide support and guidance.	• There are currently no backlogs. • Requirement to source venues to run further training courses.	**2nd Line:** • Quality & Safety Committee August 2023	• No gaps currently identified.	1. Further training for staff to be arranged.	March 2024 CN

People

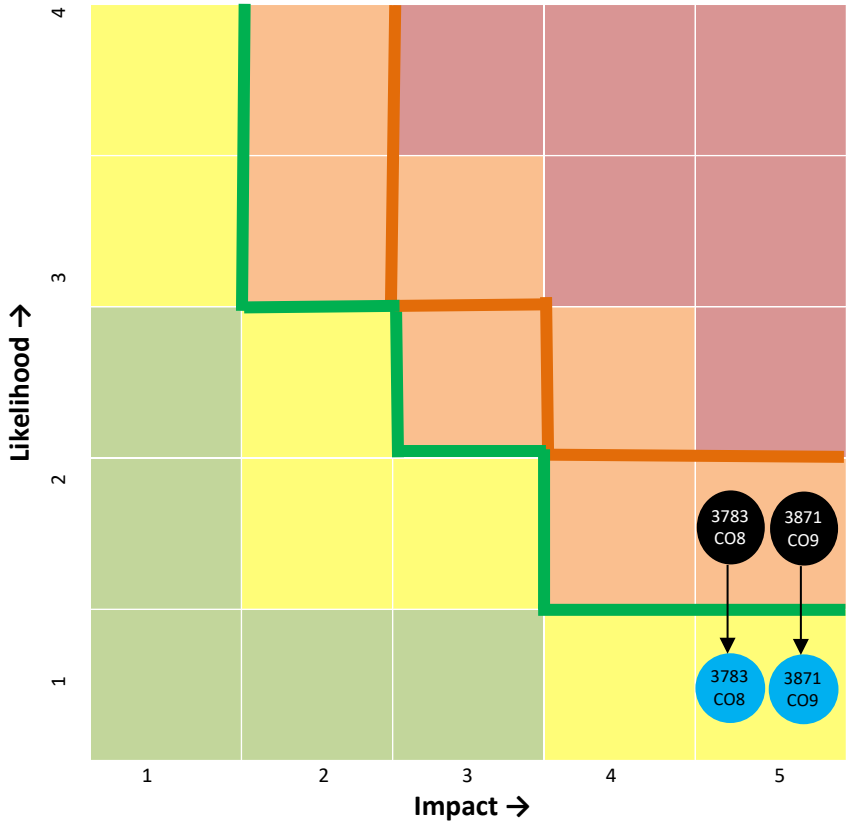
To ensure wellbeing and motivation at work and to minimise workplace stress.

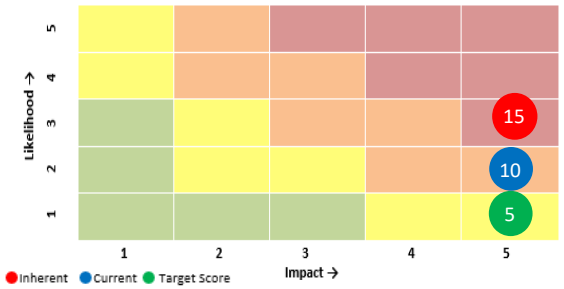
Monitoring: People Committee

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

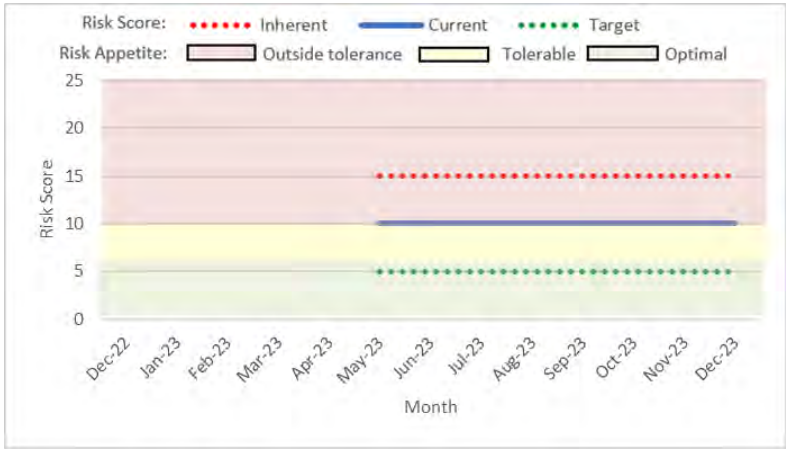
Ref.	Purpose of the objective	Scope and focus of objective
CO8	To enable better access to the right people, in the right place, in the right number, at the right time.	As part of our workforce sustainability agenda we will deliver the HR fundamentals brilliantly to: ✓ Reduce sickness absence from 6.58%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

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

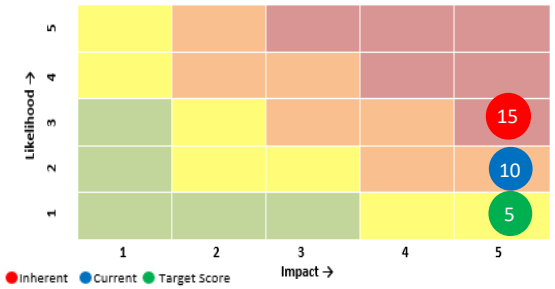


Corporate Objective: CO8 To enable better access to the right people, in the right place, in the right number, at the right time				**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 5 : Workforce Sustainability**			
	Risk Statement:	There is a risk that we may not deliver the workforce sustainability agenda objective, due to issues with staff retention and keeping colleagues well in work, that may result in an increase in sickness absence, vacancies, time to hire challenges and an increase in employee relations cases.			
Lead Committee	**People**		**Risk Appetite**	Cautious	
Lead Director	**CPO**		**Risk category**	Staff Capacity & Capability, Staff Engagement Staff Wellbeing.	
Date risk opened	**19.06.23**		**Linked risks**	3572, 3229, 3227	
Date of last review	**14.11.23**		**Risk treatment**	Treat / Tolerate	

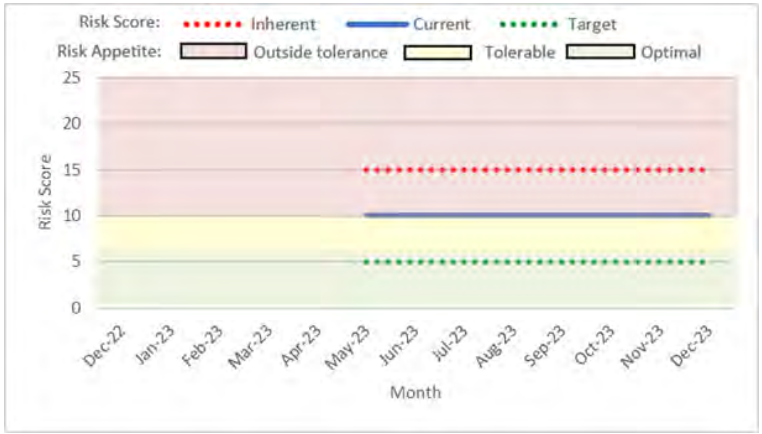
Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3783** Linked risks to corporate risk register: **ID 3572** Industrial action **ID 3229** Staff absence wellbeing **ID 3227** Maintaining safe staffing levels	• Workforce planning 2023/24 • Empactis relaunch • Civility Programme (just & learning culture) • People Dashboard refresh • Newton Europe Commission (pending) • National Staff Survey (October 2023 go live) • Launched start of year events – new appraisal season and route plan appraisal approach.	• Lead for people dashboard refresh and reporting mechanisms • Workforce Planning is currently based round Operational Planning round and doesn't provide future strategic overview of workforce for the future	**2nd Line:** • The sustainable workforce programme aims to implement robust trust wide workforce planning methodology and plans. • Empactis relaunch reports to Transformation Board monthly under sustainable workforce workstream • Civility Programme reports to Our Family, Our Future, Our Focus under the culture and leadership workstream. • Newton Europe Commission updates via ETM • Our Family, Our Future, Our Focus oversees National Staff Survey. • First start of year event 28th June. Assurance reporting regarding compliance and quality improvements will be to People Committee.	• Turnover reporting identifies that circa 25% of leavers, leave within the first 12 months of employment.	1. Identify lead for people dashboard refresh and reporting mechanisms. 2. Deep dive work to be undertaken for those leaving within first 12 months and reasons for leaving, with associated action plan to be developed. 3. Development of a People Strategy to address overall workforce sustainability risk.	1. September 2023 - CPO 2. October 2023 – D/CPO & AD for SE & W 3. December 2023 - CPO

Corporate Objective: CO9 To ensure we improve experience at work by actively listening to our people and turning into positive action.			**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 6 : Staff Engagement**		
	Risk Statement:	There is a risk that we may not deliver the cultural development agenda objective, due to a lack of sufficient workforce awareness about EDI and we do not have substantive Workforce EDI resource, which may result in failure to deliver our strategy and statutory duties under the Equality Act.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.
Date risk opened	**02.11.23**		**Linked risks**	-
Date of last review	**14.11.23**		**Risk treatment**	Treat / Tolerate

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3871**	• Actions contained within the 3 pillars of OFOFOF – Wellbeing; Culture & Leadership and associated governance framework • National Staff Survey • New Appraisal Framework "My Route Planner" • Understanding of data in WRES, WDES and Gender Pay Gap Report • NHSE EDI High Impact Improvement Targets	• EDI resource temporarily funded until November 2024. • People Strategy, which will align and coordinate activity under development. • EDI Steering Group not yet established.	• OFOFOF meetings established and continue to drive forward positive activity. • Culture & Engagement Programme launched. • Turnover of staff, and staff engagement actively monitored at Divisional Assurance and RAPID meetings. • Recruitment and retention standing agenda item for People Committee to enable high level monitoring and assurance. • WWL achieved highest Staff Engagement score in 2022 National Staff Survey, and highest response rate in Greater Manchester. • Staff network established.	• Data linked to protected characteristics signifies lower staff experience for black, Asian and minority ethnic staff and Disabled staff. • Further information required to support organisation review NHSE EDI Objectives.	1. Develop business case for substantive EDI funding 2. Establish EDI Steering Group to allow for effective monitoring of achievement of EDI Strategy. 3. Develop WRES Action Plan with engagement of FAME Network 4. Develop WDES Action Plan with engagement of Disability Staff Network. 5. Board Development Workshop focussing on EDI 6. Implementation of EDI High Impact Objectives.	1. August 2024 (AD SE & W) 2. January 2024 (CPO) 3. October 2023 (EDI Lead) 4. October 2023 (EDI Lead) 5. January 2024 (CPO) 6. January 2024 (CPO, EDI Lead)

Performance

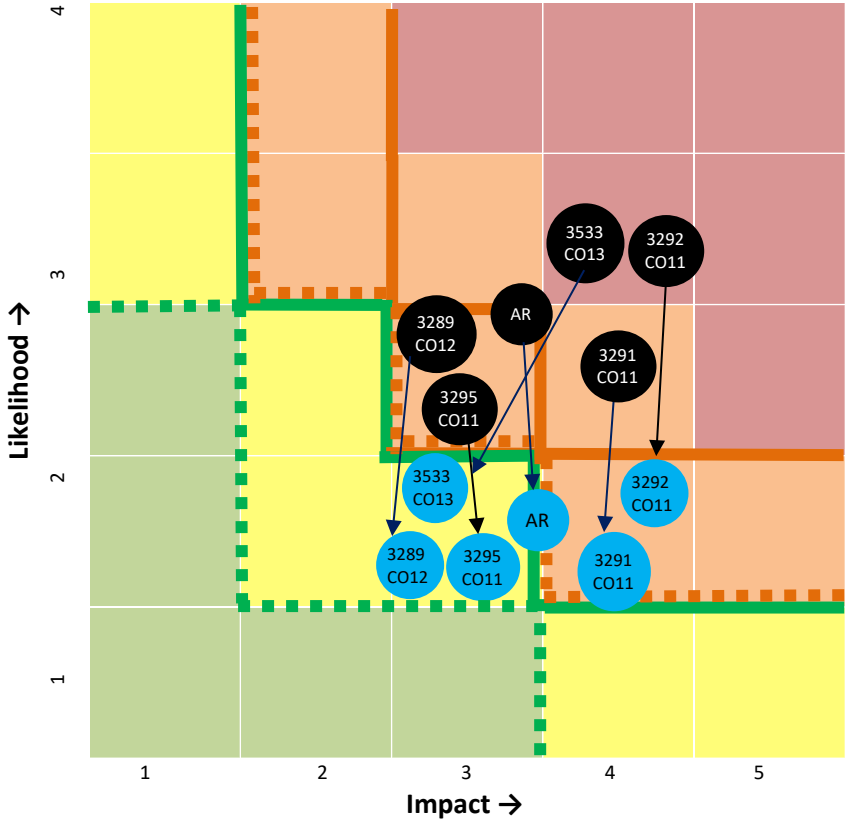
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

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

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



Risk Appetite

Optimal Risk Range (Financial Duties: Minimal ≤ 3)

(Performance: Cautious ≤ 6)

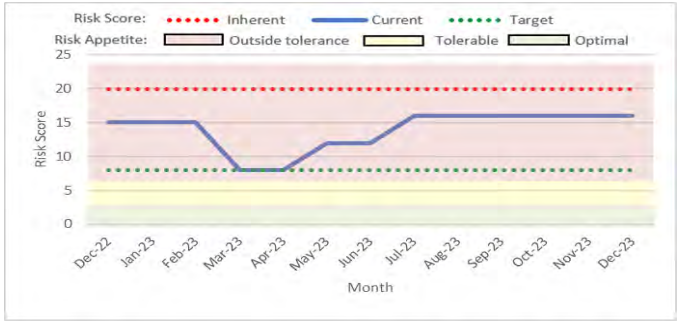
Tolerable Risk Range (Financial Duties: Minimal 4-6)

(Performance: Cautious 8-10)

AR *Average risk score for F&P strategic priority*

Corporate Objective: **C11** Deliver our financial plan, providing value for money services				**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 7: Financial Performance: Failure to meet the agreed I&E position**			
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties resulting in the Trust receiving significantly less income than the previous financial year.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal	
Lead Director	**CFO**		**Risk category**	Financial Duties	
Date risk opened	**19.10.21**		**Linked risks**	-	
Date of last review	**21.11.23**		**Risk treatment**	Treat	

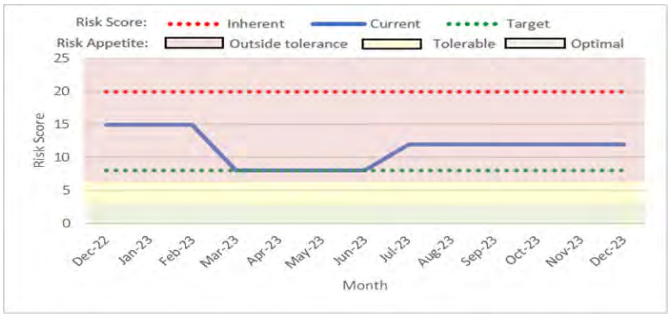
Risk Score Timeline



Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
Threat: **(ID 3292)**	• Final plan signed off by Board and submitted to NHSEI – 4th May 23. • Work is ongoing with NHSE GM ICB and locality to manage the £11.9m funding gap from the withdrawal of locality support. Shortlist of options identified, although in year gap remains. • All divisions accepted budgets in April 23. • CIP target agreed with programme for delivery and actions. • Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity and operational and inflationary pressures (Ext.). • Robust forecasting including scenario planning for worst, most likely and best case. • Executive oversight and challenge of CIP & Financial performance through RAPID, Transformation Board & Divisional Assurance Meeting. • Pay control group established with scrutiny and rigour over agency spend in line with national agency controls. • Stringent business case criteria to ensure only business critical investments are approved. • Escalation meeting held with NHSE in April 23 to review financial plan. • Full review of financial position by locality partners. • RAPID meetings held for all divisions monthly in Q1 and as per RAPID metrics in Q2. • Escalation reduction plan agreed through ETM. • PWC concluded diagnostic into the drivers of financial and operational performance and key actions being progressed. • GM standardised financial controls has been shared by GM and are being implemented across WWL. • NHSE has authorised additional external support to GM ICS to support in rapidly improving the financial position across the system (Ext). • GM ICS appointed a Turnaround Director to oversee and support the turnaround, including supporting monthly Finance Performance Review Meetings (FPRM). • ERF baseline adjustment of 2% to reflect industrial action in April. • National funding announced to cover the costs of industrial action from June to October 23 and further ERF baseline adjustment of 1% for GM (Ext). • Executive groups established focused on grip and control and medium term financial sustainability.	• System and locality financial support withdrawn. • Current plans to mitigate do not cover the gap currently. • No additional funding available for NRTR, additional beds and escalation costs. • Awaiting confirmation on WWL allocation of additional funding to cover increased costs associated with industrial action. • No medium to long term resource confirmation or financial planning. • Limited guidance on ERF arrangements.	**1st Line:** Monthly RAPID meetings for applicable divisions. **2nd Line:** Finance & Performance Committee Nov 23.	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Locality discussions ongoing around reducing escalation costs over Q3. 2. GM System PMO established to support delivery of I&E position (Ext).	Dec 23/ CFO Mar 24/ CFO

Corporate Objective: C11 Deliver our financial plan, providing value for money services				**Overall Assurance level**	**High**
Principal risk	**Risk Title:**	**PR 8: Financial Sustainability: Efficiency targets & Balance Sheet**			
	Risk Statement:	There is a risk that efficiency targets will not be achieved, resulting in a significant overspend and that there is insufficient balance sheet flexibility, including cash balances, to mitigate financial problems.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal	
Lead Director	**CFO**		**Risk category**	Financial Duties	
Date risk opened	**19.10.21**		**Linked risks**	-	
Date of last review	**21.11.23**		**Risk treatment**	Treat	

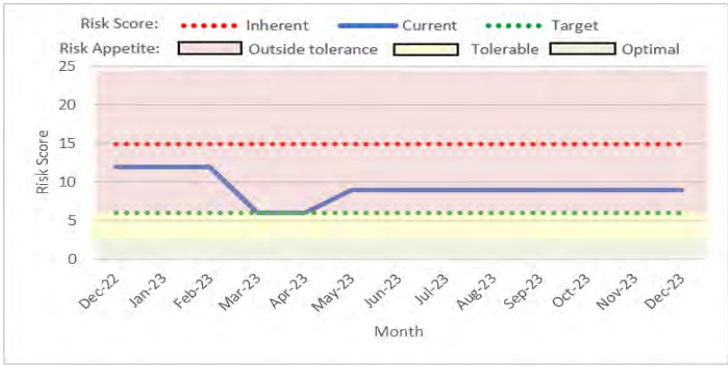
Risk Score Timeline



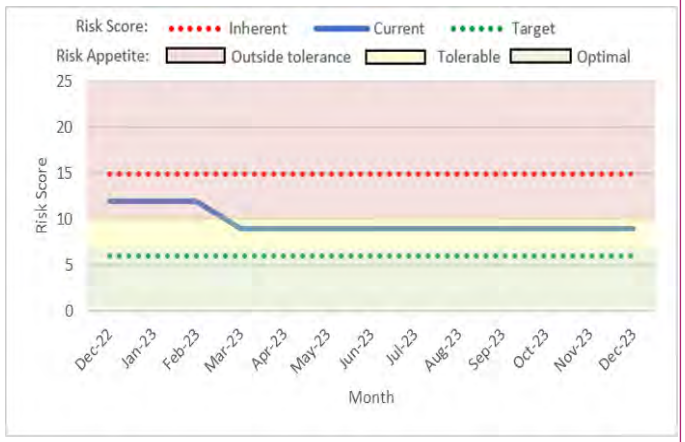
Opportunity / Threat	Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3291)**	• Robust CIP divisional delivery approach and governance. • Work is ongoing to identify a bridge for the locality funding included in CIP. • Monitored via Divisional Assurance Meetings, with additional escalation through RAPID if Divisional delivery is off plan. • Further oversight at Executive Team, Transformation Board, F&P Committee and Board of Directors. • Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext). • Transformation Board input & oversight of strategic programmes. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT. • RAPID recovery metrics include recurrent CIP delivery. • Release of potential balance sheet flexibility included within 2023/24 financial plan. • Enhanced balance sheet reporting including cash metrics to SFT and within monthly finance report. • Clinical leadership established reviewing benchmarking opportunities for quality improvements through model hospital and GIRFT and reported through CAB, ETM and Divisional Assurance Meetings. • GM Cash management group being established in GM with WWL representation (Ext). • Internal cash management group established and strategy being developed. • Cash forecast reviewed with no support required in Q3. • Cash position assessment, risks and mechanisms for accessing cash support shared with Finance and Performance Committee (July, Sept and Nov 23). • Current and forecast cash position and an update on the development of the cash and treasury management strategy and action plan shared with Finance and Performance Committee (Sept 23). • GM cash planning ongoing as part of Trust Provider Collaborative (Ext). • GM ICB have agreed to make contract payments on 1st of month (rather than 15th) to support cash management. • PWC undertaken forensic review of Statement of Financial Position (SoFP) and concluded that remaining balance sheet flexibility is limited (Ext).	• Limited mechanisms to facilitate delivery of system wide savings. • GM system efficiency requirement with no plan. • Unidentified CIP 6% in year. • GM Cash Management Strategy not yet developed (Ext).	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee Nov 2023	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Monthly updates on CIP presented to Executive Team, with regular updates to Divisional Teams. 2. GM PMO established leading on system efficiency target £130m (Ext). 3. Cash management strategy developed.	Throughout 2023/24 CFO/DCEO Throughout 2023/24 CFO/DCEO Q3 CFO

Corporate Objective: C11 Deliver our financial plan, providing value for money services				**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 9: Estates Strategy - Capital Funding**			
	Risk Statement:	There is a risk that there is inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal	
Lead Director	**CFO**		**Risk category**	Financial Duties	
Date risk opened	**19.10.21**		**Linked risks**	-	
Date of last review	**21.11.23**		**Risk treatment**	Treat	

Risk Score Timeline



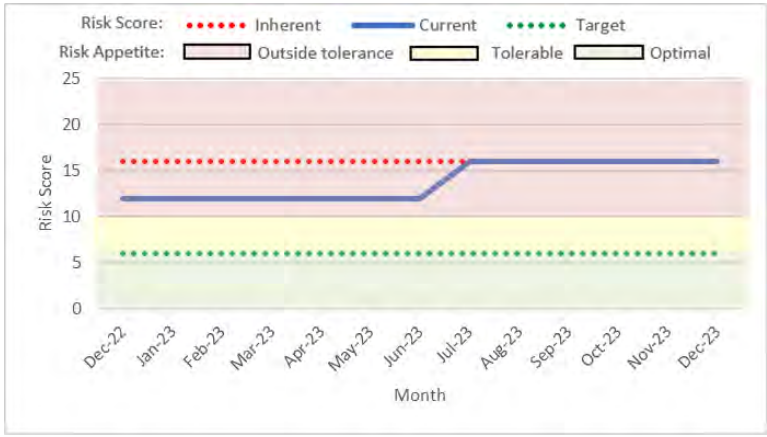
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3295)**	• Lobbying via Greater Manchester (Ext). • Capital Priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified within plan. • Reprioritisation of additional capital schemes to ensure the capital programme is reflective of organisational priorities (Sep 2023 ETM/F&P). • 3 year capital allocations available to inform more longer term system planning. • Strategic capital group established with oversight of full capital programme. • Operational capital group established to manage the detailed programme. • Attendance at GM capital leads group (Ext). • Programme Boards established for major capital schemes. • Work ongoing to bid for additional PDC funding. • Proportionate reduction accepted via majority of GM providers with a proposal to increase the contingency beyond allowable value to ensure GM CDEL plans are within envelope (excluding pre-committed bespoke transaction impacting NCA and MFT £40m). • Accelerated timescale for endoscopy required to secure national PDC funding – approved at national panel. • Theatre 11 PDC funding approved at national panel (July 23) in line with WWL capital strategy. • Exploring options with commercial partners to facilitate capital investments outside of CDEL in line with strategy. • Identified opportunities to lease rather than purchase in line with IFRS 16. • £10m national support (of the £40m required) for the GM bespoke transaction has been agreed.	• Impact of inflation in terms of project costs and timescales. • GM overcommitment on CDEL plan with agreement not yet reached with NHSE – potential further reductions to CDEL limit expected, including for IFRS16 leases. • Cash for capital investments identified is subject to achievement of I&E position including CIP delivery.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - Nov 2023	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring of Capital spend in line with trajectory. 2. Development of capital reporting through the refreshed DFM App. 3. Discussions ongoing with national team re. additional capital funding to support the £30m GM bespoke transaction and contingency (Ext). 4. Discussions ongoing across GM in relation to the remaining overcommitment of £18m.	Throughout 2023 CFO Q4 2023/24 CFO Q4 CFO Q3 CFO

Corporate Objective: **CO12** To minimise harm to patients through delivery of our elective recovery plan					**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 10: Elective services**			Risk Score Timeline	
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to industrial action, demand management schemes not resulting in a reduction in demand and insufficient diagnostic capacity to deliver elective waiting times, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.				
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious		
Lead Director	**COO**		**Risk category**	Performance Targets		
Date risk opened	**19.10.21**		**Linked risks**	3572, 3718		
Date of last review	**20.11.23**		**Risk treatment**	Treat		

Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: (ID 3289) Linked risks on corporate risk register: **3572** Industrial action **3718** Elective Recovery	• Patients waiting over 78 weeks who were impacted by the e-referral drop off issue have now been booked, except for patient choice. • NHSE have reduced the ERF target from the original target of 103% of 19/20 value of weighted activity to 100% for WWL to take into account the activity lost during the industrial action in year. • Divisions have re-evaluated activity plans due to National choose and book system and capacity reducing from the Junior Doctors and Consultants industrial action. • On track to eliminate waits over 65 weeks except for Gynaecology and Community Paediatric patients. • Continue to exceed the trajectory for the cancer faster diagnosis standard. • Implementation of Community Diagnostic Centres which will provide more capacity without waiting list initiatives. • Monitor through divisional assurance meetings with clear escalation protocols to exec team meetings and F&P Committee - developed into an app. • Transformation Plan - elective productivity and capacity aims to increase diagnostics and support delivery of electives and develop elective capacity. • Providing mutual support from GM and region for high volume high complexity work.	• Elective activity below planned levels year to date primarily attributed to lost activity due to industrial action. • No new dates for Industrial action announced, but no resolution provided. • Demand for patients on cancer pathways exceeds capacity and impacts on delivery of non-cancer elective work. • Mutual aid required from GM for Gynaecology and Community Paediatric patients. • Diagnostic capacity insufficient to deliver elective waiting times in some modalities. • Follow up waiting list is increasing. • Further work is required on DNAs linked to the paper on deprivation. • Increase productivity to meet organisational targets	**2nd Line:** • Integrated performance report through Finance & Performance Committee – Nov 2023	•No gaps in assurance currently identified.	1. Implementation of Transformation Programme 2. Funding from national team and reprofiling of activity plan. 3. Request for mutual aid from GM for Gynaecology and Community Paediatric patients.	March 2024 COO March 2024 COO March 2024 COO

Corporate Objective: CO13 Improve the responsiveness of urgent and emergency care				**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 11: Urgent and Emergency Care**			
	Risk Statement:	There is a risk to urgent and emergency care delivery as we are consistently operating above 92% occupancy levels, due to insufficient capacity and ongoing industrial action, resulting in lack of capacity, longer waits, delayed ambulances, no right to reside patients, reduced patient flow and more scrutiny through NHS England.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious	
Lead Director	**COO**		**Risk category**	Performance Targets	
Date risk opened	**05.09.22**		**Linked risks**	3423	
Date of last review	**20.11.23**		**Risk treatment**	Treat	

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3533)** Linked risk on corporate risk register: **3423** ED – Increase in attendances and insufficient patient flow	• Emergency Care Intensive Support Team (ECIST) programme of works commenced on 1st October 2023 for 4 months to support the existing hospital transformation programme. • Newton Europe working with Better Care Fund to support the Director of Integration with the Home First and Integration programme. • A&E performance at month 7 is at risk given ongoing pressures. • Delay in ambulance handovers within 60 minutes continues to improve. • Hospital Discharge and Flow Programme led by COO. • The urgent and emergency care transformation board supports system wide change. • Incident response team in place to manage industrial action risk.	• Insufficient capacity with 98.6% occupancy rate. • Corridor care • 12 hour waits are currently increasing. • Number of no rights to reside patients is reducing. • Work required further upstream regarding higher acuity of patients in borough.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – Nov 2023	•No gaps in assurance currently identified.	1. Work closely with colleagues in Wigan locality to progress WWL Transformation Plan and Hospital Discharge and flow programme.	March 2024 COO

Partnerships

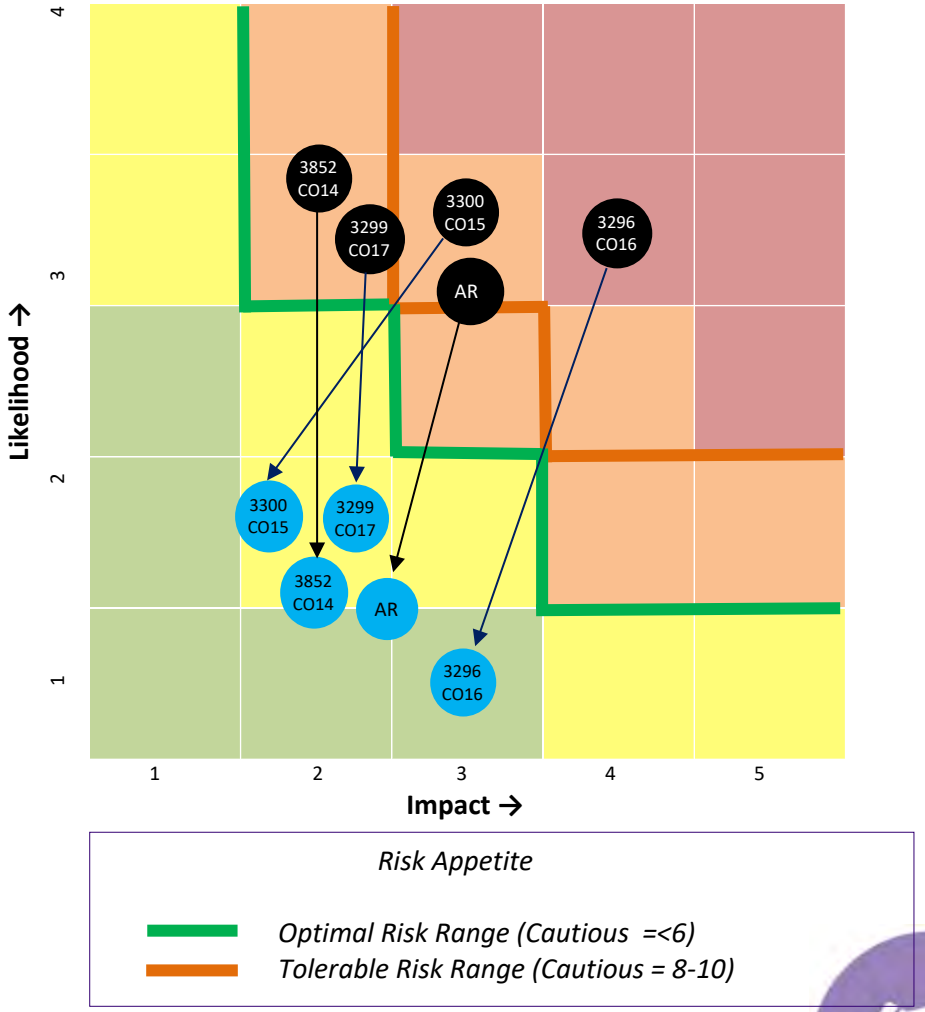
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

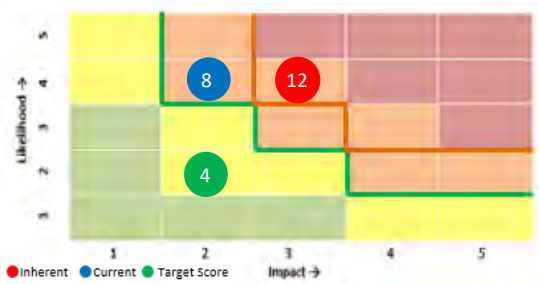
Monitoring: Board of Directors

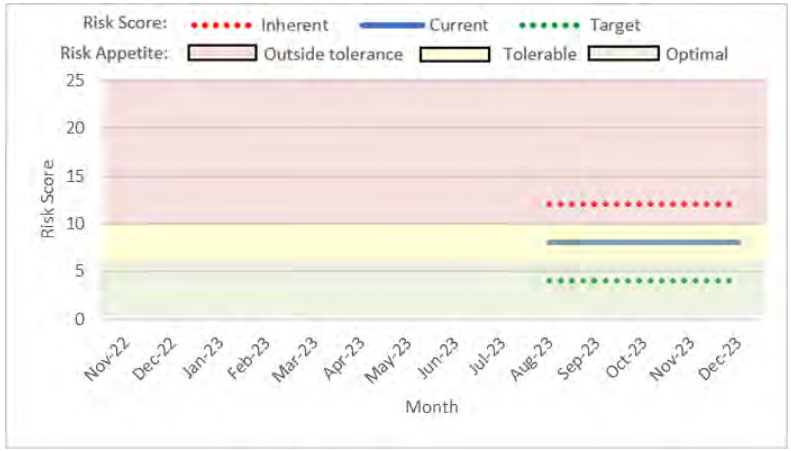
The following objectives are aligned to the **partnerships** strategic priority:

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

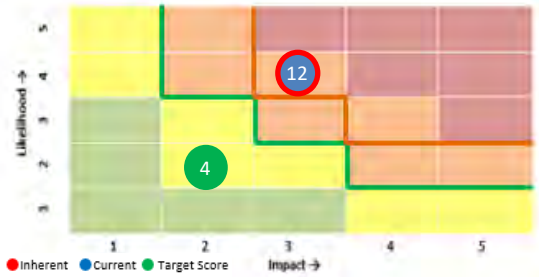
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:

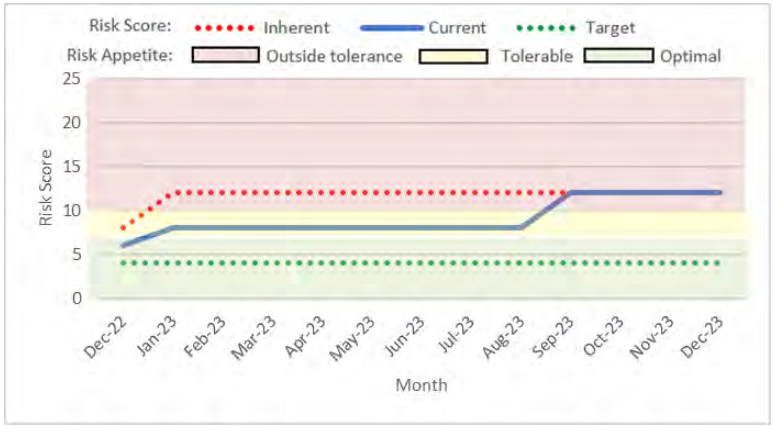


Corporate Objective: **CO14** To improve the health and wellbeing of the population we serve					**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 12: Supporting widening access to employment for local residents**			Risk Score Timeline	
	Risk Statement:	There is a risk that access to funding for support initiatives which support widening access to employment for local residents is less certain, due to pressures on the Trust's financial position, which may impact on delivery of the objective.				
Lead Committee	**Board of Directors**		**Risk Appetite**	Cautious		
Lead Director	**DSP**		**Risk category**	Strategy		
Date risk opened	**25.09.23**		**Linked risks**	-		
Date of last review	**24.11.23**		**Risk treatment**	Treat		

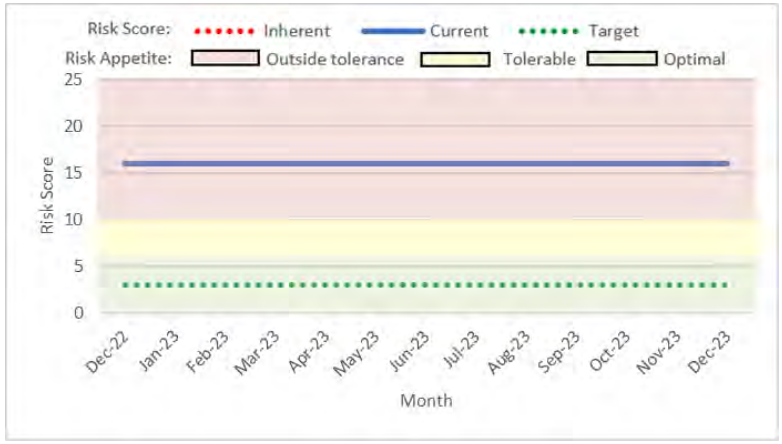


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3852)**	• Progress reviewed through Anchor Institution Steering Group.	•Recurrent funding to support ongoing development and delivery of widening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

Corporate Objective: **CO15** To develop effective partnerships within the new statutory environment					**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 13: Partnership working - CCG changes**			Risk Score Timeline	
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.				
Lead Committee	**Board of Directors**		**Risk Appetite**	Cautious		
Lead Director	**DSP**		**Risk category**	Strategy		
Date risk opened	**19.10.21**		**Linked risks**	-		
Date of last review	**24.11.23**		**Risk treatment**	Treat		

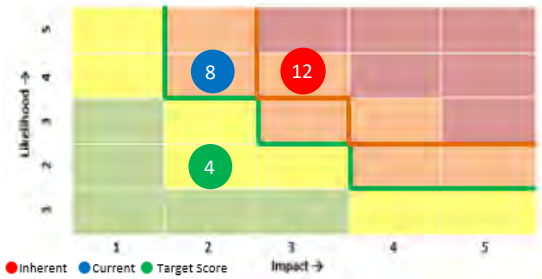


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3300)**	• Locality meeting structures in place to support lasting corporate knowledge.	Despite bringing people from the ICB and other system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

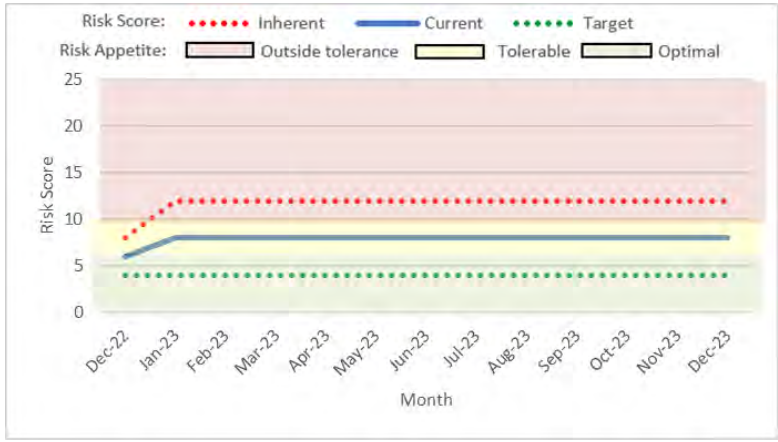
Corporate Objective: C16 Progress towards becoming a Net Zero healthcare provider					**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 14: Estate Strategy - net carbon zero requirements**			Risk Score Timeline	
	Risk Statement:	There is a risk that the Trust will not meet its net zero commitments and Climate Change will have an impact on the Trust delivering services, that cannot be mitigated.				
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious		
Lead Director	**DSP**		**Risk category**	Sustainability /Net Zero		
Date risk opened	**19.10.21**		**Linked risks**	-		
Date of last review	**19.09.23**		**Risk treatment**	Treat		

Strategic Opportunity /Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3296)**	• Sustainability Manager in post. • Band 7 Energy Manager approved. • Climate Change Adaptation Plan is in development. • Heat Decarbonisation Plan has been approved for funding at ETM. • Prioritised investment plan, Net Zero Strategy and Green Plan have been produced to outline how the trust will address its impact on climate change. • Net Zero and sustainability e-learning programme rolled out. • Governance structures set up to address divisional sustainability issues. • Sustainability and Net zero included in corporate objectives process for 2023-24.	• Recurrent baseline emissions assessment (funded for 2019-2023) • Climate Change Adaptation Plan (in development) • Sustainable Travel Plan (in development) • Sustainability Impact Assessment (developed not integrated into QIA) • Capital funds required to fund adaptation measures. • Sustainability Assurance Framework • Lack of functioning sub meters to monitor energy use	• Bimonthly Finance & Performance Committee AAA reporting • Bimonthly Greener WWL Steering Group • Annual Sustainability report • Annual Carbon Footprint • Response plans for business continuity, critical and major incidents • Annual self-assessment against the NHS EPRR framework	• EPRR Self assessments reflecting climate change risk assessments (in development)	1. Climate change adaptation plan to be produced, approved, and implemented. 2. Complete carbon footprint assessment annually. 3. Map annual progress towards net zero against net zero trajectory 4. Net Zero Investment Plan and Climate Change Adaptation Plan to be integrated into Capital planning. 5. Climate Change Adaptation to be incorporated into Estates Strategy and site masterplans. 6. Heat Decarbonisation strategy to be integrated into Estates Strategy and site masterplans. 7. Sustainable Travel Plan to be produced and incorporated into Estates strategy and site masterplans. 8. Incorporate Sustainability Impact Assessment into Quality Improvement Assessment 9. Further develop governance structures to ensure all areas captured.	March 2024 / DSP

Corporate Objective: **CO17** To increase research capacity and capability at WWL in collaboration with EHU with a plan to make progress towards our ambition to be a University Teaching Hospital	**Overall Assurance level**	**Medium**

Principal risk	**Risk Title:**	**PR 15: University Teaching Hospital - University Hospital Association criteria**		
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to uncertainty regarding achieving the required core number of university Principal Investigators, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.		
Lead Committee	**Board of Directors**		**Risk Appetite**	Cautious
Lead Director	**MD**		**Risk category**	Strategy
Date risk opened	**19.10.21**		**Linked risks**	-
Date of last review	**24.11.23**		**Risk treatment**	Treat

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3299)**	• Project documentation including action log in place. • Research Committee assurance (Sept23) • 5 colleagues confirmed as meeting the substantive employment to EHU.	•A core number of university Principal Investigators. There must be a minimum of 6% of the consultant workforce (for WWL likely to be between 9 and 12 PIs) with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. •We are achieving the criteria of a 2 year average of £200k/annum Research Capacity Funding awarded by end of March 2026. (An extension grant has been awarded to the NIHR funded SOFF trial which raises the NIHR grant income profile over the next 2 years.)	**2nd Line:** • Board of Directors – Oct 2023	• None currently identified.	The key actions for increasing University employed research Principal Investigators. The Research Finance Investment Group will meet from mid-November following observation of the first 6 months income/expenditure run rate of 2023-24 financial year, according to the Research Financial Investment Strategy and incorporating the principles within the Joint Clinical Academic Workforce (JCAW) paper. Current status: ✓ 1 substantive EHU clinician with Honorary Consultant status in WWL, exists since October 2021 ✓ Consultant Diabetologist appointed at EHU (HCC WWL). Dec23 ✓ 2 substantive EHU Clinical Academics offered Honorary Clinical Contracts with WWL (n progress) ✓ The CD for Research offered a substantive appointment at EHU with HCC at WWL (in progress) ✓ CI for Rapsody in discussion for transfer to EHU.	AR/AW March 2024

University Hospital Status
Aims, Outcomes and Measures

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Programme Aim: One of WWL's three to five-year strategic corporate objectives is to become a University Teaching Hospital. The University Hospital Association (UHA) is the body that awards University Hospital Status and there are a list of criteria that an organisation must meet to achieve University Hospital Status. A project group, set up in 2021, made up of key members of WWL's board, Research and Education Teams and Edge Hill University (EHU) will work towards meeting the criteria and collate evidence to support WWL's application to become a University Teaching Hospital in 2026.

Outcome: The criteria set out by the UHA have all been met and evidenced allowing us to successfully apply for University Hospital Status in March 2026.

Measure 1: Achieve a minimum of 6% of the consultant workforce 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. **For WWL that number is 14.**

Measure 2: Achieve an average Research Capability Funding(RCF) allocation of at least £200k average p.a. over the previous two years.

Measure 3: Suite of evidence that shows we have met the full criteria list set out by UHA.

(Will be measured from March 2024 when new Education Manager is in post).

University Hospital Status
Delivery milestones (next 12 months)

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Key: On Target, Behind Schedule, Stopped, live issue, complete

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24

UHG Project Plan

- Agreed research strategy between WWL and EHU.
- Contact successful applicants to better understand the application progress and report back to the group.
- Update wording on contracts to clarify arrangements to return to WWL once EHI contract ceases .
- Arrange for Trust's CEO to attend formal meetings with the Faculty Dean's Advisory Committee.
- Collate evidence to show where we have met UHA criteria (those that are green or amber on the tracker).
- Make progress towards achieving criterion 1ci "A core number of university principal investigators. There must be a minimum of 6% of the consultant workforce 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" .(Six by March 2024).
- Make progress towards achieving criterion 1ciii "An average Research Capability Funding allocation of at least £200k average p.a. over the previous two years." (target to be met 2025/2026).
- Monitor progress via University Hospital Group meetings every two months.

University Hospital Status
Measurement Dashboard

Performance

Measure 1: Achieve a minimum of 6% of the consultant workforce with substantive contracts of employment with EHU

Updated 13-11-2023

Number of Consultants WWL (wte)	Target 6% Clinical Academics	In progress	Achieved	Target Year
223.66	14	4	2	2025/26

1		1	2021/22
3	4		2022/23
4	4	1	2023/24
6			2024/25
12			2025/26

6 clinical academic appointments by the end of 2023/24 (March):

2 EHU substantive academics are being offered WWL Honorary Contracts

1 EHU clinical academics (Education) already employed in 2021/22

1 EHU new clinical academic (Education) to be employed in December23

2 WWL consultant is being offered employment with EHU, then provide a HCC with WWL.

Measure 2: Achievement of £200k RCF over previous two years

Average RCF over 3 years (2023-2026)

202,653

Average RCF over 2 years (2024-2026)

203,314

Funding should be achieved by 2026 allowing application for university hospital status to be submitted in April 2026.

If RESET funding continues, we may be able to bring this forward to April 2025.

University Hospital Status
AAA Report

	Issue	Action
Advise Areas of on-going monitoring and any new developments	Challenge around achieving a minimum of 6% of the consultant workforce with substantive contracts of employment with EHU with an honorary contract with the Trust. This equates to 14 consultants in total.	• Contract wording is being changed to provide assurance to Consultants that there is the option to return to their substantive organisation (in this case WWL) once contract ends with EHU, to make applying/taking these contracts more attractive. • A consultant tracker will be updated each month to track progress against target and will be reviewed at the University Hospital Group Meetings. • Research Finance Investment group set up November 2023 which will review availability of funding and ability to invest in future recruitment of consultant research posts. • Aiming for six consultants by March 2024.
	Challenge in achieving of £200k RCF over previous two years.	• Work is ongoing to secure research funding that meets RCF criteria.
Assure Areas of assurance	Joint research strategy between WWL and EHU.	• This is in progress and should be complete by February 2024.
	University Hospital Status - Application process.	• Work is ongoing to ensure we fully understand how to apply and what a successful application looks like – this is on target to be completed by February2024. • Evidence will be gathered from March 2024 to show where we have met the UHA's criteria.
	Requirement of Trust CEO to attend formal meetings with the Faculty Dean's Advisory Committee.	• When the new CEO for WWL is in post EHU will work with us to identify an appropriate meeting for the new CEO to attend – this should be completed by the end of March 2024.

University Hospital Status

Appendix 1: UHA Criteria – RAG rated for latest position

Criteria Checklist for University Hospital Status

1. In Terms of Research
a. The Trust shall have in place with the University a Memorandum of Understanding on Joint Working for Effective Research Governance; it will actively investigate joint Research Offices to foster more efficient working;
b. The Trust shall demonstrate that it is working collaboratively with the university to develop an agreed joint research strategy;
c. There shall be evidence of significant research activity within the Trust, much of which will involve collaboration with university staff. This will include:
i. A core number of university principal investigators. There must be a minimum of 6% of the consultant workforce with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question.
ii. The research output to be REF returnable;
iii. For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.
Further details of RCF allocations can be found here
2. The Faculty and University Hospital shall maintain strategic links and a close working relationship, which shall include:
1. University representation on the Trust's Local Awards Committee for considering nominations for Clinical Excellence Awards;
2. University representation on the Trust's Advisory Appointments Committees for Consultant posts;
3. Board membership of a non-Executive Director from the Faculty;
4. The Trust's Chief Executive attending formal meetings with the Faculty Dean's Advisory Committee.
3.The Trust shall provide for the University practice placements for undergraduate medical students and for students from at least one other healthcare profession (dentistry, nursing, or one or more of the allied health professions).
4. The Trust shall provide for undergraduate students appropriate library facilities, IT facilities with Internet access, and teaching facilities. There may be integrated provision for postgraduate and undergraduate education.
5.The Trust shall have a Lead Placement Contact approved by the Faculty of Medicine, to be responsible for undergraduate education, for each of the professions for which it provides placements.
6.The Trust must be able to demonstrate to the University that it promotes a culture of excellence in medical education and provides high quality clinical training. This will require evidence of the following:
a. Flexibility:
i. Flexibility in light of any changing needs of the University in respect of undergraduate education;
b. Appropriate human resources:
i. Ability on part of Trust staff to deliver the curriculum and assessments determined by the university;
ii. Provision by Trust staff of appropriate student supervision as agreed with the University. This may involve staff from a range of professions and grades;
iii. The participation by core Trust teaching staff in appropriate training;
c. A collaborative working partnership:
i. The availability of Trust staff to provide teaching and supervision and to respond to student queries and problems in a timely manner;
ii. Collaboration between Trust staff and University staff, for example, regarding curriculum development and ED&I arrangements;
iii. Full cooperation by Trust staff in monitoring and evaluating the quality of education provision, and in facilitating student evaluation;
iv. The readiness of Trust staff to respond to feedback from students and the Faculty;
v. Evidence of action by trust on Faculty quality assurance measures;
d. Resources:
i. Provision of appropriate support staff, equipment and accommodation for Lead Placement Contracts;
ii. Provision for students of access to lockers and appropriate facilitates;
e. For Trusts in England, evidence of compliance with:
i. HEE's Education Contract and the schedule on the Tri-Partite Agreement.

Title of report:	Bi-annual Staffing Review October 2023
Presented to:	Board
On:	06.12.23
Presented by:	Rabina Tindale, Chief Nurse
Prepared by:	Deputy Chief Nurse and Divisional Directors of Nursing and Allied Health Professionals
Contact details:	T: 01942 82 2176 E: allison.luxon@wwl.nhs.uk

Executive summary

The purpose of this report is to provide the Board assurance of the ongoing monitoring and review of staffing establishments and to advise the Board members of any recommended change to these establishments. This report is a mandated requirement of NHS England.

This report is produced in addition to the quarterly safe staffing assurance reports as mandated by NHSE.

The report makes the following recommendations for consideration.

- It is evident from the information provided within the report that whilst the Trust does not meet the minimum national requirements for the skill mix, it is believed the patient profile can be appropriately cared for with the current skill mix of staff. This will need to be reconsidered once the number of patients who are medically optimised for discharge decreases to ensure the skill mix is appropriate for inpatient areas and to assure ourselves that we have sufficient registered staff to appropriately direct and provide oversight of patient care and quality and be responsive to operational pressures.
- It is recommended that the purpose of CAU and the new operating model as a frailty unit be established at pace, a new staffing review to be undertaken to support the new model before any additional funding is agreed.
- Langtree, It is recommended the organisation completes the transformation work being undertaken to improve flow, to allow the support from ECIST and Newton Europe to demonstrate the expected results in ensuring patients are cared for in the right place, reducing medical outliers and improving discharge, following this a further staffing review needs to be undertaken to determine the right model and level of funding required.
- It would be prudent to consider an investment in a pool of B2's to support the delivery of 1:1 care for 10 L4 patients 12 hours/day (27 WTE) at a cost of £934k (7 day/3 Night). These

staff would work across all areas on the acute site and would reduce the current run rate of NHSP spend. Despite work undertaken the average weekly spend currently being incurred is £40.5k/week. It is recommended that a robust plan be developed to ensure there is evidence that this would be the correct model for the organisation and that operationally it would not result in staff being aligned to individual wards and reluctant to move. Therefore this investment is not recommended at this precise stage.

- It is recommended that a review of Bryn Ward and Winstanley is undertaken to confirm the operating models and subsequent staffing levels, currently both wards still have staffing levels to support their original function, creating an over establishment.

Once the above recommendations have been acted upon and efficient operating processes in place, it is highly likely that there will be sufficient investment and sufficient staff within the organisation to meet SNCT requirements against a new staffing review.

There will need to be consideration given to funding a pool of staff for enhanced care observations in the future.

Therefore at this moment in time any additional investment in nurse staffing is not recommended.

Link to strategy

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

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

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

Risks associated with this report and proposed mitigations.

Financial implications

There is a risk to achieving the corporate objective of financial balance due to overspend on temporary staffing, until the recommendations have been acted upon and a new review be undertaken.

Legal implications

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

People implications

Future investment in the unregistered workforce provides an opportunity for the Trust to continue the ambition to be the employer of choice within the locality. Furthermore, this presents the opportunity

to further develop the workforce to engage in cross boundary working within social care and the care home sector.

Wider implications

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

Recommendation(s)

Board is requested to receive the paper for discussion of the recommendations contained within the report.

Bi Annual Nurse Staffing Review (October 2023)

1 Introduction

1.1 The purpose of this paper is to provide the Board assurance that nursing establishments are sufficient to meet the needs of the patients in our care, and to meet patient needs at times of peak demand.

1.2 This report will include reference to current funded establishments, national guidance, acuity and dependency measures and incidents of harm which have been triangulated to formulate the recommendations within this report.

1.3 This report covers adult and children's inpatient areas only, however the report will take the opportunity to call out areas that will require further consideration as we move to make our services more sustainable.

1.4 The Maternity staffing review and associated recommendations will be reported separately to the Board as per the requirements for CNST.

2 Background

2.1 Throughout 2012 and 2013[1][2][3][4][5] a series of reports were published describing the critical role of nurse staffing in the delivery of high-quality care and excellent outcomes for patients.

2.2 In 2013 it was nationally mandated that all NHS Organisations review staffing levels at least twice/year and for the findings of the review to be shared with the Trust Board and that decisions made following receipt of the report to Board be documented to provide assurance of Board level accountability and responsibility for staffing levels.

2.3 In November 2014 NHS England published 'Safer Staffing: A Guide to Care Contact Time[6]. This report outlines further requirements to provide assurance of staffing levels and the importance of the provision of nurse-to-patient direct care time.

2.4 Developing Workforce Safeguards 2018 states each Trust must demonstrate compliance with National Quality Board guidelines with respect to workforce, and for a declaration of safety in this regard to be made within the Trust Annual Governance Statement. This should be jointly signed by the Chief Nurse and the Medical Director.

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[1] NHS England (2012): *Compassion in Practice*

[2] The Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013): *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry.*

[3] Prof. Sir Bruce Keogh, NHS England (2013): *Review into the quality of care provided by 14 hospital trusts in England: overview report.*

[4] Don Berwick. Department of Health (2013): *A promise to learn, a commitment to act: improving the safety of patients in England.*

[5] Cavendish, C., Department of Health (2013): *The Cavendish Review: an independent review into healthcare assistants and support workers.*

[6] NHS England (2014): *Safer Staffing: A Guide to Care Contact Time.*

3 Methodology

3.1 Since 2011 WWL has undertaken adult nursing establishment review on a quarterly basis changing to bi-annual in line with National Guidance; March, and September utilising the Safer Nursing Care Tool™ (SNCT). This tool was developed in collaboration with the Association of United Kingdom Hospitals (AUKUH) utilising the research evidence undertaken by Keith Hurst[7]. The tool is recognised by the Quality Management Board (QMB)[8]. SNCT utilises methodology to determine the staffing required to deliver nursing care to patients within a given area dependent on actual individual patient levels of acuity and dependency. The tool also takes into consideration patient flow and nurse sensitive indicators (NSI's) in determining the appropriate level of care. Professional judgement is required to determine the skill mix of the staff employed within each area, and to assess the variability of staffing requirements which may be affected by changes in acuity and dependency levels of patients, and the environment that the patients are cared for (e.g., individual ward layout).

3.2 In January 2019 the Trust invested in SafeCare, a system that allows the measurement of the acuity and dependency needs of patients within inpatient areas to determine the hours of care required by the patient occupying the beds.

4 Safer Nursing Care Tool (SNCT)

4.1 The Trust utilises SNCT to determine the acuity and dependency of patients within our hospital. The tool incorporates agreed multipliers for adult and paediatric inpatient and assessment areas. Descriptions of the multipliers can be found at Table 1. Staff undertake assessment of the acuity and dependency needs of patients twice daily during their shift and this information, aligned with actual staffing levels on the wards, provides an indication of whether there is surplus or insufficient nursing time available to deliver care to the patients in each clinical area.

4.2 Professional judgement should be applied to the data provided by SNCT to ensure there is due consideration of environmental factors and skill mix, and triangulation quality outcomes and nurse sensitive to assist in the determination of the establishment required.

4.3 The Trust holds current licences to utilise the SNCT within adult inpatient areas, children and young people's inpatient areas, the emergency department (ED), and a Community Safe Nurse Staffing Tool (CSNCT). These latter 2 tools have not been utilised for the purposes of this report as staff training the training of staffing and collaboration with regards to data collection is being co-ordinated by Greater Manchester ICB.

4.4 When establishment reviews are undertaken additional SNCT data is collected at 1500hrs across all participating areas Monday to Friday for 20 days. This data is verified by divisional Matrons prior to submission to provide assurance with regards to the accuracy of the assessment of the patients and to prevent gaming; gaming is the term used when the needs of the patients are scored higher than required.

5 Quality Indicators

5.1 Data with respect to hours of time required based on acuity and dependency cannot be viewed in isolation but must be viewed alongside quality metrics, which provide an indication of outcomes

[7] Hurst, K (2012): *Safer Nursing Care Tool Staffing Multipliers (2012) – Method and Results*

[8] Quality Management Board (2013): *How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.*

and avoidable harms that occur within our clinical areas. These are reported monthly to the Trust Board within the performance report and also included in the safe staffing reports received quarterly by Q&S. These metrics are CDT rates, number of falls, number of pressure ulcers, number of medicine administration errors and number of red flags reported, and these are usually referred to as Nurse Sensitive Indicators (NSI's).

5.2 An increase in harms or red flags provides a trigger to senior nursing staff that staffing may either be inadequate for patient need or the skill mix may be incorrect resulting in delays/omissions of care.

6 Professional Judgement

6.1 Allied to the use of SNCT is the use of Professional Judgement (PJ) to confirm appropriate staffing levels. This is a bottom-up approach to the determination of staffing levels based on the judgement of experienced nurses to agree and determine the number and grade of staff required to provide care on a specific ward. PJ enables the consideration of the environment and skill mix/experience of staff to inform decisions about establishment setting. This is agreed with Divisional Directors for Nursing and includes the agreed allowance for the uplift of staff.

7.Skill Mix

7.1 The RCN[9] recommends a ratio of 65:35 registered nurses/unregistered staff in inpatient areas and 70/30 for assessment areas. Following nursing establishment review in 2017 the Trust Board agreed the minimum ratio for registered/unregistered staff was to be set at 55:45; this was revised following the Bi-annual staffing review in February 2020 to 60:40 in inpatient areas and 65:35 within assessment areas.

7.2 The reduction in the ratio of registered nurses to unregistered nurses does affect the ability of the Trust to release staff to support the delivery of care during periods of operational pressures without reliance on temporary staffing to back fill. The reduction in the ratio of registered nurses also impacts on the ability to provide oversight of patient care, and RN direct scrutiny, assessment and evaluation of care delivered to our patients.

8 Uplift

8.1 The RCN recommend that nursing establishments are uplifted by 23% to support study leave, annual, and sickness/absence; NHSI recommend that the uplift in staffing is 22-25%. Trust Board agreed previously that the uplift would be set at 20% and this has remained unchanged. Across Greater Manchester the average uplift is 23%. It is recommended that the Board considers uplifting the staffing establishment to 22% in line with national recommendations; the additional 2% uplift will more accurately reflect time required to undertake mandatory training.

9 Supervisory Ward Leaders

9.1 The Trust Board approved the funding of supervisory ward leaders in October 2021 and has continued to receive reports on the actual release of ward leader time within the quarterly safe staffing reports.

[9] RCN (2010): *Guidance on safe nurse staffing levels in the UK*

10 Position Regarding Acuity and Dependency.

10.1 Comparison of acuity and dependency data is provided in Charts 1a and 1b.

10.2 When considering the categorisation of patients', it should be noted that patients in categories 1a, 2 and 3 should all be regarded as being acutely unwell. It would be expected that any patients assessed as Level 3 on an inpatient ward would be awaiting transfer to an ITU bed.

10.3 Level 2 patient needs can be aligned to patients who have not been assessed as requiring HDU care but are requiring a higher level of registered nurse input to deliver ward based care.

10.4 Since September 2021, the number of patients assessed as requiring care at Ib level has exceed the combined total of patients assessed at levels), 1a and 2. This position has shifted in the current reporting period signally an increase in the acuity of patients and a reduction in dependency needs. This shift in nursing needs reflects the pattern of emergency attendances requiring admission via our emergency department and additionally is reflecting the deterioration in physical health being seen as a result of patients waiting for elective surgery.

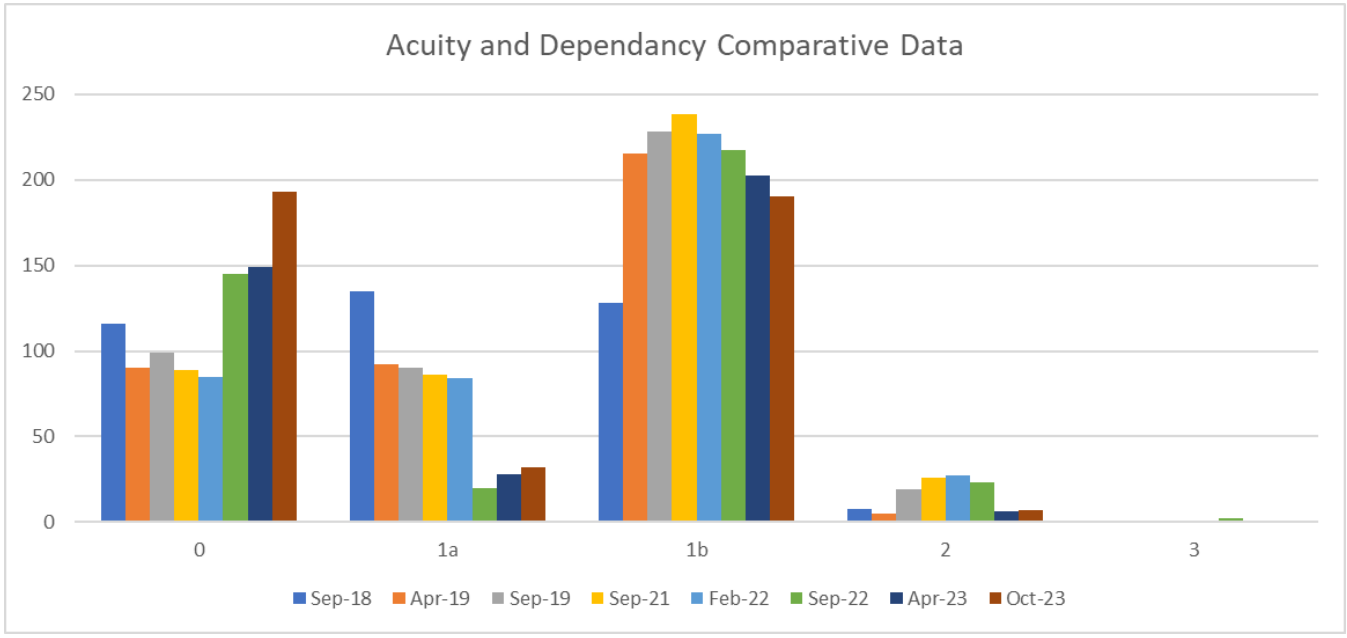
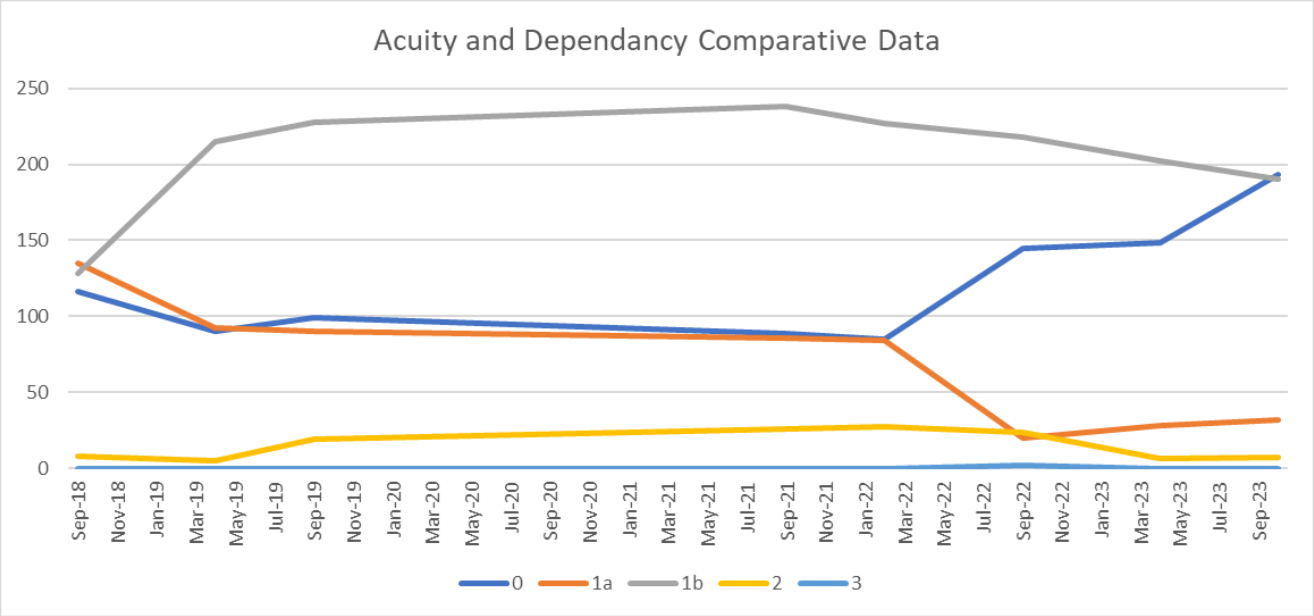


Chart 1a



	Sep-18	Apr-19	Sep-19	Sep-21	Feb-22	Sep-22	Apr-23	Oct-23
0	116	90	99	89	85	144.9	148.76	193
1a	135	92	90	86	84	19.87	27.76	32
1b	128	215	228	238	227	217.63	202.55	190
2	8	5	19	26	27	23.25	6.45	6.8
3	0	0	0	0	0	2.02	0	0

Chart 1b

10.5 Whilst level 1b patients do have greater dependency needs registered nurses are still required to prescribed and assess the effectiveness of care delivered to our patient. Patients within this category may also have complex discharge needs, safeguarding needs and complex dressings that require registered nursing time and therefore it should not be assumed that all the care for these patients can be provided by unregistered staff.

11 Nurse Sensitive Indicators (NSI's)

11.1 NSI's are measures and indicators reflecting the structure, process and outcomes of nursing care. These measures help to reflect the impact of care that nurses working in inpatient services provide. In addition, they assist in determining the link between the care provided and funded staffing establishment within the ward. NSI data is reported monthly to Board within the Safe Staffing Report.

11.2 Strong visible leadership is key to the maintenance of high standards, avoidance of harms and continuous quality improvement. It is therefore recommended that the number of budgeted Band 6 staff within inpatient areas is standardised to ensure senior leadership presence throughout the 7-day, 24-hour continuum. This will also offer greater opportunity for staff progression and assist in recruitment and retention of staff.

11.3 Progress with ward assessment against standards of care has continued across adult inpatient areas and is regularly reported via quarterly Aspire reports to Quality and Safety Committee.

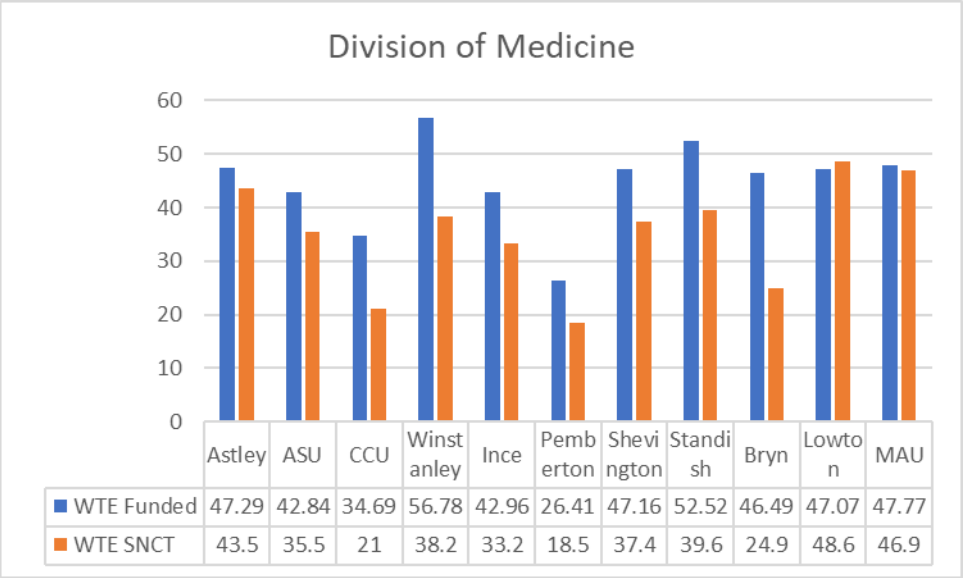
11.4 The Trust also receives quarterly reports detailing progress made with harm free care with specific focus on the reduction of falls and pressure ulcers acquired within our care.

11.5 For the purposes of this report NSI's will be captured alongside divisional information to support triangulation of information and provide the rationale for the recommendations with regards to staffing requirements.

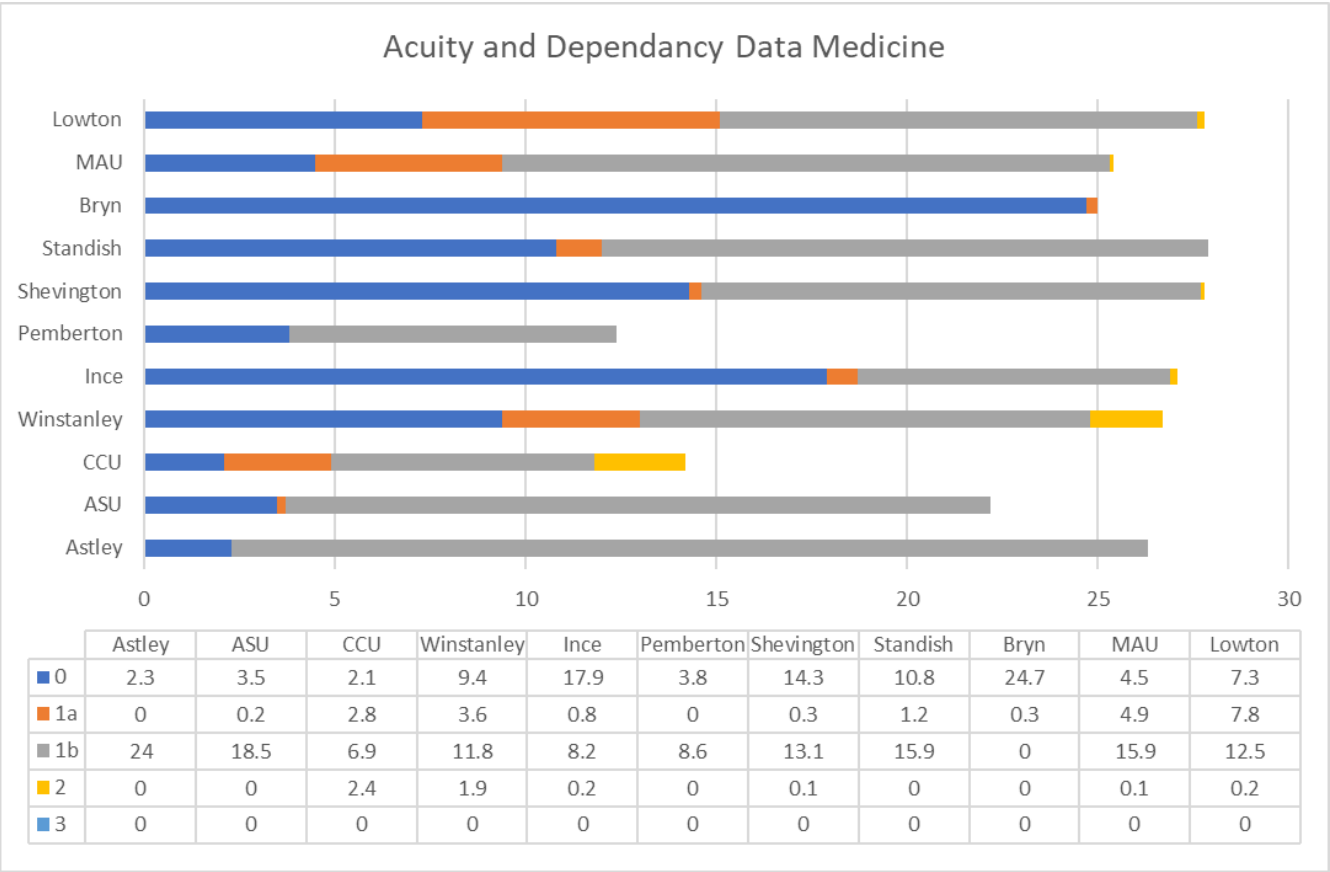
.12 Current Position, SNCT and Professional Judgement

Division of Medicine

12.1 Actual funded hours versus SNCT required hours are provided in Chart 7.



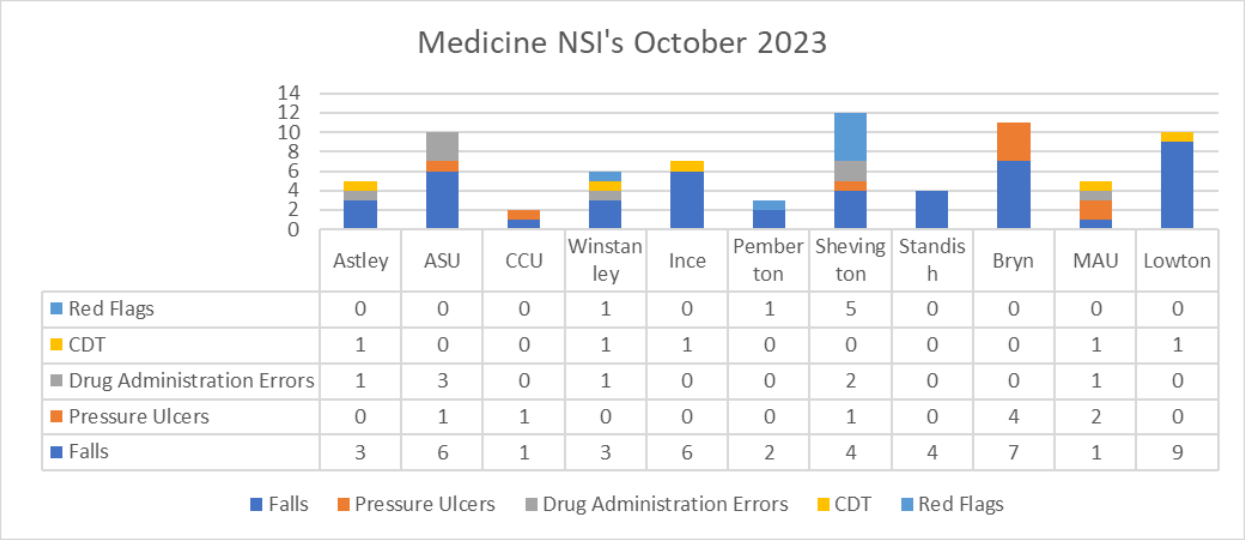
	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	Lowton	MAU
WTE Funded	47.29	42.84	34.69	56.78	42.96	26.41	47.16	52.52	46.49	47.07	47.77
WTE SNCT	43.5	35.5	21	38.2	33.2	18.5	37.4	39.6	24.9	48.6	46.9



	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
0	2.3	3.5	2.1	9.4	17.9	3.8	14.3	10.8	24.7	4.5	7.3
1a	0	0.2	2.8	3.6	0.8	0	0.3	1.2	0.3	4.9	7.8
1b	24	18.5	6.9	11.8	8.2	8.6	13.1	15.9	0	15.9	12.5
2	0	0	2.4	1.9	0.2	0	0.1	0	0	0.1	0.2
3	0	0	0	0	0	0	0	0	0	0	0

Chart 7

12.2 As previously mentioned within section 11 of the report NSI's are provide a helpful indication of nurse staffing risk factors. Chart 8 provides detail of the NSI indicators for the inpatient areas in the Division of Medicine that were reported during the data capture period.



	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Red Flags	0	0	0	1	0	1	5	0	0	0	0
CDT	1	0	0	1	1	0	0	0	0	1	1
Drug Administration Errors	1	3	0	1	0	0	2	0	0	1	0
Pressure Ulcers	0	1	1	0	0	0	1	0	4	2	0
Falls	3	6	1	3	6	2	4	4	7	1	9

Chart 8

12.3 When considering the data provided above the following points should be taken into consideration.

- Drug administration errors were reported to have occurred on 5 on the inpatient wards. All 5 errors involved controlled drugs and all incidents reported resulted in no harm to patients. Controlled medications should all be checked and administered by 2 registered staff.
- There were 5 CDT's reported which remain subject to investigation to identify and share the learning from these incidents.
- Pemberton Ward: the recommended staffing for this area would not support delivery of safe staffing if SNCT were utilised in isolation. The issue arises as the area is all single room occupancy and SNCT does not work effectively in areas where there is a small bed base. During this time 1 red flag was raised relating to a reduction of registered nurses on a shift; this was mitigated by temporary redeployment of staff from another area. Both falls that occurred resulted in no injury to the patient and appropriate risk assessments with supporting actions to reduce the risk of falls had been implemented. On these occasions professional judgement is applied to the staffing model. It is therefore recommended that the funded establishment remains unchanged in this review.
- CCU; this area again has a small bed base; however, the acuity of patients is high. Furthermore, staffing for the area needs to provide oversight of the telemetry that is undertaken on inpatient areas across the Trust and there is no mechanism within SNCT to capture this. From a harms perspective there was 1 fall and 1 pressure ulcer reported. There were no red flags raised relating to staffing over the course of. It is recommended that the staffing associated with the area remains unchanged.
- Winstanley Ward; staffing for the clinical area was uplifted to support the professional of an enhanced respiratory unit in 2019. This model remained in place throughout the pandemic. Although demand for enhanced respiratory support has decreased, it is recognised that the Trust is approaching the season for increased presentation of respiratory illness and therefore it is recommended that there are no changes to the staffing model at this moment in time. The Division of Medicine will need to undertake further work on demand mapping to advise whether this enhanced level of support is still required, and also need to consider how

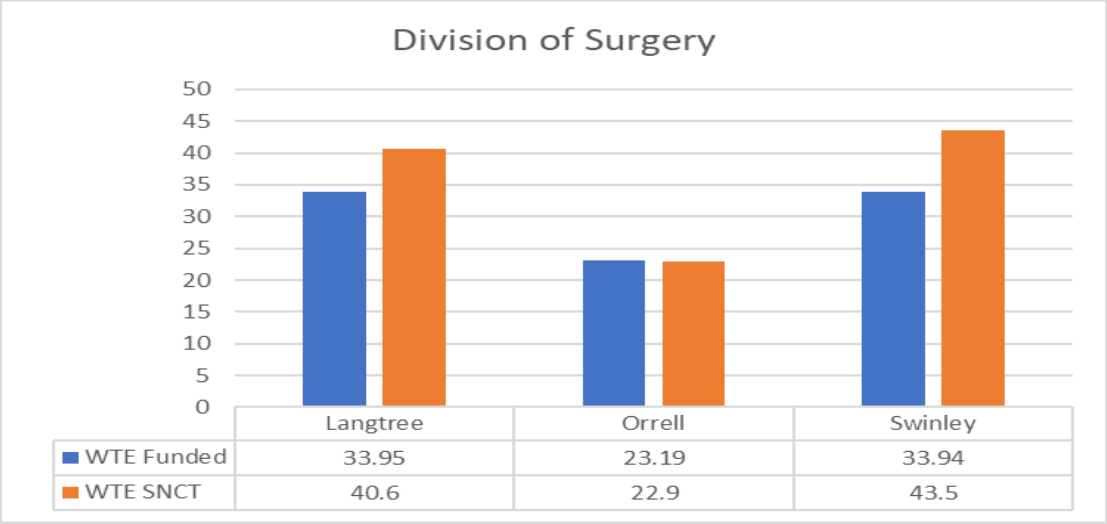
staff are effectively used and appropriately trained to mitigate the risk of harm occurring as the SNCT data suggests that staff available to deliver care is in excess of the patients care requirements.

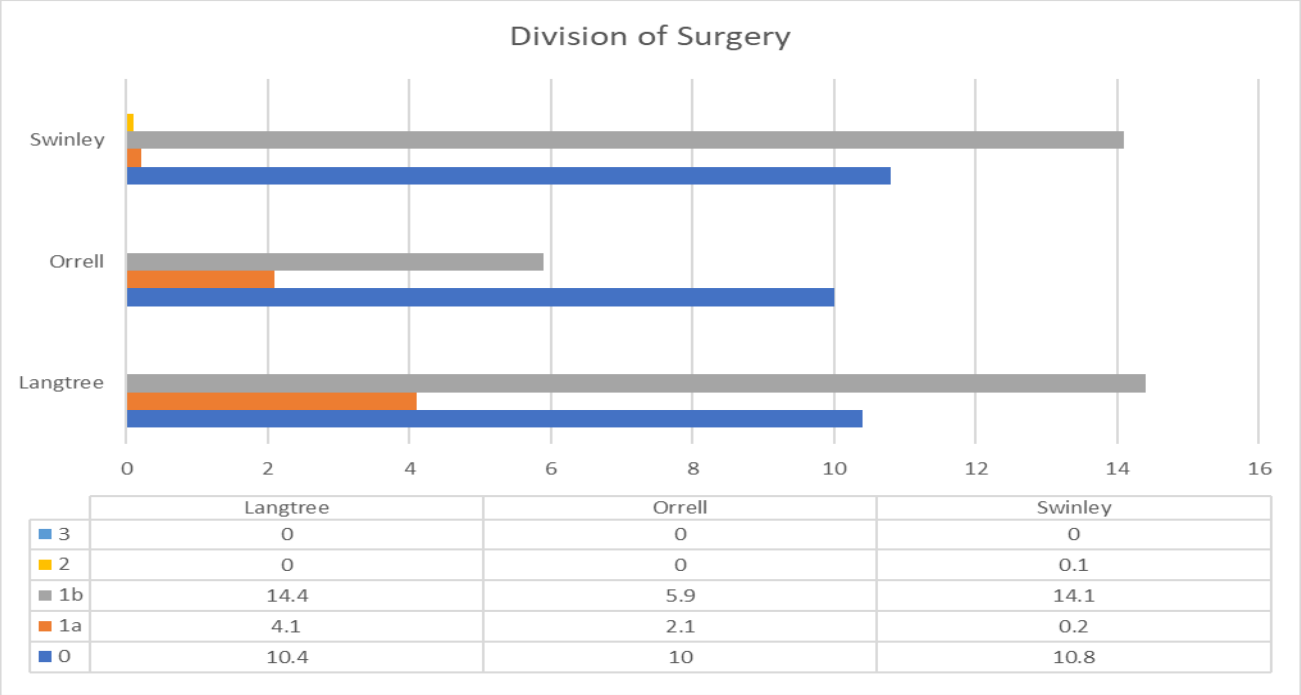
- Bryn Ward: Bryn ward was opened in response to the COVID-19 pandemic an initially was utilised to provide additional inpatient capacity. The ward was repurposed in 2022 to provide additional medical assessment beds and the staffing complement increased in response to the change in the patient profile. In August 2023 the ward was repurposed again and now provides beds to accommodate medically optimised patients. Despite all the patients being assessed as only requiring ward level care and having low levels of dependency 4 pressure ulcers and 7 falls were reported to have occurred during the data capture period despite the area being over-established. It is recognised that there has been a shift in the acuity and dependency of the patients within the clinical area, and a subsequent increase in patient turnover. Professional judgement determines that the clinical area requires 30 WTE staff to safely meet the needs of the patients and in consideration of the clinical environment with a 42:58 ratio, and therefore a reduction of 16.49 WTE staff is required.
- Shevington Ward; Shevington ward is a gastroenterology inpatient ward. The patients admitted there often have complex needs included dependency on drugs and alcohol which impact on patient's capacity and behaviours as they undergo treatment. The potential for violence and aggression in the clinical area is high, and therefore it is recommended that the staffing for the area remains unchanged. The falls reported were related to patient presentation and appropriate mitigation was put in place to reduce risk; the same patient fell on more than one occasion and all falls resulted in no harm to patients.

12.4 Further to the inpatient wards the Division of Medicine have also raised staffing pressures within the Paediatric Emergency Care Centre (PECC). Since 2019/20 PECC has seen an increase in the number of attendances to the department.

Division of Surgery

12.4 The divisions funded WTE v SNCT recommended WTE can be found in chart 9.

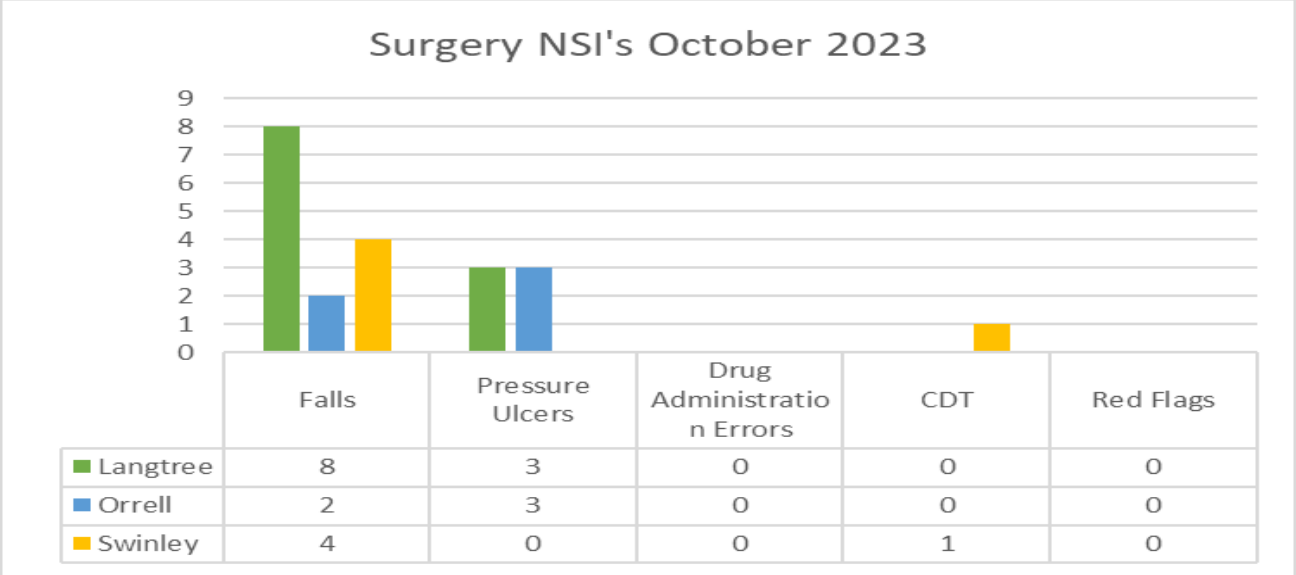




	Langtree	Orrell	Swinley
3	0	0	0
2	0	0	0.1
1b	14.4	5.9	14.1
1a	4.1	2.1	0.2
0	10.4	10	10.8

Chart 9

12.5 Details of NHSI's reported can be found in chart 10.



	Falls	Pressure Ulcers	Drug Administration Errors	CDT	Red Flags
Langtree	8	3	0	0	0
Orrell	2	3	0	0	0
Swinley	4	0	0	1	0

Chart 10

12.6 When considering the data above the following points should be taken into consideration.

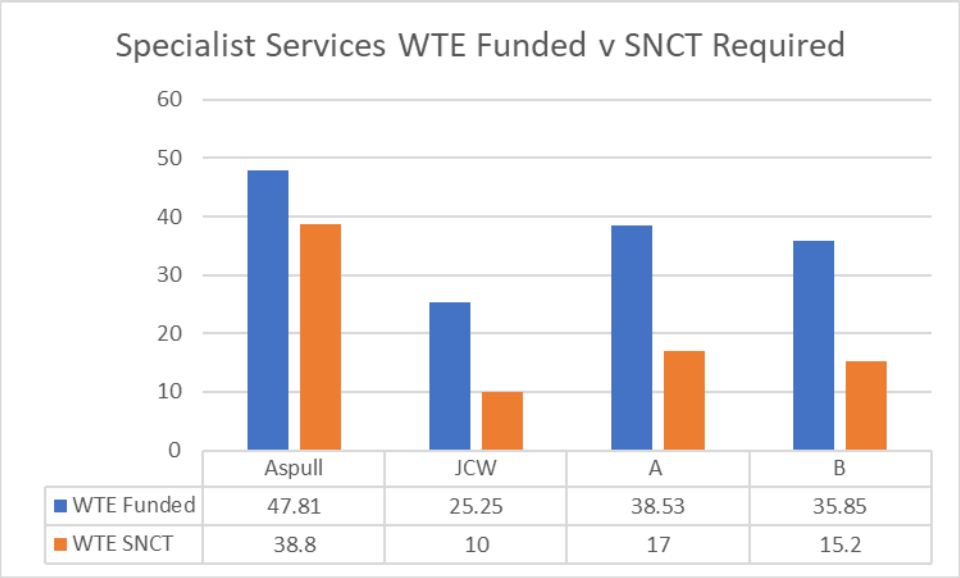
- Orrell wards funded versus SNCT recommended staffing is virtually aligned. 5 harms were reported during the data capture period, 2 falls and 3 pressure ulcers. There were noted to be no shortfalls in staffing during this period of time.
- Swinley Ward; SNCT advises increasing the establishment on this ward based on the nursing needs required. The Division is planning to align staffing and the Early Pregnancy Unit (EPU) onto Swinley ward following incidents reported involving the management of early pregnancy loss on the acute site, particularly out of hours. It is not recommended at this stage that the staffing for the area is changed until the service is reconfigured. It is proposed that once the

service changes are determined, including staff transfer, that SNCT is completed again to determine whether further changes to the funded establishment are required. From a harms perspective there were 4 falls and 1 CDT reported.

- Langtree ward; whilst SNCT recommends an increase in the funded establishment of 6.66 WTE staff, this reflects the changes in both acuity and dependency of the acute surgical patients and the medical outlier patients in the area. The clinical area has seen an increase in both falls and pressure ulcers and is currently staffing above the roster establishment by way of mitigation. To safely staff the area due to the environment the funded establishment needs to be increased by 8.07 WTE to ensure support throughout the 24-hour continuum.
- However, an investment to support this uplift is not recommended at this stage. It is recommended the organisation completes the transformation work being undertaken to improve flow, to allow the support from ECIST and Newton Europe to demonstrate the expected results in ensuring patients are cared for in the right place, reducing medical outliers and improving discharge, following this a further staffing review needs to be undertaken to determine the right model and level of funding required.

Specialist Services Division

12.7 The data provided in Chart 11 provides the funded v the SNCT recommended establishment and the acuity and dependency of the clinical area.



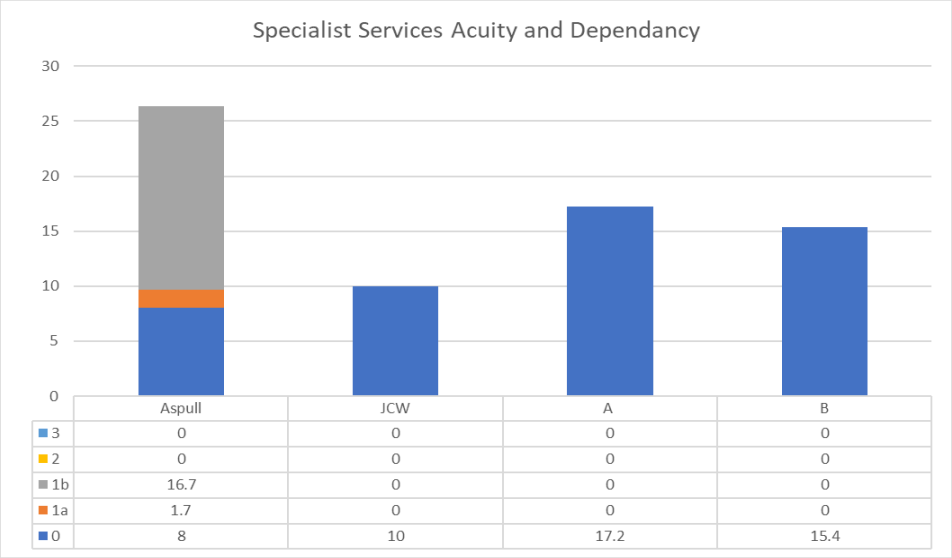


Chart 11

12.8 Specialist Services NSI information is presented in Chart 12.

Chart 12

12.9 When considering the data above the following points should be taken into consideration.

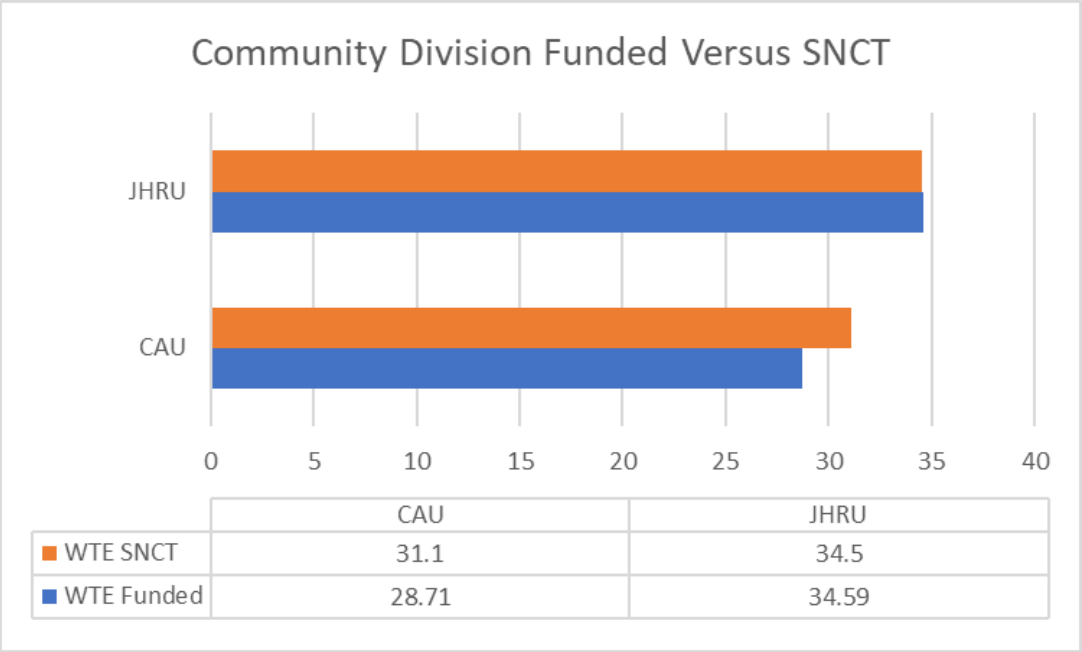
- Activity on the Wrightington site was reduced during the month of October and low bed occupancy has impacted on the SNCT staffing recommendations across all the areas in Wrightington Hospital.
- JCW is the private patient ward on the Wrightington site and comprises of 16 individual rooms. SNCT is not designed currently to take into consideration additional staffing factors associated with care of single room clinical areas, or clinical areas with a small bed base and therefore professional judgement is required. 2 falls occurred as demonstrated within Chart 12 all resulting in no patient harm.
- Wards A and B design are 50% bay 50% single room configurations. SNCT does not adjust to match this configuration of beds and therefore recommended staffing levels, alongside low occupancy during the data capture period, does not reflect actual requirements. Despite the ward configuration falls reported were low in comparison to other areas in the division. There is a potential correlation to the low levels of occupancy during October and the levels of harm,

and also recognition that there would be staff hours over what was required which will have positively impacted on a reduction of harm.

- It is recommended that staffing is not adjusted on the Wrightington site. This recommendation reflects the elective hub status of the site and the anticipated increase in bed occupancy.
- Aspull Ward: historically this clinical area has always declared a high number of level 1b patients when assessing patient nursing need. The additional scrutiny applied during this round of data capture has identified that the assessment of need previously may not have been correct. However professional judgement suggests that the establishment is correct for the environment that care is delivered in and therefore no changes to the establishment are required. There were 4 red flags raised all of which related to a delay in the administration of pain relief to patients. 3 no harm falls were reported, and 3 pressure ulcers were also reported for the ward.

Community Division

12.10 The data provided in Chart 13 provides the funded v the SNCT recommended establishment and the acuity and dependency of the clinical area.



	CAU	JHRU
WTE SNCT	31.1	34.5
WTE Funded	28.71	34.59

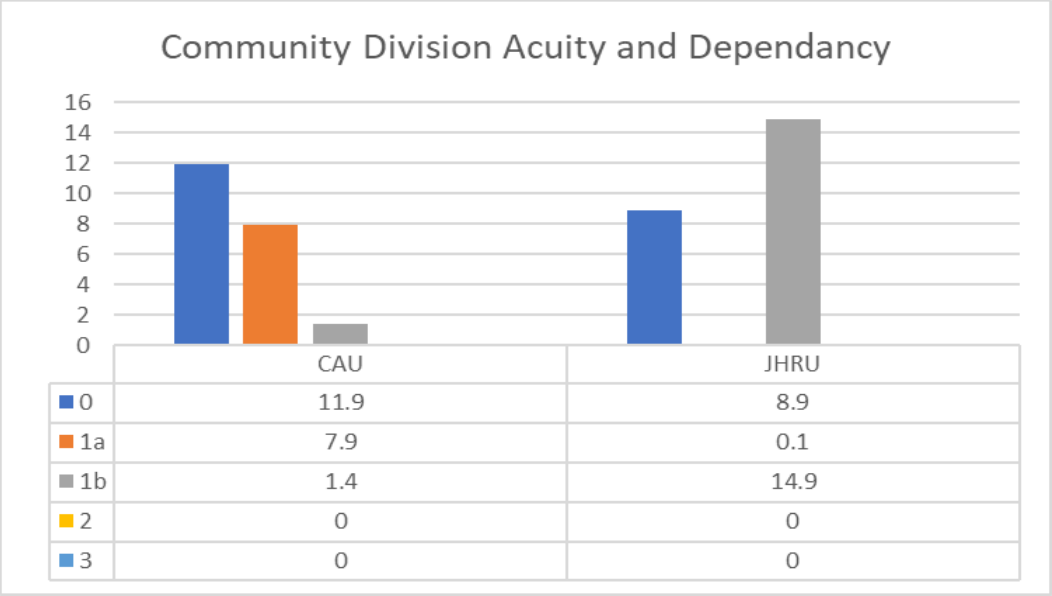


Chart 13

12.11 NSI's for the inpatient areas within the community are provided in chart 14.

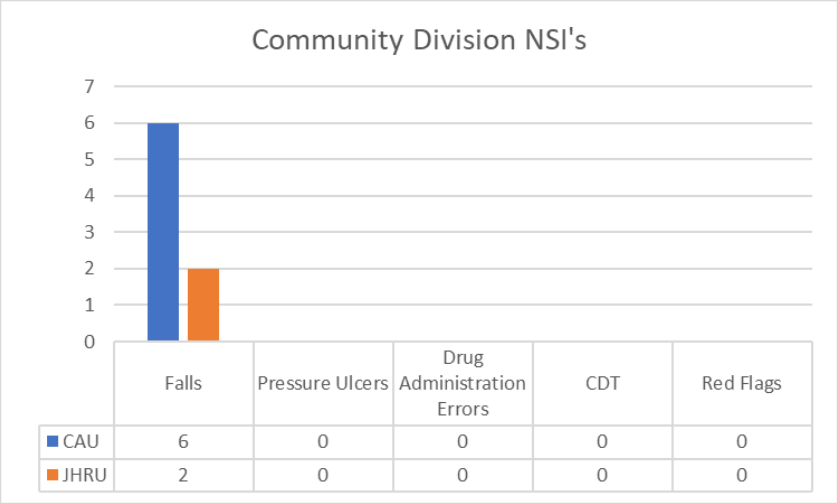


Chart 14

12.12 The funded v SNCT requirements are virtually aligned for JHRU, and therefore there are no recommended changes to the establishment. It should be noted that the staffing model is currently being evaluated in line with the plans to repurpose the area from reablement beds to intermediate care beds. Further assessment of patient need against the staffing model will need to be undertaken once this work has been completed. 2 falls were reported on the unit during the data capture period. All risk assessments and mitigation had been put in place to reduce the risk of falls.

12.9 There is a planned reset of the service on CAU to support increased direct reviews and admissions onto the unit. Whilst under the current configuration SNCT recommends an increase in headcount of 2.39 WTE staff. Due to the clinical environment of the area and visibility for staff of patient in bays and single room the division have been utilising 5.38 WTE additional B2's above funded establishment. This change was implemented following several reported pressure ulcers and inpatient falls where harm occurred, and the change has positively impacted on the incidence of avoidable harms within the clinical area, despite 6 falls occurring. However the unit is undergoing

a review and It is therefore recommended this is completed at pace and a new staffing review be undertaken.

12.10 There is currently no funded uplift to District Nursing Services provided by the Trust which directly impacts on the ability of the service to flex to cover planned and unplanned leave without increasing the case loads of the clinical staff. This is something to be considered at some stage in the future. To achieve a 20% uplift in the service there would need to be a headcount increase of 22.37 WTE at a cost of £820k.

13 Enhanced Observations

13.1 NHSE recommends that staffing reviews take into consideration requirements for the delivery of enhanced care.

13.2 Additional staff are utilised by the Trust to support the delivery of enhanced observation to those patients who are subject to a Depravation of Liberty Safeguard (DOLS) or who are at high risk of falls.

13.3 Over the course of the current financial year there has been increased scrutiny of the use of additional staff to support the delivery of enhanced observations to provide assurance that staff are working within the legal framework required and that the assessment of patient needs is correct. This has resulted in a reduction in demand and the ability to more accurately identify the resource required.

13.4 It has been recognised that our patients do not require observation throughout the 24-hour continuum and that this does not reflect least restrictive practice. It has further been recognised that consent from patients is required when we are placing patients on 1:1 care where these patients have capacity to make decisions, even if these decisions are unwise.

13.5 Current average spend on temporary staffing equates to £40k/week.

15 Recommendations

15.1 It is evident from the information provided within the report that whilst the Trust does not meet the minimum national requirements for the skill mix, it is believed the patient profile can be appropriately cared for with the current skill mix of staff. This will need to be reconsidered once the number of patients who are medically optimised for discharge decreases to ensure the skill mix is appropriate for inpatient areas.

15.2 It is therefore recommended that the below actions are taken.

- In recognition that the Trust has a high proportion of patients who should be receiving care outside of hospital, it is recommended that the Trust current agreed skill mix of staff remains unchanged. It is recommended that this remains under consideration by the Trust so we are able to demonstrate our ability to respond to operational pressures and in order to assure ourselves that we have sufficient registered staff to appropriately direct and provide oversight of patient care and quality.
- The patient safety risks identified on CAU may no longer be relevant as the unit is currently exploring a new operating model. it is recommended that the establishment is not increased by 5.38 WTE B2's to support the delivery of bay watch at a cost of £194k, but to establish and confirm at pace how the unit is expected to operate as an intended frailty unit and the staffing be reviewed in line with the changes.

- On reflection of the increased sustained acuity on Langtree ward it is recommended the organisation completes the transformation work being undertaken to improve flow, to allow the support from ECIST and Newton Europe to demonstrate the expected results in ensuring patients are cared for in the right place, reducing medical outliers and improving discharge. Therefore, at this stage it is not recommended that the establishment be increased by 5.38 WTE B5 nurses at a cost of £252k.

- It would be prudent to consider an investment in a pool of B2's to support the delivery of 1:1 care for 10 L4 patients 12 hours/day (27 WTE) at a cost of £934k (7 day/3 Night). These staff would work across all areas on the acute site and would reduce the current run rate of NHSP spend. Despite work undertaken the average weekly spend currently being incurred is £40.5k/week. It is recommended that a robust be plan be developed to ensure there is evidence that this would be the correct model for the organisation and that operationally it would not result in staff being aligned to individual wards and reluctant to move. Therefore this investment is not recommended at this precise stage.

15.3 Future consideration also the following 2 recommendations is requested 1 of which will result in a reduction in the current temporary spend run rate being incurred in PECC.

- Investment in the establishment of Paediatric Emergency Care of 5.38 WTE B5 RSCN's at a cost of £252K. The current run rate for NHSP in the area is £351K so this will result in a run rate in expenditure of £98k.

- There is currently no uplift within the District Nursing budget to allow for annual leave, sickness, study leave etc therefore when there are staff absences these need to be covered by temporary staffing or increases in the caseload of the remaining staff. To provide a 20% uplift in the service would require an increase in headcount of 22.37 WTE at a cost of £ £820k.

15.4 The review recommends a number of actions need to be taken in individual areas, a further staffing review then be undertaken which would allow the organisation to make a fully informed decision on the level of investment required.

NHS Resolution

NHS Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Year 5 Maternity Incentive Scheme Compliance.

Wrightington Wigan. And Leigh Teaching Hospital NHS Foundation Trust

Name of Person completing the form:		Cathy Stanford Divisional Director of Midwifery and Child Health
Date form completed:		27.11.2023
Date due to Trust Board for final Sign off of declaration form:		06/12/2023
Do you submit your CNST progress to the Trust Board as per the Perinatal Quality Surveillance Model?:		Yes
Date of update to Trust Board:		06/12/2023

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST.

The scheme incentivises **ten** maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

To be eligible for payment under the scheme, Trusts must submit the completed Board Declaration form to NHS Resolution nhsr.mis@nhs.net by 12 noon on 1 February 2024.

The LMNS is expected to have oversight and assurance that providers are meeting the ten safety actions leading up to the submission on 1st February 2024.

In line with section 4.7 of the Three-Year Plan for Maternity and Neonatal Services is for ICBs to oversee and be assured of trust's declarations to NHS Resolution for the maternity incentive scheme (CNST). This document supplements the Standard Operating Procedure document for CNST Year 5 Returns.

The proposed process for oversight and assurance allows for overall compliance of the ten safety actions. The process includes three elements:

A. The submission of evidence to the LMNS/ ICB stated in the CNST document.
B. The development of an assurance process to have oversight and gain assurance of the ten safety actions.
C. The process of sign off by NHS GMEC ICB CEO

The submission of evidence to the LMNS/ ICB stated in the CNST document.

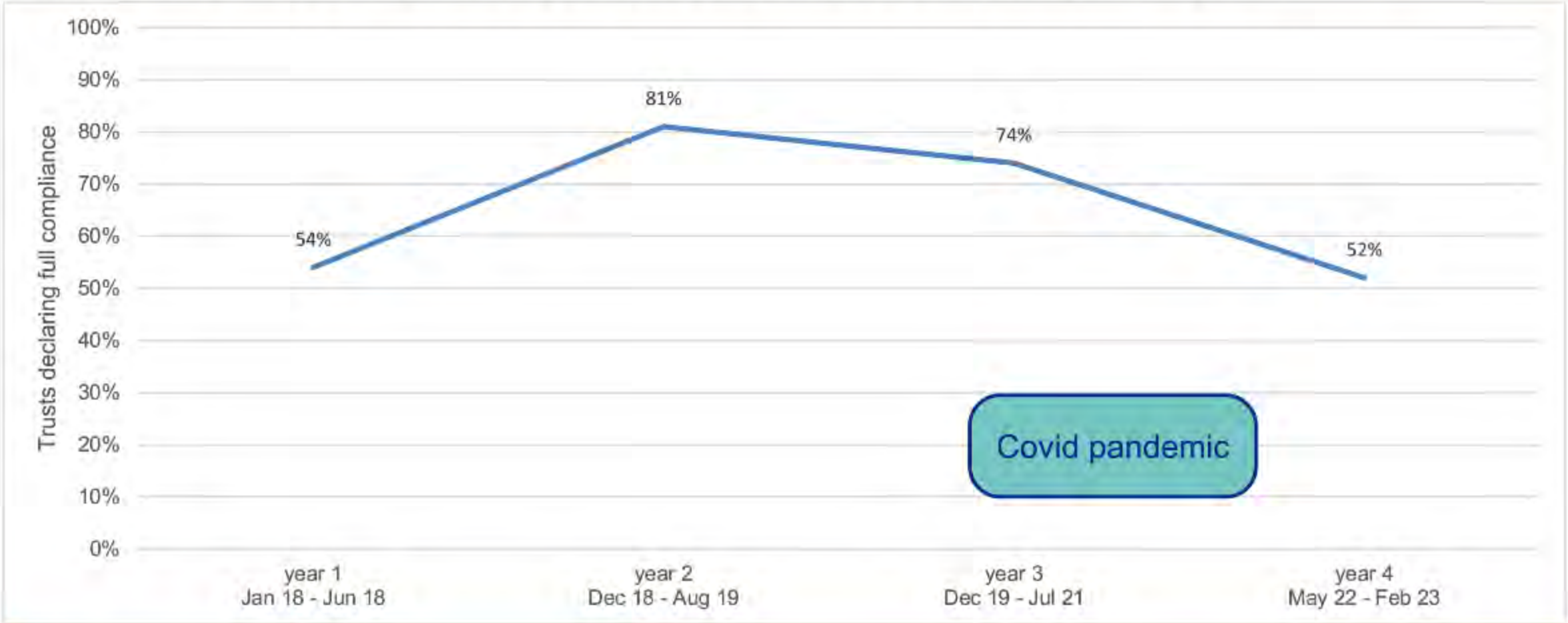
In order to meet the CNST requirements for sign off the Board declaration form and presentation will need to be presented to the Board in December and any outstanding actions for Training completion communicated for assurance to the Board Members in January 2024

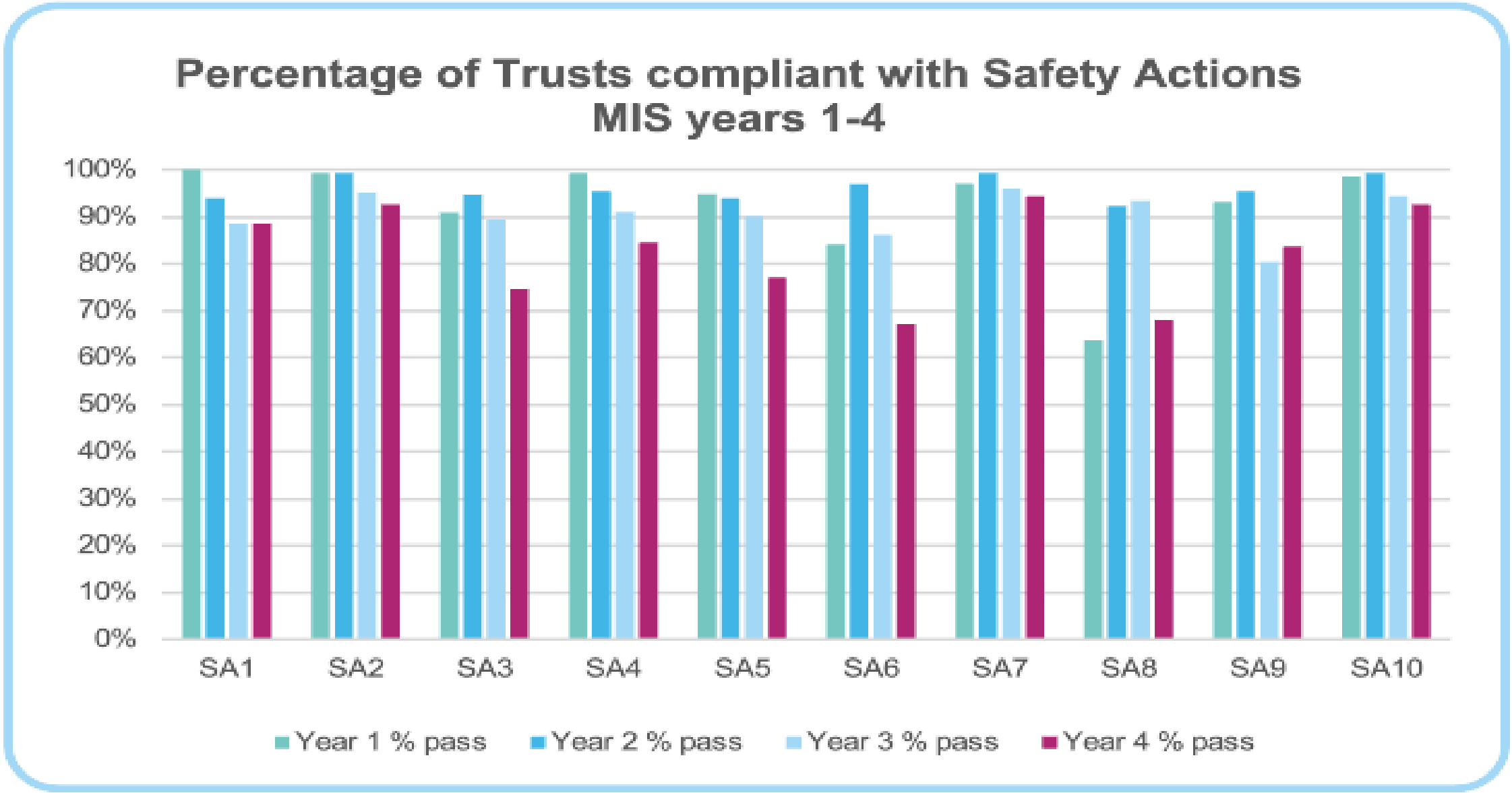
The CNST document outlines that the LMNS, or in some instances the ICB require sight of or 'sign off' of certain pieces of evidence. A list of the evidence required, and dates required to be submitted to the LMNS, are presented in the table within the next slides:

MIS full compliance MIS years* 1-4

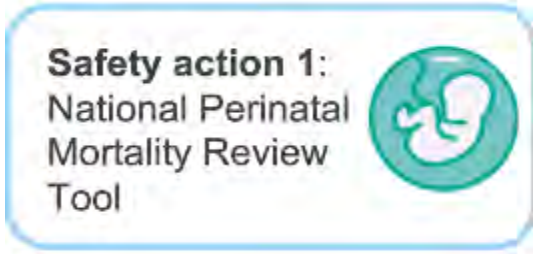
NHS Resolution

*Although each iteration of the MIS is referred to as a 'year', these time periods have varied in response to external factors.




Percentage of Trusts compliant with Safety Actions
MIS years 1-4
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
SA1
SA2
SA3
SA4
SA5
SA6
SA7
SA8
SA9
SA10
Year 1 % pass
Year 2 % pass
Year 3 % pass
Year 4 % pass

Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

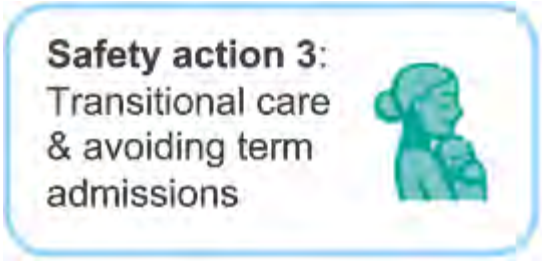


Requirements number	Safety action requirements	Likely to be compliant for submission date ? (Yes/ No /Not applicable)	Actions for compliance
A	All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	Yes	
B	For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	Yes	
C	For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	Yes	
D	Quarterly reports should be submitted to the Trust Executive Board from 30 May 202	Yes	

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

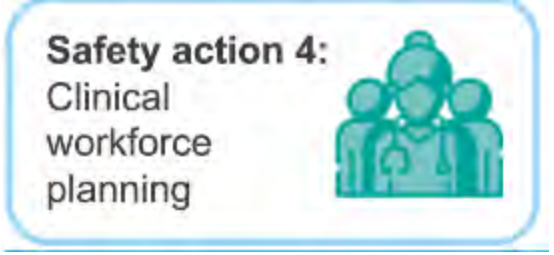
Requirements number	Safety action requirements	Confident / Requirement met? (Yes/ No /Not applicable)	Actions for compliance
1	Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics 2023. Final data for July 2023 will be published during publication October 2023.	Yes	
2	July 2023 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. (Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances).	Yes	
3	Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: Midwifery Continuity of carer (MCoC) Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.	Yes.	
	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.	Yes	
	ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation.	Yes	
4	Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.	Yes	
5	Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.	Yes	

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?



Requirements number	Safety action requirements	Requirement likely to be met by Submission date? (completed /Yes/ No /Not applicable)	Actions for compliance
A	Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Yes	
B	A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided.	Yes	
	An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.	Yes	
C	Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.	Yes	

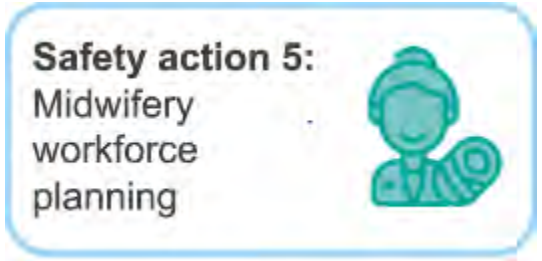
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?



Requirements number	Safety action requirements	Likely to be compliant by submission date? (Yes/ No /Not applicable)	Actions for compliance
Obstetric medical workforce			
A	1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.	Yes	
	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	Yes	
	2) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	Yes	
	3) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further nonattendance.	Yes	
	4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.	Yes	

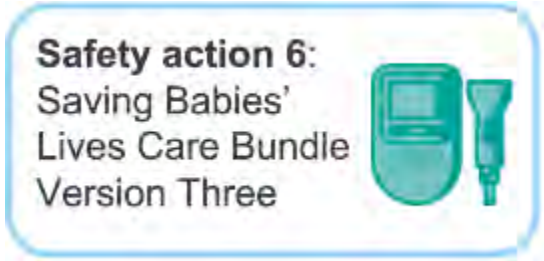
Anaesthetic medical workforce			
B	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes	
Neonatal medical workforce			
C	The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.	Improving compliance	Action plan ongoing
	If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.	Yes	Action plan ongoing
	If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies.	Not applicable	
	Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	Yes	Action plan ongoing

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?



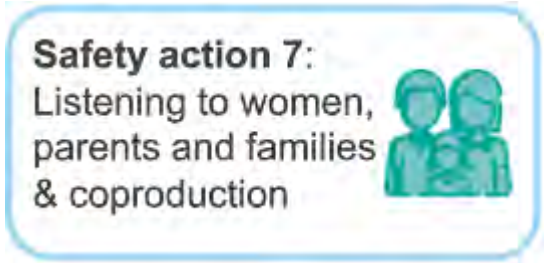
Requirements number	Safety action requirements	Requirement met or likley to be met for the submission date? (Yes/ No /Not applicable)	Actions for compliance
A	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	Yes	
B	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	Yes	
C	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.	Yes	
D	All women in active labour receive one-to-one midwifery care.	Yes	
E	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period	Yes	

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?



Requirements number	Safety action requirements	Requirement met or likely to be met for the submission date? (Yes/ No /Not applicable)	Actions for compliance
A	Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.	Yes.	
	implementing 70% of interventions across 6 elements overall and implementing at least 50% of interventions in each individual element.	Yes.	
B	Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.	Yes.	

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

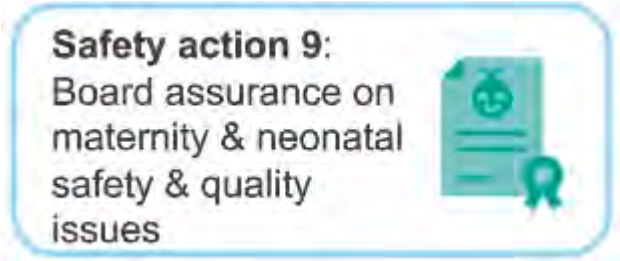


Requirements number	Safety action requirements	Likely to meet requirement by submission date? (Yes/ No /Not applicable)	Actions for compliance
A	Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.	Yes	
B	Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	Yes	
C	Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.	Yes	

Safety action 8: Can you evidence the following 3 elements of local training plans and ‘in-house’, one day multi professional training?

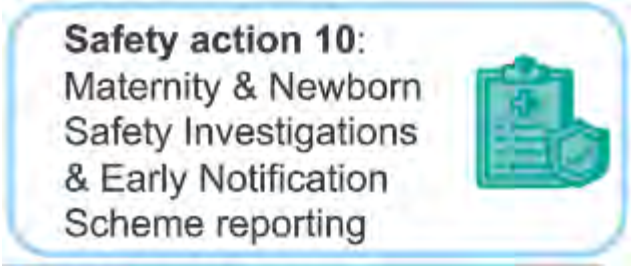
Requirements number	Safety action requirements	Requirement likley to be met by submission date? (Yes/ No /Not applicable)	Actions for compliance
A	A local training plan is in place for implementation of Version 2 of the Core Competency Framework.	Yes	
B	The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.	Yes.	
C	The plan is developed based on the “How to” Guide developed by NHS England.	Yes	

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



Requirements number	Safety action requirements	Requirement likely to be met prior to submission date ? (Yes/ No /Not applicable)	Actions for compliance
A	All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.	Yes	
B	Evidence that quarterly discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.	Yes	
C	Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures. Meeting are to be quarterly and 2 in the reporting period.	Yes	

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6th December 2022 to 7 December 2023?



Requirements number	Safety action requirements	Requirement likely to be met prior to submission date? (Yes/ No /Not applicable)	Actions for compliance
A	Reporting of all qualifying cases to HSIB/CQC//MNSI from 6th December 2022 to 7 December 2023.	Yes	
B	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6th December 2022 until 7 December 2023.	Yes	
C	For all qualifying cases which have occurred during the period 6th December 2022 to 7 December 2023, the Trust Board are assured that:	Yes	
	i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme	Yes	
	ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes	

Thank You.
Any Questions

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Incentive Scheme Year 5 (CNST) Compliance Update Report.
Presented to:	Trust Board
On:	6 December 2023
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Divisional Director of Maternity and Child Health
Contact details:	01942 773107 cathy.stanford@wwl.nhs.uk

Executive Summary

Maternity Incentive scheme Year 5

Year 5 of the Maternity Incentive Scheme is due for submission by 12 noon on 1 February 2024.

There has been some significant changes in regard to the reporting elements and training requirements in Year 5, with oversight being provided by the Local Maternity and Neonatal System (LMNS).

There are detailed spreadsheets for both Saving Babies Lives Version 3 and the Core Competency Training Framework which have both been submitted to the LMNS for approval and to demonstrate compliance as per the GMEC schedule.

Evidence for all safety actions was submitted to the LMNS in October which demonstrated compliance against all the standards as assessed by the panel. Advice was given in regard to additional evidence requirements, and this has now also been submitted. This will be presented to the ICB in December and the minutes from the committee will provide evidence of sign off prior to submission of the Board Declaration Form.

The Board Declaration form has been submitted for preliminary approval however it should be noted that this will only be able to be fully completed once the Saving Babies Lives compliance status is received from the LMNS in January after ICB and LMNS approval and sign off.

Additionally Multi-disciplinary Training compliance will only be determined after December 1st

The Board are requested to receive virtual update on these and any other outstanding issues in January prior to the deadline for submission

Report

Perinatal Mortality Report, Safety Action 1.

All actions are fully compliant, this is reported to Board via the Quarterly Perinatal Quality Surveillance Report. Q4 Q1 Q2 have all been submitted in the reporting period. Q3 will be due in January.

Maternity Services Data Set (MSDS). Safety Action 2.

All actions fully compliant. Score card received from NHS Digital. No concerns identified with submitted data.

Term admissions to NNU. Safety Action 3 .

The ATAIN action plan to reduce to Term Admissions to the Neonatal Unit has been submitted to Board and Quality and Safety Committee for oversight and assurance in August and summaries are included within the Quarterly Perinatal Quality Surveillance Reports . The updated version will be presented at Quality and Safety Committee in December.

Clinical Neonatal Nurse Workforce Planning. Safety Action 4.

The Neonatal Staffing review has been completed which incorporated staffing requirements for the Transitional care beds within the Maternity ward as well as ensuring compliance with BAPM recommendations for safe Staffing. This was presented to Board in August.

Tier 1 Neonatal Medical staffing

This action requires and action plan to demonstrate progress against previously agreed action plans
The action plan has been in place since Year 3 of the MIS which demonstrates year on year progress of working towards the BAPM . WWL have successfully secured two training places for Advance Neonatal Nurse Practitioners due to a successful funding bid from the Trust and funds received from the Neonatal Critical care Review. The successful candidates will commence training in January 2023. Additionally, rotas are being reviewed to allow more designated cover for the NNU and the Trust has recently recruited 3 Lond term staff Grade Locum Doctors to cover the NNU. This will demonstrate substantial improvement from Year 4 position.

Remaining ongoing actions are detailed below. (please see submitted full action plan for complete oversight)

NWNODN Workforce Action Plan (2021/Year 3 with 2022/Year 4)
2023 (year 5) Update for Maternity Incentive Scheme Safety Standard 4 Neonatal Workforce Compliance. (Actions 9 & 10 remain ongoing

9.	Review of AHP services and how they support and enhance the Neonatal workforce.	Review options for shared roles with neighbouring units. (Recruit on a session basis for shared posts)	Training and competency packages will be developed with support from the NWNODN. Job Descriptions to be developed	Recruit on a session basis as an option associated competencies, and training will be required Recruit to the following recommended posts. • Dietetics • Physiotherapy • Speech and Language therapists • Pharmacy Technician • Psychologist	Christos Zipitis Divisional Medical Director Consultant Paediatrician.	Ongoing	Currently no funding for Additional AHP roles as recommended **October 2023 Update** Will need to explore further funding for AHP roles as per recommendations Currently compliant for Pharmacy support as designated senior paediatric pharmacist in post Speech and Language and Dietetic support is on a request basis from WWL community Services Physiotherapy is provided within the community following discharge from NNU
November 2023 Update Funding secured for part time Psychologist role to be shared with neighbouring unit, this is in addition to the existing pharmacist hours in place. Speech and language are available upon request. Physiotherapy is available in the community following discharge. Dietetic support remains difficult to achieve due to the training requirements of the existing Trust staff however the Neonatal service are actively pursuing this option with community service leads.							
10.	The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of medical staffing.	• Rota Gaps for Tier I added to risk register. • Outline business case to be resubmitted for additional ANNP and/ or medical trainees • Recruitment of staff to commence training as ANNP	Full rota cover remains an ongoing priority and vacant shifts are actively managed within the Division. There is an agreed plan within the Division to recruit to Advanced Neonatal Nurse Practitioners which will cover the shortfalls going forward and provide additional skilled senior support to the Neonatal unit. This is not an immediate solution as staff will need to be trained through accredited Training Programme which	Year 3 Maternity Incentive Scheme (CNST) action plan and compliance paper agreed and supported by Trust Board Preliminary Outline Business Case.docx BC2022-046 - Advanced Neonatal Funding required for additional ANNP training programme once approval received. AB WWL NWNODN 2022 10 28.pdf **October 2022 Update.** Funding received from NWNODN to support the Tier 1 Rota Gap and provide Tier 1 cover 24/7. However, the current gap is not fully addressed by allocated funding.	Cathy Stanford Divisional Director of Midwifery and Neonates Christos Zipitis Divisional Medical Director Consultant paediatrician	**September 2021** Full business case to be completed and sent for approval. Recruitment and selection for substantive additional ANNP with allocated funds and additional Divisional Top-up **October 2022 Update** Tier 1 neonatal cover – additional 3 new Clinical recruits, (long term staff grade locums)	**February 2022 Update** Funding was received in 2022 to increase Neonatal Nurse staffing and to support the Advance Neonatal Nurse recruitment **October 2022 Update.** Funding received from CCR to support the recruitment for an additional ANNP post. WWL will utilise any underspend to cover locum/agency gaps to help

			will take 2 years until completion.	WWL Example Template Action Pla **October 2023 Update** Rota review currently being undertaken to include in-post ANNP to provide night cover alongside additional Clinical Fellows posts. Current Deanery trainee allocation is predominantly GP trainees who cannot provide cover for NNU Outline Business Case ANNP V03 13.0		these will fill the Gaps from shortfall in allocated trainees and will allow for 1 SHO covering neonates 9 am to 9 pm weekdays and weekend and deliveries out of hours. Awaiting notification of places on January 2024 ANNP course for 2 existing members of staff as not been able to recruit to the fully funded ANNP post despite being out to	with safety until the additional ANNP post is recruited to. Overnight cover – there remains a shortfall as only one Tier 1 SHO covering both neonates and paediatrics. **October 2023 Update** Outline Business case completed to fund ANNP training and therefore increase the level of cover by an addition 2 x ANNP (Band 8a) to ensure compliance with a Tier 1 Rota 24/7 to cover the Neonatal Unit . Places requested for ANNP course for 2024
						recruitment several times	
November 2023 Update 2 training places secured, and Interviews will take place w/c 27/11/23 for January 2024 start date Rota cover improved with dedicated SHO covering 9-9 7 days per week. Existing ANNP also able to cover some weekend or night shifts as duties allow, once trained (12 months) additional 2 ANNP will be able to provide a more robust rota cover. Rota templates have been developed which will require approval which are inclusive of ACP (to free up Rainbow Ward SHO to cover neonates) and ANNP.							

Anaesthetic Medical Workforce

Rotas remain compliant as required with ASC Standard 1.7.2.1

Obstetric Workforce .

Compensatory Rest

The RCOG recommends a period of compensatory rest for Consultants and Senior Specialty and Specialist (SAS) doctors when working as non-resident on call out of hours,

Standard 4 requires Trusts provide assurance of compliance or that an action plan is in place demonstrating working towards full compliance. See below for ongoing action plan

Compensatory Rest Action Plan updated October 2023.

Complete	Partially complete/ Ongoing	Overdue	Not due

Recommendations	Action	Lead	Timeframe	Rag Rating	Evidence	Comments
1. The BMA and RCOG recommend following on-call that consultants have a period of compensatory rest. Compensatory rest would: • Patient safety would not be compromised due to excessively long periods of working.	The BMA and the RCOG recommend that following disturbance non-resident consultants have a full 11 hours consecutive rest per day. • Weekend On call rota to be changed to allow compensatory rest as a starting point.	Shatha Attarbashi Clinical Director Obstetrics and Gynecology. Christos Zipitis Divisional Medical Director.	June 2023		**May 2023. Update** Obstetric rota's now allow for compensatory rest following weekend on calls	Work remains on going with Business case to secure funding for additional consultants
• mean that clinics and theatre lists would not be cancelled following on-call, which is a better experience for patients. • Staff wellbeing will be maintained.						
2. **R**educe the likelihood of cancelling any Gynaecology cancer patients to reduce the impact on diagnosis and treatment.	• Increase medical staffing to allow for compensatory rest following on call 7 days per week	Shatha Attarbashi Clinical Director Obstetrics and Gynecology. Christos Zipitis Divisional Medical Director.	April 2024		**October 2023 Update.** Current medical staffing does not allow for 7 day per week compensatory rest. Outline Business case for additional funding to increase Consultant body to be submitted	**October 2023 Update.** • Job plans have been aligned to minimise risk of cancellations the following day when Compensatory rest is to be taken following busy on call shifts. • Weekend on calls have been split to prevent long periods on call. • Business case Produced.
3. Demonstrate compliance with RCOG recommendations	• Evidence any episodes of non-compliance with RCOG recommendations by Datix submission and feedback from consultants.	Shatha Attarbashi Clinical Director Obstetrics and Gynecology. Eve Broadhurst Head of Governance	Ongoing		No Incidents reported via Datix	
		Maternity and Child Health				
3. Risk Assessment to be completed and remain on risk register until resolution and actions in place	• Risk assessment to be submitted to RMG for ongoing monitoring	Eve Broadhurst Head of Governance Maternity and Child Health	April 2023		**May 2023 Update** Risk on Risk register scoring at 12 reduced from 15.	**October 2023 Update.** No further Updates risk remains at Divisional level.

Maternity Workforce/ Safe staffing. Safety Action 5

A workforce review for Maternity Services has been completed alongside the analysis of the Birth-rate Plus report which had identified an additional staffing shortfall. A full staffing review paper was submitted to

Quality and Safety Committee and Board in June 2023 which included the proposals for the development of enhanced Community Midwifery teams who are now providing support for the most vulnerable women and those living in the lowest deciles of deprivation within the Borough, in order to improve outcomes for mothers and babies within this group.

An additional uplift to 25% was also requested and agreed in principle however a business case now needs to be developed to support the additional uplift to base line staffing and the shortfall as identified by BirthRate+.which is 6.30wte overall. Funded vacancies currently stand at 8.76wte.

The second biannual paper is submitted for the December Board which acknowledges the in-principal uplift but also recognises the financial constraints the Trust is under at present.

Maternity Red Flags and 1-2-1 Care in Labour.
All actions met for this standard

At WWL, we have introduced the Birth Rate Plus acuity tool which has set standards within the app to guide and support safe staffing. This is currently in use in the intrapartum area however this will be also introduced to the inpatient ward areas very soon. Data is reviewed monthly to validate, as the app provides safe staffing assurance every 4 hours, this has resulted in an increase in the number of red flags as it is completed 4 hourly which may involve the same patient over periods of time, which further supports the need for data validation. Additionally, this does not rely of staff reporting red flags via Datix which are often under reported and will give a true reflection of the number of red flag incidents occurring and monitoring of themes.
The Maternity Red Flags are reported on the Maternity Dashboards and Perinatal Quality Surveillance reports and Dashboard. An additional report has been produced since the introduction of the Birthrate+ acuity tool which includes detail and actions, and this will be presented to the Quality and Safety Committee in December and re submitted to the LMNS for approval.

MIS Year 5 requires that an action plan is required if 1-2-1 care in labour is unable to be provided. It also states that the shift leader must remain supernumerary and only allows for one occasion per week when this did not happen. An action plan is not permissible for this standard and any more than one per week would result in overall non-compliance of the standards.

There have been no occasions were more than 1 red flag has been reported per week during the MIS reporting period of 30 May – 22 November due to lack of supernumerary shift coordinator.(This will have to be monitored daily and validated prior to the end reporting date of December 7th). The Maternity Managers on call rota supports the intrapartum and inpatient areas when acuity is high thereby reducing the risk of this occurring.
1-2-1 care in labour has remained at 100% for the whole of the reporting period,

Saving Babies Lives Care Bundle V3 (SBL v3). Safety Action 6

SBL compliance has been monitored by the LMNS. Compliance needs to be that providers are able to demonstrate implementation of 70% of the interventions across all 6 elements overall and implementation of at least 50% of interventions in each element. These are calculated within the extensive spreadsheet provided by NHSE and at the last submission in October WWL was assessed as 87% and 80%. There will be a further submission assessed in January which is expected that Trusts may drop slightly in their compliance as some of the parameters have been extended but it is expected from our own date that We will remain within the compliance rate and may even increase on some of the measures.

Maternity Voice Partnership (MVP) Safety Action 7

This standard requires evidence of co-production with the MVP and ensuring that service user feedback is collated and acted upon. Evidence submitted also included that the chair is renumerated and that workplans are funded. This was assessed as meeting the standard by the LMNS

Mandatory training. Safety Action 8

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

Monthly compliance is reported on the Maternity Dashboards and Quarterly Perinatal Quality Surveillance report.

The final training date will be on the December 1st and 90% of all staff groups attendance is expected to be achieved, however NHSR have recently sent an update that attendance for PROMPT and CTG training will be accepted at 80% as long as an action plan is in place to achieve 90% within 3 months. This will allow a buffer should any staff be unable to attend due to sickness, but all outstanding staff are currently rostered to attend.

Board Assurance Safety Action 9

This standard requires that all 6 principles of the Perinatal Quality Surveillance Model are fully implemented and embedded. It also requires that the Board are sighted on and discuss safety intelligence and any concerns raised by staff or service users. Evidence of this should be reflected within the Board minutes and the LMNS/ICS and local and regional Learning systems.

Following submission of evidence to the LMNS they requested evidence that the Maternity Clams score card was triangulated against current themes and trends and any recent litigation complaints and claims. This has been completed and is submitted below for Q1&2 for Board review and will also go to Quality and Safety Committee and Maternity and Neonatal Safety Champions forum.

Claims scorecard 01/04/2012- 31/03/2022

Top injuries by volume	Volume	Top injuries by value	Volume
Adtnl/unnecessary Operation(s)	6	Brain Damage	2
Psychiatric/Psychological Damage	6	Loss Of Baby	2
Unnecessary Pain	5	Fatality	4
Fatality	4	Adtnl/unnecessary Operation(s)	6
Not Specified	2	Stillborn	2
Top causes by volume	**Volume**	**Top causes by value**	**Volume**
Fail / Delay Treatment	11	Fail / Delay Treatment	11
Foreign Body Left In Situ	3	Fail To Monitor 2nd Stg Labour	3
Fail To Warn-Informed Consent	3	Fail To Supervise	1
Fail To Monitor 2nd Stg Labour	3	Fail/Delay Admitting To Hosp.	1
Inappropriate Treatment	2	Failure To Perform Tests	2

Maternity Incentive Scheme - Safety Action 9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or Directorate) quality meeting.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust
Advise, Resolve, Learn

Complaints Q1 2023-24

Communication: Pressured to agree a plan for early delivery without sufficient information – inappropriate plan
Communication: Lack of consent for episiotomy/rude staff member
Clinical Treatment: Pressured for VBAC without full information - ruptured uterus
Clinical Treatment: Several concerns which could have been clarified with better communication and a missed postnatal visit leading to a delay in treatment.
Clinical Treatment: Concerns re retained placenta and perception of delayed transfusion

Incidents Q1 2023-2024

Neonatal death – fetal fibronectin not used (Fail/delay treatment/perform tests).
Consent – Failure to obtain consent re treatment
BCG given to baby inappropriately – poor communication with mother
Near miss X 3 – delay in Quad test/delay following up HVS result & antibiotics/delay in Anti-D as no appointment on system – poor communication between staff

Themes Q1 2023-24

Fail/delay treatment/perform tests
Inappropriate plan/treatment
Lack of information giving before and after birth
Lack of informed consent
Poor communication to families and between professionals

Learning Q1 2023-24

VBAC proforma to be completed to ensure informed consent.
Fetal fibronectin to be offered in cases of suspected pre-term labour 22-35 weeks' gestation to inform plan of care.
Ensure Quad offered and appt booked if unable to obtain NT
BCG is not suitable for babies whose mothers have had immuno-suppressants in pregnancy
Ensure women and their families can discuss events prior to discharge

Actions Q1 2023-24

VBAC audit/identify barriers	By 31.8.2023 FK	
Appoint Pre-term Birth Lead Midwife	By 20.11.23 CS	
Behaviour workshops	By 31.12.2023 JB	
Share learning re BCG via In Safe Hands	By 1.10.23 EB	
Share learning re benefits of p/n debrief	By 1.10.2023 EB	

Claims scorecard 01/04/2012- 31/03/2022

Top injuries by volume	Volume	Top injuries by value	Volume
Adtnl/unnecessary Operation(s)	6	Brain Damage	2
Psychiatric/Psychological Damage	6	Loss Of Baby	2
Unnecessary Pain	5	Fatality	4
Fatality	4	Adtnl/unnecessary Operation(s)	6
Not Specified	2	Stillborn	2
Top causes by volume	**Volume**	**Top causes by value**	**Volume**
Fail / Delay Treatment	11	Fail / Delay Treatment	11
Foreign Body Left In Situ	3	Fail To Monitor 2nd Stg Labour	3
Fail To Warn-Informed Consent	3	Fail To Supervise	1
Fail To Monitor 2nd Stg Labour	3	Fail/Delay Admitting To Hosp.	1
Inappropriate Treatment	2	Failure To Perform Tests	2

Maternity Incentive Scheme - Safety Action 9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or Directorate) quality meeting.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust
Advise, Resolve, Learn

Complaints Q2 2023-24

Patient Care Felt bullied into changing care plan from elective LSCS to IOL/membrane sweep despite declining membrane sweep/induction. Felt midwife comments re 'choice' after the sweep to be ill-timed/inappropriate. Inappropriate plan re fetal movements.
Patient Care Attempt to identify gender of 19-week baby made by staff after late fetal loss. Incorrect gender given. Chromosomal results not relayed to mother at time of receiving. Informed in debrief meeting. Distress caused.

Incidents Q2 2023-2024

Therapeutically cooled baby at term – CTG interpretation/some delay in delivery.
2 X late onset neonatal seizures with changes on MRI (Difficulties with neonatal intubation & interpretation of neurological picture/CFM when complicated by pain).
Difficult maternal intubation at GA BMI >50.

Themes Q2 2023-24

Inappropriate plan/treatment (FMs)
Lack of informed consent – hearing women's choices (LSCS/sweep)
Brain damage/Fail/delay treatment (interpretation of CTG/CFM/use of neonatal video laryngoscope)
Loss of baby/Psychological harm (gave opinion on gender)

Learning Q2 2023-24

Women's preferences and concerns are central for the decision-making process for LSCS (NICE, 2021,23).
No attempt should be made to identify a baby's gender before 24 weeks gestation.
Use of Oxford pillow to aid with positioning for GA BMI >50.
Use of video laryngoscope to assist with difficult neonatal intubation (previous incidents with same learning).

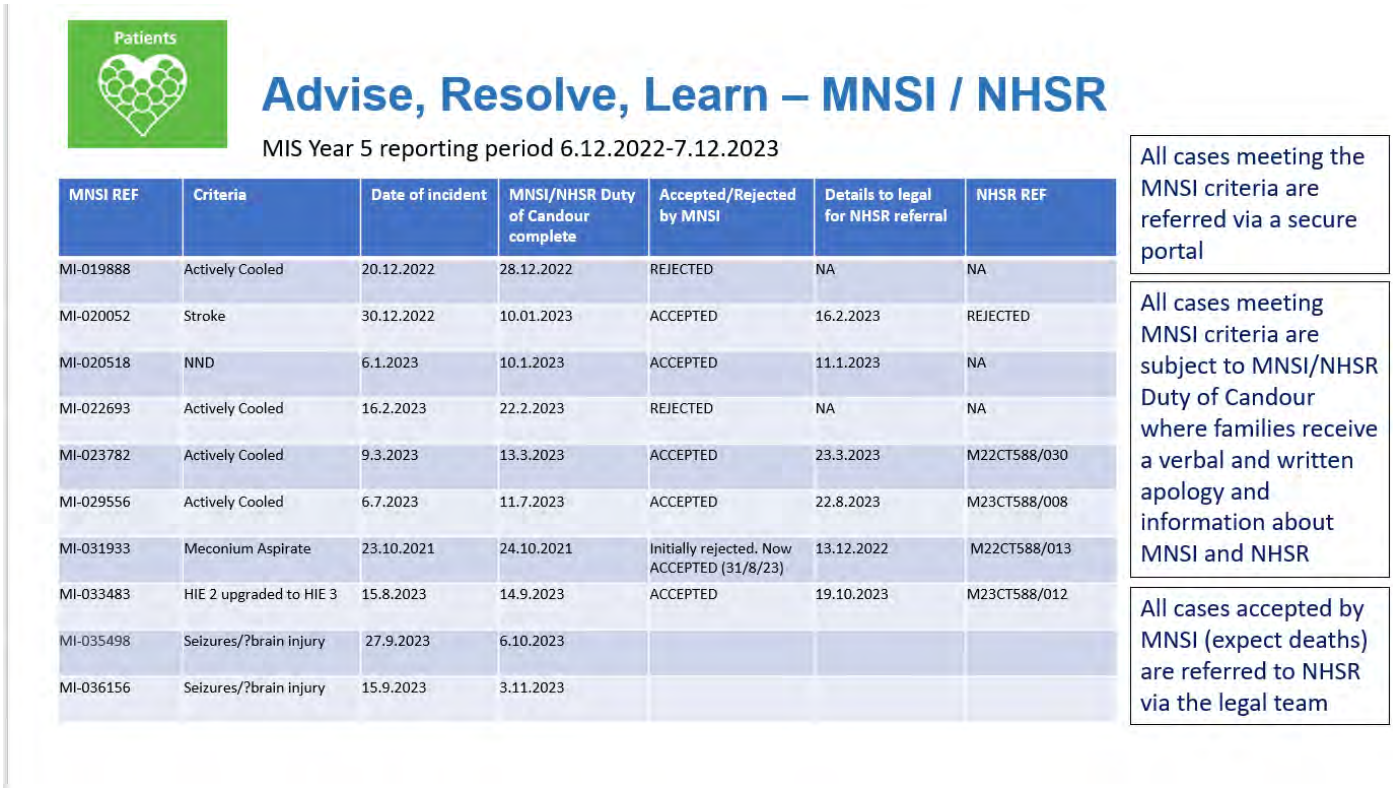
Actions Q2 2023-4

New CTG sticker incorp risk assessment	By 30.9.2023 JB	
Check gender on chromosomal tests	By 31.11.2023 SB	
Behaviour workshops	By 31.12.2023 JB	
Share learning re benefits of use of Oxford Pillow	By 31.10.23 ST	
Explore barriers to use of neonatal video laryngoscope	By 30.11.2023 CZ	

Maternity and Newborn Safety Investigations Special Health Authority (MNSI) Formally HSIB and NHSR reporting. Safety Action 10

All actions are fully compliant, this is reported to Board via the Quarterly Perinatal Quality Surveillance Report. Q4 Q1 Q2 have all been submitted in the reporting period. Q3 will be due in January.

The LMNS has requested that further evidence of Duty of Candour and patient information has been given for all cases reported to both MNSI and NHSR, evidence of this will be included within the Perinatal Quality Surveillance Report going forward but a table to evidence this retrospectively is included below.



MNSI REF	Criteria	Date of incident	MNSI/NHSR Duty of Candour complete	Accepted/Rejected by MNSI	Details to legal for NHSR referral	NHSR REF
MI-019888	Actively Cooled	20.12.2022	28.12.2022	REJECTED	NA	NA
MI-020052	Stroke	30.12.2022	10.01.2023	ACCEPTED	16.2.2023	REJECTED
MI-020518	NND	6.1.2023	10.1.2023	ACCEPTED	11.1.2023	NA
MI-022693	Actively Cooled	16.2.2023	22.2.2023	REJECTED	NA	NA
MI-023782	Actively Cooled	9.3.2023	13.3.2023	ACCEPTED	23.3.2023	M22CT588/030
MI-029556	Actively Cooled	6.7.2023	11.7.2023	ACCEPTED	22.8.2023	M23CT588/008
MI-031933	Meconium Aspirate	23.10.2021	24.10.2021	Initially rejected. Now ACCEPTED (31/8/23)	13.12.2022	M22CT588/013
MI-033483	HIE 2 upgraded to HIE 3	15.8.2023	14.9.2023	ACCEPTED	19.10.2023	M23CT588/012
MI-035498	Seizures/?brain injury	27.9.2023	6.10.2023			
MI-036156	Seizures/?brain injury	15.9.2023	3.11.2023			

All cases meeting the MNSI criteria are referred via a secure portal

All cases meeting MNSI criteria are subject to MNSI/NHSR Duty of Candour where families receive a verbal and written apology and information about MNSI and NHSR

All cases accepted by MNSI (expect deaths) are referred to NHSR via the legal team

Conclusion

The Board are requested to review the summary of Maternity safety actions alongside the in-person presentation and Board Declaration Form detailing compliance against all of the 10 Safety Actions and request the Board permission to declare compliance against the Year 5 Maternity Incentive Scheme once the January Virtual update has been received.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Staffing Paper. (2nd Biannual Report)
Presented to:	Trust board
On:	6 December 2023
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Link to strategy

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

Risks associated with this report and proposed mitigations.

Detailed in the report body.

Financial implications

Cost implication of increased staffing requirements.

Legal implications

None identified.

People implications

Patient Safety and Staff wellbeing considerations

Wider implications

Trust Reputation and risk of regulatory requirements not being met.

Executive summary

Safety action 5: of the CNST Maternity Safety Actions, requires that Maternity Services submit a midwifery staffing oversight report that covers staffing safety issues to the Board Bi-annually, to demonstrate effective workforce planning. There are specific recommendations that must be achieved:

- A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
- 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.
- All women in active labour receive one-to-one midwifery care.

The final Ockenden Review published in March 2022 details a series of immediate recommendations for all NHS hospital trusts in England to meet, with the aim of providing assurance of maternity safety within each provider trust's maternity services.

NICE (2015) published guidance on safer midwifery staffing and identifies red flags where further action is required to ensure safety of women and babies. This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags.

Staffing levels and skill mix are key elements of a safe, effective, and high-quality service. In maternity, workforce planning is unique as each care 'episode' spans around 6-8 months, within both hospital and community settings, and involves a series of scheduled and unscheduled care which often involves unexpected inpatient admission as well as the birth itself. The activity within maternity services is dynamic and can rapidly change. It is therefore essential that there is adequate staffing in all areas to provide safe high-quality care by staff who have the requisite skills and knowledge.

Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers. The BR+ Acuity tool supports this, which is a safe staffing tool for delivery suite and Maternity ward activity.

One of the Ockenden recommendations was to undertake a maternity workforce gap analysis and set out plans to meet Birthrate+ standards for maternity workforce recommendations. As an immediate action all Trusts in line with CNST maternity safety action 5 were asked to provide a review of the Midwifery workforce to demonstrate an effective system of clinical workforce planning to the required standard. This was completed for WWL in March 2023.
Birthrate Plus provides an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the service.

This staffing report will focus on the recommendations of the Birthrate Plus Report (2023) and how safer staffing is facilitated by adoption of the recommendations, as outlined in the previous staffing paper presented in June 2023.

In March 2023 the Three Year Delivery Plan for Maternity and Neonatal Services (2023) NHSE was published, this sets out a series of actions for Trusts to make care safer, more personalised and more equitable for women, babies and families.
Services are being asked to concentrate on four high level themes, with theme 2 setting out three areas of action for maternity and neonatal staffing:

- continue to grow the workforce.
- valuing and retaining the workforce.
- investing in skills.

Staffing

The Maternity service has been out to recruitment continually since we received funding from the Ockenden bid. The bid was submitted to increase the establishment due to the shortfall we had in staffing at the time.
We were unable to fully recruit to all the vacancies at that time, however the number of vacancies had been slowly reducing but this continues to fluctuate with additional leavers. The maternity staffing pressures remain on the risk register and a robust workforce plan is in development to address the ongoing attrition of the aging workforce. Scoping is in place to identify the number of staff who plan to retire or reduce hours in the next 5 years to ensure that shortfalls in the establishment do not reach the same high levels of 2021/22.
WWL have recruited an international midwife and have committed to the International Recruitment programme, however it is not envisaged that we would need further international recruits at this time.

The Board are requested to review the findings of the report, outlining the current establishment and existing vacancies in line with The Maternity Incentive Scheme Safety Action 5 and receive a biannual staffing report for maternity services. Additionally, the Board are requested to note the request for an additional uplift to be added to the baseline establishment to allow for the increased training needs to comply with Saving Babies Lives and The Maternity Incentive Fund (MIS) Year 5 training requirements, but also the recommendations within the final Ockenden Report that average sickness levels from the previous 3 years, maternity leave and annual leave (inclusive of Trust Birthday Leave) is calculated within the uplift .

Report

Birthrate+

Birthrate+ is currently the only midwifery specific, national, tool that gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services.

Birthrate+ has been completed within WWL as commissioned by the Local Maternity/ Neonatal System (LMNS) and findings from this are included within the report. The review identified that a significant uplift was required to ensure that all Midwifery Mandatory Training is included within the calculations considering the Maternity Incentive scheme (CNST) recommendations and the Immediate and Essential Actions (IEA's) from the Ockenden reports, this is in addition to the specialist Midwifery posts that are required to sustain the service safely and effectively to meet the requirements of the National reports and recommendations.

The BR+ (2023) review refers to the numbers of both clinical and non-clinical midwives required based against activity and acuity within the service and includes 10% MSW's into the recommended establishment for postnatal care.

For Postnatal care in hospital, it suggests that up to 10% of this can be provided by Maternity support workers (MSW's), In the community setting this can be up to 20%. However, the overall, ratio of trained staff to Maternity support workers is recommended to be 90/10. It is noted that clinical staffing can be adjusted to include a varied skill mix to support the midwifery workforce suggesting that this is a local decision dependent upon the configuration of services and clinical judgement. Many maternity services use the skills of maternity support workers to support in this way. There is a review of MSW roles taking place to ensure that the staffing ratios are appropriate in all areas, remaining mindful that

the maternity pathway is provided by midwives whose roles and responsibilities are defined in statute and cannot therefore be legally delegated (RCM). Birthrate+ additionally states that antenatal and Intra-partum care can only be provided by a Midwife.

Recruitment.

Recruitment and retention continue to be a focus within the service and due to national and regional workforce challenges, all options are being explored to support the midwifery workforce.

WWL has recently recruited one international Midwife who has successfully completed her OSCE and is awaiting her NMC Pin. In September 9wte newly qualified Midwives commenced in post and they have now completed their inductions. They are currently finishing their supernumerary periods and will then be counted within the staffing numbers which will significantly reduce the bank usage. A further 3.68 Midwives will commence in January/ February following successful completion of their Midwifery training, which again will significantly reduce the vacancies and 1wte in April who is currently on maternity leave.

In the last 6 months several senior posts (Band 7) have been recruited to ensure the correct senior leadership is in place across the service. These posts include:

- Diabetes Specialist Midwife
- Quality and Safety Midwife
- Additional Fetal Surveillance Midwife (awaiting interview)
- Additional Saving Babies Lives Midwife
- Triage Team Leader
- Antenatal Clinic Manager (awaiting interview)

Uplift to baseline staffing.

Training requirements for Midwives have increased significantly since the introduction of the Maternity Incentives Scheme and the Saving Babies Lives Care Bundle. Each Midwife needs a minimum of 5 days annually to be compliant with current requirements, this does not include the Trust mandated ELearning and any additional role specific modules such as NIPE (new-born and Infant Physical examination), Accredited Neonatal Life Support, Leadership and Critical Care, therefore it is requested that the uplift of 20% is increased to 25% which will incorporate training needs but also the recommendations within the final Ockenden Report that average sickness levels from the previous 3 years, maternity leave

and annual leave (inclusive of Trust Birthday Leave) is calculated within the uplift and meet the training requirements of the 3 Year plan.

An increase in uplift from 20 to 25% would increase the establishment by 4.81wte.

Sickness

The current overall sickness levels for maternity services has been as high as 9.7% in recent months with some improvement now being demonstrated in October down to approximately 7%.

All support measures are in place for staff well being and staff sign posted as appropriate to the wellbeing team and occupational Health services.

Professional Maternity Advocates are available for all staff to also support with wellbeing.

Sickness processes are adhered to with HR support. Roster management has been reviewed to ensure shift patterns are not too onerous and assurance that Roster rules are in place to support staff health and wellbeing.

Retention.

Secondment funding has been received from NHSE&I to support Midwives and Midwifery support worker retention with a band 7 preceptorship Lead Midwife and a Band 4 Midwifery Support Worker (MSW's) in post.

The job purpose of these roles is to focus on recruitment and retention, providing a comprehensive preceptorship package, pastoral support through the recruitment process to in post as a newly qualified midwife and the upskilling of MSW's. In addition, supporting the transition of the International Recruits from recruitment to practice. It is understood that this funding will be put into baseline budgets but will be at the discretion of the ICB as to whether these posts are considered necessary going forward.

The RCM has raised awareness around the lack of experienced midwives and the challenges around their retention, therefore plans are ongoing to commence a supportive development package for midwives progressing to Band 6. It has been recognised that the additional responsibilities can be a factor in high attrition rates if the support that has been in place during the preceptorship period is withdrawn.

To ensure the retention of all grades inclusive of band 7 and above, a developmental plan is in place to support their transition into the senior posts and allow for succession planning.

Development of staff and succession planning is key to retention to maintain skilled experienced employees and a sustainable workforce.

As of November 2023, there were 8.76 wte clinical midwife vacancies against a budgeted baseline of 144.46 wte midwives, 2 of these post (Band 7& 8 are out to recruitment) however Birthrate+ recommended that a further 1.71wte were required which was based on the current 20% uplift not the recommended 25%. (3.88 of the vacancies have a January start date & 2.88 wte are currently still out to recruitment).

Current Vacancy Position (Staffing figures correct at 19.04.2023)

	Band 5/6	Band 7	Band 8a and above	Total
Clinical Vacancies	**6.76**	**1.0**	**1.0**	
Upcoming vacancies in next 3 months	**3.0**	**0**	**0**	
Additional Birthrate+ recommendations	**1.71**	**Not currently funded.**		
Additional uplift to 25%	**4.81**	**Not Currently funded**		
Total proposed vacancies inclusive of BR+ and additional uplift to 25%.	**15.28 (6.30 of which is unfunded)**			

A detailed analysis of the current vacancies is included in appendix 1.

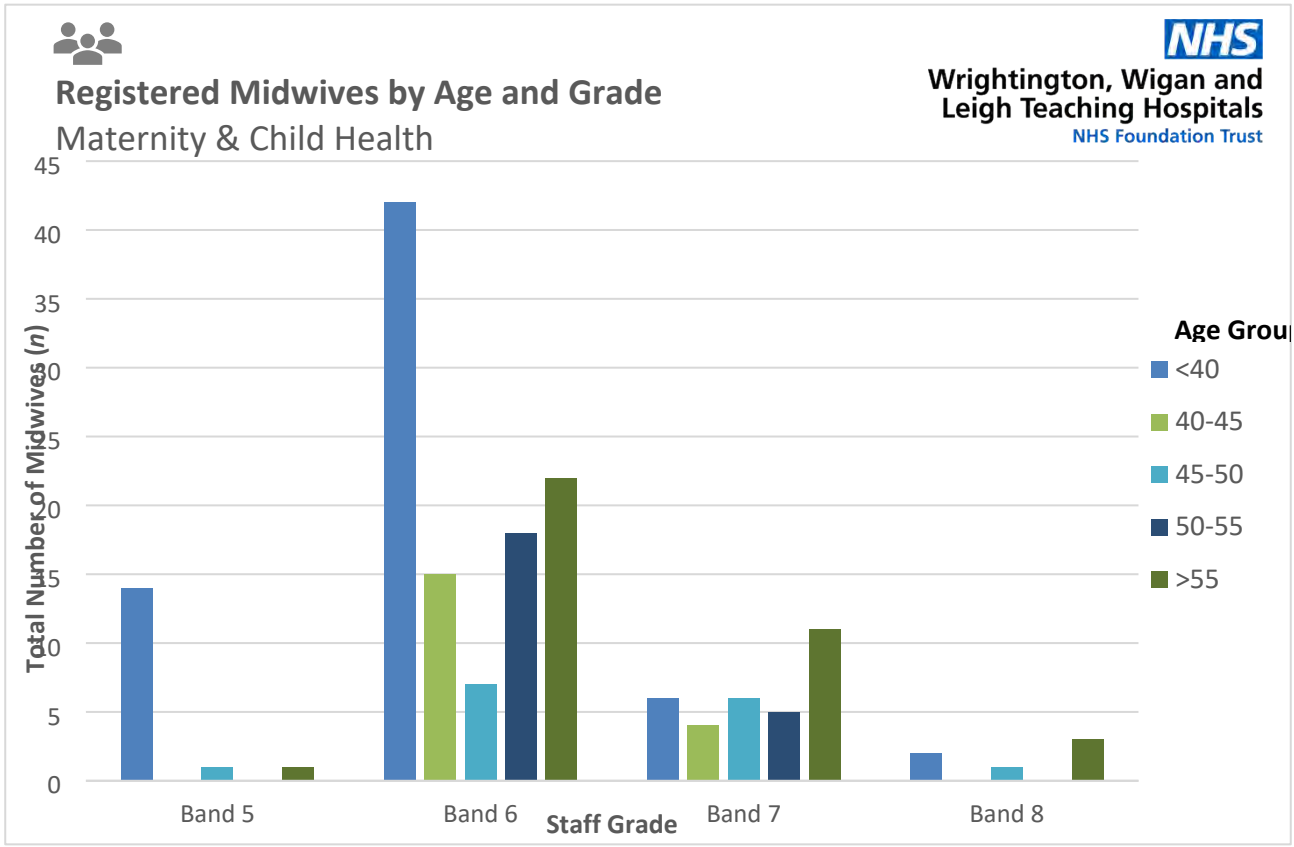
Workforce Profile

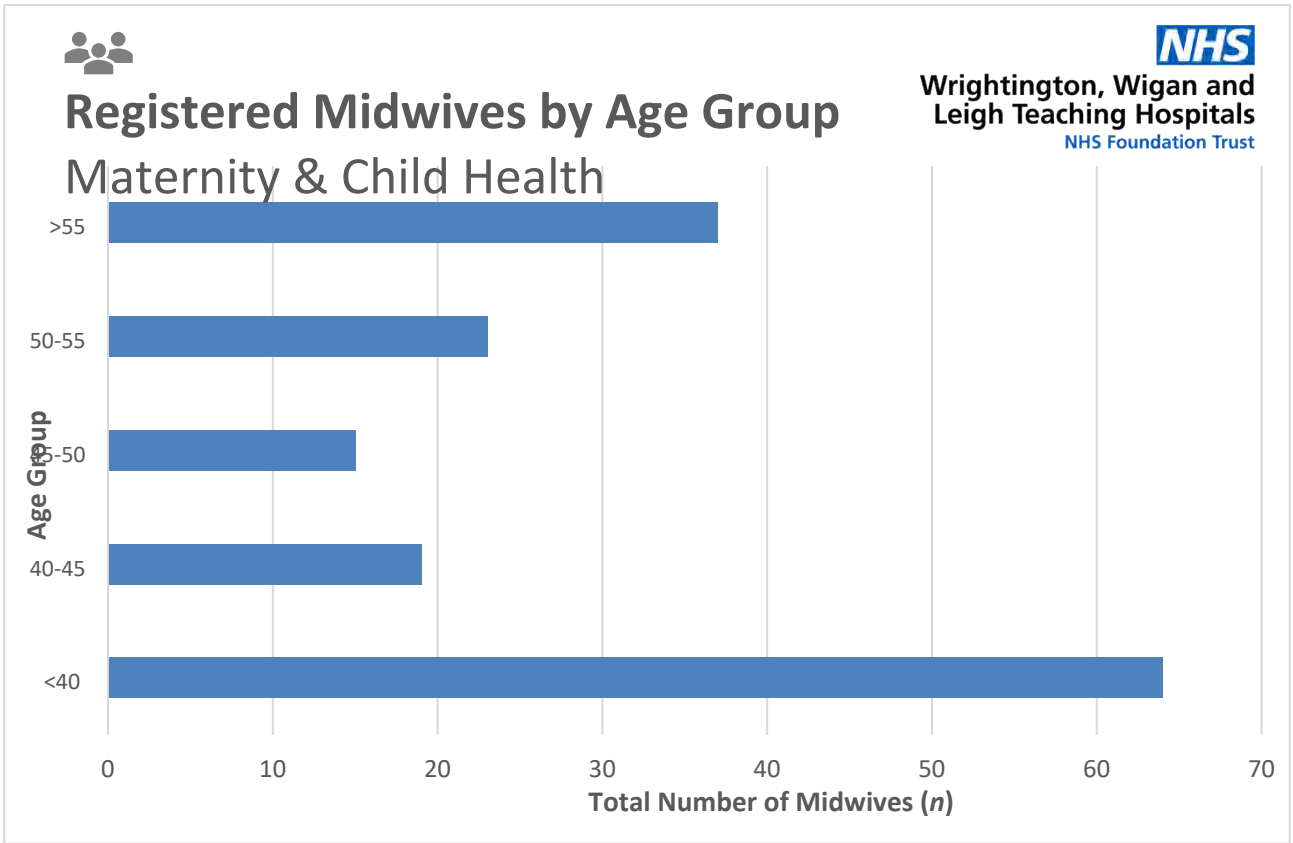
The age profile of the midwifery workforce has shifted slightly in the last 12 months with the biggest group of registered midwives (41%) are now under 40.

21% of staff are aged 40-50yrs

Approximately 38% of the workforce is over 50, with this being more heavily weighted within the higher bands.

Regional and national workforce planning has seen a year-on-year increase in the numbers of student midwives being recruited to Midwifery training programmes in response to the aging workforce and high attrition rates in some areas.


Registered Midwives by Age and Grade
Maternity & Child Health
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust
Total Number of Midwives (n)
45
40
35
30
25
20
15
10
5
0
Band 5
Band 6
Band 7
Band 8
Staff Grade
Age Grou
<40
40-45
45-50
50-55
>55


Registered Midwives by Age Group
Maternity & Child Health
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust
Age Group
>55
50-55
45-50
40-45
<40
0
10
20
30
40
50
60
70
Total Number of Midwives (n)

Supernumerary Shift Coordinators and 1-2-1 Care in Labour

A supernumerary band 7 coordinator is available on each Delivery Suite shift (defined as having no caseload of their own during their shift) this is the gold standard recommendation to provide a helicopter overview. This is to ensure safe oversight of all activity within the unit and to provide support and guidance to all staff. Furthermore, the provision of one-to-one care in active labour is reported to ensure safe staffing, these reporting metrics are shared with the trust board and the local clinical networks.

The Maternity Incentive Scheme Year 5 has been explicit for this reporting period that noncompliance with supernumerary shift coordinator cannot happen more than once per week, which is putting additional pressure on the Maternity Senior Managers on call as they will have to attend the unit when this is not able to be facilitated or risk failing CNST, as an action plan is not able to be submitted to demonstrate compliance for this standard.

Data is collated from the Birthrate Plus acuity tool which is completed 4 times per day. If the entry is not imputed at the designated time, it will not be recorded on the graphs, however an additional data entry can be inputted to provide narrative for viewing.
The perinatal surveillance dashboard and maternity dashboard capture this standard to evidence compliance.

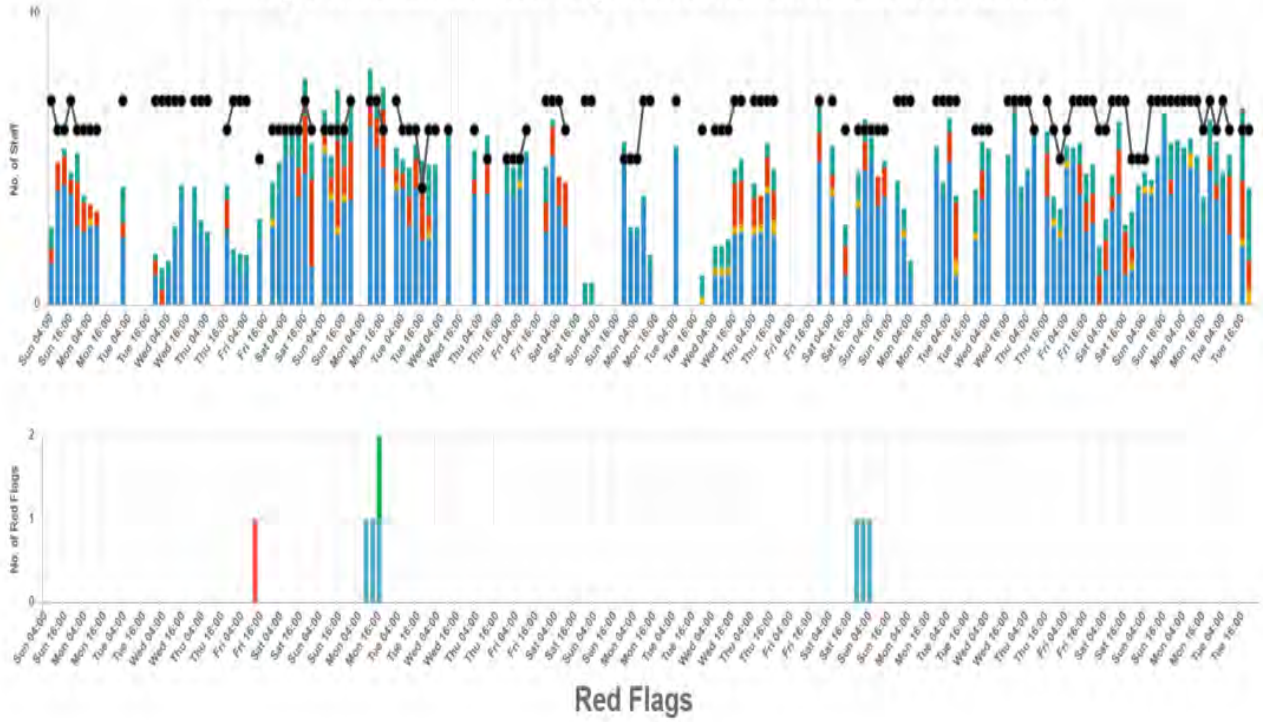
Maternity Fed Flags

Maternity red flags events are captured on the monthly dashboard and currently reported via Datix.
With the introduction of the BR+ acuity tool there has been a significant rise in red flag events as these are being captured real time by the shift coordinator and not reliant on staff reporting via Datix. Whilst there is a rise it is considered to be a more reflective and accurate recording of these events and will be closely monitored for any themes or trends and the data analysed to ensure it is not reporting the same event numerous times.
(See below for an example of the Acuity Tool. The red flag in red is the shift Coordinator not being Supernumerary).

birthrateplus® | Safe Staffing for Maternity Services

Wrightington, Wigan and Leigh NHS Foundation Trust - Delivery Suite

Staffing v Workload with Red Flag Events From 01/10/2023 to 31/10/2023



Number & % of Red Flags Recorded

From 01/10/2023 to 31/10/2023

RF1	Delayed or cancelled time critical activity	6	75%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	13%
RF10	Coordinator unable to maintain supernumerary status - providing 1:1 care	0	0%
RF11	Coordinator unable to maintain supernumerary status -NOT providing 1:1 care	1	13%
	Total	8	

Escalation policy

The maternity service follows the agreed Greater Manchester and Eastern Cheshire Maternity Escalation Procedures leading to a Temporary Divert Policy, which includes mitigation and escalation for managing any shortfalls in staffing.

A maternity SitRep is completed daily and shared with maternity managers. A GM wide electronic SipRep is also in place to be completed daily and will include the status from all GM Maternity units and monitored through the Local Maternity System (LMNS) in conjunction with NWAS.

This is supported by the Birthrate+ acuity tool across the maternity floor (currently only in use on delivery suite as awaiting the postnatal update) which has been purchased to support the real time reporting of acuity and activity and will identify where staff are required and provide assurance that the correct staffing levels are in place against activity and acuity.

Enhanced continuity Community Teams

The roll out of enhanced continuity teams is linked to the Long-Term Plan to help improve outcomes for the most vulnerable mothers and babies and two enhanced Continuity Teams have been established which focus care on women at greatest risk of poor outcomes from the most deprived neighbourhoods in deciles 1&2, as defined by the Indices of multiple Deprivation (IMD). They will provide care to all women of Black, Asian and minority Ethnic backgrounds regardless of deprivation decile once staffing levels allow, currently they are providing enhanced care for all non-English speaking women and those in decile 1. It is notable that the number of Black, Asian, or Mixed ethnicity women lining within the Borough is increasing year on year and currently is approximately 13.79%

Staffing for the enhanced teams has come from within the current establishment as community teams caseloads have been adjusted. There are approximately 40% of women that live in a postcode from the bottom deciles of deprivation i.e., Decile 1&2.

The teams will expand with the plan to eventually support enhanced teams for women within deciles 1-4, as vacancies are filled, and the budgeted establishment is increased to include Birthrate+ recommendations and an additional uplift to 25%. This in effect is a return to geographically based community midwifery with realistic caseloads that allows for continuity in the antenatal and postnatal period with additional time for support and holistic care provision.

Daisy Team.

Daisy team is a team of 7 Midwives, 2 maternity Support workers and an admin assistant. Daisy team provide care to the most complex and vulnerable women within the Borough and hold a much-reduced caseload which is approximately 175 women per annum. Currently WWL receive some funding from the local authority, however this funding has not increased since the team was first in place and the team has increased from the original 3 Midwives to its current establishment which was increased when continuity of Care was introduced, and a 24/7 service was provided by Daisy team.

When Continuity of care was stepped down due to staffing shortfalls the staffing establishment for the team was not aligned back to the previous funding stream and therefore, the service is currently funding these posts at risk within its current budget. Work is ongoing with the ICS to establish an appropriate funding stream for this team if it is to continue in its current form or to identify what the team caseload would look like moving forward.

Summary.

Maternity staffing over the last 12 months has significantly improved however staff retention and attraction is the key to ensure safe and effective maternity services.

The evidence described in this report identifies the work force planning that is being undertaken and the planning tools (BR+) being used currently to review establishments.

The report identifies the actions that have been taken to reduce staff shortages locally , however the experience of working through the COVID-19 pandemic and the numerous reports highlighting concerns within Maternity Services has led to the low staff morale nationally, this combined with midwives' retirement, relocation, promotion, it impacts locally on midwifery recruitment and retention and work needs to continue to support the Midwives we have to remain in post.

By introducing new models of maternity staffing with new roles, opportunities for development and promotion alongside more flexible working patterns to improve work life

balance, this will support and sustain the current midwifery workforce, but this will require continual investment to ensure that a safe maternity service can be provided.

The shortfall in the 6.52 wte unfunded posts will continue to require backfill to ensure that all training requirements are met in line with The Maternity Incentive scheme year 5 and onwards into Year 6.

It is recognised that the current financial restraints will determine whether the recommendations for an additional uplift and increase in baseline staffing is accepted. Additionally, it is important that WWL continue discussions with the ICS considering the significant shortfall in funding for the Daisy Team, as this model with improving outcomes for the most vulnerable women is very much unique to Wigan Maternity services and the Wigan Borough Local authority.

Appendix 1.

Ward / Department	Role	Band	Current Budgeted WTE	Contracted Actual WTE	BR+ / Required WTE	Budget to BR+/Required Variance WTE
Delivery Suite	Shift Coordinator	7	6.24	6.28	5.38	0.86
	Core Midwives	6/5	26.04	25.18	26.90	(0.86)
	Induction of Labour Bay	6/5	5.38	5.38	5.38	0.00
Maternity Ward	Core Midwives	6/5	18.83	17.50	18.83	0.00
	Elective C-Section	6/5	1.54	1.54	1.54	0.00
Triage	Triage	7/6	8.06	8.36	8.06	0.00
DAU	DAU	6	0.72	0.48	0.72	0.00
Ante Natal Clinic	Ante Natal Midwives	7/6	8.74	7.52	8.74	0.00
Community Midwives	Core Midwives	7/6	25.11	23.30	25.10	0.01
Daisy Team	1:12 Ratio	7/6	6.50	7.30	7.00	(0.50)
Enhanced Community Team 1	1:36 Ratio	7/6	4.50	4.06	4.50	0.00
Enhanced Community Team 2	1:36 Ratio	7/6	4.50	4.02	4.50	0.00
Supernumerary Management Time	Delivery Suite	7	1.00	0.96	1.00	0.00
	Maternity Ward	7	1.00	1.00	1.00	0.00
	Ante Natal Clinic	7	0.50	0.00	0.50	0.00
	Triage & Day Assessment	7	0.50	0.00	0.00	0.50
	Community	7	1.50	1.50	2.00	(0.50)
	Daisy Team	7	0.50	0.50	0.50	0.00
	Enhanced Team 1&2	7	1.00	1.00	1.00	0.00
Subtotal			**122.16**	**115.88**	**122.65**	**(0.49)**
Specialist Midwives	Governance and Risk midwife	7	1.00	1.00	1.00	0.00
	Digital Midwife	7	1.00	1.00	1.00	0.00
	Infant Feeding	7/6	1.80	1.80	1.80	0.00
	Perinatal Mental Health Midwife	7	1.00	1.00	1.00	0.00
	Practice Development Midwife	7	1.00	1.00	1.00	0.00
	3rd Trimester Scanning	7	0.32	0.32	0.16	0.16
	Bereavement Midwife	7	1.60	1.60	1.40	0.20
	SBL Lead Midwife	7	1.00	1.00	1.00	0.00
	SBL Midwife	7	0.60	0.00	0.60	0.00
	Screening Midwife	7	1.20	1.20	1.20	0.00
	Diabetes Specialist Midwife	7	1.00	1.00	1.00	0.00
	Quality & Safety Midwife	7	1.00	1.00	0.60	0.40
	Fetal Surveillance Midwife	7	1.00	0.00	1.00	0.00
	Smoking Cessation Midwife	7	1.00	0.96	0.96	0.04
	Perinatal Mental Health Midwife	6	1.00	0.00	1.00	0.00
	Education Lead for Maternity Outpatients	7	1.00	0.00	1.00	0.00
Subtotal			**16.52**	**12.88**	**15.72**	**0.80**
Funded secondments from current establishment that	Practice Education Facilitator (NHSEI Funded	7	0.00	0.80	0.80	(0.80)
	Preceptorship Midwife (NHSEI Funding)	7	0.00	1.00	1.00	(1.00)
Managerial Roles	Div Dir of Midwifery and Child Health	8d	1.00	1.00	1.00	0.00
	Dep Div Dir of Midwifery and Child Health	8c	1.00	1.00	1.00	0.00
	In Patient Matron	8a	1.00	0.96	1.00	0.00
	Outpatient Matron	8a	1.00	0.00	1.00	0.00
	Head of Governance	8b	1.00	1.00	1.00	0.00
Specialist/Managers	Fetal Surveillance and Safety Lead Midwife	8a	1.00	1.00	1.00	0.00
	Transformation and Project Lead Midwife	8a	1.00	1.00	1.00	0.00
Subtotal			**7.00**	**7.76**	**8.80**	**(1.80)**
Grand Total			**145.68**	**136.52**	**147.17**	**(1.49)**

20% to 25% Uplift	4.81
Total additional budget required	**6.30**

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 it.**

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 each 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 - **safety action 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 2022/23 financial year or 2023/24 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 1 February 2024.

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 1 **February 2024** 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_2024

Safety action No. 1

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

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
5	Were 60% 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 60% of the reports published within 6 months of death?	Yes
7	Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales?	N/A
8	Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	N/A
9	If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted?	N/A
10	PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted?	N/A
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
12	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	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.	Yes
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 30 May 2023 until 7 December 2023

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.		
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? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● 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) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	Yes
8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	N/A

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity :		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	Yes
2	**OR** b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	Yes
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Yes
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	N/A
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	No
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	Yes

8	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person?	Yes
9	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	Yes
Do you have evidence that the Trust position with the above has been shared:		
10	At Trust Board?	Yes
11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
13	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes
	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)	
c) Neonatal medical workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	No
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
16	LMNS?	Yes
17	ODN?	Yes
d) Neonatal nursing workforce		

18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	Yes
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	N/A
Was the agreed action plan shared with:		
20	LMNS?	N/A
21	ODN?	N/A

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

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? Evidence should include: 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? Evidence should include: ● 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. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● 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. ● 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.	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. Can you provide 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? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status 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 an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes
4	d) Have all women in active labour received one-to-one midwifery care?	Yes
5	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
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	Yes
7	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 five reporting period?	Yes

Safety action No. 6

Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2022 to 1st December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes
5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes
Can you demonstrate the following at the end of 12 consecutive months ending December 2023? 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted. If this is the case, please select 'Yes'		
Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
10	90% of obstetric consultants?	Yes
11	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)?	Yes

12	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
Maternity emergencies and multiprofessional training		
13	90% of Obstetric consultants?	Yes
14	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
15	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?	Yes
16	90% of maternity support workers and health care assistants attend the maternity emergency scenarios training?	Yes
17	90% of obstetric anaesthetic consultants?	Yes
18	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota?	Yes
19	Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care?	Yes
20	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area **or** does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support		
21	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
22	90% of neonatal junior doctors (who attend any births)?	Yes
23	90% of neonatal nurses (Band 5 and above who attend any births)?	Yes
24	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
25	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)?	Yes
26	All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024.	Yes
27	Have you declared compliance for any of Q10-Q25 above with 80-90%?	No
28	If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period?	N/A

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)
1	**Required Standard A.** **Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	Yes
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	Yes
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Yes
Required standard B. **Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:**		
5	The Trust Board?	Yes
6	LMNS/ICS/Local & Regional Learning System meetings?	Yes

7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes
8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C.** **Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes
11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	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
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	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 that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

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 (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes

7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and ‘in-house’, one day multi professional training?	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/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	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	Q4 Clinical workforce planning	**To be met by**	Q2 = 2025/26

Work to meet action	*Outline Business case completed to fund ANNP training and therfore increase the level of cover by an additional 2 x ANNP (Band 8a) to increase compliance with the Tier 1 rota 24/7 to cover the Neonatal Unit. 3 Long Term Locum Srtaff Grade have also been recruited additionally thereby improving dedicated NNU cover overall.*

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

Action plan owner	*Christos Zipitis Divisional Medical Director and NNU Lead Paeadiatrician . Cathy Stanford Divisional Director of Maternity and Child Health*
Lead executive director	*Professor Sanjay Arya Medical Director Baord Level Safety Champion. Rabina Tindale Chief Nurse Board Level Safety Champion*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Tier 1 cover for NNU should not just be a tick box exercise but rather come with enhanced quality of care. The overwhelming majority of medics on Tier 1 rota are GP trainees who struggle with neonatal procedures and have no experience/expertise in neonates. The number of career trainees on this rota is low and we need to increase this number together with the number of ANNPs to meet this standard reliably and add to the*
Rationale	*By Increasing the numbers of advance Neonatal Nurse practitioners and the number of career paediatricians on Tier 1 rota we will be able to offer continuous, reliable and sustainable 24/7 cover for the neonatal unit. This will increase the quality of care for this patient population*
Benefits	*Rota cover improved with dedicated SHO covering 9-9 7 days per week. Existing ANNP also able to cover some weekend or night shifts as duties allow, once trained (12 months) additional 2 ANNP will be able to provide a more robust rota cover. Rota templates have been developed which will require approval which are inclusive of ACP's and together with the career paediatricians on Tier 1 rota should be able to improve the*
Risk assessment	*24/7 dedicated Neonatal cover will not be achieved , and the risk is that Neonates may not be provided with optimum medical care if medical staff are busy within other areas of the service.*

	How?	**Who?**	**When?**
Monitoring	ation plan remains ongoing monitored through Divisonal Governance Forums the the Local Neonatal	Head of Governance	Monthly review and updating as necessary. Submission as requested by the NNODN

Action plan 2

Safety action	Q4 Clinical workforce planning	**To be met by**	Q2 = 2025/26

Work to meet action

Increase number of Consultant Obstetricians to provide compensatory rest 7 days per week. Job plans have been aligned to minimise risk of cancellations the following day when Compensatory rest is to be taken following busy on call shifts. Weekend on calls have been split to prevent long periods on call. A business case has been produced to increase the consultant body

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

Action plan owner

Divisional Operational Team

Lead executive director

Professor Sanjay Arya Medical Director,. Board Level Safety Champion.

Amount requested from the incentive fund, if required

Reason for not meeting action

Funding needs to be sourced for increased posts as not enough consultants in post to provide 7 day per week cover

Rationale

Currently Commpensatory Rest is covered within the on call rotas at weekends only. Job plans have been reviewed to ensure that duties following on calls are not critical such as theatre sessions

Benefits

Job plan reviews ensure that safety and productivity is maintained across the service and that rest periods are optimised. Split on calls over the weekend allow for more rest time as whole weekend of on call shifts are now discontinued to prevent onerous and exhausting working patterns during periods of increased activity and accuity. Risk had been added to the Corporate Risk register for ongoing monitoring and review.

Risk assessment

Clinicains will continue to work outside of the RCOG recommendations if additional Consultants are not employed, funding for these posts is the primary issue at present however this is actively being progressed within the Trust.

	How?	Who?	When?
Monitoring	Corporate Risk Register and Divisonal Governance Forums.	Maternity and Neontal Quadumverite and Corporate Risk team (	Monthly

Action plan 3

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	

	How?	Who?	When?
Monitoring			

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			

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	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes	Yes	-	You have met the action as well as submitting an action plan, please check
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	**10**	**1**		**You have a validation on 1 safety action. Please recheck the tab B (Safety Actions Summary Sheet) and/or tab C (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS Resolution.**
Total sum requested			**-**	

Sign-off process confrming 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.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** 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.
* 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 group will escalate to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Wrightington, Wigan and Leigh NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
For and on behalf of the board of	Wrightington, Wigan and Leigh NHS Foundation Trust
Name:	
Position:	
Date:	

Agenda item: [22]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 7 (October 2023)
Presented to:	Board of Directors
On:	6th December 2023
Presented by:	Tabitha Gardner [Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: Heather.Shelton@wwl.nhs.uk

Executive summary

Description	Performance Target	Performance	Explanation
Revenue financial plan	Achieve the financial plan for 2023/24.	Amber	The Trust is reporting a deficit of £9.7m year to date, which is £8.5m adverse to plan. As per the NHSE guidance, we have included our assessment of API underperformance year to date within the month 7 position (but not within forecast). Our current assessment is an underperformance of £5.0m, which is driven by reduced activity during industrial action. Our assessment is based on the NHSE reported values for months 1-4 and internal calculations for months 5-7. This includes the 2% reduction for the industrial action in April. Of the underperformance, an estimated £2.3m is outside of the GM ICB. There is £1.5m of expenditure associated with the industrial action within the year to date position. This is not reflected within the NHSE full year forecast as it is assumed that these will be funded to negate the financial impact above plan. On 8th November 2023, NHSE announced an additional £800m nationally to cover the cost of industrial action to date. At the time of writing, the impact of this is being assessed for both GM ICB and the Trust. Escalation expenditure of £6.1m has been incurred year to date. Work continues to safely de-escalate the main hospital site. So far there have been some reductions in the use of escalated areas, with work ongoing with external agencies (Newton Europe and ECIST) and the locality to reduce non elective length of stay. CIP delivery has been above plan for month 3 to 7, with the year to date underperformance of £0.5m reflecting slippage in month 1 to 2. This is expected to be recovered with forecast delivery of the CIP target of £24.4m in

			full (a saving of c.5%). Work is underway to develop CIP plans for the next two years. The Trust has planned for non-recurrent balance sheet support of £8.9m within the 2032/24 plan. Year to date, £7.8m has been released through a full review of payables and deferred income. This is £4.0m above the planned release of £3.9m. This has been utilised to mitigate the underlying run rate whilst work continues to reduce this. The final plan for 2023/24 included an income assumption of £11.9m from Wigan Council. On the 19th June, Wigan Council notified the Trust that they are now unable to provide funding in 2023/24 due to their own financial position. As at month 7, £5.0m has been bridged against the £11.9m. This includes £1.5m funding from GMICB for the Jean Hayes Reablement Unit, of which £0.9m has been recognised YTD. At the last FPRM meeting it was acknowledged that there is a shared responsibility within the ICB to resolve this issue. At present, the Trust is formally forecasting to deliver the full year planned deficit of £6.5m. The current most likely scenario, shared with GM and NHSE is a deficit of c£12m. There are significant risks to achievement of the financial plan including delivery of CIP (£24.4m), mitigations to the loss of council income (£11.9m), the impact of further industrial action, de-escalation and delivery of the elective activity plan.

Activity	Achieve the elective activity plan for 2023/24.	Red	The month 7 activity data highlights that the Trust has not achieved the YTD elective activity plan that was submitted to NHSE and this this has been impacted by industrial action. The month 7 position includes an under performance of £5.0m YTD and includes the notified target reduction of 2% for April's industrial action. As advised by GM ICB, we have excluded the YTD over performance on GM ICB unbundled activity (£1.0m) within our reported month 7 position. The Trust received notification on the 8th November of a revised target reduction to account for industrial action from June to October which would improve the YTD position by £0.7m but does not cover the full impact of the industrial action.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Amber	Cash is £21.2m at the end of month 7 which is £8.4m below plan. Cash has decreased by £2.1m from the previous month. The variance to plan relates to the revenue deficit, capital underspend and other timing differences. The operating cash days metric is 16 days at the end of October compared to 18 at the end of September.
Capital expenditure (CDEL)	Achieve CDEL for 2023/24.	Amber	Capital expenditure against internal CDEL was £1.5m in month 7 against a plan of £1.2m, which is £0.3m above plan. Year to date, capital expenditure is £2.4m below the internal CDEL plan. This is primarily due to Community Diagnostic Centre (CDC) and Leigh Laminar Flow Theatre, which is expected to be recovered during the year. A number of GM providers have reduced their forecast CDEL spend to reflect the agreed adjustments to mitigate the system overcommitment. For WWL, this was a reduction of £1.1m from £11.6m to £10.5m.

Cost Improvement Programme (CIP)	Deliver the planned CIP of £24.4m, of which £19.7m is recurrent.	Amber	In month 7, £2.1m CIP has been delivered which is above plan. Year to date, CIP delivery is £0.5m below plan due to slippage in the first two months. As at month 7, the in-year unidentified gap is £0.4m (2%). The divisional recurrent CIP target includes £0.2m unidentified with a significant proportion remaining high risk. There are non-recurrent mitigations in place to offset this. The unidentified gap relates predominantly to the centralised CIP.
Temporary expenditure	To remain within the agency ceiling set by NHSE and reduce bank expenditure.	Amber	Divisional agency expenditure is £0.9m in month 7, a slight increase from last month. The Trust is operating within the agency ceiling with agency representing 2.8% of the total pay bill year to date (compared to the ceiling of 3.7%). Bank expenditure within the divisions was £2.5m in month 7, a decrease of £0.1m from last month.
Business conduct	Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days.	Amber	BPPC for month 7 is 93.9% by volume and 92.2% by value, which is similar to previous months. An action plan is in place to improve the BPPC to the target of 95.0%.
Financial risk	Report the financial risks through the Board Assurance Framework.	Red	The financial environment for 2023/24 for both revenue and capital is extremely challenging and is likely to impact on the ability of the Trust to deliver its strategic objectives. The Trust continues to engage with PWC and the turnaround director on several areas including financial controls, the statement of financial position, underlying position and the financial scenarios. There are a range of risks which are driving an underlying deficit, including continued escalation into unfunded areas, high volumes of no right to reside patients and sustained levels of high length of stay. Other risks include bridging the loss of the Wigan Council income, delivery of the activity plan, likely further industrial action, temporary staffing spend, delivery of the CIP plan and cost inflationary pressures.

Link to strategy

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

Risks associated with this report and proposed mitigations.

There is a significant financial challenge associated with delivery of the planed deficit of £6.5m, as well as the sustainability risk of operating at a deficit. The Trust is currently £8.5m adverse to plan at the end of month 7, which exceeds the planned deficit for the financial year by £2.0m.

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

There is a risk to delivery of the activity plan, primarily due to the loss of activity during industrial action. Year to date, the estimated impact against the NHSE plan is an underperformance of £5.0m. On 8th November, NHSE announced £800m additional national funding to support the impact of industrial action on NHS providers. The funding will be allocated to systems based on the number of staff that were impacted by industrial action, with a GM ICB allocation of £46.3m (5.6% of the £800m). Each ICB has been asked to determine the distribution of funding within their system, taking account of all financial pressures and risks. NHSE have set out an expectation that all systems deliver their agreed 2023/24 plan following receipt of this funding (a break even plan for GM ICB).

Other issues presenting material risks to delivery of the revenue plan are delivery of the planned CIP of £24.4m, the impact of further industrial action and the safe reduction of expenditure associated with escalation over the winter period. Further work is ongoing within the Trust transformation programmes as well as the ICB and the locality to address escalation. Fortnightly updates on CIP are provided to either the Transformation Board or Executive Team. Newton Europe have been commissioned to provide a system wide diagnostic review which will then quantify the opportunities to improve the effectiveness and efficiency across the Wigan system. The diagnostic work will focus on admission avoidance, length of stay within WWL, discharge pathways and outcomes and Intermediate Care. The Trust is expecting an opportunities matrix to be published imminently to support the design and implementation of new efficiency schemes.

The Trust has planned for non-recurrent balance sheet support of £8.9m within the 2032/24 plan. Year to date, £7.8m has been released through a full review of payables and deferred income. This is £4.0m above the planned release of £3.9m. This has been utilised to mitigate the underlying run rate whilst work continues to reduce this. In month 7, there is £0.6m of balance sheet release, in line with the monthly plan. The most likely scenario assumes that £11.9m of balance sheet support is released in total to support the 2023/24 financial position.

Three scenarios have been modelled to consider the year end deficit in a best case, mid case and worst case. These range from the best case scenario being delivery of plan to the worst case scenario being a deficit of £16.3m (£9.8m worse than plan). The current mid case scenario is a £11.8m deficit (£5.3m worse than plan). There has been no material change to the mid case forecast scenarios over the last 3 months. The forecast scenarios have not been adjusted to consider the impact of the additional industrial action funding and ERF baseline adjustment announced on 8th November 23.

At present the Trust's cash balance is below plan, but there remains sufficient cash to service the planned deficit and the planned capital program. The loss of the Council income had a direct impact on cashflow and will need to be mitigated to preserve cash. A cash management strategy is under development both locally and across Greater Manchester, with cash expected to become an issue for several providers across GM this financial year based on current trajectories.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Wider implications

There are no wider implications in this report.

Recommendation(s)

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

Financial Performance

Key Messages

In month 7, The Trust has reported an actual deficit of £3.5m, which is an adverse variance of £1.4m to plan. The position includes the reduction in income for under performance on the activity plan.

Year to date, the Trust has reported an actual deficit of £9.7m, which is £8.5m adverse to the planned deficit of £1.2m.

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

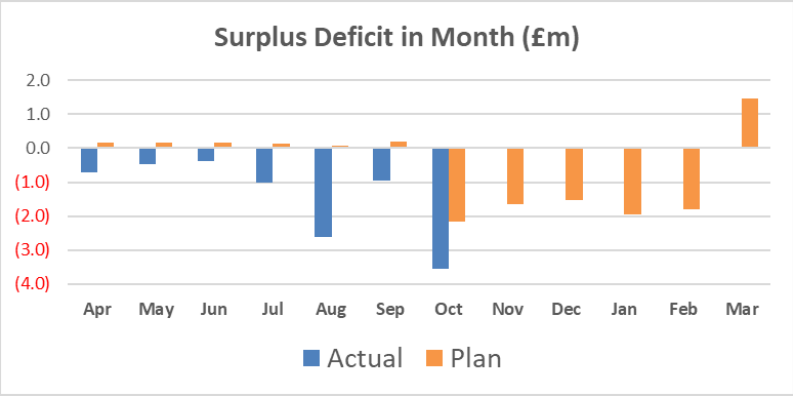
The Trust reported an actual deficit of £3.5m in month 7 (Oct 2023), which is an adverse variance of £1.4m to the plan. Year to date, the Trust is reporting an actual deficit of £9.7m which is £8.5m adverse to plan.

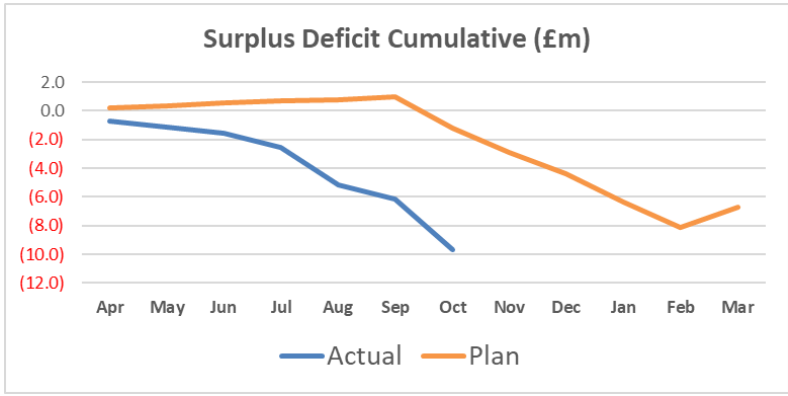
Year to date, GM providers are collectively reporting a deficit of £177.5m, which is £88.3m adverse to plan. The GM ICS draft position for month 7 is not known at the time of writing (month 6 YTD £187.6m deficit; £167.2m adverse to plan). Due to increasing regional and national scrutiny on the financial performance NHSE has authorised additional external support to the system which includes the appointment of a turnaround director with support from PWC.

NHSE have advised to include the performance against the aligned payment incentive (API) within the year to date position, but not the forecast. Our current assessment is an underperformance of £5.0m, which is driven by reduced activity during industrial action.

Escalation expenditure of £6.1m above plan has been incurred YTD and there is £1.5m of pay expenditure associated with the industrial action within the YTD position.

The Trust has planned for non-recurrent balance sheet support of £8.9m within the 2032/24 plan. In month £0.6m has been released, and year to date £7.8m has been released through a full review of payables and deferred income. This is £3.9m above the planned release of £3.3m.





Key Financial Indicators

Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Financial Performance							
Income	40,280	41,344	(1,064)	288,839	296,728	(7,889)	506,768
Pay	(30,226)	(29,850)	(376)	(209,204)	(203,897)	(5,307)	(351,791)
Non Pay	(11,856)	(11,851)	(5)	(76,893)	(81,500)	4,607	(139,842)
Financing / Technical	(1,740)	(1,816)	76	(12,419)	(12,556)	138	(21,829)
Surplus / Deficit	(3,542)	(2,173)	(1,369)	(9,677)	(1,225)	(8,452)	(6,693)
Adjusted Financial Performance *	(3,526)	(2,157)	(1,368)	(9,619)	(1,112)	(8,506)	(6,500)
Memo Items							
CIP	2,091	2,034	57	13,740	14,228	(488)	24,404
Bank Expenditure	2,490	1,164	(1,325)	17,969	6,311	(11,658)	12,136
Agency Expenditure	872	1,049	177	5,780	7,741	1,960	12,593
Cash Balance	21,259	29,660	(8,401)	21,259	29,660	(8,401)	30,403
Capital Spend - CDEL	1,519	1,194	(325)	7,119	9,529	2,410	11,640
Capital Spend - PDC	1,013	821	(192)	6,131	5,750	(381)	13,150

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

Financial Performance

- Income is £1.1m adverse to plan in month and £7.9m adverse to plan year to date. This includes £5.0m of activity underperformance YTD.
- Operating expenditure is £0.4m adverse to plan in month 7. Year to date, operating expenditure is £0.7m adverse to plan.

Temporary Spend

- Bank spend £2.5m in month and £17.9m year to date.
- Agency spend for the Trust is £0.9m in month and £5.8m year to date. Currently below the agency ceiling at 2.8% of total pay bill (ceiling 3.7%).

CIP

- £2.1m transacted in month, which is above plan.
- £13.7m transacted year to date, £0.5m adverse year to date due to slippage in earlier months.
- Split in month: Divisional £1.5m; Centralised CIP £0.6m.

Cash

- £21.3m cash balance.
- £8.4m worse than plan.

Capital

- Capital spend of £2.5m against a plan of £2.0m in month.
- CDEL exependiture £1.5m which is £0.3m behind plan in month.
- PDC expenditure £1.0m which is £0.2m behind plan in month.

Divisional Performance



Medicine

- (£1.1m) Adverse to plan in month
- (£0.7m) Escalation
- (£0.1m) Unachieved CIP
- (£0.1m) Supernumerary staff and unfunded nurses
- £0.1m CDC
- (£0.3m) Other smaller items

Surgery

- (£0.2m) Adverse to plan in month
- (£0.1m) Industrial action
- (£0.1m) Clinical supplies and drugs
- £0.1m CIP
- (£0.1m) Other smaller items

Specialist Services

- £0.2m Favourable to plan in month
- (£0.2m) PAWS
- £0.1m CIP
- £0.1m Private patient income
- £0.1m Vacancies
- £0.1m CDC

Community

- On plan
- £0.2m vacant posts
- £0.1m – Virtual Hub & Frailty SDEC
- (£0.1m) Non pay pressures
- (£0.3m) Temporary staffing spend – vacancy cover (DN, CAU, JHRU)
- (£0.1m) Other smaller items

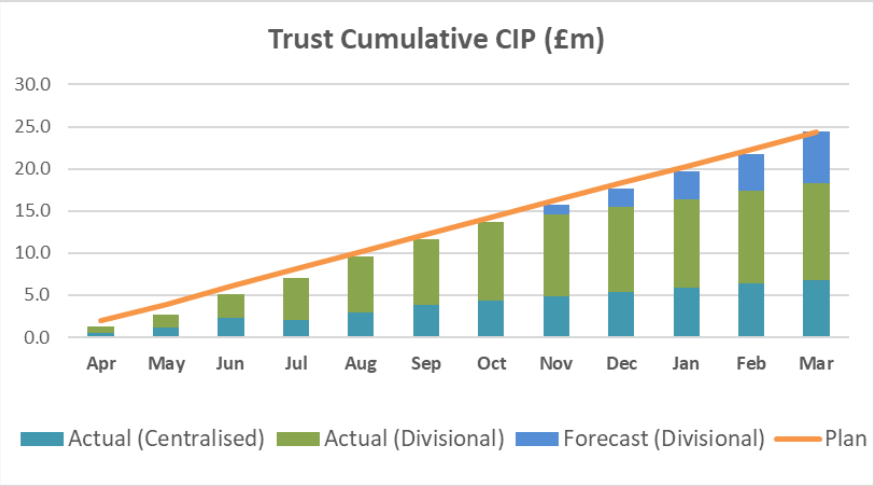
Estates & Facilities

- £0.3m Favourable to plan in month
- £0.3m Energy
- (£0.1m) Inflationary pressure on leases
- £0.1m Other smaller items

Corporate Divisions

- £0.4m favourable in month
- £0.3m IM&T – vacancies and non-pay
- £0.1m Medical Director

Cost Improvement Programme



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

In month 7, actual CIP of £2.1m has been transacted which is on plan. £1.5m has been transacted against the divisional CIP target (including the divisional stretch).

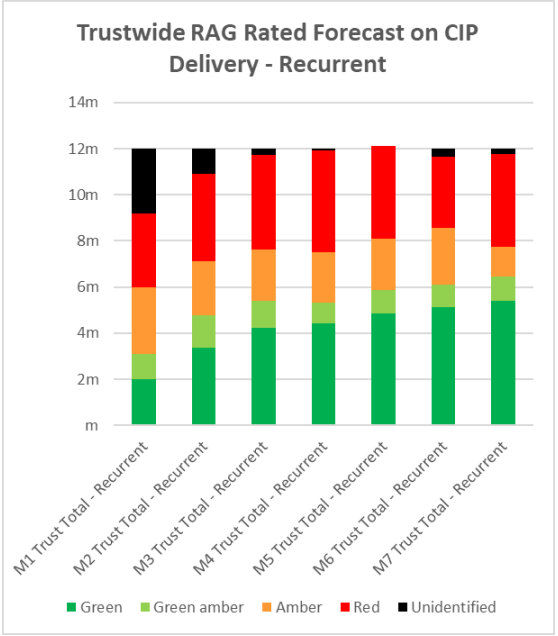
The Divisional CIP transacted in month is split £1.0m for transactional schemes and £0.4m for transformational schemes.

The chart on the right shows the RAG rated forecast for the divisional CIP of £12.0m. As at month 7, the in-year unidentified gap is now £0.7m (6%). The recurrent CIP gap is now £0.2m.

£5.4m has been transacted recurrently in year for divisional CIP. This comprises of £1.1m private patient income, £2.5m of non-pay savings, with the remainder being a combination of smaller schemes.

Transformational schemes are £2.6m of the in-year forecast which includes income from private patients and an improvement in spend being driven through the Model Hospital/ Nation Cost Collection Index programme.

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



Forward Look

	Following the Financial Performance and Recovery meeting on 24th October 2023, the following actions were formally requested for the next meeting on 7th December: • To consider what joint action can be taken with the ICB to engage with the local authority and ascertain the mitigating measures that can be taken to bridge the income gap. • To outline the mitigating measures to be taken in year to minimise the likelihood of the Trust failing to deliver its plan. • To provide a progress update on implementation of grip and control measures and to quantify the anticipated benefit. • To share the high level two year transformation programme. • To revise the report into non-essential, loss-making services.
	Newton Europe have been commissioned to provide a system wide diagnostic review which will then quantify the opportunities to improve the effectiveness and efficiency across the Wigan system. The diagnostic work will focus on admission avoidance, length of stay within WWL, discharge pathways and outcomes and Intermediate Care. The Trust is expecting an opportunities matrix to be published imminently to support the design and implementation of new efficiency schemes.
	The BMA have announced a pause in industrial action for junior doctors and consultants during November. This is to provide an opportunity for constructive negotiation to commence to resolve the pay dispute. However, it should be noted the BMA are balloting their members to extend strike mandates across the consultant and junior doctors. SAS doctors are also being balloted on taking action during November and December.
NHS England	NHSE have published details of their plan to start addressing the significant financial challenges created by industrial action in 2023/24. There is an allocation of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding and a reduction in the elective activity target for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year. Discontinuing the application of holdback to the Elective Recovery Fund (ERF) for the rest of the year and formally allocating systems their full ERF funding. The GM ICB share of the £800m is £46.3m (5.8%), with decisions required by the ICB about how this will be distributed within systems.

	A ‘Future Funding Flows’ task and finish group has been created within GM. The purpose of the group is to produce a full contract reconciliation for all providers to identify areas where costs and income are not aligned and where commissioning decisions are required. The group is reconciling the flow of system funding, covid funding and ERF between current funding streams and historic intentions. The system funding work is intrinsically linked to the contract reconciliation and will be used in the development of medium and long term financial plans.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

M7 Balanced Scorecard

Board of Directors Meeting:
6 December 2023

M7 Scorecard

Quality and Safety (Chief Nurse & Medical Director)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
SHMI Rolling 12 Months	Jul-23	106.73	100	●	▲	106.73
HSMR Rolling 12 months	Aug-23	92.80	100	●	▲	92.80
Never Events	Oct-23	0	0	●	↔	2
Number of Serious Incidents	Oct-23	8	10	●	▲	54
STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers	Oct-23	1	0	●	▼	8
STEIS Reportable Serious Falls	Oct-23	0	0	●	↔	0
Methicillin-Resistant Staphylococcus Aureus (MRSA)	Oct-23	0	0	●	↔	0
Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Oct-23	2	0	●	▲	9
Clostridium Difficile (CDT)	Oct-23	6	4	●	▲	33
Complaints Responses	Oct-23	79.4%	85%	●	▲	72.08%
Patient Experience (FFT)	Oct-23	89.3%	N/A	N/A	▲	90.09%

People (Chief People Officer)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Leaders Forum reach (Number of Leaders attending the Forum)	Oct-23	118	110	●	▼	1,019
FTSU contacts	Oct-23	3	-		▼	38
Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog / Blog)	Oct-23	7	6	●	↔	47
Your Voice Score (QTR) - Engagement score	Jun-22	3.94	4.0	●	↔	
Your Voice Score (QTR) - Psychological Safety	Jun-22	3.71	3.75	●	↔	
Your Voice Score (QTR) - Well-being score	Jun-22	3.35	3.5	●	↔	
Mandatory training compliance	Oct-23	95.54%	95%	●	▼	95.88%
Rostering timeliness	Oct-23	64.86%	75%	●	▼	75.29%
Appraisal	Oct-23	80.52%	90%	●	▼	80.92%
Usefulness of Trust wide communication	Nov-22	81.00%	70%	●	↔	N/A
Rate card adherence (Medical)	Oct-23	39.28%	80%	●	▼	46.36%
% Turnover Rate	Oct-23	8.95%	10%	●	▲	9.32%
Vacancy rate	Oct-23	6.20%	5%	●	▲	5.90%
Sickness - %age time lost	Oct-23	5.55%	5%	●	▲	4.86%

Performance (Deputy Chief Executive)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Ambulance handovers 60+ minutes delay	Oct-23	97	0	●	▼	598
Reduce 12-hour waits in EDs	Oct-23	14.9%	10%	●	▲	14.54%
A&E waiting times : patients seen within 4 hours	Oct-23	67.53%	76.41%	●	▼	69.50%
G&A Bed Occupancy - Acute Adult Inpatient Wards	Oct-23	98.59%	95%	●	▲	98.68%
85% Paediatric Bed Occupancy	Oct-23	65.40%	85%	●	▲	51.75%
85% Critical Care Bed occupancy for Adults and Children	Oct-23	52.33%	85%	●	▼	60.59%
Virtual ward patients	In Dev.					
No Right to Reside Patients (excluding Discharges)	Oct-23	144	50	●	▲	144
Cancer - waits longer than 62 days	Oct-23	42	43	●	↔	42
Patients waiting over 78 weeks (except patient choice and clinically complex)	Oct-23	0	0	●	↔	-
Total patients waiting over 65 weeks (except patient choice and clinically complex)	Oct-23	1,269	216	●	▲	1,269
Reduce waits of over 52 weeks by 50% by March 2024	Oct-23	4,247	1,800	●	▲	4,247
Percentage of patients waiting less than 6 weeks for diagnostic tests	Oct-23	67.86%	87%	●	▼	75.00%
Diagnostic activity compared to 19/20 levels	Oct-23	14,443	14,361	●	▼	103,554
Meet the cancer faster diagnosis standard by March 2024	Sep-23	81.00%	67.5%	●	▲	78.58%
Reduction in outpatient follow-ups	Oct-23	21,621	22,876	●	▲	21,621
Day case rate	Oct-23	85.25%	84%	●	▲	84.27%
Elective Theatre Utilisation	Oct-23	85.44%	85%	●	▼	83.33%
Elective Recovery Plan	Oct-23	97.05%	100%	●	▲	93.94%
2-hour urgent community response	Sep-23	75.70%	70%	●	▲	74.62%

Finance (Chief Finance Officer)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Cash (£'000s)	Oct-23	21,259	29,660	●	▼	201,963
Cost Improvement Programme (CIP) (£'000s)	Oct-23	2,091	2,034	●	▲	13,740
Capital Expenditure (£'000s)	Oct-23	2,532	2,015	●	▼	13,250
Agency Expenditure (£'000s)	Oct-23	872	1,118	●	▲	5,780
Better Payment Practice Code (BPPC)	Oct-23	94.60%	95%	●	▲	93.85%
Agency % of Total Pay	Oct-23	2.88%	3.7%	●	▲	2.76%
Adjusted Financial Performance (£'000s)	Oct-23	(3,526)	- 2,157	●	▼	(9,619)
Surplus /Deficit (£'000s)	Oct-23	(3,542)	- 2,173	●	▼	(9,677)

M7 Commentary (Page 1 of 2)

Quality and Safety (Chief Nurse & Medical Director)

Patient Safety
In October, there were 8 incidents escalated to StEIS. These were 1 maternity incident relating to delivery of a baby, 1 alleged abuse incident, 1 hospital acquired pressure ulcer incident, 2 incidents of missed opportunity to escalate deterioration, 2 incidents of diagnostic delays and 1 delay in carrying out surgery . Themes and trends from these incidents link to wider work underway. These are contained within the Quarter 2 StEIS report but include improvement work with the management of pressure ulcers, treatment delays issues and work underway to review high risk areas to review standard procedures for follow up and a new policy and procedure on Least Restrictive Practice, with associated training that is being rolled out to all applicable Staff.

Changes made include improvements with the management of sepsis and an improving trend across all AQ metrics, launch of the Patient Safety Incident Response Framework (PSIRF) with new structures and a toolbox of investigation processes and upgrades in the incident reporting system to ensure the Trust is ready for the new requirements of national reporting through the Learning from Patient Safety Events (LFPSE) framework.

Harm Free Care
The trust continues to make good progress in reducing category 3 and 4 pressure ulcers both hospital acquired and those on the district nursing case load.

Complaints
The month of October saw another high response rate of 79%. This has brought the year to date figure up to 72% overall which is increasing consistently. This is a significant improvement from our starting position 3 years ago of 29%.

Although this is below trajectory, significant work continues to support Divisions in managing and responding to complaints. An increased effort has been made to de-escalate complaints by earlier discussions with complainants to understand their concerns and provide them with as much information as possible at that early stage. This has allowed us to de-escalate a number of complaints at this early stage and thereby contribute to the increased complaints response performance figures.

People (Chief People Officer)

Wellbeing:
Demand for support from the Staff Psychological Service remains high. 40 referrals received into Service in October 2023.
Group programmes well received - 13 People on Bereavement Support groups during September-October, more ongoing until January. 2 ACT groups at Leigh, Wrightington & RAEI.
TRiM: 1 incident reported in September, no take up for assessments yet.
Wellbeing Pit Stops/Drop ins/Team Session: Resilience sessions for Pharmacy, Complex Care Admin and Access to Health Record; Drop ins for ED and FY doctor and GTEC staff. Health Checks: Boston House, Chandler House, RAEI, Leigh Infirmary.
Leadership & teams:
Team Culture programme:
Culture and Engagement Teams programme applications – 8 teams are undergoing survey for winter cohort, 1 team confirmed for spring cohort.
Culture & Engagement Enhanced Programme – 3 new teams referred to enhanced programme to receive tailored support.
Collaboration with the ASPIRE programme for white wards to refer to be on the Culture and Engagement Teams programme in readiness for ASPIRE re-accreditation.
Goal Setting and Appraisal:
42.7% of staff have completed goal setting declaration, an increase since last month of 8%. Surgery has the lowest completion rate.
Route plan appraisal completions show a small decrease at 79.9% since last month at 81.6%.
EDI:
EDI Lead (Workforce) has started in post to refresh EDI strategy and delivery plan.
WDES and WRES reports received by ETM and draft action plans published on Trust website pending Board approval. Action plan to support working towards becoming Anti-racist organisation and Disability Confident Leader.
Culture
FTSUG – discussions ongoing with NHS GM. Agreement in principle for them to provide the service at an agreed fee. Seeking confirmation regarding MOU agreement and recruitment process.
Comms and visibility:
Four Executive Vlogs - plus CEO vlog, ASTB and LF. 148 on ASTB, Usefulness survey due in Nov.
NSS 2023 - open until 24th November, current response rate lower than expected based on last year's; NSS promotion at Leaders' Forum in October and weekly comms and onsite engagement.
STAR Awards recognition event took place on 13th October and was well received by attendees.
Personal development:
Induction review: Plans for new Welcome day underway, first run on 20th November at Wrightington; planned marketplace and guest speakers invited to welcome new staff.
Mandatory training – nationally mandated training 95.5% small fall (-0.3%). Locally mandated training 91.1% and small decrease of 0.7% since last month.
Medicine has the largest number of staff who are non-compliant in both National and Local compliances.
The staff group of Medical and Dental has the lowest % compliance for both National and Local. LE (Lead Employer) Doctors compliance is lower than the rest of M&D.

M7 Commentary (Page 2 of 2)

Performance (Deputy Chief Executive)

Unscheduled Care :

Ambulance handover delays above 60 minutes remained above plan in October which is a reflection of the consistent escalation of the ED corridor in month – however, initiatives such as direct access to SDEC and 'fit to sit' will support a positive improvement. It should be noted that whilst performance dipped in October, this is against the trend and we remain the top performing Trust in GM against this metric due to the ongoing service transformation delivered by the ED team. The NRTR list remained consistently above 100 patients in October, although we are seeing an improvement in November. As a consequence, bed occupancy remained over 98% which negatively impacted 12 hour wait times in ED. Teams are working closely with ECIST and Newton Europe on a number of actions to manage discharge and flow effectively.

Scheduled Care :

Cancer continues to perform well, with 42 patients waiting 62 days or more for treatment or step down in October against a plan of 43. The Faster Diagnosis Standard continues to be achieved consistently ahead of the March 31st target.
There are 0 patients waiting beyond 78 weeks who are not either patient choice or clinically complex. Clearance of 65 weeks waits by March 31st is on track in all but 2 specialties - Gynaecology, driven by a sustained and significant increase in cancer referrals and high numbers of industrial action cancellations, and Community Paediatrics, driven by pathway changes in GMMH. Mutual aid continues to be explored for both specialties. Internal capacity increases may be possible to reduce the risk but would require premium spend.
The 52 week plan has been revised and re-submitted to GM in month to take into account 1000 mutual aid patients accepted by WWL over 52 weeks and the 1000 long waiting e-referral drop off patients added back to our waiting list in April.
Within October, the WWL day case rate was the best in GM at 85.2% and theatre utilisation was above target at 85.44%. However, elective activity is significantly behind plan, driven by an under-performance in T&O. A detailed recovery plan is in development.

Finance (Chief Finance Officer)

Surplus/Deficit
The Trust reported an actual deficit of £3.4m in month 7(Oct 2023), which is an adverse variance of £1.4m to the plan. Year to date, the Trust is reporting an actual deficit of £9.7m which is £8.5m adverse to plan.

Adjusted Financial Performance
The adjusted financial performance is a deficit of £3.5m which is £1.4m adverse to the plan of £2.1m deficit.

Agency Expenditure
Agency expenditure is £0.9m in month 7. Year to date, agency spend is £5.8m which is £1.9 favourable to plan.

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

Capital Expenditure
Capital expenditure against internal CDEL was £1.5m in month 7 against a plan of £1.2m, which is £0.3m above plan. Year to date, capital expenditure is £2.4m below the internal CDEL plan. This is primarily due to Community Diagnostic Centre (CDC) and Leigh Laminar Flow Theatre, which is expected to be recovered during the year.

Cash
Cash is £21.2m at the end of month 7 which is £8.4m below plan. This has decreased by £2.1m from the previous month. The variance to plan relates to the loss of assumed council income which was included in the plan and other timing differences. The operating cash days metric is 16 days at the end of October compared to 18 at the end of September.

Cost Improvement Programme (CIP)
In month 7, £2.1m CIP has been delivered which is above plan. Year to date, CIP delivery is £0.5m below plan due to slippage in the first two months.

Better Payment Practice Code (BPPC)
BPPC for month 7 is 93.9% by volume and 92.2% by value. Performance by volume has improved from the previous month (93.7%) and deteriorated by value (92.3%). An action plan is in place to improve the BPPC to the target of 95.0%.

Holistic narrative

The Trust has experienced a high level of pressure through month 7 due to consistently high levels of NRTR and high levels of occupancy. This has impacted on ambulance hand over times, LOS and 12 hour waits in ED. Escalated areas remain in place which impacts on the patient experience and the financial position of the Trust. Work is ongoing with the ECIST and Newton Europe teams to improve patient discharge and flow.

There were 8 incidences reported through STEIS, which is below the monthly expected levels.

Agency expenditure remains below planned levels, although the adherence to rate card pay rates is significantly lower than target and on a downward trajectory. Work is ongoing across all pay spend areas to manage expenditure levels to improve the financial position of the Trust. Mandatory training compliance, appraisal and staff survey are all either above target or on an upward trajectory. However, the percentage sickness time lost and the percentage vacancy rate have both increased in month and are above the target, although the YTD figures demonstrate a lower trend.

From a financial perspective, expenditure across both pay and non pay were higher in month 7 than the run rate. Additional grip and control measures are being put into place to support the financial position and manage expenditure.

Change log

Ref	Metric	Change	Date	Requested by:
23/24 01	Sickness Absence	Change target from 4% to 5%	22/05/2023	Deputy Chief People Officer
23/24 02	Ambulance Handovers under 30 minutes	Remove metric	13/04/2023	Deputy Chief Executive
23/24 03	Ambulance Handovers under 15 minutes	Remove metric	13/04/2023	Deputy Chief Executive
23/24 04	Cancer referrals - 115& of pre-covid average	Remove metric	13/04/2023	Deputy Chief Executive
23/24 05	Patients waiting over 104+ weeks (except patient choice or clinically complex)	Remove metric	13/04/2023	Deputy Chief Executive
23/24 06	Outpatient utilisation (In Dev)	Remove metric	13/04/2023	Deputy Chief Executive
23/24 07	Outpatient DNA rates	Remove metric	13/04/2023	Deputy Chief Executive
23/24 08	Virtual Outpatient Consultations	Remove metric	13/04/2023	Deputy Chief Executive
23/24 09	Total Waiting List - RTT position	Remove metric	13/04/2023	Deputy Chief Executive
23/24 10	A&E waiting times : patients seen within 4 hours	Add metric	13/04/2023	Deputy Chief Executive
23/24 11	85% Paediatric Bed Occupancy	Metric added	13/04/2023	Deputy Chief Executive
23/24 12	85% Critical Care bed occupancy for Adults and Children	Metric added	13/04/2023	Deputy Chief Executive
23/24 13	Patients waiting over 65+ weeks (except patient choice or clinically complex)	Add metric	13/04/2023	Deputy Chief Executive
23/24 14	Patients waiting over 52+ weeks by 50% by Mar 24	Add metric	13/04/2023	Deputy Chief Executive
23/24 15	Virtual ward patients - add placeholder whilst metric under development	Add metric	13/04/2023	Deputy Chief Executive
23/24 16	Number of diagnostics received completed within 6 weeks	Add metric	13/04/2023	Deputy Chief Executive
23/24 17	Diagnostic activity compared to 19/20 levels	Add metric	13/04/2023	Deputy Chief Executive
23/24 18	Meet the cancer faster diagnosis standard	Add metric	13/04/2023	Deputy Chief Executive
23/24 19	Reduction in outpatient follow - ups	Add metric	13/04/2023	Deputy Chief Executive
23/24 20	Day case rate	Add metric	13/04/2023	Deputy Chief Executive
23/24 21	2 hour urgent community response	Metric added	13/04/2023	Deputy Chief Executive
23/24 22	Sepsis - Screening and Antibiotic Treatment (In Dev.)	Remove metric	03/07/2023	Medical Director
23/24 23	Change order of Quality & Safety metrics	Re-order metrics	03/07/2023	Medical Director
23/24 24	All	Improve the visualisation of the report	19/07/2023	Executives
23/24 25	All	Change the format of the report from Word to PowerPoint	18/09/2023	DAA
23/24 26	All	Added sparklines for 6 months to show trends	18/09/2023	Executives
23/24 27	Methicillin-Susceptible Staphylococcus Aureus (MSSA) and Clostridium Difficile (CDT)	Revised numbers to be just WWL acquired numbers; not borough wide	17/11/2023	Deputy Director Infection Prevention and Control
23/24 28	Clostridium Difficile (CDT)	Added an in month threshold in line with 23/24 agreed threshold	17/11/2023	DAA
23/24 29	Percentage of patients waiting less than 6 weeks for diagnostic tests	Changed the wording from 'Number of diagnostics received completed within 6 weeks'	17/11/2023	DAA

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report
Presented to:	Board of Directors
On:	27th November 2023
Item purpose:	Information and approval
Presented by:	Claire Wannell, Chief Operations Officer and Accountable Emergency Officer (Interim)
Prepared by:	Mark Taylor, Head of Resilience
Contact details:	T: 0300 777 3858 E: mark.taylor1@wwl.nhs.uk

Executive summary

The Emergency Preparedness, Resilience and Response (EPRR) readiness of NHS organisations is a legal requirement under the Civil Contingencies Act (2004) which identifies acute NHS Providers as Category One responders with specific duties. Also the NHS Act (2006) as amended by the Health and Social Care Act (2012) provides additional statutory requirements on the Trust in relation to emergency preparedness. NHSI/E fulfil this requirement via an annual self-assessment against the EPRR core standards; this is undertaken by the Head of Resilience on behalf of the Accountable Emergency Officer. In addition to the core standards there is also an annual deep dive into a wider preparedness area which for 2023 is training.

Overall the Trust is rated as "partially compliant" with 14 out of 62 core standards and 6 out of 10 deep dive competencies being "partially compliant" and the remainder being "fully compliant". Action plans are in place to resolve these within the next 12 months which is the requirement in the standards.

This represents a slight reduction from 2022 which is a result of the EPRR team being redeployed during COVID-19 and the training, exercising and planning activities being put on hold to allow all available resources to support the response to the pandemic. This activity has now been restarted but implementation has been affected by the ongoing industrial action events during 2023 requiring a coordinated response.

Recommendation(s)

The Board of Directors are asked to note the findings of the self-assessment as laid down in this report and approve the action plan to improve compliance within the next 12 months. The Board of Directors are also asked to consider the reviewed and updated Incident Response Plan and approve it for use within the Trust.

The WWL Way

Report

Introduction

This paper outlines the purpose and outcome of the annual Emergency Preparedness, Resilience and Response (EPRR) core standards self-assessment. The assessment was carried out by the Head of Resilience in conjunction with relevant subject matter experts. The overall outcome is "partially compliant".

Legislative and Statutory Context

The Civil Contingencies Act (2004) specifies that NHS Acute Providers are Category 1 Responders meaning they are at the core of the response to emergencies. Such responders are subject to the full set of civil protection duties as follows:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place business continuity arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance coordination.
- Cooperate with other local responders to enhance coordination and efficiency.

Similarly, the NHS Act places specific duties on the NHS to ensure it is prepared for relevant emergencies which, in relation to providers, are defined as "any emergency which might affect the provider (whether by increasing the need for the services that it may provide or in any other way)". The underpinning principles of EPRR in the NHS are as follows:

- Preparedness and anticipation
- Continuity
- Subsidiarity
- Communication
- Cooperation and integration
- Direction

Background to the Core Standards

NHS England has a statutory duty to seek formal assurance of EPRR readiness through the EPRR annual assurance process. In a change to the process, the Trust's self-assessment for 2023/24 is subject to review and approval by NHS England Northwest, based on the Trust's own statement of compliance and a portfolio of evidence provided to the panel including copies of policies, plans, minutes, training and exercising programmes, etc. Each year, NHSE decide on a specific area in which to undertake a deep dive assessment, for 2023/24 this deep dive is on EPRR Training.

Summary of 2023 Results

Domain	Total No. of Standards	Fully Compliant	Partially Compliant	Non-Compliant
Governance	6	6	0	0
Duty to Risk Assess	2	2	0	0
Duty to Maintain Plans	11	9	2	0
Command and Control	2	1	1	0
Training and Exercising	4	1	3	0
Response	7	6	1	0
Warning and Informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	9	3	0
TOTAL	**62**	**48**	**14**	**0**
	Overall Rating	**77%**		

For 2023 there are 62 core standards and the Trust is fully compliant with 48 of them (77%). This results in an overall assessment of "partially compliant" (classed at 77%-88%). There are zero standards against which the Trust is non-compliant and 14 standards against which the assessment is "partially compliant". There is a requirement to have in place a recovery plan to return the Trust back to a compliant status with 12 months. The areas for improvement, along with their respective recovery plans are set out in Appendix 2.

Where standards are not fully compliant an action plan to address the gaps within 12 months is required. A copy of the action plan is included at Appendix 1 and this will be monitored through the EPRR group chaired by the Deputy Chief Executive (Accountable Emergency Officer).

The deep dive in 2023 relates to EPRR Training. There are 10 measures of which 4 were deemed to be fully compliant and 6 partially compliant.

Conclusion

The outcome of the self-assessment is "partially Compliant" which provides some assurance regarding the emergency planning, response and recovery arrangements of the Trust. The standards assessed as partially compliant are largely due to the legacy of covid or new requirements such as the minimum occupational standards. An action plan is in place to ensure the Trust will be fully compliant with the current standards by August 2023 and this will be managed and monitored by the EPRR group.

Appendix 1: Recovery Plan

Core Standards

Standard	Requirements	Improvement Plan
Duty to maintain plans	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	External partners to be consulted with when developing internal plans and results of consultations recorded.
Duty to maintain plans	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment.	Plans to support an incident requiring countermeasures to be improved including arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination.
Command and Control	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	EPRR Training Prospectus to be developed, published and training programme delivered along with records of training to be put in place.
Training and Exercising	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	EPRR Training Prospectus to be developed to set out training needs for staff with response roles, a matrix to be put in place to identify those staff and a training needs analysis to be undertaken.
Training and Exercising	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely test incident response arrangements.	An exercising and testing programme to be put in place, reported and monitored by the EPRR Group.
Training and Exercising	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards.	System for recording training and exercising attendance to be put in place.
Response	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker.	Training regarding personal records and decisions logs to be implemented and a cadre of 24/7 incident loggists to be identified and trained.

Standard	Requirements	Improvement Plan
Business Continuity	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	An exercising and testing programme to be put in place, reported and monitored by the EPRR Group.
Business Continuity	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	A process of internal audit is to be developed and included in future board reports.
Business Continuity	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A process of internal audit is to be developed and included in future board reports.
Business Continuity	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A system to assess BC plans of suppliers and contractors to be put in place and included in internal audit arrangements.
Hazmat/CBRN	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out-of-date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable.	EPRR to work with Division of Medicine and Estates & Facilities to put in place a full preventative programme of maintenance for Hazmat/CBRN equipment held in Emergency Department.
Hazmat/CBRN	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination.	An exercising and testing programme to be put in place, reported and monitored by the EPRR Group
Hazmat/CBRN	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme.	An exercising and testing programme to be put in place, reported and monitored by the EPRR Group

Deep Dive Standards

Standard	Requirements	Improvement Plan
EPRR Training	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	EPRR Training Prospectus to be developed, published and training programme delivered along with records of training to be put in place.
EPRR Training	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	A matrix to be put in place to identify those staff and a training needs analysis to be undertaken.
EPRR Training	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Training reports to be developed for the EPRR Group and onto Board as well as the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF).
EPRR Training	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Ensure all training developed or commissioned is aligned to JESIP doctrine and referenced against the National Occupational Standards for Civil Contingencies.
EPRR Training	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Process for recording debriefs and their findings to be put in place, along with appropriate reports to EPRR Group and Board.
EPRR Training	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Feedback and assessment processes for all training to be put in place, recorded and reported appropriately.

Title of report:	Equality, Diversity and Inclusion Annual Monitoring Report – April 2022 to March 2023
Presented to:	Board of Directors
On:	06 December 2023
Presented by:	Juliette Tait
Prepared by:	Debbie Jones / Toria King / Suzi Speakman
Contact details:	EqualityandDiversity@wwl.nhs.uk

Executive summary

There are a number of equality based national laws and guidelines which mandate and guide how NHS organisations should demonstrate equality. These include the Legal Framework, NHS Constitution, NHS Equality Delivery System (EDS2022), Workforce Race Equality Standard and Disability Equality Standard, and the Accessible Information Standard. This report evidences how the Trust has delivered on these and other requirements during the last 12 months and summarises the priorities for the year ahead. This report aims to provide an overview of the Trust's EDI journey in the financial year 2022-23, highlighting the data collected between 1st April 2022 and 31st March 2023, and the actions taken to enhance EDI within this timeframe.

Wrightington Wigan and Leigh (WWL) Teaching Hospitals NHS Foundation Trust is committed to pursuing equality, diversity, and inclusion (EDI) for both patients and staff. As an employer and health service provider, WWL NHSFT takes the issues of fairness, rights and equality very seriously. Equality, diversity and inclusion is a key part of our values and runs through everything we stand for and do. By investing in equality, diversity and inclusion we aim to improve staff experience, our services and our patient care. We will continue to ensure that our staff and service users are in a safe, inclusive and accessible environment and that our services are accessible to all communities across the borough of Wigan.

Over the past few years we have made substantial progress in embedding equality, diversity and inclusion into our core business activities. We will continue to make progress by ensuring these values are mainstreamed through all aspects of our service provision, and in how we work in partnership with our employees and our local communities.

Link to strategy

Equality, Diversity and Inclusion Strategy 2022 - 2026

Risks associated with this report and proposed mitigations

Challenge from the local community and loss of reputation and public confidence could arise as a subsequence. Non-compliance / failure to address national requirements could impact on our Care Quality

Commission Scores. The key risks to the Trust therefore in terms of service delivery are non-completion of equality impact assessments, failure to provide accessible information in a patient's preferred format and the limited availability of equality information against some of the protected characteristics.

The key risks to the Trust in terms of employment practice are: continuation of a disproportionately low percentage of black and minority ethnic applicants being appointed following shortlisting, compared to white applicants. Furthermore, improved levels of declared workforce data in respect particularly of sexual orientation and disability status would enable the Trust to more effectively assess whether or not its employment practices are fit for purpose moving forward.

Financial implications

N/A

Legal implications

Failure to actively promote equality across all protected characteristics could constitute failure to meet the requirements of Equality Legislation / Statutory Bodies.

People implications

N/A

Wider implications

Failure to actively promote equality across all protected characteristics could see the Trust receive challenge from the local community and loss of reputation and public confidence could arise as a consequence. Non-compliance / failure to address national requirements could impact on our Care Quality Commission Scores.

Recommendation(s)

The Board of Directors are invited to receive and approve the Annual Equality, Diversity and Inclusion Monitoring Report.

Report

Introduction

Wrightington Wigan and Leigh (WWL) Teaching Hospitals NHS Foundation Trust is committed to pursuing equality, diversity, and inclusion (EDI) for both patients and staff. This report aims to provide an overview of the Trust's EDI journey in the financial year 2022-23, highlighting the data collected between 1st April 2022 and 31st March 2023, and the actions taken to enhance EDI within this timeframe. The report focuses on key initiatives and strategies aligned with the Trust's EDI Strategy aims of:

- Increasing diversity and accessibility
- Eliminating inequality
- Improving the experience for protected groups

In May 2022, the EDI Workforce Team was expanded to include an EDI Administrator. The principle aim of this role is to help with the development of the Diversity Staff Networks, and to relieve the operational pressure from the EDI Workforce Lead. This welcome addition to the team has enabled our Staff Diversity Networks to go from strength to strength in this year. Details of WWL's staff networks will appear in this report.

Alongside the annual Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and Equality Delivery System (EDS), this year the Trust has collected and utilised various data sources to inform its EDI initiatives, including the Race Equality Code and the Rainbow Badges Phase 2 Scheme. There has also been a thematic analysis of the Trust's National Staff Survey Data with an EDI lens. A summary of the results of these is shared in this report, along with a discussion of next steps.

2022 was the pilot year for Trusts to begin to use EDS2022 (an accountable improvement tool for NHS organisations in England). It was not compulsory to do so, but WWL decided to apply the new framework requirements and use the pilot results as a baseline to give us a greater understanding of where we need to focus our attention for 2023. A summary of our scores and actions going forth are included within this report.

Over the past 12 months, The Trust has continued to make progress in relation to meeting the core requitements of the Accessible Information Standard and has continued to work in partnership with patients and staff. During 2022/23, WWL continued to undertake equality analysis on all policies and practices, to ensure that any new or existing policies and practices do not disadvantage any group or individual. Equality Impact Assessments are now included as a pre-visit intelligence requirement within ASPIRE (Ward accreditation framework) at all levels.

In 2022/23 equality diversity and inclusion at WWL is more recognised and considered than ever before. Governors, Board and the Executive Team have had EDI training over the past year, and an EDI Communications Plan has meant that there is not a week goes by without an EDI-related communications article. Staff have been empowered to celebrate diversity and understand religious and cultural events that they would not normally have been aware of, with the launch of the EDI Calendar and the Team Inclusion Challenge. As a long-term supporter of Wigan Pride, WWL were delighted to be awarded as the headline sponsor for Wigan PRIDE 2022.

WWL has continued to enhance patient experience, by engaging and involving patients, and their families. During 2022/23 WWL sourced and implemented transparent face masks, to help improve communication. A review of interpreter and translation services was untaken, along with the implementation of video remote interpreting for British Sign Language. A further 5-year contract was secured with AccessAble for the provision of on-line Access Guides to all Trust sites wards and departments

Further Details of these key achievements are included within this report.

Our 2022-26 Equality Objectives

Our Workforce and Patient Services Priorities for 2022/23

The following table provides an update on the actions progressed during 2022/23 against the Trust's Annual Equality Objectives:

Workforce

Objective	Progress
Implement and / or extend the remit of Colleague Diversity Networks for the following protected groups: • **Disability & long-term conditions** • **Ethnic minorities** • **LGBTQIA+**	**The True Colours Network is WWL's LGBTQIA+ Network**. Since its launch last year it has had a big presence in the Trust with its opening event being the Headline Sponsors of Wigan Pride 2022. This opportunity enabled WWL to celebrate diversity but also address health inequalities of the LGBTQIA+ community. Lots of wards and community sites joined in the festivities and WWL's Health Outreach and Inclusion Team were able to offer free HIV/STI testing on the day which was a real achievement. The True Colours Network has also been on WWL Radio and has a constant narrative through WWL Communications channels to educate and raise awareness of issues faced by the community. The network is also advised on policy and will release a new Gender Identity and Intersex Policy later in the year. The network was also invaluable in supporting the rollout of the Rainbow Badges Assessment Scheme in which WWL gained a bronze award. This scheme audited our trust on how well it serves the LGBTQIA patient and staff community. The network will now work with teams and departments to implement the resulting action plan. **WWL's Disability and Long-Term Conditions Network** was launched last year and has had some great success too. An ongoing Hidden Disabilities Project looks promising and a subgroup - The Autism Peer Support Group, which is for autistic members of staff, all members of staff who have autistic family members, has been invaluable to those involved. The network is also working in consultation with WWL's Policy Development Group and the Staff Psychological Support Service in order to bespoke services for neurodiverse staff. The network has also been in consultation on developing a Dyslexia Support Guidance Document and in helping WWL to roll out the Oliver McGowan Mandatory Training on autism and learning disabilities. **WWL's For All Minority Ethnicity Network** has gone from strength to strength this year and increased its membership by over 100 members and allies during a road show in the spring. The network continues to celebrate cultural diversity and has been involved in international nurse welcome events, WWL's Policy Development Group and advising WWL's Executive Team.

Positive action to increase diversity and improve experience at all levels and within all staff groups, including leadership roles	**WRES (Workforce Race Equality Standard)** WWL's latest WRES report is located at: WWL Teaching Hospitals NHS Foundation Trust | Workforce Race Equality Standard.
Improvements in the WRES, WDES and Gender Pay Gap Outcomes	The most apparent areas of disparity are: **Indicator 1:** A lower proportion of BAME staff at AfC Band 6 and 7, compared to white staff. **Indicator 3:** The relative likelihood of staff entering the formal disciplinary process (2.19) **Indicator 8b:** Discrimination from managers (BAME 20.9% vs White 6.7%) **See Appendix 1 to view the Action Plan implemented to improve the disparity ratios highlighted in the report.** **WDES (Workforce Disability Equality Standard)** The latest WDES report and associated action plan can be found at: WWL Teaching Hospitals NHS Foundation Trust | Workforce Disability Equality Standard. In summary, the main areas of disparity are: • The number of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. • Bullying, harassment and discrimination (particularly from managers) • Presenteeism (loss of productivity that occurs when staff are not fully functioning in the workplace due to an illness, injury, or other condition). **The action plan aims to address these points and can be found at the same link above.** **Gender Pay Gap** The most recent Gender Pay Gap Report, available on publication of this EDI annual report, relates to data collected as of 31st March 2022. The data highlights that as at 31st March 2022, the Trust has a **30.11% mean average gender pay gap** with females earning **£6.87 an hour less** than males. This position is comparable to the 2021 figure of 30.21%.

Improvements in the WRES, WDES and Gender Pay Gap Outcomes	As at March 2022 the Trust has a **13.27% median hourly rate gender pay gap** with females earning **£2.17 an hour less** than males. This position has improved since 2021 (15.02%). A key factor underpinning the Trust`s gender pay gap is due to a significant proportion of male staff being constituted within the Medical and Dental Staff Group which is within the higher earning quartiles. If we exclude Medical and Dental staff from the Trust wide gender pay gap figures, the Trust`s mean average gender pay gap is **3.56%** which equates to females earning **£0.58 less** than male staff per hour. Section 2.4 of the report provides granular analysis of the pay gap at staff group level. As at 31st March 2022 male staff proportionately continue to be heavily constituted within the highest earning quartile (quartile 4) accounting for **30.01%** of quartile 4, when male staff represent 19% of the overall Trust workforce. A key factor is due to the Medical and Dental workforce being predominantly male at 71% and this staff group are predominantly constituted within the highest earning quartile. Compared to the previous year in 2021, there were a similar percentage of males in the highest earning quartile at **29.98%**. As at 31st March 2022 female staff proportionately continue to have lower representation in the highest earning quartile at **69.99%** compared with female staff representing 81% of the overall workforce. Compared to the previous year in 2021, there were a similar percentage of females in the highest earning quartile at **70.02%**. The average bonus gender pay gap as at 31st March 2022 is 55.90%. This is comparable to the previous year when the figure was 55.92% in 2021. The bonus pay is primarily related to clinical excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role, but awards made in the reporting year were distributed equitably among all eligible consultants. New local clinical excellence awards are not paid in the same month each year, though are always backdated to April. This can also impact slightly on the reported pay gap position. Gender Pay Gap actions are focused primarily on the medical and dental profession, as a start. Executives have agreed an action plan for this division, based around the themes of inclusive recruitment, informal networking, clinical excellence awards and bullying and harassment.
Delivery of the in-year actions as defined by the following programmes: • **Disability Confident Scheme** • **Race Equality Code** • **Rainbow Badge Awards Scheme**	Over the past financial year, the Trust has been through the assessments of the Race Equality Code, the Rainbow Badges Assessment and has looked more closely at what makes WWL Disability Confident to provide assurance that WWL are living the principles that are required of us as a Disability Confident employer.

Delivery of the in-year actions as defined by the following programmes: • **Disability Confident Scheme** • **Race Equality Code** • **Rainbow Badge Awards Scheme**	The results of the two assessments and our deep dive of the Disability Confident Framework, shone a light on actions that are recommended to improve the EDI experience of our staff. A thematic analysis was conducted on the recommended actions and ten themes were discovered which were shared with the Staff Diversity Network Chairs. These themes were: • Data • Equality Impact Assessments • Employee Relations • Recruitment • Induction • Talent Development • Leadership • Objectives • Policy • Training There were also some themes that were specific to certain networks ('Accessibility', for instance). The Network Chairs shared these themes with their network members and allies and asked what our staff would want divisions, the networks, and the EDI team to prioritise. Details of the types of actions suggested under each of these themes were also shared for staff to make an informed choice. The feedback has been considered by WWL's Workforce EDI Lead who has since planned the Workforce EDI Action Plan. This is outlined below: By 31st March 2024, the Trust will have a **clearer understanding of the data it holds** in relation to the diversity of the workforce. This will be through increased declaration rates **and improved and increased data collection** through more inclusive questions and opportunities to collect this data such as when colleagues access wellbeing support and apply for e.g., flexible working. The **induction process for our international staff** will be more tailored and our staff diversity networks will be a very present addition to induction of all staff groups. Improvements will have been made in our standard **recruitment procedures** and groups who do not fare as well as others through our recruitment process will be targeted with **positive action strategies.** This will also be true **for talent progression** within the Trust.

Delivery of the in-year actions as defined by the following programmes: • **Disability Confident Scheme** • **Race Equality Code** • **Rainbow Badge Awards Scheme**	**HR will be upskilled on bias and our zero-tolerance** approach to bullying, harassment, discrimination, and violence will be more robust and transparent. Tracking of incidents of which groups experience bullying, harassment, discrimination, or violence will be monitored, and divisional leads will tackle themes in their divisions. The Performance Management Policy will be fairer, having been reviewed by our Staff Networks and Datix incidents will be reported according to diversity information. All new leaders undergoing Leadership Onboarding will have Inclusive Leadership training and VSMs and the Board will have received **EDI and Equality Impact Assessment training**. Our staff requiring **reasonable adjustments** will experience a smoother, more supportive procedure and staff will have access to a Dyslexia Guidance Document. All **HR Policies will be made more inclusive** in language and content with the addition of **new policies** that are particularly relevant to those with protected characteristics and their managers. Finally, our three **Diversity Staff Networks** will be stronger and confident to work on projects, alongside our **EDI Champion Network** who will be trained in the main EDI topic areas of anti-racism, LGBTQIA+ and disability inclusion.

Patient Services

Objective	Progress
Understand and improve the experience of patients across all protected characteristics. **Identify variations in patient access, safety and experience of our services and develop plans to address these.**	WWL has continued to enhance patient experience, by engaging and involving patients, and their families. During 2022/23: WWL rolled out **transparent face masks**, to help improve communication for patients, not only for those who have hearing difficulties or are deaf, but for patients with cognitive problems such as dementia, learning disabilities, autism etc. A further 5 year contract was secured with **AccessAble** for the provision of our on-line hospital accessibility checker. AccessAble Have been working with WWL since 2009, creating, developing and updating detailed Access Guides for patients to all the Trust's sites.

Understand and improve the experience of patients across all protected characteristics. **Identify variations in patient access, safety and experience of our services and develop plans to address these.**	As **Headline Sponsor for Wigan PRIDE 2022,** WWL were actively involved on the day, promoting the strong message of equality, diversity and inclusion. WWL staff were led out in the Wigan Pride parade by the Trust's Chair and Director of Strategy and Planning. WWL's Director of Corporate Affairs and LGBTQIA+ Network Chair addressed the huge crowd on the Unity Stage. The Deputy Chief Executive was also in attendance alongside more than 70 colleagues representing WWL. WWL had the opportunity to put the people of Wigan Borough at the forefront of the day, providing health advice and support, as well as listening to opinions, suggestions and concerns from those accessing WWL services. WWL's Patient Experience and Engagement Team undertook a WWL Patient Experience Survey; Advice and free sexual health testing was provided by WWL's Health Outreach and Inclusion Team, and the Trust's Breast Screening Team. Attendees also had the chance to register their interest in employment and volunteering opportunities at WWL. Engaging with patients enables us to understand and improve the experience of patients across all protected characteristics. During 2022, a patient living with a visual and hearing Impairment shared with the Trust her experience of having a day case procedure undertaken at Wrightington Hospital. The need for more **staff awareness about disability awareness** was raised. In June 2022, the patient met with the ward staff and shared her story. Staff were eager to learn from her experience and understand some of the barriers patients living with disabilities face when accessing health care. The patient's story has since been recorded and now used as a training resource. This patient's story was featured in the EDI Workshop delivered to Trust Leaders in October 2022. WWL continues to undertake 3 yearly reviews of existing **Equality Impact Assessments** (EIAs) for all divisions. Equality Impact Assessments are now a pre-visit intelligence requirement within Ward Accreditation (ASPIRE) Programme.
Meet the information and communication requirements of patients, their families & carers with a disability impairment, or sensory loss.	Over the past 12 months, the Trust has continued to make progress in relation to meeting the core requirements of the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients with a disability, impairment or sensory loss. Although a number of controls have now been implemented to demonstrate compliance with the AIS, currently there is no consistent approach Trust wide (across all standalone systems). Patients could have their information and communication needs met for some services, but not for others. WWL will continue to review during 2023/24 and address some of these challenges. In response to a patient complaint, where a patient was unable to receive their ophthalmology correspondence in their preferred format, e-mail, a 'Task and Finish' Group was set up in November 2022. A 'patients needs' scoping exercise was undertaken and a pilot at the Eye Unit at Boston House planned for May/June 2023. An audit of patients who have their

	communication needs recorded was undertaken to monitor if these needs were met and what further actions are still required.
To review the effectiveness of our interpreter and translation services.	During February/March 2022, WWL along with other Greater Manchester NHS Trusts and Local Authorities, agreed to participate in the collaborative procurement of interpreter and translation services. WWL were actively involved in a joint tender exercise looking for a contractor who could provide an interpreter and translation service which is cost effective, quality controlled and regulatory compliant. The provision of such is a fundamental requirement in the delivery of high-quality care. DA Languages were awarded the contract. From 01/08/22 WWL launched a 'one stop' GM SBS Service level agreement with DA Languages. From February 2023 an on-demand video remote interpreter service was implemented for patients requiring instant access to a British Sign Language Interpreter in A&E and Maternity Services. This is an additional interpreter service which is not intended to replace face to face BSL Interpreters, but to provide instant access in an emergency environment, when a face to face cannot be accessed.
To improve the patient experience for **patient's changing gender identity,** who require their medical records updating.	Although the Trust acknowledges there are current gaps with the updating of patient records (both electronic and paper) and awaits the release of national guidance for Acute Trusts, WWL have continued to ensure patient requests for gender identity requests are managed. The process of receiving and actioning patient requests is currently overseen by the EDI Service Lead within the Patient Experience Team. A process mapping exercise was undertaken to identify what actions were required to update a patient's records with their new gender identity (retaining previous medical history) and a draft operational procedure produced. Risks / implications and proposed mitigations have been formally recorded.

Equality Delivery System (EDS)2022

The EDS is an accountable improvement tool for NHS organisations in England. The EDS2022 is a third version of the EDS and comprises eleven outcomes spread across three domains, which are:

Domain 1	Commissioned or Provided Services
Domain 2	Workforce Health and Well-Being
Domain 3	Inclusive Leadership

The outcomes are evaluated, scored, and rated using available evidence and insight. It is the ratings that provide assurance or point to the need for improvement.

2022 was the pilot year for Trusts to begin to use EDS2022, rather than EDS2. It was not compulsory to do so, but WWL decided to use the pilot year as a transitional year to highlight any barriers / changes needed going forth. EDS2022 is mandated from 2023-2024.

Below is a summary of how WWL performed on EDS2022 in 2022-23. To read our full EDS2022 Report, please visit our WWL website at:
https://www.wwl.nhs.uk/media/corporate/Our%20organisation/EDS2022%20report%202022-23%20FINAL.pdf

The Trust has scored as follows for EDS2022:

- **Overall rating**: Developing (18 points)
- **Domain 1:** Commissioned or provided services: Developing (7.5 points)
- **Domain 2:** Workforce health and wellbeing: Developing (7 points)
- **Domain 3:** Inclusive Leadership: Developing (3.5 points)

The 'Scores' Table below shows where WWL Scores sit within the national scoring criteria:

Score card	
Each Outcome	**Overall – adding all outcome scores in all domains**
Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 30,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **31 or more,** adding all outcome scores in all domains, are rated **Excelling**

It is important to understand that the results WWL has achieved this year are a baseline and will give us greater understanding of where we need to focus our attention for 2023-24.

Action plans and next steps

Domain 1: Commissioned or Provided Services

The Trust scored well in this domain, but it is important to note, that scores were proposed by Service Leads during this transitional/pilot year. No stakeholder engagement was feasible this year. Although WWL applied the revised EDS framework requirements for 2022/23 for Domain 1, due to current challenges including time constraints; updated guidance only being issued December 2022; the need for clearly defined service expectations / collaborative working; it was not possible to host stakeholder events and focus groups this year. In December 2022, it was agreed that evidence and proposed scores be submitted for review to Healthwatch Wigan and Leigh. Healthwatch agreed for this to be presented at their Healthwatch Board Meeting in January 2023 and feedback be given. Healthwatch Wigan and Leigh Committee and Board however declined to comment due to time constraints and not feeling involved in the process from the start. As WWL were unable to host stakeholder events and focus groups this year, scores were proposed by the service leads based on their evidence submission.

It was agreed that the two services identified for review for the pilot would be rolled over to 2023/24 along with one other additional service. Service Leads will collate evidence and insight on the services selected for EDS evaluation and scoring for 2023/24. The EDI Service Lead will work collaboratively with different stakeholders to obtain feedback and agree scoring. Responsibilities for the implementation of actions identified for Domain 1 on the improvement plans will sit with the Service Leads. Divisions will be supported to incorporate the EDI Outcomes of Domain 1 within their own divisional action plans.

Domain 2: Workforce Health and Wellbeing

The Trust scored well in this domain, despite a lot of the content being new. Stakeholders will be supported to develop their own action plans to evidence further progression for the 2023 submission. Themes of actions include evidencing impact (e.g., of wellbeing initiatives on diverse groups of staff).

Domain 3: Inclusive Leadership

Outcome 3A (inclusive leadership) was scored by a Peer Reviewer and WWL's EDI Workforce Lead.

The peer-reviewed feedback received is as follows:

"Provided evidence of discussion of statutory compliance, but limited evidence of discussion as EDI as part of business as usual.

Provided evidence of providing reasonable adjustments and consideration of individual needs for colleagues. Would like to see evidence of leaders championing their support through Trust wide comms/staff network champion.

Provided evidence of attending workshops/NW EDI Group, would like to see leaders setting EDI objectives as part of their annual appraisal."

Feedback from WWL's EDI Workforce Lead is for leaders to ensure that they describe how any EDI learning that they have done has impacted their actions going forward. This is important as some leaders simply listed events that they attended that had an EDI topic.

Some of the more in depth evidence from Outcome 3A was:

- *"Led a North West Wide Programme of work to agree a new approach to attendancemanagement – built on creating a well-being culture, person centered approaches and including disability and adjustment passports. Agreed at People Committee December 2022 that WWL would be an early adopter site.*

- *Identified potential issue about cultural onboarding for first generation in country doctors – asked FAME network to consider how we might improve this.*

- *Deep dive ER review into cases involving BAME colleagues – completed with input from FAME network, looking for positive action possibilities.*

- *Divisional ER reviews aligned to just & learning culture principles.*

- *Executive Scrutiny Panel involvement for potential disciplinary cases – considers alternatives to formal disciplinary action and actively considers potential contributory factors associated with protected characteristics"*

Feedback for Outcome 3B:

To gain the higher level, both equality and health inequalities must be standing agenda items in some board and committee meetings. Equality and health inequalities impact assessments are completed for all projects and policies and are signed off at the appropriate level where required. BME staff risk assessments are completed. Required actions and interventions are measured and monitored. It will need to be decided which meetings should have EDI as standing items.
Building routine scrutiny of Equality Impact Assessments into processes is another action that will ensure a higher score for 3B next year.

Feedback from 3C:

Currently, Trust Board do not ensure the implementation of or monitor Health Inequality Impact Assessments or the full requirements of the Accessible Information Standard. WWL is continuing to make progress in relation to meeting the core requirements of the Accessible Information Standard. In March 2021 changes were made to incorporate the capture of accessible information requirements in PAS for elective in-patients and out-patients. Although many controls have now been implemented to demonstrate compliance with the AIS, currently there is no consistent approach Trust wide (across all standalone systems). Patients could have their information and communication needs met for some services, but not for others. Looking forward, we aim to continue integration of the AIS in the Trust's IT systems to support patients and service users in accessing care services appropriate to their communication requirements.

National Staff Survey

Data from the National Staff Survey 2022 was analysed for experiences of staff from minority groups.

Key findings include:

- Disabled staff score lower on every People Promise and Theme compared to the Trust average. They also score lower than staff from ethnic minority groups.

- Staff from ethnic minority groups score lower, or the same as the Trust average on all People Promises and Themes with the exception of 'We are Always Learning' where they score higher.

- Highlighting the disparity between white, non-disabled staff and disabled and ethnic minority groups (in particular black staff) regarding the organisation acting fairly with regard to career progression/promotion.

- We have a disproportionate amount of bullying occurring to those with protected characteristics.

Key actions to address these themes are below:

- Using a compassionate, person-centred lens, engage with staff on expectations to support new models of care and transformation plans, including redeployment to support areas where there is increased demand or staff absence.

- Consider how we enable staff being bullied by a manager to feel psychologically safe to raise this at the appropriate level, without fear of retribution, especially staff with protected characteristics.

- Human Resource Policy training and guidance to empower managers to address issues of incivility, bullying and negative culture and create confidence to take action and to reduce formal grievances.

- Plans for Talent Management Strategy to be actively inclusive and to consider positive action programmes of work/opportunities for staff from protected groups.

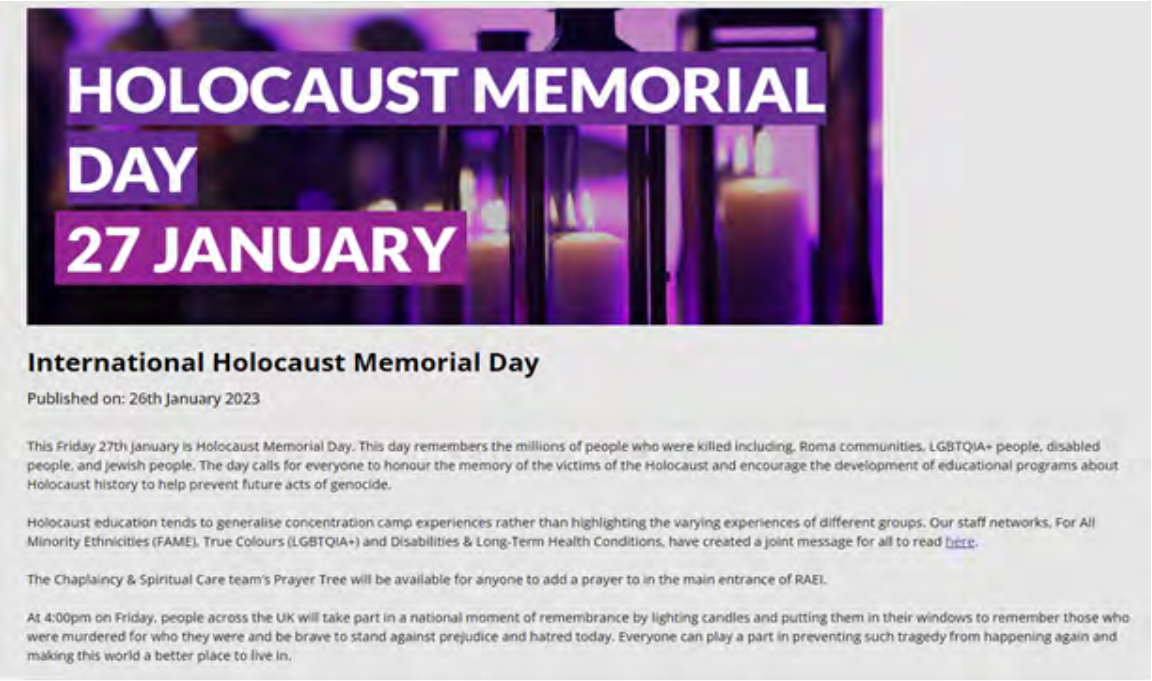
- Monitor incidents of bullying, harassment and abuse at HR level and HR to be given the confidence to work with EDI-related employee relation cases.

- Need for a Zero-Tolerance Campaign at patient level and promotion of Violence and Aggression Policy.

- Continue to work with the Disability Network on a new Attendance Management Policy and more streamlined reasonable adjustments process.

Key EDI Progress during 2022/23

In 2022-23, Equality Diversity and Inclusion at WWL became more recognised and considered than ever before. Governors, Board and the Executive Team have had EDI training over the past year, and an **EDI Communications Plan** has meant that there is not a week that goes by without an EDI related communications article.



International Holocaust Memorial Day

Published on: 26th January 2023

This Friday 27th January is Holocaust Memorial Day. This day remembers the millions of people who were killed including, Roma communities, LGBTQIA+ people, disabled people, and Jewish people. The day calls for everyone to honour the memory of the victims of the Holocaust and encourage the development of educational programs about Holocaust history to help prevent future acts of genocide.

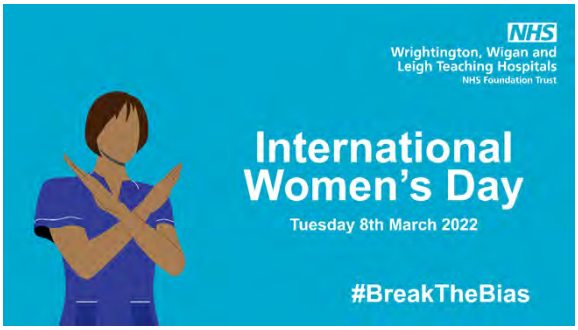
Holocaust education tends to generalise concentration camp experiences rather than highlighting the varying experiences of different groups. Our staff networks, For All Minority Ethnicities (FAME), True Colours (LGBTQIA+) and Disabilities & Long-Term Health Conditions, have created a joint message for all to read here.

The Chaplaincy & Spiritual Care team's Prayer Tree will be available for anyone to add a prayer to in the main entrance of RAEI.

At 4:00pm on Friday, people across the UK will take part in a national moment of remembrance by lighting candles and putting them in their windows to remember those who were murdered for who they were and be brave to stand against prejudice and hatred today. Everyone can play a part in preventing such tragedy from happening again and making this world a better place to live in.

There are also a range of **MS Teams Backgrounds to celebrate key annual EDI events,** such as South Asian Heritage Month, Black History Month, International Women's Day, Disability History Month etc.

Staff have been empowered to celebrate diversity and understand religious and cultural events that they would not normally have been aware of, with the launch of the **EDI Calendar** and the **Team Inclusion Challenge**.



For this, staff were challenged to choose one date from the EDI Calendar each month to celebrate and to share this via the staff Facebook or Twitter pages using the hashtag #WWLEDI.

Some staff chose dates that were important to someone in their teams, some chose dates they had never heard of, so that they could learn something new!

Monthly Webinars on EDI Topics are available for all staff and staff are invited to Network Forums every quarter, to share their concerns, ideas and experiences.

For the first time, there was an **EDI Award at WWL's Recognition Awards (the STAR) Awards**, and EDI was a corporate objective to focus staff attention on the topic from 2021-2022.

The **EDI Intranet Page** now has a dedicated support page which has 'signposts' to many external support services on the topics of e.g. LGBTQIA+, disability, carers support, mental health, menopause, international support groups e.g. British Asian Nurses Association etc

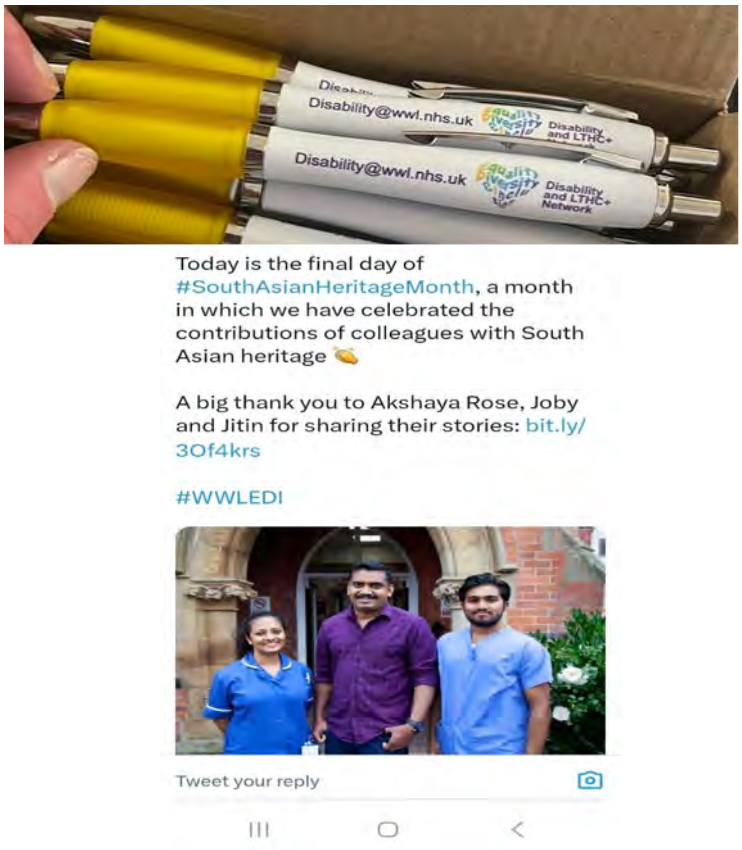
WWL's Recruitment Team are now proactively showcasing our inclusive culture on Social Media and Microsoft Teams regularly to celebrate equality, diversity and inclusion by posting on Twitter to showcase their work:

WWL has **4 Staff Diversity Networks**, each with protected time and defined roles in the committees.

The **EDI Champions Network** was established to be a group of people who were keen to expand their knowledge and understanding of EDI topics and to be active bystanders in our Trust. The Trust established **10 EDI Gold champions** who have been through an intensive training course on the topics of anti-racism, LGBTQIA+ inclusion and neurodiversity. They have also been trained to cascade this training to their home teams and the wider EDI champion network. So far, the anti-racism training has been re-delivered with ambitions to re-deliver another two topics in the coming months.

The WWL **For All Minority Ethnicity (FAME) Network** has gone from strength to strength this year and increased its membership by over 100 members and allies during a road show in the spring. The network

continues to celebrate cultural diversity and has been involved in international nurse welcome events, policy development group and advising WWL's Executive Team.



True Colours Network is WWL's LGBTQIA+ Network. Since its launch last year, it has had a big presence in the Trust with its opening event being the headline sponsors of Wigan Pride 2022. This opportunity enabled WWL to celebrate diversity but also address health inequalities of the LGBTQIA plus community

WWL's Disability and Long-Term Conditions Network which launched last year has had some great success too.

Diversity Demographic Data

Having a clear profile of our staff and patients helps to advance equality of opportunity and meet the needs of our patients and staff in designing our services and employment practice.

Workforce:

Workforce data is collected routinely by the Trust:

- Age
- Disability
- Ethnicity
- Sex
- Marital Status
- Maternity
- Religion & Belief
- Sexual Orientation

In terms of workforce data, we have reviewed the data which is available to us with regards to age, disability, ethnicity, sex, marital status, maternity, religion & belief and sexual orientation. Other than in respect of Recruitment and Selection statistics, the Trust does not hold workforce data on gender reassignment

Summary of Headline Data:

- **83% of the workforce is of White Ethnicity**. This figure remains slightly lower than the Wigan borough figure of 95%. 15.7% of the workforce profile is from Black and Minority Ethnic Groups, with 10.1% of Trust Board being BAME, this is over representative of the Wigan population.
- **The split between staff aged under 50 and over 50 has remained fairly static.**
- **3.7% of the workforce declared they are living with a disability**. This is under representative of the Wigan population (20%). Trust representation has increased slightly compared to the 2022 figure (3.1%), although undeclared rates have decreased slightly from 21.7% to 19.1%.
- **The workforce profile remains predominantly female at 81%** whereas the local population is 51% female. However, this is in keeping with the gender profile of the healthcare profession in general and the NHS in particular.

- **Almost 59% of staff who have disclosed their religion and belief and describe themselves as Christian compared to 2021 Census Wigan borough figure of 63%.** 21% of Trust staff have not disclosed their religion and belief, a slight decrease compared to the previous year at 23.4%.
- **80% of staff describe themselves as heterosexual 2022: 75%).** However, 18% of staff have not disclosed their sexual orientation, this is slightly less than last year's rate of 20%

See Appendix 2 for Full Details.

Service Users (Patients)

The Trust has historically only had very limited information on the protected characteristics of the people who use our services. As a consequence, it can be difficult for us to determine the extent to which we are providing services which are responsive to individual needs. The following patient demographics are collected routinely by the Trust:

- Age
- Sex
- Ethnicity
- Religion and Belief

For the purposes of this report, we have reviewed the data which is available to us in terms of age, sex, ethnicity and religion and belief, along with local data and reports. Where we do not have sufficient data in terms of disability, sexual orientation, marriage and civil partnership and transgender, we have used regional or national data as an estimate.

Summary of Headline Data:

- The population of England and Wales has increased by more than 3.5 million in the 10 years leading up to Census 2021. **In Wigan, the population size has increased by 3.6%, from around 317,800 in 2011 to 329,300 in 2021.** This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.
- **Overall picture of WWL patient service access continues to reflect broad similarity to local demographics** (Census 2021 Wigan Borough statistics).
- **Over last 12 months, 2% decrease in total in-patients/out-patients of British White ethnicity. 0.5% increase in patients of Black and Minority Ethnic (BAME) backgrounds. 89% British White / 5.2% BAME. No statistical significance reported.** 1.5% increase in those not stated (5.8%). Over last 10 years steady increase in BAME activity 2012/13: 2.7% / 2022/23: 5.2%.
- Ethnicity overall reflective of local population – Census 2021 Wigan Borough data reported that 95% of the local population were of British White ethnicity, 5% from other Black and Minority ethnic backgrounds. Asian people were the largest minority group in Wigan accounting for 1.8% of the population. 3,907 or 1% (3907) of the Wigan population are black. In England, in comparison the proportion of the population that is white is 81%, 10% Asian and 4% Black,
- **Over last 10 years, steady increase in % of patients of Black and Minority ethnicity attending A&E**. 2012/13: BAME 3.1%. 2022/23: BAME 8.9%.
- Higher % of Black and Minority Ethnic Groups using maternity services in comparison with overall out-patient / in-patient activity. Data historical – British White 83% / BAME 16% / 1% not stated. No statistically significant difference noted. Data in line with growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers.

- **In Wigan, the % of people who did not identify with at least one UK national identity increased from 2.2% in 2011 to 4.1% in 2021.** During the same period, the % increased from 5.4% to 9.5% in Bolton. Although figures are lower in Wigan, the borough has received a sizeable number of refugees and migrants over the last decade and it is likely that the population will become more diverse over the coming years.
- **The top languages interpreted during 2022/23 were: British Sign Language; Farsi; Kurdish Sorani; Romanian; Polish; Arabic; Urdu; Cantonese; Russian; Portuguese; Spanish**.
- **As with most healthcare services in the UK, women are more likely to use hospital services than men** – 57% of out-patients during the last 12 months were female.

- **The population has continued to age.** Census 2021 results reported 19.3% of residents were aged 65 years and over (16.3% a decade earlier). The proportion of Wigan residents aged 65+ was higher than the national average (18.6%) with Wigan also experiencing a higher rate of growth over the last decade (23%) compared to the national average (20%) Maintaining the health and resilience of older people is important both for the individuals themselves and in ensuring the sustainability of local health and adult social care services. The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs. During 2022/23 39% of patients accessing WWL services were aged 65 years and over. 42% aged 31-64 years. Trends show a 2% increase in patients aged 65+ years over the last 12 months and 1% decrease in those aged 18-30 years.

- **Wigan Census 2021 showed that 20.2% of Wigan residents are living with a limiting long-term illness, health problems or disability** – higher than the national average 18%. 1 in 6 (16%) of the local population are living with hearing loss (60,500 residents). 10,500 Wigan Residents are estimated to be living with sight loss. Figures are expected to rise over the next 10 years.

- **Census 2021 data reported over 74,000 people in Wigan who have been diagnosed with a long-term condition. Long-term conditions or chronic diseases are conditions that currently have no cure, and are managed with drugs and other treatment**, for example diabetes, COPD, asthma, pulmonary disease, arthritis, and hypertension.

- **ONS data shows 6,773 people in Wigan identified as a sexual orientation other than heterosexual when the Census was undertaken in March 2021 (2.5% of respondents).** The most common LGB+ sexualities were gay or lesbian (57%) and bi sexual (35%). Data on sexual orientation is limited to those who responded, so data is expected to be higher. 84,983 people living in Greater Manchester do not identify as heterosexual (3.8% of the population aged 16 and over).

- **Census 2021 reported that 95% of resident's gender identity was the same as registered at birth.** 11,946 residents did not respond; 470 resident's gender identity was different from sex registered at birth; 372 residents identified as trans man/trans woman; 66 residents identified as non binary; and 57 residents identified as other gender identities. Data on gender identity is still currently limited, although data collection methodology and question design are developing. **Despite laws and attitudes towards people who identify as LGBTQI+ changing significantly in even just the last decade, discrimination remains. Research evidence demonstrates that LGBTQI+ people experience significant health inequalities in terms of health outcomes, health care service provision and health risk factors in comparison to cis-heterosexual populations.**

- **Levels of deprivation in Wigan are significantly worse than the England average.** Within most deprived 20% in UK. People living in the most-deprived areas of Wigan have a life expectancy nearly a decade shorter than the least-deprived areas.

See Appendix 3 for Full Details.

The Year Ahead – EDI Strategy

The year ahead focusses on bringing to life the actions from the data we have collected in 2022-23. This includes data from WRES, WDES, National Staff Survey, Rainbow Badges, Race Equality Code and the Disability Confident scheme.

The focus will very much be on embedding EDI into everyday practice, getting governance structures right, and empowering divisional leads to lead on EDI improvement in their areas.

There will be a continuation of work to celebrate and recognise diversity and one of the tools being launched in 2023 to enable this is the EDI Learning Toolkit. This will complement the EDI Calendar in that it empowers staff to discover more about EDI topics that they do not already know about. This self-serve, interactive toolkit enabled staff to browse recommended reading, TV shows, podcasts, websites etc on a variety of topics.

Our Staff Networks will continue to grow and thrive and will continue to be valued for their voice and direction in many aspects of how the Trust works. Staff will continue to have their voices heard through these forums.

In 2023/24 the Trust will continue to embed and integrate the EDS2022 in terms of both service provision for patients and employment practice. In line with the requirements of EDS2022, the Trust will aim to continuously improve services all service users and especially those that are categorised as having protected characteristics and underrepresented groups. This will be done in partnership with staff, service users and local interest groups.

for

Although many controls have now been implemented to demonstrate compliance with the Accessible Information Standard (AIS), currently there is no consistent approach Trust wide (across all standalone systems). Patients could have their information and communication needs met for some services, but not for others. As we enter 2023-2024, we look forward to continued integration of the AIS in the Trust's IT systems to support patients and service users in accessing care services appropriate to their communication requirements.

We will continue to work in partnership with staff and patients. For staff, this means continuing to raise awareness of initiatives and engaging with protected groups to ensure that all staff feel valued, respected and able to progress through the organisation. It also means the opportunity to share and build on areas of good practice whilst addressing areas for development. For patients and carers, this means being able to access our services, receive care and support and be treated as individuals with dignity.

We recognise that people in our community have different needs and qualities. Understanding the diversity and needs of our local population can help us to plan and deliver services better. To achieve this we need to engage with our communities to better understand their needs based on their protected characteristics. We will look at how we capture patient feedback from our services for people with unique needs, to understand and improve the patient experience. We will work with colleagues, patients, families and communities to improve the way we collect and use data across all the nine protected characteristics. We recognise the importance of equality monitoring. Data enables us to identify if any patients with a protected characteristic are facing any barriers to healthcare. At present, patient demographics are only routinely collected across four protected characteristics (age; sex; ethnicity and religion and belief) within the Trust. Over the next 12 months we will review how our demographic data collection can be expanded to include disability, sexual orientation, gender identity and then marriage and civil partnership and maternity and pregnancy.

We are committed to tackling health inequalities and understand that some groups of people, including protected characteristic groups, experience different access, experience, and outcomes when they use NHS services. Undertaking Equality Impact Assessments (EIAs) helps us to understand how our policies and services may affect different groups of people. EIAs help us to think about how what we do may impact on all members of the community and provide us with an opportunity to consider how we can further promote inclusion and diversity in everything we do. The culture of EIAs will be pursued to provide assurance that the Trust has carefully considered any potential negative outcomes. This will include the impact on our armed forces community and their families, who have been shown to suffer significant disadvantage in accessing healthcare due to service-related obligations, ensuring that any inequalities are identified and tackled in an open and transparent way.

We will work with maternity services to improve equity for mothers from ethnic minority backgrounds who have long been known to face additional maternity risks, with maternity mortality rates significantly higher

for white women. We will further integrate our Learning Disability Services by working closely with partners to improve experience and outcome.

Appendix 1 – WRES Action Plan

	Please specify which actions are different to current practice, and which are continuation	***Please specify KPIs and timelines for monitoring the actions***	***How will actions be made sustainable***
Actions around WRES Indicator 1: Recruitment and Promotion	Improve the race disparity ratio particularly for nurses/midwives moving from band 5 to 6/7 (New Action)	KPI = Clinical BME Staff more equally represented in bands 6 and 7.	This will be underpinned by the recruitment project and the Trust-wide scheme for nurturing high potential leaders which is currently being developed.
Actions around WRES Indicator 2: **Appointments**	To explore how international recruitment can be accurately captured within the TRAC data which informs this indicator. (New Action)	KPI = Improvement in shortlisting and appointment ratio for BME staff. Timeline = Data should be accurately recorded before the end of March 2023.	Once in place, international recruitment will be accurately being captured on an ongoing basis.
	EDI Leads and FAME network working with recruitment team to identify potential areas of bias in the recruitment process.	KPI = Improvement in shortlisting and appointment ratio for BME staff. Timeline = Recruitment Project to start this financial year and continue into next	Managers will need to be supported with understanding how to apply any changes in recruitment processes. Training and guides will support managers.
Actions around WRES Indicator 3: **Disciplinary**	Disciplinary themes were reviewed and BME staff were more likely to have Information Governance related allegations. FAME network have provided feedback on IG training and their recommendations are to be discussed and taken forward with IG. (New Action)	KPI = Reduction in disciplinary cases for staff in relation to IG	Reviewed training offer will be available for all at induction.
	Manager training for Disciplinary and Grievance to be reviewed to include diversity and culture. (New Action)	Timeline = Next financial year	Ensure that all relevant managers receive the training and offer refresher training
Actions around WRES Indicator 4: Education	To explore how recording CPD and non-mandatory training can be built into the new Learning Management System.	KPI = To be able to record data for this metric. Timeline = from Q1 2023/24	Once built into Learning Hub, this will need a team/person to keep track of the data

Actions around WRES Indicator 5: **Bullying Harassment from Public**	Staff have been recruited to EDI Gold Champion roles and will commence training in November. EDI Champions and FAME allies will play an important role in challenging behaviours and processes. (New Action)	KPI = Reduction in percentage of staff experiencing bullying, harassment or abuse from the public. Timeline = EDI Gold Champion training for anti-racism will finish in January. Full course of training will not finish until August 2023.	Once trained the EDI Gold Champions will train others within the Trust, sharing the knowledge and skills they have gained from the course.
	Recommendation for figures to be shared at a FAME network event to gather more specific feedback.	Timeline = Gather feedback by January 2023 so that actions can be built into 2023-24 action plan	FAME Staff Network relaunched and will have regular events with members and allies from October 2022.
	Zero tolerance policy and process being reviewed (New Action)	Timeline = Actions to come out of EDS assessment by March 2023	Actions will be taken forward by relevant stakeholders and improvement will be assessed at the following EDS assessment. Actions will be monitored at EDI Strategy Group Meetings.
Actions around WRES Indicator 6: **Bullying Harassment from Staff**	Staff have been recruited to EDI Gold Champion roles and will commence training in November. EDI Champions and FAME allies will play an important role in challenging behaviours and processes. (New Action)	KPI = Reduction in percentage of staff experiencing bullying, harassment or abuse from the public. Timeline = EDI Gold Champion training for anti-racism will finish in January. Full course of training will not finish until August 2023.	Once trained the EDI Gold Champions will train others within the Trust, sharing the knowledge and skills they have gained from the course.
	Recommendation for figures to be shared at a FAME network event to gather more specific feedback.	Timeline = Gather feedback by January 2023	FAME Staff Network relaunched and will have regular events with members and allies from October 2022.
	HR team to be trained or supported in ER cases to confidently tackle accusations of discrimination or bias. (New Action)	Timeline = Q3 of 2023/24	Training will be embedded into onboarding for relevant HR roles

	Zero tolerance policy and process being reviewed (New Action)	Timeline = Actions to come out of EDS assessment by March 2023	Actions will be taken forward by relevant stakeholders and improvement will be assessed at the following EDS assessment. Actions will be monitored at EDI Strategy Group Meetings.
Actions around WRES Indicator 7: **Equal opportunities**	A Trust-wide scheme for nurturing high potential leaders is currently in the design process. EDI Lead for Workforce is closely linked in as a key stakeholder to ensure equitable selection procedures are designed in. Positive action for ethnic minority staff is being considered as part of the design. (New Action)	Timeline = Q1 of 2023/24 onwards	Positive action will be built into the model of talent spotting
	At an EDI Workshop in Oct 2022, approximately 40 leaders in the Trust will be encouraged to look at their recruitment and promotion data to identify areas for improvement to diversity in their divisions. (New Action)	KPI = Engagement from leaders at EDI Strategy Group Meetings during 2023	EDS 2022 supports the shift in responsibility for EDI from the select few to leaders across the Trust.
Actions around WRES Indicator 8: **Discrimination from a Leader**	Staff have been recruited to EDI Gold Champion roles and will commence training in November. EDI Champions and FAME allies will play an important role in challenging behaviours and processes. (New Action)	KPI = Reduction in percentage of staff experiencing discrimination at work from Manager/team leader or other colleagues	Once trained the EDI Gold Champions will train others within the Trust, sharing the knowledge and skills they have gained from the course.
	Recommendation for figures to be shared at a FAME network event to gather more specific feedback.	Timeline = Gather feedback by February 2023 so that actions can be built into 2023-24 action plan	FAME Staff Network relaunched and will have regular events with members and allies from October 2022.

	Zero tolerance policy and process being reviewed (New Action)	Timeline = Actions to come out of EDS assessment by March 2023	Actions will be taken forward by relevant stakeholders and improvement will be assessed at the following EDS assessment. Actions will be monitored at EDI Strategy Group Meetings.
	HR team to be trained or supported in ER cases to confidently tackle accusations of discrimination or bias. (New Action)	Timeline = Q3 of 2023/24	Training will be embedded into onboarding for relevant HR roles
	Inclusive leadership session being included for new manager induction programme. (New Action)	Timeline = from Q1 of 2023/24 onwards	Built into the programme
Actions around WRES Indicator 9: **Board Representation**	Continue to monitor data as current board is representative of overall workforce in terms of ethnicity.	KPI = Board representation to remain representative of overall workforce in relation to ethnicity	Actions taken forward from the Race equality code will help to sustain this.

Appendix 2 – Headline Data

Our People (Workforce)

Age

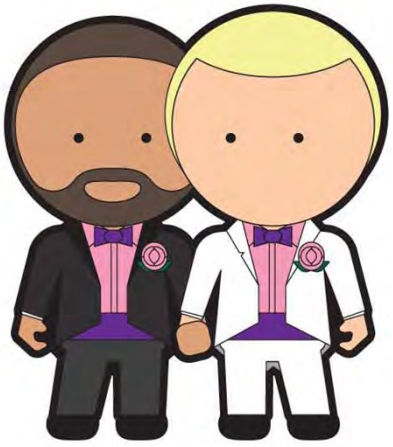
As at 31 March 2023 WWL Trust staff breakdown was:

62% Aged Under 50 **38%** Aged over 50

The proportion of staff in each age bracket has stayed relatively static compared to 2021.

Performance management cases split by age were at 57% for under 50 and 43% for over 50 which is not in proportion to the workforce representation.

Marriage and Civil Partnership



As at 31 March 2023

53% of staff were **Married**

2% were in a **Civil Partnership**

33% single, 8% divorced / legally separated, 1% widowed, 3% unknown.

Figure has remained relatively static over a period of several years.

The WWL Way

Disability

As at 31 March 2023

3.7% of the Workforce have declared that they are living with a disability.

This has increased slightly compared to the 2022 figure (3.1%) although there is still a large amount of undeclared data 19.1% this has decreased over the previous years: 2022: 21.7%, 2021: 26.6%, 2020 & 2019 was 29% & 2018 was 32%)

For Non-Clinical Staff there is an under representation of disabled staff in Band 7 and 8b and above.

For Clinical Staff there is an under representation of disabled staff particularly in Bands 8b, 8c, Very Senior Management and in Medical & Dental.

Pregnancy and Maternity

As at 31 March 2023, a snap shot from the Electronic Staff Record indicated that:

2.48% of female staff were on **Maternity Leave**

This is comparable to the previous two years.

Religion and Belief

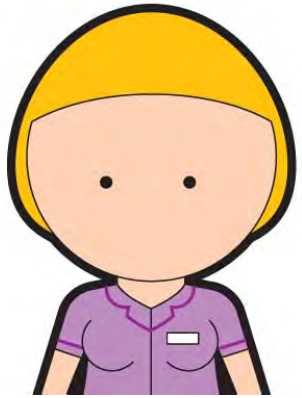
As at 31 March 2023

59% Christian **20%** Other **21%** Unknown

Remaining staff split across a range of religions and beliefs with the highest number being in Atheism category (7.8%) and Other Religion (7.1%).

A significant proportion of staff have not declared their religion and belief. (21%) although this is down slightly from last year.
(2021 Census, The Wigan borough figure for Christianity is 63%)

Sexual Orientation



Workforce as at 31 March 2023:

80% Heterosexual
1.4% Gay or Lesbian
0.7% Bisexual
0.1% Other

18% did not wish to disclose
(a decrease from last year's 20%)

There is comparable representation of gay, lesbian or bisexual staff across AFC bands except 8c, 8d and 9.

Ethnicity

As at 31 March 2023:

83% of Staff of White Ethnicity (2021 Census, Wigan Borough White representation is 95%)

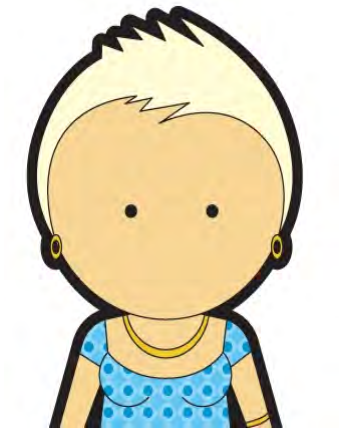
15.7% of Staff from Black & Minority Ethnic Groups

1.3% Not Stated

10.1% of the Trust Board membership is BME.

23.43% of **Disciplinary** cases were in respect of BAME staff members which slightly above the workforce profile.

Sex



Workforce as at 31 March 2023:

81% Female

19% Male

(2021 Census, 51% female / 49% male within Wigan population)

39% of **Disciplinary** cases were in respect of male staff members which is over representative of the male workforce profile. This is an decrease from the previous year's data at 47% of disciplinary cases in respect of male staff members.

Gender Reassignment

Transgender information for current staff is not recorded on ESR so we cannot therefore undertake workforce profile monitoring at present.

Our Service Users (Patients)

Ethnicity (Out-Patients & In-Patients)

During 2022/23

89% of Patients of British White Ethnicity

5.2% of Patients from Black & Minority Ethnic Groups (BAME)

5.8% Not Stated

During last 12 months, 2% decrease in patients of British White Ethnicity. 0.5% increase in patients of Black & Minority Ethnic Origin. 1.5% increase in those not stated.

Over last 13 years steady increase in BAME activity 2010/11: 2.9% / 2022/23: 5.2%.

Ethnicity (Accident & Emergency)

During 2022/23

89.2% of Patients of British White Ethnicity

8.9% of Patients from Black & Minority Ethnic Groups (BAME)

1.9% Not Known

During last 12 months, 1.1% decrease in patients of British White Ethnicity. 1.4% increase in patients of BAME Origin.

Over last 10 years steady increase in BAME activity in A&E. 2012/13: 3.1% / 2022/23: 8.9%

Ethnicity overall reflective of local population – Census 2021 Wigan Borough data reported that 95% of the local population were of British White Ethnicity, followed by the Asian ethnic group 2%, mixed multiple ethnic groups 1%, Black 1% and Other 1%.

In England more broadly the portion of the population that is white is 81%. 10% are Asian and 4% are Black.

Ethnicity (Maternity Admissions)

During 2022/23

83% of Patients of British White Ethnicity

15.5% of Patients from Black & Minority Ethnic Groups

1.5% Not Known

Higher % of Black and Minority Ethnic Groups using maternity services than overall out-patient / in-patient activity. No statistically significant difference noted – data historical. Data in line with significant growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers.

During last 12 months: 3.8% decrease in patients of British White Ethnicity. 3.5% increase in patients of Black and Minority Ethnic Backgrounds. During last 8 years: 7% decrease in patients of British White Ethnicity. 6% increase in patients of Black and Minority Ethnic Backgrounds

Interpreter & Translation Services

During 2022/23
Top Languages Requested
British Sign Language; Farsi; Kurdish Sorani; Romanian; Polish; Arabic; Urdu; Cantonese; Russian; Portuguese; Spanish

Language Trends remain static, with an increase in Kurdish Sorani, Romanian, Urdu and Farsi

During 2022/23:

39 Translations into other languages
14 Other formats - 8 Large Print / 6 Braille Translations requested
This will continue to increase with the implementation of the Accessible Information Standard

Ethnic Population in Greater Manchester

In Wigan, the percentage of people who did not identify with at least one UK national identity increased from 2.2% in 2011 to 4.1% in 2021. During the same period, the % increased from 5.4% to 9.5% in Bolton. In 2021, over 95% of the population was White British. This compares to just under 80% in England as a whole. Although figures are lower in Wigan, the borough has received a sizeable number of refugees and migrants over the last decade and it is likely that the population will become more diverse over the coming years.

Ethnic minority populations living in Wigan include Long-term resident ethnic minority population and asylum seekers and refugees, migrants, Gypsies and Travellers, European Roma and Overseas students. Although the numbers are small compared to the size of the total population and
some only stay for a short period of time, some will have
specific health needs that need to be addressed.

Local Authority (Census 2021)	White British	Mixed	Asian or Asian British	Black or Black British	Other
Wigan	95%	1%	2%	1%	1%
Bolton	71.9%	2.2%	20.1%	3.8%	1.9%
Salford	82.3%	3.1%	5.5%	6.1%	2.9%

Sex (Out-Patients)

During 2022/23
57% Female
43% Male

2021Census Wigan Borough figures: 51% of the local population female

As with most healthcare services in the UK, women are more likely to use hospital services than men.

Age

During 2022/23
% of patients accessing hospitals services

9% Under 18 **10%** 18-30 Years
42% 31-64 Years **39%** 65+ Years

1 in 6 residents in Wigan are now aged over 65 years.

Set to increase over the next 20 years

Age overall reflective of local population – Wigan Census 2021 reported 19.3% of residents were aged 65 years and over (16.3% a decade earlier). **The proportion of Wigan residents aged 65+ was higher than the national average (20%)**

Maintaining the health and resilience of older people is important both for the individuals themselves and in ensuring the sustainability of local health and adult social care services.

The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs. Trends show a 2% increase in patients aged 65+ years over the last 12 months and 1% decrease in those aged 18-30 years.

Religion and Belief

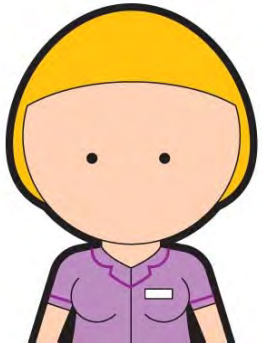
During 2022/23
% of patients accessing out-patient services

65% Christian
14% None
0.6% Muslim
0.1% Buddhist
0.1% Jewish
0.1% Spiritualist
19% Unknown
0.2% Hindu
0.2% Atheist
0.2% Islam
0.0% Unitarian

Religion overall reflective of local population – 2021 Census Wigan Borough figure reported that 63% of the population were of Christian Belief

Trust Data affected by the high proportion of religion not known (123,379 patients).

Sexual Orientation and Gender Identity



Census 2021 Data

6,773 Wigan Residents (2.5%) identified as a sexual orientation other than heterosexual.

Most common LGB+ sexualities were gay or lesbian (57.4%) and bisexual (35.2%)

Data on sexual orientation is limited to those who responded, so data is expected to be higher.

Census 2021 Data

255,782 Residents (95%) Gender identity is the same sex as registered at birth
11,946 Residents (4.5%) Chose not to answer
470 Residents Gender identity different from sex registered at birth (no specific identity given)
216 Residents Trans man
156 Residents Trans woman
66 Residents Non-binary
57 Residents All other gender identities

Data on gender identity is still currently limited, although data collection methodology and question design are developing. Despite laws and attitudes towards people who identify as LGBTQI+ changing significantly in even just the last decade, discrimination remains. Research evidence demonstrates that lesbian, gay, bisexual, and trans (LGBTQI+) people experience significant health inequalities in terms of health outcomes, health care service provision and health risk factors in comparison to cis-heterosexual populations.

84,983 people living in Greater Manchester do not identify as heterosexual (3.8% of the population aged 16 and over)

In response to national research, NHS England is spearheading a collective drive to improve the experience of trans and non-binary people when accessing health and care services.

Disability

Wigan Census 2021 showed that 20.2% of Wigan residents are living with a limiting long-term illness, health problems or disability – higher than the national average 18%.

The Royal National Institute for Deaf People (RNID) estimates that

1 in 6 (16%) of the population are living with hearing loss.

60,500 Wigan Residents (RNID, 2020a).

Improving Health & Lives (IHAL) estimate that

1.9% (6,170 residents) have learning disabilities.

Royal National Institute for Blind People estimates that

10,500 of Wigan Residents are living with sight loss **(1,730** registered blind or partially sighted)

By 2032, figures are expected to rise to

12,600 of Wigan Residents living with sight loss

1 in 5 people will start to live with sight loss in their life time / Every day **250 people** start to lose their sight (UK Stats)

The Accessible Information Standard

A law to ensure that people who have a disability, impairment or sensory loss are given information they can easily read or understand. Making information easier to understand for people living with communication and information needs.

WWL is committed to working towards meeting the core requirements of the Standard for everyone we serve.

Patients with disabilities often report barriers to using health services, in terms of transport difficulties, distance and needing someone to accompany them. Poor communication leads to non-attendance for appointments. These are issues currently being reviewed within Wigan Borough Locality Plan.

Census 2021 Wigan Borough reported

20% of Wigan Residents living with a limiting long-term illness, health problems or disability which limits daily activities at work.

Higher than national average 18%

The 5 most common conditions which account for 54% of DLA Claims

Arthritis; Learning Disabilities; Heart Disease; Disease of muscles, bones & joints; Hyperkinetic syndromes

1 in 4 people experience a mental health problem during their life. Having a long-term condition increases the risk that an individual will have a mental health.

The number of people who are at risk of having poor mental wellbeing in Wigan is high because of the high levels of deprivation.

Marriage and Civil Partnership (aged 16 and over)

Census 2021 Wigan Borough reported

43.8% Wigan Residents are **Married or in a registered Civil Partnership**

37.2% Wigan Residents have **never been Married or in a registered Civil Partnership**

386 Wigan Residents are or have been in a **Registered Civil Partnership (opposite sex and same sex), this includes 219 people currently in a same sex civil partnership. 625 were in a same sex marriage.**

Complaints

527 Complaints Received during 2022/23

297 Female **227** Male **3** Unknown

484 British White Ethnicity

19 Black & Minority Ethnic Background

24 Not Stated

60% Aged 50 years or above

5 Main Subject Complaints

- Clinical treatment
- Communications
- Patient Care
- Admissions and Discharges
- Value and Behaviour

No trends in relation to protected characteristics noted

Wigan Borough Population

The population of England and Wales has increased by more than 3.5 million in the 10 years leading up to Census 2021.

In Wigan, the population size has increased by 3.6%, from around 317,800 in 2011 to 329,300 in 2021. This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.

In 2021, Wigan ranked 31st for total population out of 309 local authority areas in England, which is a fall of six places in a decade.

At 3.6% increase, Wigan's population is lower than the increase for the North West (5.2%)

As part of the 2021 census, households in England and Wales were classified in terms of four different "dimensions of deprivation"; based on unemployment, health, education, and type of dwelling. Analysis from the Office for National Statistics recorded that 53.4% of households in Wigan and Leigh were classed as being deprived.

Levels of deprivation in Wigan significantly worse than England average.

Within most deprived 20% in UK.

People living in the most-deprived areas have a life expectancy nearly a decade shorter than the least-deprived areas.

A detailed account of all Trust Equality Monitoring Data for 2022/23

can be accessed via our Trust Website

https://www.wwl.nhs.uk/Equality/equality_information.aspx

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WRES & WDES Annual Reports 2023; including our commitments to becoming an Anti-Racist Organisation and Disability Confident Employer.
Presented to:	Board of Directors
On:	06 December 2023
Presented by:	Juliette Tait
Prepared by:	Suzi Speakman, Assistant HR Business Partner & Angelique Hartwig, Head of Staff Experience
Contact details:	Suzi.speakman@wwl.nhs.uk; angelique.hartwig@wwl.nhs.uk

Executive summary

As a public sector NHS Organisation, the Trust is required to collect data and report a range of Equality & Diversity measures which include the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

This report summarises the Trust`s latest Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) information.

WRES (Workforce Race Equality Standard)

This year's WRES metrics suggest that our position against the indicators has deteriorated since 2022 and highlights key gaps in providing fair treatment and equal experiences for our colleagues from Black, Asian and Minority Ethnic groups. Key findings include:

- Inequality in career progression in clinical roles from lower to middle levels.
- Higher percentage of Black, Asian and Minority Ethnic staff experiencing discrimination or bullying, harassment and abuse at work compared to white staff.
- Increased likelihood for Black, Asian and Minority Ethnic colleagues of not being appointed from shortlisting.
- Decreased perceived fairness with regards to opportunities for career progression or promotion compared to white staff.

Workforce Disability Equality Standard (WDES)

This year's WDES metrics suggest that our position against some indicators has improved whilst others have deteriorated since 2022. There are still key disparities in experiences at work between staff with or without disabilities, long-lasting health conditions or illnesses which will need addressing to eliminate inequalities and achieve an inclusive culture. Key findings include:

- Increase in the disability declaration rate and improved representation across clinical and non-clinical staff groups.
- Improved likelihood of disabled staff being appointed from shortlisting and decrease in perceived pressure from managers to come into work despite not feeling well enough to perform.
- Consistently worse staff experience across all People Promises compared to non-disabled staff.
- Continuing disparity in experiences of bullying, harassment and abuse from colleagues, managers and the public compared with non-disabled colleagues.
- A third of staff with long-lasting health conditions continue to feel like they haven't received reasonable adjustments to carry out their staff which no significant changes this last year.
- Reduction in percentage of staff with long-lasting health conditions feeling their work is valued by their organisation and that they have equal opportunities for career progression or promotion.

Workforce Disability Equality Standard (WDES) & Workforce Race Equality Standard (WRES) actions will be included in the EDS action plan, along with objectives contained within the NHS EDI Improvement plan.

Ultimately, Trust Board are required to sign off the actions to support improvements in the WRES and WDES and this will be presented to Trust Board in December 2023, following further engagement with the staff networks. Given the timescales however, it should be noted that the plans will be published on the website, noting draft status, with effect from 1st November 2023, as is our statutory duty.

Link to strategy

Equality Strategy 2022.

Risks associated with this report and proposed mitigations

It is noted there are possible risks of adverse publicity being generated due to the Trust`s WDES & WRES returns and in addition this could negatively impact upon the engagement of disabled and Black, Asian and Minority Ethnic staff who may feel unfairly treated and disengaged. Whilst it is recognised these risks exist it is noted there has been no adverse publicity generated to date in response to the publishing of the Trust`s previous WDES & WRES returns. In addition, there is not yet any qualitative data that suggests engagement levels have been adversely impacted linked specifically to the Trust`s WRES & WDES returns.

There are possible risks of employment tribunal claims concerning the areas of disparity highlighted within the WDES & WRES. The developed Equality, Diversity and Inclusion Strategy, the recruitment of an EDI Specialist on a permanent basis to focus on employment related matters and reviewing our practices against frameworks such as North West Anti-Racism Framework and Disability Confident will help to mitigate these risks.

Financial implications

As noted above there are possible risks of employment tribunal claims concerning the areas of disparity highlighted within the WDES & WRES.

Legal implications

As noted above there are possible risks of employment tribunal claims concerning the areas of disparity highlighted within the WDES & WRES.

People implications

The people issues which arise from the WDES & WRES are wide ranging and at the heart of this issue is fairness and equality of opportunity for Black, Asian and Minority Ethnic (BAME) and Disabled staff within the organisation.

The re-framed approach to EDI and the development of a new strategy which emphasises that EDI is the responsibility of all leaders will support our aim to provide a fair and inclusive environment for Disabled and Black, Asian and Minority Ethnic staff.

Wider implications

It is noted there are possible risks of adverse publicity being generated due to the Trust`s WDES & WRES, however, to date no publicity of this nature has arisen in response to the publishing of the Trusts previous WDES & WRES data over the past 4 years.

Recommendation(s)

The Board of Directors are recommended to support and acknowledge the ongoing work on assessment frameworks for the NW BAME Assembly Anti-Racist Framework and Disability Confident Scheme to address deeper inequalities highlighted by our WRES and WDES data.

The Board of Directors are Committee are also asked to receive and acknowledge the draft Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Action Plans that accompany this paper, which will be presented to the Board in December 2023.

Statutory Equality & Diversity reporting

1 Background

As a public sector NHS organisation, the Trust is required to collect data and report a range of Equality & Diversity measures which include the Workforce Race Equality Standard (WRES) Workforce Disability Equality Standards (WDES).

This report summarises the Trust`s latest Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES).

2 Workforce Race Equality Standard (WRES)

2.1 Information on the WRES

In 2016 NHS organisations through the NHS standard contract were required to implement the Workforce Race Equality Scheme (WRES). The WRES has been mandated through the NHS Standard Contract since 2015 to support NHS organisations in making improvements against a set of nine indicators to ensure employees from Black, Asian and Minority Ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace. These indicators cover areas such as recruitment, bullying and harassment, discrimination and career progression. The WRES supports us to identify appropriate positive action to eliminate discrimination, harassment and unfair treatment of Black, Asian and Minority Ethnic staff in the workplace.

2.2 WRES: Key themes for the Trust

Appendix 1 includes the Trust`s WRES submission for 2023 which relates to data from 1st April 2022 – 31st March 2023. The data collection is extensive and is drawn from a range of sources including the Electronic Staff Record (ESR), the Trust`s recruitment system TRAC and a number of National staff survey indicators. Five metrics is based on ethnicity declaration data on ESR, with Black, Asian and Minority Ethnic representing 14% of our workforce, (compared with 4.3% for the Wigan Borough) and all other metrics are derived from responses from staff to the National Staff Survey data (10.4% Black, Asian and Minority Ethnic staff representation).

Appendix 2 also includes the national and regional comparison data for WRES. The Trust ranked in the top 5 % of all Trusts on one metric (Board representation) and in the bottom 5% on two metrics, including race disparity ratio for clinical roles and discrimination. Please note that the national and regional data contained in this report is under embargo, until NHS England publishes the annual WRES and WDES reports. Please note, benchmarking data may be subject to change and therefore, we advise caution in interpreting the results. Any reference to national benchmarking will be removed from the WRES submission and action plan for publication on the WWL website by 31st October.

Key points to note are:

- **Black, Asian and Minority Ethnic representation at Board Level is similar to representation in workforce but underrepresented at clinical Band 6 roles or above (ratio 5.4) as well as for medical staff at Consultant level and above (2.3),** with both disparity ratios having worsened since 2022. WWL ranks worse than 99% of Trusts in terms of race disparity ratio at clinical lower to middle level.

- **White staff were 2.3 times more likely to be appointed from shortlisting compared with Black, Asian and Minority Ethnic applicants**. This is a deteriorating trend from last year's likelihood of 1.44 and the worst position in over 5 years. WWL performed worse than 86% of Trusts.

- **Black, Asian and Minority Ethnic staff were twice as likely than white staff to enter a formal disciplinary process.** The metric shows a deteriorating trend over the past two previous years (2022, 1.51; 2021, 1.34), however this figure is not significantly different from "1.0" or equity due to the small number of staff affected.

- **Black, Asian and Minority Ethnic staff experience higher levels of bullying, harassment and abuse from other staff compared to white staff**. Black, Asian and Minority Ethnic Staff's experience of bullying, harassment and abuse from service users and managers has shown a deteriorating trend since last year, whilst the experience of such behaviour from colleagues has improved slightly.

- **Black, Asian and Minority Ethnic staff report much higher levels of discrimination at work from Manager/Team Leader or other Colleagues than white staff,** 24% vs 6.5% for white staff and national average for Black, Asian and Minority Ethnic staff at 17.3%. WWL performed worse than 97% of Trusts has seen an 12.2% increase in reporting of discrimination against Black, Asian and Minority Ethnic staff and small improvement for white Staff (.4% decrease) over the last two years.

- **There has been a decrease in the number of Black, Asian and Minority Ethnic staff reporting that the Trust provides equal opportunities for careers progression or promotion** for the first time in three years **(39% in 2022, compared to 50% 2021).** The latest figure is lower than for white staff (58%) and in national comparison (47% national average for Black, Asian and Minority Ethnic staff) as well as the lowest since 2019 (35%) which suggests a significant drop in perceived fairness for career progression.

This year's metrics highlight the deteriorating trends for key WRES indicators, including higher percentage of Black, Asian and Minority Ethnic staff experiencing discrimination or bullying, harassment and abuse at work from other staff, increased likelihood for Black, Asian and Minority Ethnic colleagues of not being appointed from shortlisting and decreased perceived fairness with regards to opportunities for career progression or promotion compared to white staff.

3 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that enables NHS organisations to compare the experiences of disabled and non-disabled staff.

The WDES is mandated through the NHS Standard Contract and the WDES enables NHS Trusts and Foundation Trusts to better understand the experiences of their disabled staff. It supports positive change for existing employees and enables a more inclusive environment for disabled people working in the NHS. Like the Workforce Race Equality Standard on which the WDES is in part modelled, it also allows the ability to identify good practice and compare performance regionally and by type of trust.

There are 10 WDES metrics, which cover such areas as the Board, recruitment, bullying and harassment, engagement and the voices of disabled staff.

3.1 WDES: Key themes for the Trust

Appendix 3 includes the Trust`s WDES submission for 2023 which relates to data from 1st April 2022 – 31st March 2023. The data collection is extensive and is drawn from a range of sources including the Electronic Staff Record (ESR), the Trust`s recruitment system TRAC and a number of National staff survey indicators. Four metrics are based on staff's declared disabilities (3.8% of workforce) whereas all other metrics are based on the National Staff Survey responses from staff who have declared a long-lasting health condition or illness (24% of respondents to the survey (N=573).

WWL ranked 154 out of all 212 Trusts in England based on metric performance and weightings of scores. The Trust ranked more than 5% better than national average on one metric and worse than 5% than the national average on six metrics. Please note that national comparison data is embargoed and will not be shared as part of the publication of WDES submission and action plan. Please see Appendix 5 for the summary of the Trust's results in national comparison.

Key themes are as follows:

- **Improved declaration rate of a disability:** Our disability declaration rate has continuously improved over the last 4 years, with 3.8% staff having declared a disability, however WWL scores in lower than national average 4.9% and in the bottom 10% of Trusts for disabled representation in non-clinical workforce
- **Likelihood of appointment after shortlisting was similar for disabled and non-disabled staff** (relative likelihood of 1.09), which has seen a significant improvement from 2021 to 2023 and is only slightly lower than national average of 1 which indicates equity
- **Relative likelihood of disabled staff entering a capability process on the grounds of performance management was similar to non-disabled staff**
- **Staff with a long-lasting health condition scored lower on every People Promise and Theme** compared to the Trust average in 2022. They also scored lower than staff from ethnic minority groups.

- **A third of staff with a long-lasting health condition reported not having had appropriate reasonable adjustments** which is lower than national average (68.5 vs 73.4%).
- **Staff with a long-lasting health condition reported feeling less valued** than non-disabled staff, 32 vs. 45% (lower than national average, 35.2%).
- **Staff with a long-lasting health condition feel treated less fairly with regards to career progression/promotion compared to non-disabled staff and in national comparison** (49% vs 57.8% non-disabled staff; 52.1% national average)
- **Staff with a long-lasting health condition reported more experiences of bullying, harassment or abuse compared to non-disabled staff.**
- **Reporting of incidents of harassment or bullying were similar for disabled and non-disabled staff** but lower compared to national average**.** Additional feedback from the qualitative analysis of National Staff Survey comments support perceptions that staff feel that issues raised or their feedback is not acted on, both regarding complaints about negative behaviour/bullying and when asked to complete surveys.
- **No disabled representation on the board** (lower than national average 5.7%) and this has not changed over the past 5 years.
- **Disability disparity ratios across pay bands have improved since 2023 for clinical roles** and are better than national average, however **disabled staff were underrepresented at non-clinical Band 4**, 1.5%.

This year's metrics show some positive improvements, including the increase in the disability declaration rate by 0.7% since 2022 and representation across clinical and non-clinical staff groups, the improved likelihood of disabled staff being appointed from shortlisting and decrease in perceived pressure from managers to come into work despite not feeling well enough to perform.

Although there has been a slight improvement since last year, we continue to see staff with long-lasting health conditions experiencing more bullying, harassment and abuse from colleagues, managers and the public than non-disabled colleagues. A third of staff with long-lasting health conditions continue to feel like they haven't received reasonable adjustments to carry out their staff which no significant changes since last year. There has been a reduction in percentage of staff with long-lasting health conditions feeling their work is valued by their organisation and that they have equal opportunities for career progression or promotion.

4 Actions in response to the WDES & WRES

The Trust has introduced its EDI Strategy 2022 which sets out the aims and objectives for the period 2022 to 2026 as well as the governance structure. Key objectives include inclusive recruitment processes, reducing bullying, harassment, and victimisation, amplifying diverse voices and reducing inequality in employment/ HR processes. Key achievements in the past year include the successful implementation of our 3 diversity networks - disability and long-term condition, FAME and True Colours (LGBTQIA+), and building a community of 50 ED&I champions who locally influence positive change for our colleagues at the Trust.

Our Colleague Diversity networks for True Colours, FAME and Disability and Long-Term Conditions, are well established with nearly 200 members overall. The networks have led on key projects such as Headline Sponsorship for Wigan Pride 2022, rollout of the Rainbow Badges Assessment Scheme, Hidden Disabilities Project, policy development work, and celebrating cultural diversity.

Over the past financial year, the Trust has also been through the assessments of the Race Equality Code, the Rainbow Badges Assessment and has looked more closely at what makes WWL Disability Confident to provide assurance that WWL are living the principles that are required of us as a Disability Confident employer. The results of these assessments and the latest WRES and WDES data shine a light on actions that are recommended to improve the EDI experience of our staff. This year's action plans aim to make further progress against our strategic objectives and also align with the High Impact Actions of the newly introduced NHS EDI Improvement Plan which include developing measurable EDI objectives at Board level, addressing health inequalities within our workforce, create inclusive recruitment and talent management processes, improve induction offer for international recruited staff, eliminate pay gaps and eliminate conditions for bullying, harassment and physical harassment to occur.

Traditionally, action plans to address the WRES and the WDES have focused on individualised actions that sit against the particular metric that the organisation is seeking to improve. Whilst some successes have been reported over the years, the real change comes from developing much deeper plans that will address inequalities in its broadest sense, thus impacting positively on the metrics in the WRES and the WDES. This year's WRES and WDES action plans focuses on changes in culture that will impact on the underlying causes that may be creating inequalities. It brings to the fore established frameworks that are evidenced as being exemplar models that will enable change in culture when considering inequality.

4.1 Governance

The Chief People Officer will establish the EDI Steering Group, as referenced in the EDI Strategy 2022, which will report into the People Committee. To ensure enough focus can be given to the improvements required in the actions plans outlined below separate working groups may be established to support delivery.

5 Action Plans

ETM should note that the detailed actions plans will be developed with the understanding that upon further review of the NHS EDI Improvement Plan that one consolidated plan will be formed to ensure all mandatory objectives are captured.

5.1 WRES Action Plan

The Northwest Anti Racist Framework (Appendix 5) was launched in early 2023, and on the 26th June 2023 the Co-Chairs of the NHS Black Asian & Minority Ethnic Assembly wrote to all NHS North-West Trusts inviting them to adopt the Anti Racist Framework that had been developed by the Assembly.

The framework provides a mechanism for NHS organisations to work towards the ambition of becoming actively anti-racist organisations. It aims to enable organisations to put into action quickly, the steps needed to reduce inequalities and eliminate racism, which can be evidenced by the WRES data, not only in WWL, but in many other Trusts across the country.

The framework seeks to embed the change needed to transform our services into places where this activity is not seen as just a nice thing to do but is seen as mission critical to all that we do and stand for.

The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Through the embedding of themes, deliverables and actions outlined into structures, processes, policies and culture, will help create meaning and measurable change within the workforce and service delivery.

The framework is organized into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination.

It is proposed that the three levels of achievement become the foundation for the action plan that the Trust is required to publish.

Additionally, ETM should note that engagement has taken place with members of the FAME Network and other colleagues and, following feedback, a specific review of recruitment processes will be commissioned to ensure there are no points of discrimination on any point of the process, and that managers are well trained in using the policy. On top of this the Nursing Professional Practice Team undertook a listening exercise with our nurses who have been recruited via international routes, and a specific piece of work should also be commissioned to ensure they feel supported in the workplace.

5.2 WDES Action Plan

Similarly, as to the WRES, if the Trust requires to see real change in the metrics outlined in the WDES, focus needs to be made on the cultural issues that prevent our disabled workforce from feeling supported in the workplace.

The Disability Confident Scheme creates a movement of change, creating a positive and engaging narrative of how people with differing abilities can add value to a workplace. WWL is already signed up to becoming a Disability Confident Employer and the next step to be aimed for is to become a Disability Confident Leader.

Given that the Disability Confident Employer was declared some time ago, it is proposed that the Trust revisits this framework, not only through the recommended self-assessment process but by a thorough peer review involving our staff networks and those with lived experience to ensure we are meeting all of the objectives outlined in the scheme. The Trust should quickly look at the Disability Confident Leader framework to ensure stretch targets are embedded.

6 Recommendation

People Committee is recommended to support the ongoing work on assessment frameworks for the NW BAME Assembly Anti-Racist Framework and Disability Confident Scheme to address deeper inequalities highlighted by our WRES and WDES data.

Appendix 1

Workforce Race Equality Standard (WRES) 2023

Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:

- **Non-Clinical staff**
- **Clinical staff - of which - Non-Medical staff - Medical and Dental staff**

		Headcount			%		
Clinical / Non-Clinical	**WRES Banding**	BME	White	Unknown	BME	White	Unknown
Clinical	Band 1	1	22	0	4.3%	95.7%	0%
	Band 2	35	741	2	4.5%	95.2%	0.3%
	Band 3	20	626	5	5.3%	96.1%	0.8%
	Band 4	85	201	4	29.3%	69.3%	1.4%
	Band 5	381	673	11	35.8%	63.2%	1.0%
	Band 6	50	922	11	5.0%	93.9%	1.1%
	Band 7	15	592	6	2.4%	96.6%	1%
	Band 8a	11	145	3	6.5%	91.7%	1.8%
	Band 8b	1	12	0	7.7%	92.3%	0%
	Band 8c	0	10	0	0%	100%	0%
	Band 8d	1	5	0	16.7%	83.3%	0%
	Medical & Dental Consultant	138	88	15	57.3%	36.5%	6.2%
	VSM	1	0	0	100%	0%	0%
	Medical & Dental Non-Consultant Career Grade	83	23	12	70.3%	19.5%	10.2%
	Medical & Dental Trainee Grades	92	41	5	66.6%	29.8%	3.6%
	Other	18	7	3	64.3%	25%	10.7%
Non Clinical	Band 1	0	7	0	0%	100%	0%
	Band 2	16	623	7	2.5%	96.4%	1.1%
	Band 3	20	491	5	3.8%	95.2%	1.0%
	Band 4	18	370	4	4.6%	94.4%	1.0%
	Band 5	6	169	2	3.4%	95.5%	1.1%
	Band 6	2	105	1	1.9%	97.2%	0.9%
	Band 7	4	85	1	4.4%	94.5%	1.1%

	Band 8a	6	48	0	11.2%	88.8%	0%
	Band 8b	3	37	1	7.3%	90.3%	2.4%
	Band 8c	0	21	0	0%	100%	0%
	Band 8d	1	10	0	9.9%	90.1%	0%
	Band 9	1	10	0	9.9%	90.1%	0%
	VSM	1	6	0	14.3%	85.7%	0%
	Other	0	0	0	0%	0%	0%

	BME	White	Unknown
Total Headcount	1010	6090	97
Percentage	14%	84.7%	1.3%
Total		7197	

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts.

	White	BME	Ethnicity Unknown/ Null
Number of Shortlisted Applicants	5267	1820	490
Number Appointed from Shortlisting	1017	153	160
Relative likelihood of appointment from shortlisting	19.31 %	8.41 %	32.65 %
Relative likelihood of White staff being appointed from shortlisting compared to BME staff	2.3		

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note: This indicator will be based on year-end data. Previously this indicator has been based on a 2-year rolling average.

	White	BME	Ethnicity Unknown/ Null
Number of staff in workforce	6115	1009	98
Number of staff entering the formal disciplinary process	15 *	5 *	1 *
Likelihood of staff entering the formal disciplinary process	0.25 %	0.5 %	1.02 %
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		2	

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

All training & CPD information was not centrally recorded in 2022-23 and therefore we are unable to provide this information.

Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

White: 21.7%
BME: 24.5%

Indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

White: 21.8%
BME: 27.3%

Indicator 7 - Percentage believing that trust provides equal opportunities for career progression or promotion.
White: 58%
BME: 39%

Indicator 8 - In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.

White: 6.5%
BME: 24%

Indicator 9 - Percentage difference between the organisations' Board voting membership and its overall workforce.

Note: Only voting members of the Board should be included when considering this indicator.

	White	BME	Ethnicity Unknown/ Null
Total Board members	13 *	2 *	0 *
of which: Voting Board members	11 *	0 *	0 *
Non-voting Board members	2	2	0
Exec Board members	7 *	2 *	0 *
Non-exec Board members	6	0	0
Number of staff in workforce	6115	1009	98
Total Board Members - % by Ethnicity	86.7 %	13.3 %	0 %
Voting Board Members - % by Ethnicity	100 %	0 %	0 %
Non-voting Board Members - % by Ethnicity	50 %	50 %	0 %
Executive Board Members - % by Ethnicity	77.8 %	22.2 %	0 %
Non-executive Board Members - % by Ethnicity	100 %	0 %	0 %

Overall Workforce - % by Ethnicity	84.7	%	14	%	1.4	%
Difference (Total board - Overall workforce)	2	%	-0.6	%	-1.4	%

Appendix 2

National and regional comparison of WRES data and additional diagrams

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

North West

Summary for the 2022/23 reporting year

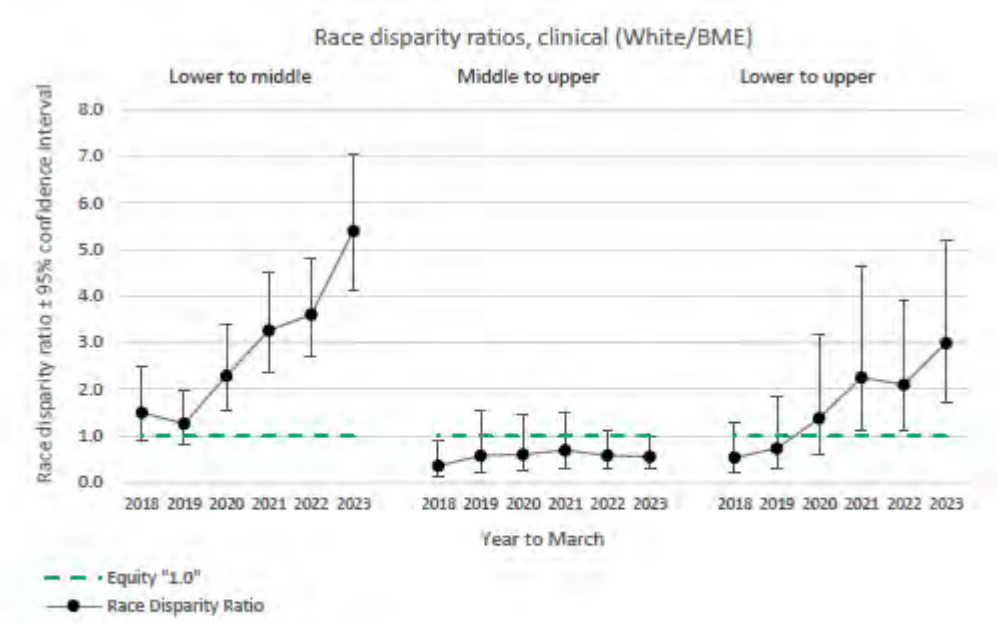
RRF

Trust type: Acute with or without Community

Indicator number and description			Trust	North West	Acute	National	Percentile rank*
Indicator 1: BME representation in the workforce by pay band							
BME representation in the workforce overall			14.0%	17.1%	28.9%	26.4%	
Pay band at which BME under-representation first occurs	Non-clinical	Band 4 -	Proportional	Band 3	Band 3	Band 3	
		Band 5 +	Proportional	Band 8A	Band 8A	Band 8A	
	Clinical	Band 4 -	Proportional	Band 3	Band 3	Band 3	
		Band 5 +	Band 6	Band 6	Band 6	Band 6	
	Medical		Consultant	Consultant	Consultant	Consultant	
Race disparity ratios	Non-clinical	Lower:middle	1.13	1.05	0.92	0.90	24%
		Middle:upper	0.35	1.39	1.40	1.36	91%
		Lower:upper	0.39	1.46	1.29	1.23	77%
	Clinical	Lower:middle	5.40	2.35	1.91	1.83	99%
		Middle:upper	0.55	1.41	1.56	1.39	55%
		Lower:upper	2.99	3.31	2.97	2.55	37%
Indicator 2: likelihood of appointment from shortlisting							
likelihood ratio White / BME			2.30	1.58	1.58	1.59	86%
Indicator 3: likelihood of entering formal disciplinary proceedings							
likelihood ratio BME / White			2.02	1.11	1.02	1.03	68%
Indicator 4: likelihood of undertaking non-mandatory training							
likelihood ratio White / BME				1.14	1.15	1.12	
Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months							
BME			24.5%	26.9%	30.6%	30.4%	18%
White			21.7%	24.2%	26.8%	26.8%	15%
Indicator 6: harassment, bullying or abuse from staff in last 12 months							
BME			27.3%	26.8%	28.5%	27.7%	55%
White			21.8%	20.7%	23.1%	22.0%	50%
Indicator 7: belief that the trust provides equal opportunities for career progression or promotion							
BME			39.0%	46.1%	46.3%	46.4%	94%
White			58.0%	59.5%	58.9%	59.1%	62%
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months							
BME			24.0%	17.0%	17.0%	16.6%	97%
White			6.5%	6.3%	6.7%	6.7%	55%
Indicator 9: BME representation on the board minus BME representation in the workforce							
Overall			-0.6%.	-5.8%.	-14.9%.	-10.9%.	2%
Voting members			-14.0%.	-5.7%.	-16.1%.	-11.1%.	57%
Executive members			+8.3%.	-10.5%.	-19.7%.	-15.7%.	26%

* ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator.

Indicator 1: Race disparity ratios indication disparity in career progression for Band 5 to Band 6 and above in clinical roles and for non-consultant specialist into Consultant level and above



Lower: clinical bands 5 and under
Middle: clinical bands 6 to 7
Upper: clinical bands 8a and above

Indicator 2: Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants

Example: a value of "2.0" would indicate that White candidates were twice as likely as BME candidates to be appointed from shortlisting, whilst a value of "0.5" would indicate that White candidates were half as likely as BME candidates to be appointed from shortlisting.

Appendix 3

Workforce Disability Equality Standard (WDES) 2023

Indicator 1 - Percentage of staff in AfC (Agenda for Change) pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff. Data for reporting year:

		Headcount			%		
Clinical / Non-Clinical	WDES Banding	No	Unknown	Yes	No	Unknown	Yes
Clinical	Band 1	14	8	1	60.9%	34.8%	4.3%
	Band 2	614	131	33	78.9%	16.8%	4.2%
	Band 3	498	134	24	75.9%	20.4%	3.7%
	Band 4	206	78	6	71%	26.9%	2.1%
	Band 5	869	161	35	81.6%	15.1%	3.3%
	Band 6	759	181	53	76.4%	18.2%	5.3%
	Band 7	464	130	19	75.7%	21.2%	3.1%%
	Band 8a	112	40	7	70.4%	25.2%	4.4%
	Band 8b	11	1	1	84.6%	7.7%	7.7%
	Band 8c	9	1	0	90%	10%	0%
	Band 8d	4	1	1	66.7%	16.7%	16.7%
	Band 9	0	1	0	0%	100%	0%
	Medical & Dental Consultant	158	80	3	65.6%	33.2%	1.2%
	VSM	1	0	0	100%	0%	0%
	Medical & Dental Non-Consultant Career Grade	95	22	1	80.5%	18.7%	0.8
	Medical & Dental Trainee Grades	100	34	4	72.5%	24.7%	2.8%
	Other	7	1	0	87.5%	12.5%	0%
Non-Clinical	Band 1	4	1	2	57.1%	14.3%	28.6%
	Band 2	496	120	28	77%	18.6%	4.3%
	Band 3	385	112	19	74.6%	71.7%	3.7%
	Band 4	303	83	6	77.3%	21.2%	1.5%
	Band 5	142	23	12	80.2%	13%	6.8%
	Band 6	87	17	4	80.6%	15.7%	3.7%

	Band 7	64	20	6	71.1%	22.2%	6.7%
	Band 8a	45	6	3	83.3%	11.1%	5.6%
	Band 8b	37	4	0	90.2%	9.8%	0%
	Band 8c	17	4	0	81%	19%	0%
	Band 8d	8	3	0	72.7%	27.3%	0%
	Band 9	9	2	0	81.8%	18.2%	0%
	VSM	7	0	0	100%	0%	0%
	Other	3	0	2	60%	0%	40%

	No	Unknown	Yes
Total Headcount	5528	1399	270
Percentage	76.81%	19.44%	3.75%
Total	7197		

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Note:

i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the Survey section to ensure comparability between organisations.

	Disabled	Non-disabled	Disability Unknown
Number of shortlisted applicants	494 *	6640 *	443 *
Number appointed from shortlisting	75 *	1096 *	159 *
Likelihood of shortlisting/appointed	0.15	0.17	0.36

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts: 1.09

Metric 3 - Capability
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Notes:
i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.
ii. This metric applies to capability on the grounds of performance and not ill health.
iii. If a member of staff enters the capability process for reasons of **both** performance **and** ill health, they should not be included in the count of "ill health only" cases.
iv. For clarification: the data required is the numbers of staff **entering** the capability process from 1 April 2021 to 31 March 2023, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	270	5528	1399
Average number of staff entering the formal capability process for any reason	1 *	4 *	1 *
Of these, how many are on the grounds of ill health only?	0 *	0 *	0 *
Likelihood of staff entering the formal capability process	0.003704	0.000724	0.000715

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff	5.116022

Metric 4

a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

i. Patients/Service users, their relatives or other members of the public

Disabled Staff: 28.2%
Non-Disabled Staff: 20.1%

ii. Managers

Disabled Staff: 16.1%
Non-Disabled Staff: 9.5%

iii. Other colleagues

Disabled Staff: 25.7%
Non-Disabled Staff: 15.5%

b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it:

Disabled staff: 45.4%
Non-Disabled Staff: 46.6%

Metric 5

Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Disabled Staff: 49%
Non-Disabled Staff: 57.8%

Metric 6

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Disabled Staff: 26.5%
Non-Disabled Staff: 19%

Metric 7

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Disabled Staff: 32.4%
Non-Disabled Staff: 45.1%

Metric 8

Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Disabled Staff: 68.5%

Metric 9

a) The staff engagement score for Disabled staff, compared to non-disabled staff.

Disabled Staff: 6.5
Non-Disabled Staff: 7.

b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Yes – A network for staff with a disability or long-term condition has been set up. The staff network will have regular events, run a project in line with the EDI strategy and act as a consultative partner.

Metric 10 - Board voting membership

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- **By voting membership of the Board**
- **By executive membership of the Board**

The data for this metric should be a snapshot as of 31st March 2023.

There are no reported disabled staff for voting or non-voting Board members.

	Disabled	Non-disabled	Disability Unknown	Total
Total Board members	0 *	14 *	1 *	15
How many are voting members?	0 *	8 *	0 *	8
Number of non-voting members	0	6	1	7
How many are Exec Board members?	0 *	5 *	1 *	6
Number of non-exec members	0	9	0	9
Number of staff in overall workforce (from Metric 1)	270	5528	1399	7197
Total Board members - % by Disability	0 %	93.33 %	6.67 %	
Voting Board members - % by Disability	0 %	100 %	0 %	
Non-Voting Board Member - % by Disability	0 %	85.71 %	14.29 %	
Executive Board Member - % by Disability	0 %	83.33 %	16.67 %	
Non-Executive Board Member - % by Disability	0 %	100 %	0 %	
Overall workforce - % by Disability	3.75 %	76.81 %	19.44 %	
Difference % (Total Board - Overall workforce)	-3.75 %	16.52 %	-12.77 %	
Difference % (Voting membership - Overall Workforce)	-3.75 %	23.19 %	-19.44 %	
Difference % (Executive membership - Overall Workforce)	-3.75 %	6.52 %	-2.77 %	

Appendix 4

The metrics are presented in the order of their rating compared to national average and ranking in national comparison from worst to best.

Metric description	RAG	National Rank 2023 (212 Trusts)	Narrative
Metric 10: Disabled representation on the board	⊘	212*	There are no reported disabled staff for voting or non-voting Board members.
Metric 1: Disabled representation in the workforce by pay band: Disability declaration rate in the workforce	⊘	188*	At Band 4 non-clinical roles and under (e.g., administrative and technical support roles, estates officer): Disabled representation was 3.5%, overall, however disabled staff were underrepresented at Band 4, 1.5%.
Metric 7: Feeling valued	⊘	(not provided)*	The percentage of staff satisfied with the extent to which their organisation values their work was significantly lower for Disabled staff (32.4%) than for Non-disabled staff (45.1%) and lower than in national comparison (35.2%)
Metric 4d: Reporting last incident of harassment, bullying or abuse	⊘	184	The percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it was similar for Disabled staff (45.4%) and for Non-disabled staff (46.6%). However, our Trust score for reporting was lower than national averages (51.3% for disabled and 49.5% for non-disabled staff)
Metric 8: Reasonable adjustments	⊘	169	There has been a slight improvement in the percentage of disabled staff that say their employer has made adequate adjustment(s) to enable them to carry out their work (68.5% this year and 67.3% last year) although the figure is still lower than in 2020 (75.4%)
Metric 5: Career progression	⊘	148	The % of staff believing that the Trust provides equal opportunities for career progression or promotion was lower for disabled (49%) staff than non-disabled staff (57.8%), this is comparable to the previous year's figures for disabled (50.8%) staff than non-disabled staff (57.9%)
Metric 3: Likelihood of entering formal capability process due to performance management	!	(not provided)	The likelihood of disabled staff entering the formal capability process for performance management is 5.12 times more likely than non-disabled staff. This figure shows a deteriorating trend compared to the last year's figure of 2022 (2.02). However, the likelihood ratio is based on a very small number of staff entering the formal Capability process (Specifically, 1 out of 270 Disabled staff entered formal Capability proceedings compared to 4 out of 5,528 Non-disabled staff).
Metric 4c: Harassment, bullying or abuse from other colleagues in last 12 months	!	122	The % of disabled staff who experience harassment, bullying and or abuse from their Line Manager, Colleagues & Patients is higher than that for non-disabled staff
Metric 9a: Staff engagement	!	121	The Staff Engagement Score for disabled staff of 6.46 is in line with national average and slightly lower than for non-disabled staff (6.93)
Metric 4b: Harassment, bullying or abuse from line managers in last 12 months	!	113	The percentage of staff experiencing harassment, bullying or abuse from line managers in last 12 months was significantly higher for Disabled staff (16.1%) than for Non-disabled staff (9.5%) which is in line with national average.

Metric 2: Likelihood of appointment from shortlisting	!	98	Non-disabled staff are equally likely (score 1.09) of being appointed from shortlisting compared to disabled staff which is a significant improvement from last year's figure of 1.70 and suggests equity in relative likelihood of appointment from shortlisting
Metric 6: Presenteeism	!	89	The % of staff saying that they have felt pressure from their manager to come to work, was higher for Disabled (26.5%) staff than non-disabled staff (19%) this is an improvement on the previous year's figures of Disabled (32.2%) staff than non-disabled staff (17.1%)
Metric 1 (equivalent): Proportion with a long-term condition or illness	!	(not provided)	In the National Staff Survey, staff can declare non-term conditions or illnesses and how this affects their experience at work. The proportion of staff declaring a long-term condition is higher than the disability declaration rate recorded through ESR, which is also seen in the national trend.
Metric 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months	⚑	41	The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months was significantly higher for Disabled staff (28.2%) than for Non-disabled staff (20.1%), but is lower than national averages (disabled staff, 33.2% and non-disabled staff 26%).

⚑ More than 5% better than national average (proportion, not percentage points)

! Within +/- 5% of national average (proportion, not percentage points)

More than 5% worse than national average (proportion, not percentage points)

*in bottom 10% of Trusts nationally; Please note that Metrics 1, 4, 5, 6, 7, 8, 9 are taken from the National Staff Survey data which includes responses from staff who have indicated that they have a long-lasting health condition or illness for more than 12 months rather than a declared disability.

Metrics derived from data collected directly from organisations, as at March 31st 2023

			Trust Values					Nat. Av.	Rank	RAG
Metric number and description			**2019**	**2020**	**2021**	**2022**	**2023**	**2023**		
Metric 1: Disabled representation in the workforce by pay band										
Disabity declaration rate in the workforce		**Overall**	**3.1%**	**2.5%**	**2.6%**	**3.1%**	**3.8%**	**4.9%**	163	✖
		Non-clinical	1.8%	2.6%	2.5%	2.8%	3.9%	5.8%	187	✖
		Clinical	2.6%	2.7%	2.9%	3.4%	3.9%	5.0%	148	✖
		Medical/Dental	0.6%	0.7%	0.9%	1.3%	1.6%	2.2%	115	✖
Pay band at which Disabled under-representation first occurs	Non-clinical	Band 4 - Band 5 +					Band 4 Proportional			
	Clinical	Band 4 - Band 5 +					Proportional Proportional			
	Medical/Dental						Proportional			
Disability disparity ratios	Non-clinical	Lower:middle	2.52	1.69	1.23	0.79	0.76	0.98		!
		Middle:upper	0.97	1.16	1.49	0.56	1.67	1.26		!
		Lower:upper	2.44	1.96	1.84	0.44	1.27	1.23		!
	Clinical	Lower:middle	0.91	0.90	0.81	0.87	0.76	0.94		!
		Middle:upper	2.76	1.04	1.02	1.57	0.94	1.22		!
		Lower:upper	0.94	0.82	0.00	1.36	0.72	1.16		!
Metric 2: Likelihood of appointment from shortlisting										
Likelihood ratio Non-disabled / Disabled				1.76	2.29	1.70	1.09	0.99	98	!
Metric 3: Likelihood of entering formal capability process due to performance management										
Likelihood ratio Disabled / Non-disabled				9.20	2.24	2.02	5.12	2.17		!
Metric 10: Disabled representation on the board										
	Overall	Members	0	0	0	0	0			
		Proportion	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%	212	✖
	Exec	Proportion	0.0%	0.0%	0.0%	0.0%	0.0%	5.4%		✖
	Non-exec		0.0%	0.0%	0.0%	0.0%	0.0%	6.0%		✖
	Voting		0.0%	0.0%	0.0%	0.0%	0.0%	5.6%		✖
	Non-voting		0.0%	0.0%	0.0%	0.0%	0.0%	6.1%		✖

Metrics derived from NHS Staff Survey 2022 (published in March 2023)

Metric number and description	Trust Values					Nat. Av.	Rank	RAG
	2018	2019	2020	2021	2022	2022		
Metric 1 (equivalent): Proportion with a long-term condition or illness								
Disabled	19.7%	19.1%	22.6%	22.9%	24.0%	23.6%		!
Metric 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months								
Disabled	27.8%	32.8%	30.7%	33.4%	28.2%	33.2%	41	✓
Non-disabled	19.1%	17.6%	22.4%	22.3%	20.1%	26.0%		✓
Metric 4b: Harassment, bullying or abuse from line managers in last 12 months								
Disabled	18.8%	16.4%	20.9%	20.3%	16.1%	16.1%	113	!
Non-disabled	17.3%	10.6%	11.5%	9.2%	9.5%	9.2%		!
Metric 4c: Harassment, bullying or abuse from other colleagues in last 12 months								
Disabled	25.0%	26.7%	25.1%	27.6%	25.7%	24.8%	122	!
Non-disabled	16.1%	14.2%	16.7%	17.5%	15.5%	16.5%		✓
Metric 4d: Reporting last incident of harassment, bullying or abuse								
Disabled	44.4%	54.2%	42.2%	44.5%	45.4%	51.3%	184	✗
Non-disabled	37.1%	44.6%	45.8%	44.3%	46.6%	49.5%		✗
Metric 5: Career progression								
Disabled	46.8%	66.1%	50.0%	50.8%	49.0%	52.1%	148	✗
Non-disabled	54.0%	57.6%	57.2%	57.9%	57.8%	57.7%		!
Metric 6: Presenteeism								
Disabled	36.4%	40.4%	33.2%	32.2%	26.5%	27.7%	89	!
Non-disabled	23.3%	21.9%	22.0%	17.1%	19.0%	19.9%		!
Metric 7: Feeling valued								
Disabled	38.5%	46.0%	34.6%	33.0%	32.4%	35.2%	139	✗
Non-disabled	43.5%	51.3%	48.3%	46.0%	45.1%	45.0%		!
Metric 8: Reasonable adjustments								
Disabled	60.5%	58.3%	75.4%	67.3%	68.5%	73.4%	169	✗
Metric 9a: Staff engagement								
Disabled	6.79	7.17	6.70	6.47	6.46	6.42	121	!
Non-disabled	7.06	7.27	7.15	7.11	7.03	6.93		!

Key to RAG rating. (N.B. These only consider data from the latest year.)	
Metric 1 declaration rates and all metrics derived from the NHS Staff Survey (4, 5, 6, 7, 8 and 9a)	
✓	More than 5.0% better than national average (proportion, not percentage points).
!	Within +/-5.0% of national average (proportion, not percentage points).
✗	More than 5.0% worse than national average (proportion, not percentage points).
Please note, for the metrics derived from the NHS Staff Survey, these RAG ratings are applied separately for disabled and non-disabled staff. In subsequent tabs in this file, the results of statistical tests are shown which compare the results for disabled staff against the results for non-disabled staff to see if there is a difference.	
Metric 1 disparity ratios, metric 2 and metric 3	
✓	The results shown are significantly better for disabled staff based on evaluation of likelihood ratios.
!	The result show no significt difference between disabled and non-disabled staff based on evaluation of likelihood ratios.
✗	The results shown are significantly worse for disabled staff based on evaluation of likelihood ratios.
Historically, metrics 2 and 3 have been evaluated using the "4/5ths rule". This is a simple statistical method but lacks analytical vigour. The tests used here (and on subsequent tabs) are much better at identifying potential issues and not flagging issues that do not exist (especially when numbers are small). Further information can be found at https://www.medcalc.org/calc/relative_risk.php. Discussions have started regarding which statistical tests it would be most appropriate to use for the WDES and the WRES, and full details will be given if any change is agreed.	
Metric 10	
✓	More than 5.0% more than propotion with long-term condition or illness in Staff Survey (proportion, not percentage points).
!	Within +/-5.0% of propotion with long-term condition or illness in Staff Survey (proportion, not percentage points).
✗	More than 5.0% less than propotion with long-term condition or illness in Staff Survey (proportion, not percentage points).

Appendix 5 North West BAME Assembly Anti-Racist Framework

5 Anti-Racist Principles

Three levels of achievement

Anti-racist framework checklist

Summary of direct deliverables

Bronze

- The appointment of a senior director level EDI lead with a commitment to advancing anti-racism within the organisation.
- Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.
- An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.
- The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.
- The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.

Silver

- Set up a local BAME leadership council within your organisation.
- Evidence of inclusive leadership education for all executive directors.
- All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met.
- An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.
- WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.

Gold

- An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher).
- An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio, WRES and other race specific targets.
- The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.
- The organisation can evidence diverse representation within their disciplinary and grievance processes.
- The organisation should bring together annually Black, Asian and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans.

Workforce Race Equality Standard (WRES) Action Plan

(Draft until Board Approval in December 2023)

WWL recognises the need to make significant improvements to improve the working experience of our staff with Black, Asian and Minority Ethnic colleagues and are committed to progressing an action plan which drives forward cultural improvements that will support improvements across all indicators. WWL will elevate the voice of Black, Asian and Minority Ethnic colleagues by measuring progress in a variety of ways but with absolute involvement of our FAME Network. This plan is supported by the organisation's implementation of the NHS England EDI Improvement Plan, and the six high impact actions contained within that.

Ref	Action	Lead	Completion Date	Success Criteria
1	Establish an EDI Governance framework which supports visible progress against our EDI Strategy.	CPO	Dec 2023	• Review Terms of Reference and membership of proposed EDI Strategy Group
2	Ensure full visibility of progress against this action plan through regular reporting through to People Committee and other Executive meetings, and regular reports to the FAME Network.	Associate Director of Staff Experience (SE) Head of SE EDI Lead (Workforce)	Jan 2024	• EDI action log in place, regular updates through to People Committee and FAME network. • Review and support FAME Network.
3	Commence our journey to become an intentionally anti-racist organisation by actively working through, and setting goals aligned to, the Bronze status of the NW Anti-Racist Framework (with stretch goals of silver and gold).	CPO Deputy CPO Head of SE EDI Lead (Workforce) EDI Lead (Service) FAME Network	June 2024	• Anti Racist statement • Assessment using NW BAME assembly Anti Racism framework • Producing action plan
4	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	Deputy CPO Head of SE EDI Lead (Workforce) Divisional EDI Leads FAME Network	Sept 2024	• Reduction in incidents of discrimination from line managers or teams. • Reduction in incidents of bullying and harassment from public, line managers and teams.

DRAFT

5	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Deputy CPO Associate Director of SE Head of SE Head of Recruitment EDI Lead Workforce	Sept 2024	• Increase relative likelihood of ethnic minority staff being appointed from shortlisting across all posts. • Improve access to career progression, training and development opportunities. • Improvement in ethnic minority representation to address clinical and non clinical disparity across the pay bands. • Year on year improvement in ethnic minority representation at Band 8+
6	Develop and implement an improvement plan to eliminate pay gaps**.**	Deputy CPO Head of SE EDI Lead (Workforce) Divisional EDI Leads FAME Network	June 2024	• Obtain divisional pay gap data and co produce action plan. • Year on year reduction in race pay gaps.
7	Develop a supportive and compassionate programme of work to support the induction and ongoing support to improve the employment experience of our International Nurse colleagues.	Deputy Chief Nurse Deputy CPO Associate Director of SE Head of Professional Practice EDI Lead (Workforce)	Sept 2024	• Increase % of international recruited nurses receiving an appraisal. • Reduction in instances of bullying and harassment from team/line manager experienced by internationally recruited staff. • Sense of belonging for internationally recruited staff.
8	Implement monitoring systems that will enable the central monitoring of access to CPD to ensure inequalities can be measured and acted upon where necessary.	Associate Director of SE Head of SE	September 2024	• Monitoring system in place and up and running.

Note: Completion date and success criteria will be included in the Board ratified version.

DRAFT

Workforce Disability Equality Standard (WDES) Action Plan

(Draft until Board approval in December 2023)

WWL recognises the need to make significant progress to improve the working experience of our staff with Disabilities and Long-Term Health Conditions and are committed to progressing an action plan which drives forward cultural change that will support improvements across all indicators. WWL will elevate the voice of disabled colleagues by measuring progress in a variety of ways but with absolute involvement of our Disabled and Long-Term Health Conditions Network. This plan is supported by the organisation's implementation of the NHS England EDI Improvement Plan, and the six high impact actions contained within that.

Ref	Action	Lead	Completion Date	Success Criteria
1	Establish an EDI Governance framework with supports visible progress against our EDI Strategy	CPO	Dec 2023	Review Terms of Reference and membership of proposed EDI Strategy Group
2	Ensure full visibility of progress against this action plan through regular reporting through to People Committee and other Executive meetings, and regular reports to the Disability & Long-Term Health Conditions Network.	Associate Director of Staff Experience (SE) Head of SE EDI Lead (Workforce)	Jan 2024	• EDI action log in place, regular updates through to People Committee and Disability and Long Term Health Condition network. • Review and support Disability and Long Term Health Condition Network.
3	Become a proud Disability Confident Employer, with stretch targets to become a Disability Leader, through a refreshed approach to the self-assessment of the Disability Confident Employer Level 2.	CPO Deputy CPO Head of SE EDI Lead (Workforce) Disability & LTHC Network Staff Side Lead	May 2024	• Disability Confident assessment and refreshed action plan • Working towards Disability Confident Leader
4	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	Deputy CPO Head of SE EDI Lead (Workforce) Divisional EDI Leads	Sept 2024	Reduction in incidents of bullying and harassment from public, line managers and teams.

DRAFT

5	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Deputy CPO Associate Director of SE Head of SE Head of Recruitment EDI Lead Workforce	Sept 2024	• Improve access to career progression, training and development opportunities. • Year on year improvement in disability and long term condition representation at Band 8+
6	Develop and implement an improvement plan to eliminate pay gaps**.**	Deputy CPO Head of SE EDI Lead (Workforce) Divisional EDI Leads Disability & LTHC Network	June 2024	• Obtain divisional pay gap data and co produce action plan. • Year on year reduction in disability pay gaps.
7	Increase the employment experience of disabled colleagues through a specific piece of work that addresses the implementation of reasonable adjustments as a supportive and compassionate approach to employment.	Deputy CPO HR Business Partners EDI Lead (Workforce)	August 2024	• Review and strengthen reasonable adjustment guidance and support for staff and managers. • Increase numbers of staff reporting having had a reasonable adjustment at WWL in NHS staff survey.
8	Increase confidence in our disabled workforce, through supporting them to openly declare disability status on our ESR system.	EDI Lead (Workforce) HR Business Partners Staff Side reps Communication Team	July 2024	• Fresh Corporate communication and disability declaration campaign. • Identify key disability declaration rate champions. • Improve disability declaration rates on ESR.
9	Review our approach to sickness management through a review of our sickness absence policy to become a person-centred wellbeing policy that supports those who may become disabled or develop a long term health condition during their employment.	Deputy CPO Strategic HR Lead Staff Side Lead HR Business Partners	Sept 2024	• Review existing sickness absence policy and associated EIA. • Co-produce revised policy in line with best practice

Note: Completion date and success criteria will be included in the Board ratified version.

DRAFT

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Committee effectiveness: recommendations and findings
Presented to:	Board of Directors
On:	6 December 2023
Item purpose:	Endorsement
Presented by:	Consent Agenda
Prepared by:	Deputy Company Secretary
Contact details:	Nina.Guymer@wwl.nhs.uk

Executive summary

An annual committee effectiveness exercise has now been completed for each of the Board's sub-committees. This was facilitated at the relevant committee meeting, with questions provided to provoke through amongst those taking part in the discussion. Those contributing included committee members and some of the authors who submit papers and present individual items on an ad hoc basis. Feedback was then reviewed and considered:

- Committee chairs and lead executives met with the Deputy Company Secretary, to consider feedback and any changes required to the way that the individual committees operate. **Feedback specific to each meeting** and actions in response, now agreed by each committee, are set out in the tables annexed to this report.

- **Feedback on the overall corporate governance processes**, relevant to every committee, has also been considered by the corporate affairs team and the Chair and recommendations have been made as to changes proposed to strengthen our overall ways of working.

Link to strategy and corporate objectives

Committee effectiveness is one of the key vehicles for ensuring that the work that we do supports delivery of our strategy and corporate objectives.

Risks associated with this report and proposed mitigations
N/A

Financial implications
N/A

Legal implications
N/A

People implications
N/A

Wider implications
N/A

Recommendation(s)

Recommendation for changes to the overall corporate governance processes:

- Committees wanted to see a clear link between the corporate objectives related to each of their workstreams. To make this clearer, through committee agendas and workplans, all of the corporate objectives have now been married up with the most appropriate report. The related corporate objective is now noted next to that item on the workplan and on the relevant agenda.

- Most committees discussed the importance of feedback and shared learning. Executive directors are therefore recommended to ensure that they build time in when commissioning reports from authors, to feed back to them and to give guidance on how the feedback and learning from the meeting should be disseminated to the relevant team(s). Also providing updates for the divisions so that committee discussion is fed back.

- The more uniform approach to the drafting and presentation of papers was positively received. It is therefore recommended that report author training for assurance committees continues and those who write reports be encouraged to attend. More focus will be given to the presentation element of the session.

- The timing of the Quality and Safety Committee had been noted as an issue, since this committee would be the first to meet following board meetings and therefore, there was a significant lag in the reporting of data from it to the Board. Resource limitations within the corporate affairs team mean that not all meetings can be facilitated in quick enough succession to allow all committees to report strictly up to date data to the Board. The monthly slots for Quality and Safety Committee and People Committee were therefore swapped, on the agreement of the Committee Chairs.

- Front sheets could be used to set out the report's journey through the assurance framework; which other groups it has been considered by and why and whether it needs to be escalated to the Board of Directors. It is proposed that this is considered.

The Board is asked to endorse both the recommendations for changes to the overall corporate governance process and the recommendations for changes to the operation of each respective committee.

Research Committee

Feedback – what could be improved?	Recommendations – what will we do to improve?
Committee membership: • We could consider including a locality partner who leads on research and innovation. • We could help to strengthen links with primary care and explore inclusion of a GP representative. • The Programme Director for Academia at Health Innovation Manchester has been invited to sit in on committee meetings – we must identify what WWL's ask of him is and ensure that we are focussing on innovation separately to research, not conflating the two.	• The Committee will seek assurance and ensure regular input from external organisations and consider broader engagement through items on its agenda. • The Committee considered both of these latter points at its September 2023 meeting and agreed that to facilitate better engagement with the borough and the system, a reporting group should be established, which will report up to the Committee itself. • It was agreed that external colleagues would be invited on an agenda driven basis when it is considered that such input is required.
The Committee has no workplan.	A workplan was approved at September 2023's meeting.
The Committee may need more focus on emerging risks and how these are raised to the board.	Strategic risks are addressed through the annual corporate objectives report; the regular section on corporate objectives within the RAF report and through regular AAA reports.
The Committee is well linked with People Committee but may be able to strengthen relationships with the other committees, perhaps in respect of digital read across, which is overseen by Finance and Performance Committee.	Each sub-board committee has a NED member sitting on the Research Committee and there is an opportunity for NEDs to discuss relevant issues at their fortnightly meetings.
Divisional spotlights and research stories have been helpful and bring the committee up to speed on what is going on practically and across the Trust.	These will continue and feature on the workplan.

Quality and Safety Committee

Feedback – what could be improved?	Recommendations – what will we do to improve?
The agenda is very full and difficult to streamline. Considerations in addressing this may include: • More time being spent considering clinical effectiveness, which could be achieved by reducing the focus on patient experience. • Condensing the workplan, with subgroups asked to oversee some areas to ease the strain on the committee and decreasing the frequency of some reports. • That to increase the length of the meeting would have resource implications for those who regularly attend, where attendance rates are currently below expected levels.	• Clinical effectiveness does now receive better focus, through clearer identification of items which link with corporate objectives, use of AAA reports from subgroups, divisional reports (and deep dives) and also when the agenda is set. • A more consistent use of AAA reports allows oversight on matters which subgroups have responsibility for management of. • A meeting has been set so that the Chair, Lead Executives, Assoc Dir of Governance and Deputy Company Secretary can review and amend the workplan. • Noted, particularly given current pressures.
Meetings fall after the Board meets, which results in lag in the data presentation, reports are often ready but cannot be presented to the Board as they have not first been seen by the committee.	This has been actioned and meeting scheduling realigned.
Holding a session with the chairs of the supporting groups may assist to align when reports are to be presented and whether they need to progress to the Board Of Directors Meeting.	Feedback is now being diarised with report authors, who now regularly produce AAA reports an agenda item will be added for all subgroups to discuss feedback from Q&S.
Does the committee need minutes and/or the AAA report from the Audit Committee as there are some crossovers in the work that is done?	This is not considered to be necessary. Each audit relevant to the duties of the Q&S Committee will be discussed by the committee on an ad hoc basis on the advice of the executive lead. An item has been added to the workplan to set out Q&S related audits agreed to be included in MIAA's annual audit schedule.
Does the committee need sight of what WWL report externally to the ICB via their Quality Committee: escalations / concerns / action plans / good practice?	As a matter of process, all reports which WWL submit to this meeting will already have been signed off by Q&S, or in all cases, an alternative WWL group or committee.
Clinical governance has improved since the Deloitte review, with more effective triangulation and better assurance now provided.	Noted.

People Committee

Feedback – what could be improved?	Recommendations – what will we do to improve?
Committee membership: • One more director member with finance and strategy insight may improve committee effectiveness. • Attendance by the Chair of OFOFOF at some meetings could be considered. • Attendance by the Director of Strategy at some meetings may provide insight in to how WWL perform at HWP/place and GM level.	• The Chair of the Finance and Performance Committee (F&P) is now a member. • The Chair of OFOFOF is attending the November meeting. We will schedule an annual update on to the workplan. • We will consider this on an ad hoc basis and bring updates when required. We have scheduled an update around transformation and WWL's anchor institution role for our November 2023 meeting.
Sometimes challenge by members of the committee can be limited.	Moving forwards, the Chair will proactively invite members to contribute on issues as appropriate. We will remain alert to potential development opportunities to share and welcome members approaching us if they feel that they have any training needs in this regard. The Committee's dynamic has now organically changed due to our F&P Chair joining the membership and us having a new Chief People Officer.
Visibility and engagement with internal stakeholders could be improved, especially at divisional level.	We now schedule regular Board walk abouts and are reinstating wellbeing walks (as well as quality walks and estates and facilities walks), which will all increase the visibility of Committee members. However, it is the responsibility of individual members to ensure their visibility. We are now looking to include regular divisional deep dives on our workplan, which will aid the link with the divisions.
Papers are much improved, succinct, assurance focussed and presented appropriately by the correct people.	Noted.

Finance and Performance Committee

Feedback – what could be improved?	Recommendations – what will we do to improve?
• Net zero and IT could feature more strongly on the agenda.	• The workplan does contain items to cover both of these areas. The Committee may want to discuss whether anything additional is required.
• There is a need to strengthen divisional reporting to the committee, to ensure better assurance.	• In addition to the divisional deep dive reports, we will once again include the slides and action logs from the divisional RAPID meetings on the consent agenda.
• Metrics relating to Integrated Care Board finance and performance should be considered by the committee.	• The F&P Chair will regularly review reports which are provided to the Greater Manchester Finance Advisory Committee and consider with the Chief Finance Officer and Chair whether any elements require review by the Committee. If so, these will be added to the agenda.
•Would any other metrics benefit from regular review, such as those around internal efficiency in relation to discharge?	• Key performance metrics for the Trust to monitor will be identified through the diagnostic work carried out under two current transformation programmes which are being led respectively by the Emergency Care Improvement Support Team (ECIST) and Newton Europe. These metrics, once agreed, will be considered by the Healthier Wigan Partnership and then will also recommended to be reviewed by the Finance and Performance Committee.
• The incoming Chair may wish to provide comments or suggestions for change.	• Following on from the last point, our F&P Chair suggests that system flow and WWL's part in the system as a whole is kept under review. The Healthier Wigan Partnership is developing a dashboard which we hope to be able to include for regular review by the Committee.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity and Neonatal Dashboard Report
Presented to:	Trust Board
On:	December 6 2023
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Gemma Weinberg Digital Midwife / Simon Needham NNU Lead Nurse for Cathy Stanford Divisional Director of Maternity and Child Health
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

Recommendation(s)

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

Maternity and Neonatal Dashboard October 2023

Introduction

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

October 2023 Exception report - Maternity
Summary

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

- There were six midwifery red flags reported. It should be noted here that the method of collecting red flag reports has changed from this month's dashboard going forward. We will now be pulling these figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. This is why there may appear to be a significant uptick in the figure going forward. The shift coordinator was able to remain supernumerary for all shifts in October and 1:1 care was 100%. There is a separate red flag report which investigates the red flags in more detail.
- There were two Maternity complaints received in October, but the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

Steis reportable Incidents

There was one stillbirth in October but no other Steis incidents.

Green

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

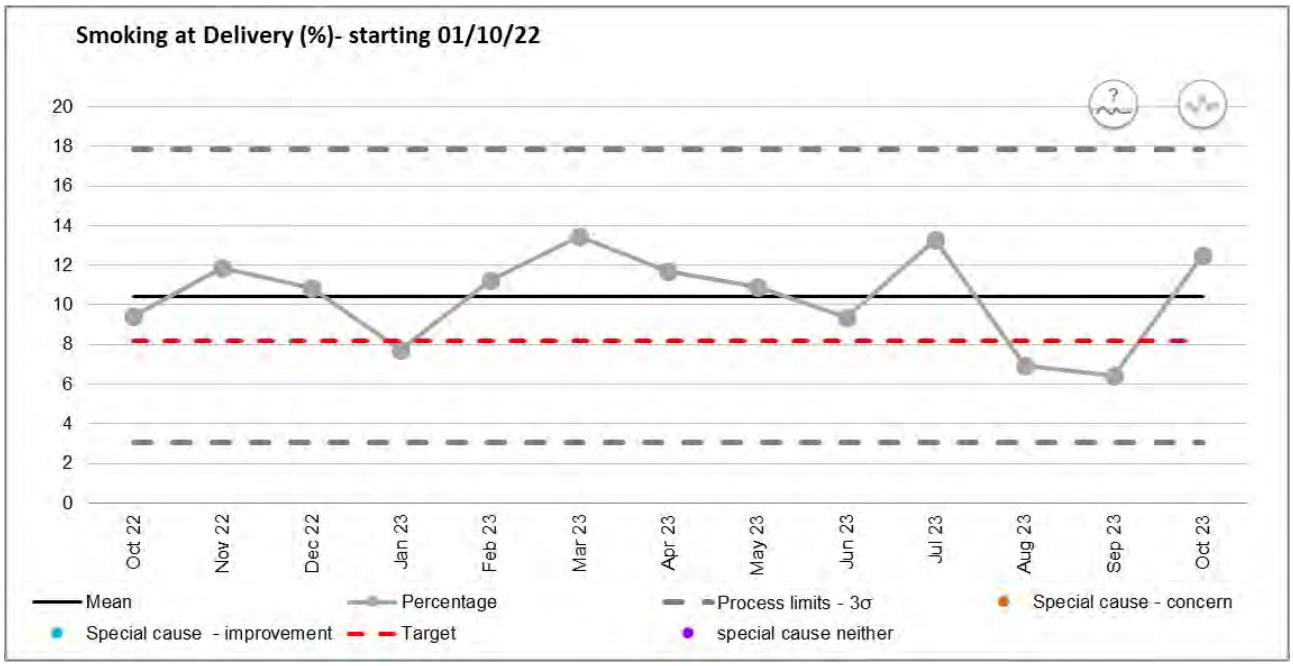
Women booked by 12+6 weeks This has remained consistently green for more than 12 months.

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

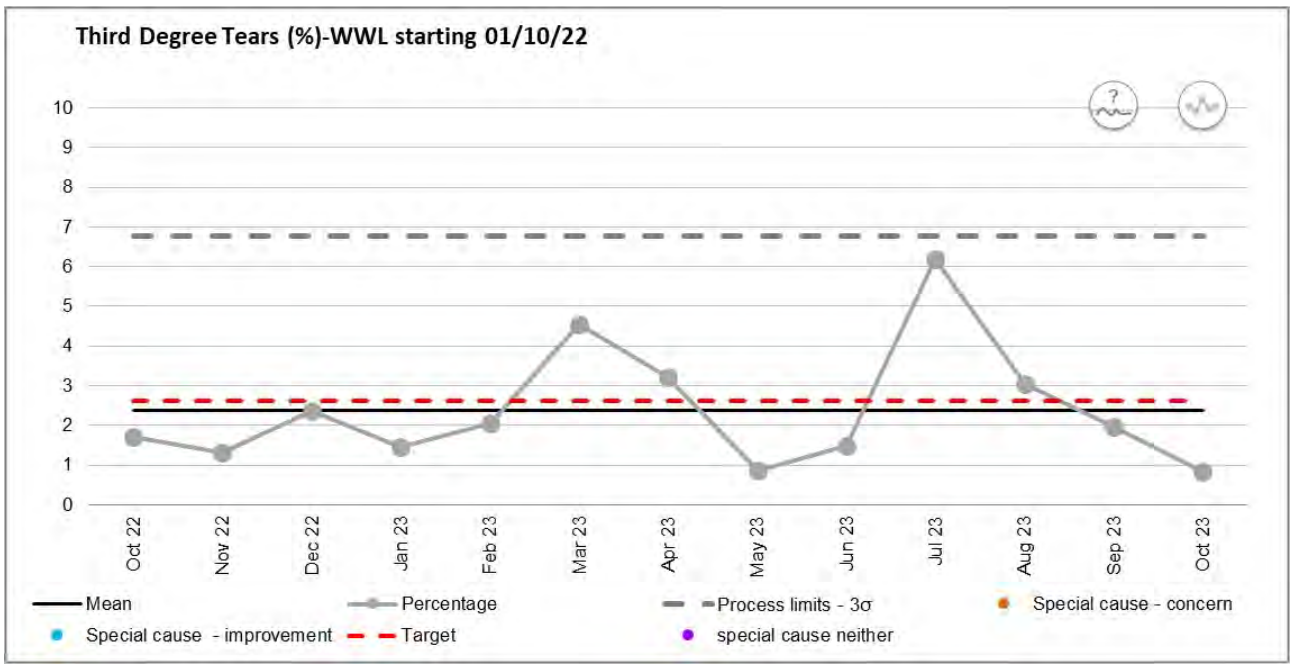
The number of mothers who have opted to breastfeed – This saw a significant drop in July, but figures have improved in the subsequent months. Work continues to improve this metric.

Number of registerable births. This had dipped into amber levels in July. The metric has returned to green levels for the past three months.

Smoking at the time of Delivery (SATOD). This saw a significant drop in the August and September figures. October sees a spike in the figure but remains green on our metrics. The metric has remained green since June 2022. Work continues to promote and encourage smoking cessation throughout pregnancy. The below SPC chart shows our SATOD rates in comparison to GM. It can be seen that in July and August, WWL figures were below the GM average for this metric (red line).



3rd / 4th degree tear. This saw a spike in July. Levels have returned to green in the months following. The below SPC chart shows how we compare to the rest of GM for this metric.



Re-admissions of babies within 30 days These figures saw a significant spike in August but have now returned to normal levels. Most cases were due to jaundice. All cases were managed appropriately and there were no omissions in care.

Bookings. These figures have been amber since June. October sees them returning to green levels.

Induction of Labour (IOL) These levels have been very up and down over the past few months with a further spike noted in July. The last three months see these figures returning to green. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes. There will be

an upcoming audit as to whether the new NICE guidelines to offer IOL at T+7 are having any effect on these metrics.

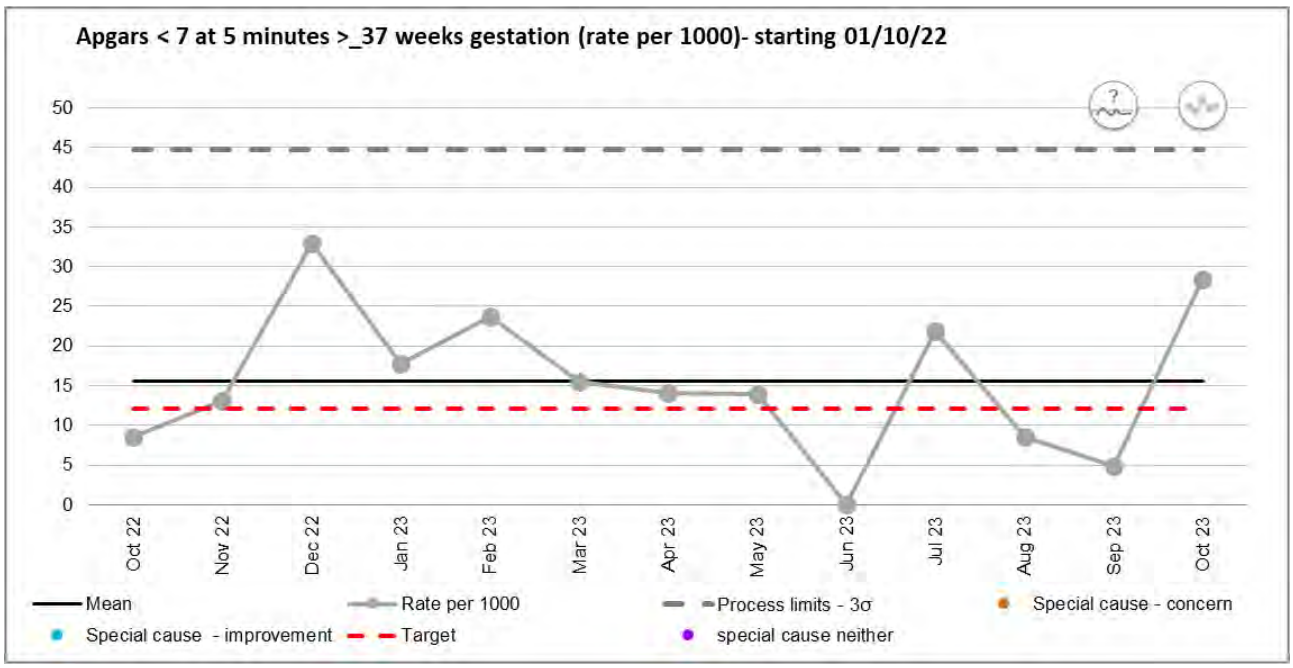
Amber

Women readmitted within 28 days of Delivery. There were 3 maternal readmissions recorded in October. Two of these were for query DVT. No omissions in care were noted.

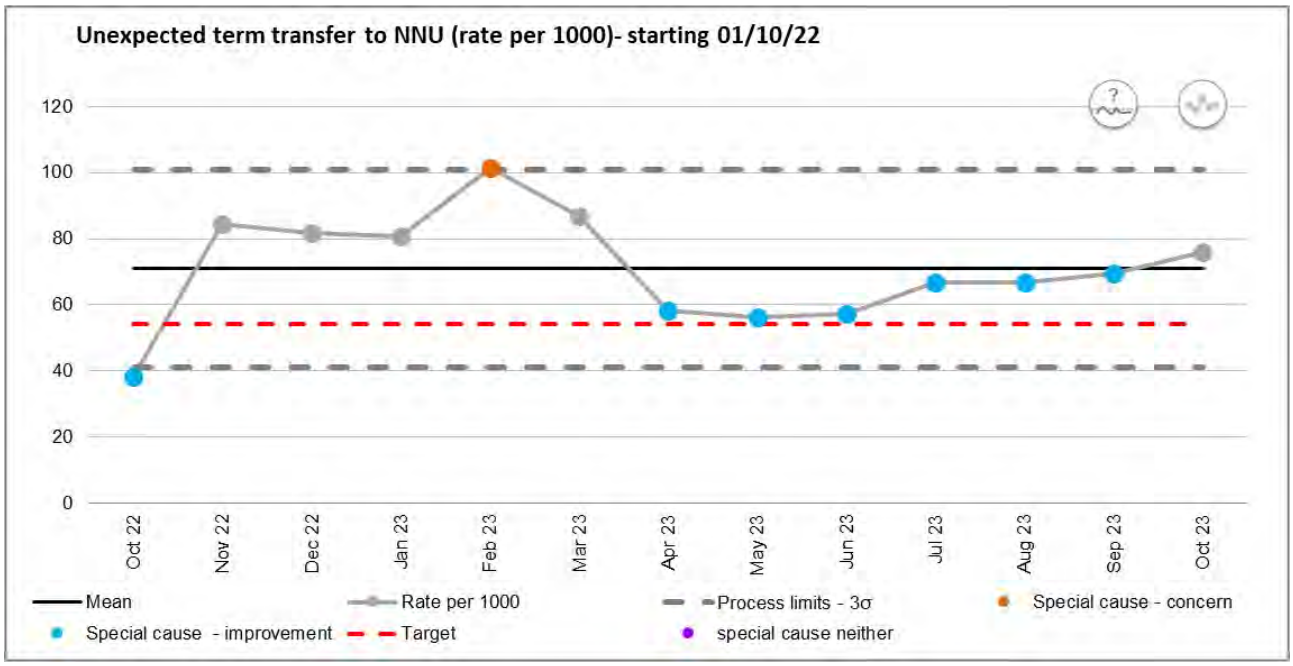
Skin to skin contact – This metric saw a rise in September, but October sees the metric return to amber levels. Work continues to improve this metric.

Red

All infants with Apgar's less than 7. This has seen a spike in October. All cases are fully investigated. The below SPC chart shows how our figures compare to the GM average.



Term admissions to NNU. This figure remains red and had been relatively static for several months. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate. A new team has been formed to look at term admissions to NNU in more detail and at the ATTAIN audit to try to improve the figures in this metric. The below is an SPC chart showing our rates in comparison to the GM average.



Conclusion

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

It should be noted that from the January data the Maternity dashboard will look different to how it does currently. This template has been used for several years and it is felt that it no longer effectively displays the data in a meaningful way. All metrics will be reviewed and compared to the GM average. This will provide more oversight in a quicker timeframe for metrics if they are a concern.

October 2023 Exception report – Neonatal

Summary

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

· There were no babies born under 27 weeks. All babies under 27 weeks require to be born in a tertiary unit (NICU).

· The shift coordinator was supernumerary for 95% of shifts in October and above the national average. The unit was above the BAPM recommendation for majority of shifts in October.

· The unit was not closed during October.

· There were no complaints received in October.

Steis reportable Incidents

There were no Steis incidents in October 2023.

Green

% of Shifts to BAPM – This metric improved to 96% and above the 90% target. Despite the ongoing challenges with staffing and unexpected levels of activity and acuity the service has been able to maintain good standards of care with good outcomes demonstrated. Work to recruit new staff remains an ongoing priority.

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

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

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

Amber

There were no amber metrics in October.

Red

Term admissions to NNU. This figure remains red now for two months. The figure over the last few months has improved from average of 6 to 7% from previous months at the start of the year. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate. A new team has been formed to look at term admissions to NNU in more detail and at the ATTAIN audit to try to improve the figures in this metric. There measures being taken and with the planned improvements to transitional care service by the end of this year we expect this figure to return to green.

Conclusion

Normal variation and fluctuations are noted with the figures this month and positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show green indicators but do show several red areas which will be observed going forward.

Persistently flagging areas will also be closely observed for patterns. The Neonatal dashboard continues to be reviewed quarterly by GM and the Neonatal/Maternity Dashboard steering group.

Safety Dashboard 2023

Maternity

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

		Goal	Red Flag	Measure	2022 Oct	2022 Nov	2022 Dec	2023 Jan	2023 Feb	2023 Mar	2023 Apr	2023 May	2023 Jun	2023 Jul	2023 Aug	2023 Sep	2023 Oct	2023 Nov	2023 Dec
Activity	**Number of Registerable Births**	**> 200**	**< 180**	**2022 Births**	**234**	**228**	**213**	**225**	**169**	**194**	**214**	**215**	**213**	**183**	**234**	**205**	**211**		
	Number of Bookings (*one month retrospective*)	**≥ 240**	**≤ 200**	**2022 Bookings**	**254**	**258**	**215**	**260**	**247**	**249**	**201**	**241**	**237**	**216**	**233**	**220**	**240**		
	Normal Births as % of Births	≥ 60%	< 55%	Nat Standard	39.74%	52.19%	46.48%	52.44%	50.89%	49.48%	45.79%	45.58%	50.70%	46.99%	46.58%	46.34%	50.71%		
	% of Successful Planned Home Births			Births/month	0.43%	1.32%	0.94%	1.78%	2.96%	0.00%	1.40%	0.93%	2.82%	1.09%	1.28%	1.95%	0.47%		
	Instrumental Deliveries as % of Births	< 12%	> 15%	Nat Average	12.39%	7.46%	7.04%	8.44%	7.10%	7.22%	12.15%	8.84%	12.68%	13.66%	9.40%	13.66%	6.16%		
	Total Caesarean Sections as % of Births	< 29%	≥ 34%	GM Average	47.44%	39.91%	46.01%	39.11%	42.01%	42.27%	40.65%	45.12%	36.15%	38.25%	44.02%	40.00%	43.60%		
	% Emergency Caesaean Sections				28.63%	25.44%	30.52%	24.44%	25.44%	28.35%	22.43%	26.51%	21.13%	27.32%	26.50%	25.37%	20.85%		
	% Elective Caesarean Sections				18.80%	14.47%	15.49%	14.67%	16.57%	13.92%	18.22%	18.60%	15.02%	10.93%	17.52%	14.63%	22.75%		
	% of Category 1 Caesarean Sections with Delay in Knife to Skin (*over 30 minutes*)				16.60%	5.55%	27.77%	37.50%	0.00%	23.07%	41.60%	23.80%	0.00%	7.69%	10.52%	7.69%	20.00%		
	% of Category 2 Caesarean Sections with Delay in Knife to Skin (*over 75 minutes*)				37.03%	19.44%	23.80%	26.60%	16.60%	15.78%	16.66%	7.14%	20.00%	21.42%	24.13%	17.85%	6.45%		
	Number of Successful VBAC Deliveries			Births/month	6	5	4	3	1	7	3	3	6	5	5	3	5		
	% of Caesarean Sections at Full Dilatation			Births/month	3.60%	7.69%	6.12%	4.55%	7.04%	9.76%	5.75%	12.37%	3.90%	2.86%	5.83%	4.88%	6.52%		
	Induction of Labour as % of Women Delivered	**< 38%**	**≥ 42%**	**Births/month**	**37.61%**	**40.79%**	**40.85%**	**31.11%**	**42.60%**	**47.94%**	**35.98%**	**45.12%**	**37.09%**	**43.17%**	**38.89%**	**35.12%**	**38.39%**		
	% of Women Induced when RFM is the Only Indication (*< 39 weeks*)				0.43%	0.44%	0.00%	1.78%	0.59%	0.52%	0.47%	0.47%	0.00%	0.00%	0.43%	0.49%	0.00%		
	% of Women Induced for Suspected SGA				4.27%	4.39%	7.51%	2.67%	5.92%	9.79%	5.61%	4.19%	5.63%	6.01%	4.70%	3.41%	4.74%		
	Average Postnatal Length of Stay	**≤ 1.5**	**≥ 1.8**	**Births/month**	**1.8**	**1.6**	**2**	**1.8**	**1.8**	**1.9**	**1.5**	**1.8**	**1.8**	**1.7**	**1.7**	**1.7**	**1.9**		
	Number of In-Utero Transfers In from Other Units				1	1	1	2	0	0	4	5	5	4	3	1	4		
	Number of In-Utero Transfers Out to Other Units				0	0	0	1	0	0	1	3	6	0	0	0	1		
	%of Women Smoking at Booking			2022 Bookings = 17%	12.20%	14.30%	11.62%	11.15%	11.74%	10.44%	9.45%	11.60%	8.86%	12.50%	14.10%	8.18%	7.91%		
	% of Women Smoking at Delivery	**14%**	**17%**	**2022 Births**	**9.44%**	**11.89%**	**10.84%**	**7.72%**	**11.24%**	**13.47%**	**11.68%**	**10.90%**	**9.38%**	**13.30%**	**6.95%**	**6.43%**	**12.50%**		

	Percentage of Babies in Skin-to-Skin Within 1 Hour of Birth	**≥ 80%**	**≤ 70%**	**Regional average**	**76.09%**	**75.77%**	**75.94%**	**74.32%**	**78.11%**	**84.90%**	**52.61%**	**83.00%**	**79.25%**	**74.86%**	**76.29%**	**81.77%**	**77.62%**		
	Percentage of Women Initiating Breastfeeding	**≥ 55%**	**≤ 50%**	**2022 Births**	**54.35%**	**47.14%**	**57.08%**	**56.76%**	**60.95%**	**54.69%**	**74.88%**	**52.00%**	**59.91%**	**49.18%**	**54.74%**	**58.62%**	**56.19%**		
	Percentage of Women Booked by 12+6 Weeks	**≥ 90%**	**≤ 80%**	**Nat Standard**	**92.91%**	**93.80%**	**95.81%**	**94.23%**	**95.14%**	**96.39%**	**96.02%**	**94.19%**	**96.62%**	**93.98%**	**94.85%**	**92.73%**	**95.42%**		
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**		
	Midwife: Birth Ratio	**≤ 1:28**	**≥ 1:24**	**WTE/Births**	**1.28**	**1.28**	**1.28**	**1.28**	**01:28**	**1.28**	**1.28**	**1.28**	**1.28**	**1.28**	**1.28**	**1.28**	**1.28**		
	1:1 Care in Labour	**100%**	**< 100%**	**Nat Standard**	**98.99%**	**98.80%**	**100.00%**	**98.93%**	**99.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**99.30%**		
	Percentage of Shifts Where Shift Co-Ordinator Able to Remain Supernumerary	**100%**	**< 100%**	**Nat Standard**	**100.00%**	**98.30%**	**98.30%**	**100.00%**	**100.00%**	**98.20%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**98.33%**	**98.39%**		
	Diverts: Number of Occasions Unit Unable to Accept Admissions				1	1	0	0	0	0	0	0	1	2	0	0	0		
	Diverts: Number of Women During Period Affected by Unit Closure				0	0	0	0	0	0	0	0	2	0	0	0	0		
	Attendance at Skills Drills/Mandatory Training	**≥ 8%**	**< 8%**	**Training Database**	**8.40%**	**9.16%**	**9.16%**	**10.53%**	**0.00%**	**15.27%**	**11.72%**	**0.00%**	**13.82%**	**12.80%**	**0.00%**	**17.83%**	**13.53%**		
Maternal Morbidity	**3rd/4th Degree Tear as % of Vaginal Births**	**< 3%**	**≥ 4%**	**2022 Births**	**1.72%**	**1.32%**	**2.36%**	**1.45%**	**2.04%**	**4.54%**	**3.22%**	**0.85%**	**1.48%**	**6.19%**	**3.05%**	**1.98%**	**0.84%**		
	% of Episiotomies in Normal Birth			Births/month	4.30%	5.88%	5.05%	5.08%	6.98%	9.38%	8.16%	6.12%	2.78%	9.30%	5.50%	6.32%	5.61%		
	Episiotomies with Episcissors				81.25%	87.50%	85.00%	83.33%	94.44%	84.00%	90.91%	86.36%	84.00%	92.59%	92.59%	81.82%	89.47%		
	PPH 500 – 1499mls as % of Births			Births/month	40.60%	42.10%	38.90%	35.59%	35.50%	38.02%	38.86%	40.00%	34.91%	42.62%	34.48%	48.77%	48.10%		
	PPH 1500 – 2499mls as % of Births			Births/month	2.13%	0.87%	2.81%	3.57%	0.59%	3.09%	3.27%	3.70%	2.88%	2.18%	6.41%	3.46%	1.89%		
	PPH > 2.5L as % of Births			Births/month	0.85%	0.43%	0.93%	0.45%	0.00%	0.52%	0.93%	0.00%	0.94%	0.00%	0.00%	0.00%	0.00%		
	Number of Blood Transfusions ≥ 4 Units			Births/month	0	0	0	0	0	0	0	0	0			0			
	Number of Women Requiring Level 2 Critical Care			Births/month	3	0	3	0	0	5	2	1	2	2	1		1		
	Number of Women Requiring Level 3 Critical Care			Births/month	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		
	Number of Women Re-Admitted Within 28 Days of Delivery	**≤ 1**	**> 4**	**16 in 2022**	**4**	**3**	**3**	**2**	**0**	**2**	**2**	**2**	**0**	**4**	**0**	**1**	**3**		
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis				0	2	0	0	1	2	2	1	0	4	0	0	0		
	Stillbirths**			Nat rate 3.5 per 1000 births	0	1	1	2	0	1	2	0	0	0	2	2	1		
	Early Neonatal Deaths (*before 7 days*)			Nat rate per 1000 births	3	0	0	1	1	0	1	0	0	0	1	1	0		
	Number of Babies Born Under 37 Weeks				20	13	17	23	12	18	10	18	21	17	22	18	11		
	Number of Neonates with Apgars < 7 at 5 Minutes (≥ *37 weeks gestation*)	**≤ 0**	**> 3**	**GM avg. 10 per 1000**	**2**	**3**	**7**	**4**	**4**	**3**	**3**	**3**	**0**	**4**	**2**	**1**	**6**		

Neonatal Morbidity & Mortality	HIE 2 & 3 > 37 Weeks (*reported retrospectively*)			GM avg. 1.95 per 1000	1	0	2	1	0	2	0	0	0	0	1	0	0		
	Shoulder Dystocia as % of Births			Births/month	0.00%	0.88%	2.35%	1.78%	0.59%	0.52%	1.87%	1.40%	0.47%	1.64%	1.28%	0.98%	1.90%		
	Singleton Babies Born < 30 Weeks Gestation			Births/month	1	0	0	1	1	2	1	0	2	0	1	1	0		
	% Whose Mother Received $MgSO_4$	100%	90%	Rolling % of eligible babies	0.00%	N/A	N/A	0.00%	0.00%	50.00%	100.00%	N/A	50.00%	N/A	100.00%	100.00%	N/A		
	Singleton Babies Born < 34 Weeks Gestation			Births/month	7	2	5	2	2	4	4	4	3	4	1	1	0		
	% Whose Mother Received Full Course of Steroids (*1 week prior to delivery*)	100%	90%	Rolling% of eligible babies	100.00%	0.00%	83.33%	50.00%	50.00%	100.00%	25.00%	100.00%	66.67%	25.00%	100.00%	66.67%	N/A		
	Mothers Who Did Not Receive Full Course and Omissions in Care Noted	**0**	**> 1**	**Eligible Mothers**	**N/A**	**0**	**0**	**0**	**0**	**N/A**	**0**	**0**	**0**	**0**	**0**	**0**	**N/A**		
	% of Babies Who Had Defered Cord Clamping				84%	84%	81%	82%	82%	82%	85%	84%	92%	84%	81%	87%	88%		
	% of Babies Born < 37 Weeks Whose Mother Recieved IV Antibiotics				35%	31%	12%	22%	0%	44%	50%	50%	14%	35%	35%	33%	0		
	Unexpected Term Admissions to NNU (*as % of births > 37 weeks gestation*)	**3.50%**	**> 4.5%**	**Births > 37 weeks/month**	**3.81%**	**8.45%**	**8.16%**	**8.08%**	**10.13%**	**8.67%**	**5.82%**	**5.64%**	**5.73%**	**6.67%**	**6.67%**	**6.95%**	**7.58%**		
Risk Management	**Number of Babies Re-Admitted Within 28 Days of Birth**	**< 16**	**> 20**	**194 in 2022**	**21**	**12**	**22**	**17**	**8**	**16**	**9**	**11**	**9**	**14**	**20**	**9**	**9**		
	Number of Incidents Reported				66	51	59	78	50	84	74	94	86	95	77	74	72		
	Number of Concise Investigations				2	1	0	0	0	0	0	0	0	0	0	0	0		
	Number of StEIS Reported Incidents				2	0	0	2	0	1	0	0	1	3	1	1	0		
	Number of Midwifery Red Flags Reported				5	1	5	5	1	4	1	0	2	5	3	4	7		
	Number of Complaints				0	1	0	1	1	2	2	4	2	0	1	0	2		
	Number of Letters of Claim Received				0	0	1	0	0	0	0	0	0	0	0	1	0		

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

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD
Number of Women Delivered	220	169	193	212	211	208	180	230	202	208			582	631	612	208	2033
Number of Registerable Births	225	169	194	214	215	213	183	234	205	211			588	642	622	211	2063
Number of Bookings(retrospective 1 month)	260	247	249	201	241	237	216	233	220	240			756	679	669	240	2344
Normal Births as % of births	118	86	96	98	98	108	86	109	95	107			300	304	290	107	1001
% of Successful Planned Home Births	4	5	0	3	2	6	2	3	4	1			9	11	9	1	30
Instrumental Deliveries as % of births	19	12	14	26	19	27	25	22	28	13			45	72	75	13	205
Total Caesarean Sections as % of births	88	71	82	87	97	77	70	103	82	92			241	261	255	92	849
% Emergency Caesaean Sections	55	43	55	48	57	45	50	62	52	44			153	150	164	44	511
% Elective Caesarean Sections	33	28	27	39	40	32	20	41	30	48			88	111	91	48	338
% of Category 1 Caesarean Sections with Delay in Knife to Skin (over 30 minutes)	37.50%	0.00%	23.07%	41.60%	23.80%	0.00%	7.69%	10.50%	7.69%	20.00%			60.57%	65.40%	25.88%	20.00%	171.85%
% of Category 2 Caesarean Sections with Delay in Knife to Skin (over 75 minutes)	26.60%	16.60%	15.78%	16.66%	7.14%	20.00%	21.42%	23.30%	17.85%	6.45%			58.98%	43.80%	62.57%	6.45%	171.80%
Number of successful VBAC deliveries	3	1	7	3	3	6	5	5	3	5			11	12	13	5	41
%of Caesarean Sections at Full Dilatation	4	5	8	5	12	3	2	6	4.00	6			17	20	12	6	55
Induction of Labour as % of women delivered	70	72	93	77	97	79	79	91	72	81			235	253	242	81	811
% of women induced when RFM is the only indication <39 weeks	4	1	1	1	1	0	0	1	1	0			6	2	2	0	10
% of women induced for Suspected SGA	6	10	19	12	9	12	11	11	7	10			35	33	29	10	107
Average Postnatal Length of Stay	1.8	1.8	1.9	1.5	1.8	1.8	1.7	1.7	1.7	1.9			17.6	5.1	5.1	1.9	17.6
Number of In-utero transfers in from other units	2	0	0	4	5	5	4	3	1	4			2	14	8	4	28
Number of In-utero transfers out to other units	1	0	0	1	3	6	0	0	0	1			1	10	0	1	12
%of Women Smoking at Booking	11.15%	11.74%	10.44%	9.45%	11.60%	8.86%	12.50%	14.10%	8.18%	7.91%			33%	0.2991	0.3478	0.0791	1.0593
% of Women Smoking at Delivery	7.72%	11.24%	13.47%	11.68%	11%	9.38%	13.30%	7.0%	6.43%	12.50%			0.3243	0.3196	0.2668	0.125	1.0357
Babies in Skin-to-Skin within 1 hour of birth	165	132	163	111	177	168	137	177	166	163			460	456	480	163	1559
Percentage of Women Initiating Breastfeeding	126	103	105	158	110	127	90	127	119	118			334	395	336	118	1183
Percentage of Women booked by 12+6 weeks	245	235	240	193	227	229	203	221	204	229			720	649	628	229	2226
Prospective Consultant hours on Delivery Suite	60	60	60	60	60	60	60	60	60	60			180	180	180	60	600
Midwife: Birth Ratio	01:28	01:28	01:28	01:28	01:28	1.28	1.28	1.28	1.28	1.28			0.183333333	1.4022	3.84	1.28	6.70556
1:1 Care in Labour	98.93%	99%	100%	100%	100%	100%	100.00%	100%	100%	99%			3.9793	3	3	0.993	9.9723
Percentage of shifts where shift Co-ordinator able to remain supernumerary	100%	100%	98.20%	100%	100	100	100	100	98.33%	98.39%			2.982	201	200.98	0.9839	405.949
Diverts: Number of occasions unit unable to accept admissions	0	0	0	0	0	1	2	0	0	0			0	1	2	0	3
Diverts: Number of women during period affected by unit closure	0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
Number of Midwives in Post	133	132	131	128	124	123	125	124	129	133			396	375	378	133	1282
Attendance at Skills Drills/Mandatory Training	14	0	20	15	0	17	16	0	23	18			34	32	39	18	123
3rd/4th Degree Tear as % of births	2	2	5	4	1	2	7	4	4	1			9	7	15	1	32
Episiotomies in Normal Birth	6	6	9	8	6	3	8	6	6	6			21	17	20	6	64
PPH >2.5L as % of births	1	0	1	2	0	2	0	0	0	0			2	4	0	0	6
Number of Blood Transfusions> 4 Units	0	0	0	0	0	0							0	0	0	0	0
Number of Women Requiring Level 2 Critical Care	0	1	5	2	1	2	2	1		1			5	5	3	1	14
Number of Women Requiring Level 3 Critical Care	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
Number of women re-admitted within 28 days of delivery	2	0	2	2	2	0	4	0	1	3			4	4	5	3	16
Number of Women Redmitted Within 28 Days of Delivery with Infection / Query Sepsis	0	0	2	2	1	0	4	0	0	0			9	3	4		
Stillbirths **	2	0	2	2	0	1	0	2	2	1			4	3	4	1	12
Early Neonatal Deaths (before 7 days)	1	1	0	1	0	0	0	1	1	0			2	1	2	0	5
Number of Babies Born Under 37 Weeks	23	12	18	10	18	21	17	22	18	11			170		57		
Number of Neonates with Apgars <7 at 5 minutes (>37 weeks gestation)	4	4	3	3	3	0	4	2	1	6			11	6	7	6	30
HIE 2 &3 > 37 weeks (reported retrospectively)	1	0	2	0	0	0	0	1	0	0			3	0	1	0	4
Shoulder Dystocia	4	1	1	4	3	1	3	3	2	4			6	8	8	4	26
Singleton Babies born <30 weeks gestation	1	1	2	1	0	2	0	1	1	0			4	3	2	0	9
% whose mother received magnesium sulphate	0	0	1	100%	N/A	1	N/A	1	1	N/A			2	2	2	0	5
Singleton Babies born <34 weeks gestation	2	2	4	4	4	3	4	1	3	0			8	11	8	0	27
% whose mother received full course steriods (1 week prior to delivery)	1	1	4	1	4	2	1	1	2	N/A			6	7	4	0	17
Births >37 weeks gestation	198	158	173	189	195	192	165	210	187	198			529	576	562	198	1865
Unexpected Term Admissions to NNU as % of births > 37 weeks gestation.	16	16	15	11	11	11	11	14	13	15			47	33	38	15	133
Number of babies re-admitted with 28 days of birth	17	8	16	9	11	9	14	20	9	9			41	29	43	9	122
Number of indicents reported	78	50	84	74	94	86	95	77	74	72			212	254	246	72	784
Number of Concise Investigations	0	0	0	0	0	0	0	0	0	0			0	0	0	0	0
Number of StEIS Reported Incidents	2	0	1	0	0	1	3	1	1	0			3	1	5	0	9
Number of Midwifery Red Flags Reported	4	1	4	1	0	2	5	3	4	7			9	3	12	7	31
Number of Complaints	1	1	2	2	4	2	0	1	0	2			4	8	1	2	15
Number of Letters of Claim Received		0		0	0	0	0	0	1	0			0	0	1	0	1
													0	0	0	0	0
Live Births	222	169	192	211	215	212	183	232	203	210			2049	638	618	210	2049
REGIONAL METRICS																	
Number of Live Births born ≥16 weeks to <24 weeks	1	1	0	0	0	1	0	1	1	0			5				10
Number of Live Births born ≥24 weeks to <37 weeks	23	12	18	10	18	20	17	19	15	11			163				263
Number of Live Births born ≥24 weeks to <34 weeks	6	2	4	3	6	8	4	5	4	0							
Number of Live Births ≥38 weeks	180	136	152	169	173	167	147	191	173	177							
Number of Live Births ≥39 weeks	145	112	110	131	135	134	117	144	132	146							
Number of Episiotomies performed	24	18	25	33	22	25	27	27	33	19							
Number of babies born <3rd centile	13	9	13	8	7	9	7	11	11	3							
Number of Major Haemorrhages > 2500mls	1	0	1	2	0	2	0	0	0	0							
Intrapartum Stillbirths	0	0	0	0	0	0	0	0	0	0							
Number of Early Neonatal Deaths 20+0 to 23+6 weeks	0	1	0	1	0	0	0	1	1	0							
Number of Early Neonatal Deaths > 24 weeks	0	0	0	0	0	0	0	0	0	0							
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate	3	1	3	3	6	7	2	5	3	0							
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	3	1	4	1	6	7	1	1	2	0							
Number of babies less than 3rd centile delivered >38 weeks	6	2	8	1	4	1	2	7	7	2							
Number of women smoking at the time of booking	29	29	26	19	28	21	27	33	18	19							
Number of women smoking at delivery	17	19	26	25	23	20	24	16	13	26							
Friends & Family Test:Q2 Birth:Percentage returned complete																	
Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended																	
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic	1	0	0	1	0	0	0	0	0	0							
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic	0	0	0	0	0	0	0	0	0	0							
Number of babies born at Home Midwife NOT present	0	0	0	0	0	0	0	0	0	0							
Number of babies born in Other location Midwife NOT present	2	2	2	3	1	2	1	1	0	3							
Episiotomies with Episcissors	20	17	21	30	19	21	25	25	27	17							
Mothers who did not receive full course and omissions in care notec	0	0	N/A	0	0	0	0	0	0	N/A			0	0	0	0	0
PPH 500-1499mls as % of births	79	60	73	82	87	74	78	80	99	101			813	0	257	101	813
PPH 1500-2499mls as % of births	8	1	6	7	8	6	4	13	7	4			64	243	24	4	64
% of babies who had differed cord clamping - ENTER NUMBER OF BABIES	.		159	181	180	196	154	190	179	184							
% of babies born <37 weeks who's mother recieved IV Antibiotics ENTER NUMBER OF BABIES	.		8	5	9	3	6	6	6	0							

			2022 Data					2023 Data												
		Indicator	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
DENOMINATOR Metrics	1	Number of Bookers	220	232	254	258	215	260	247	249	201	241	237	216	233	220	240			2344
	2	Number of Registrable Births	238	191	234	228	213	225	169	194	214	215	213	183	234	205	211			2063
	3	Number of Women Delivered	234	190	233	227	212	220	169	193	212	211	208	180	230	202	208			2033
	4	Number of Successful Planned Home Births	4	4	1	3	2	4	5		3	2	6	2	3	4	1			30
	5	Number of Midwifery Led Unit births	234	190	233	227	212	220	169	193	212	211	208	180	230	202	208			2033
	6	Number of Live Births at any gestation	238	191	234	228	213	225	169	194	214	215	213	183	232	205	211			2061
	7	Number of Live Births born ≥16 weeks to <24 weeks	0	0	0	0	0	1	1	0	0	0	1	0	1	1	0	0	0	5
	8	Number of Live Births born ≥24 weeks to <37 weeks	16	24	20	13	17	23	12	18	10	18	20	17	19	15	11			163
	9	Number of Live Births born ≥24 weeks to <34 weeks	9	4	2	2	5	6	2	4	3	6	8	4	5	4	0			42
	10	Number of Live Births ≥37 weeks	220	162	210	213	196	198	158	173	189	195	192	165	210	187	198			1865
	11	Number of Live Births ≥38 weeks	202	143	193	192	170	180	136	152	169	173	167	147	191	173	177			1665
	12	Number of Live Births ≥39 weeks	160	112	146	158	138	145	112	110	131	135	134	117	144	132	146			1306
	13	Number of Episiotomies performed	34	22	32	24	20	24	18	25	33	22	25	27	27	33	19			253
	14	Episiotomies with Episcissors	28	21	26	21	17	20	17	21	30	19	21	25	25	27	17			222
	15	Number of babies born <3rd centile	11	14	16	14	14	13	9	13	8	7	9	7	11	11	3			91
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
	17	Number of Blood Transfusions ≥ 4 Units	0	1	0	0		0	0	0	0	0	0				-			0
	18	Number of Women Requiring Level 2 Critical Care	3		3	0	3	0		5	2	1	2	2	1		1			14
	19	Number of Women Requiring Level 3 Critical Care	0		0	0	0	0		0	0	0	0	0	0		0			0
	20	Number of Major Haemorrhages ≥ 2500mls	2	1	2	1	3	1	0	1	2	0	2	0	0	0	0			6
	21	Number of Women readmitted to same Obstetric unit within 30 days of delivery	0	1	4	3	3	2	0	2	2	2	0	4	0	1	3			16
	22	Number of 3rd and 4th degree tears	7	4	4	3	5	2	2	5	4	1	2	7	4	4	1			32
	23	Number of Episiotomies in normal birth	4	7	4	7	5	6	6	9	8	6	3	8	6	6	6			64
	24	Number of Emergency LSCS	42	43	67	58	65	55	43	55	48	57	45	50	62	52	44			511
	25	Number of Elective LSCS	38	30	44	33	33	33	28	27	39	40	32	20	41	30	48			338
	26	Number of LSCS at Full Dilatation	1	3	4	7	6	4	5	8	5	12	3	2	6	4	6			55
	27	Number of Operative Vaginal Deliveries	34	16	29	17	15	19	12	14	26	19	27	25	22	28	13			205
	28	Number of Normal Vaginal Deliveries	123	106	93	119	99	118	86	96	98	98	108	86	109	95	107			1001
	29	Number of Inductions (excluding augmentations)	98	73	88	93	87	70	72	93	77	97	79	79	91	72	81			811
	30	Number of women induced only when RFM is the only indication < 39 weeks	2	1	1	1	0	4	1	1	1	1	0	0	1	1	0			10
PERINATAL Morbidity and Mortality Metrics	31	Number of Stillbirths	1	1	0	1	1	2	0	2	2	0	1	0	2	2	1			12
	32	Number of Intrapartum Stillbirths	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	2	0	0	0	1	0	1	0	0	0	1	1	0			4
	34	Number of Early Neonatal Deaths > 24 weeks	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0			0
	35	Number of Neonates with suspected HIE Grade 2 and 3, ≥ 37 Weeks	0	0		0		1	0	2	0	0	0	0	1	0	0			4
	36	Number of Neonates with Apgars <7 at 5 Minutes, ≥ 37 Weeks	4	4	2	3	7	4	4	3	3	3	zero	4	2	1	6			30
	37	Number of admissions to Neonatal Unit ≥ 37 Weeks	4	15	8	18	16	16	16	15	11	11	11	11	14	13	15			133
	38	Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate	5	3	2	0	4	3	1	3	3		7		5	3	0			25
	39	Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	5	4	2	0	5	3	1	4	1	6	7		1	2	0			25
	40	Number of babies less than 3rd centile delivered >38 weeks	5	5	8	9	4	6	2	8	1	4	1	2	7	7	2			40
PROCESS	41	Average Postnatal Length of Stay for Women	1.6	1.7	1.8	1.6	2	1.8	1.8	1.9	1.5	1.8	1.8	1.7	1.7	1.7	1.9			17.6
	42	Number of In-utero Transfers In	2	2	1	1	1	2	0	0	4	5	5	4	3	1	4			28
	43	Number of In-utero Transfers Out	0	0	0	0	0	1	0	0	1	3	6	0	0	0	1			12
	44	Diverts: Number of occasions the unit has been unable to accept admissions	0	1	1	1	0	0	0	0	0	0	1	2	0	0	0			3
	45	Diverts: Number of women during the period affected by the units closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
	46	Number of women booked by 12 + 6 weeks	199	206	236	242	206	245	235	240	193	227	229	203	221	204	229			2226
	47	Number of women smoking at the time of booking	39	27	31	37	25	29	29	26	19	28	21	27	33	18	19			249
	48	Number of women smoking at delivery	30	17	22	27	23	17	19	26	25	23	20	24	16	13	26			209
	49	Number of women initiating breast feeding including attempted and expressed	136	118	125	107	121	126	103	105	158	110	127	90	127	119	118			1183
	50	Number of babies that received Skin to Skin contact within 1 hour of birth	184	141	175	172	161	165	132	163	111	177	168	137	177	166	163			1559

	51	Number of successful VBAC deliveries	5	3	6	5	4	3	1	7	3	3	6	5	5	3	5			41
Patient Experience	52	Friends & Family Test:Q2 Birth:Percentage returned complete																		0
	53	Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended																		0
Workforce	54	Number of women receiving 1:1 midwifery in labour	1	1	1	1	180	185	0.99	1	173	171	176	160	1	1	0.993			870
	55	Midwife to Birth Ratio	28	28	28	28	28	28	28	28	28	28	1.28	1.28	1.28	1.28	1.28			146.4
COVID -19	56	Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic	2	0	2	0	3	1			1						0			2
	57	Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic	0	0	0	0	0				0						0			0
Safety	58	Number of babies born at Home Midwife NOT present	2	1	0	0	1	0	0	0	0	0	0	0	0	0	0			0
	59	Number of babies born in Other location Midwife NOT present	0	0	3	1	0	2	2	2	3	1	2	1	1	0	3			17

Safety Dashboard 2023

Neonatal

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

					2022			2023										
		Goal	Red Flag	Measure	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Safety	**% of Shifts Staffed to BAPM**	**100%**	**< 90%**	**Badger**	**88.87**	**98.33**	**93.50**	**87.10**	**100.00**	**52.94**	**72.41**	**68.97**	**66.67**	**88.71**	**94.44**	**98.08**	**96.77**		
	% of Shifts with Supernumeary Shift Leader	**100%**	**< 50%**	**Badger**	**50.97**	**52.62**	**50.16**	**54.61**	**57.10**	**57.42**	**56.90**	**67.24**	**65.00**	**85.48**	**79.63**	**82.69**	**95.16**		
	Unit Closed Due to Capacity	**0**	**≥ 1**	**Datix**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		
	Unit Closed Due to BAPM/Staffing	**0**	**≥ 1**	**Datix**	**0**	**1**	**0**	**0**	**0**	**0**	**1**			**0**	**0**	**0**	**0**		
Admissions	Number of Births from Maternity			Maternity Data	234	228	213	224	170	194	214	215	213	183	234	205	211		
	Admissions Under 27 Weeks to NNU	**< 1**	**≥ 1**	**Badger**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**0**	**0**		
	Admissions 27+1 – 34 Weeks to NNU			Badger	16	28	31	35	22	34	30	32	7	4	6	4	0		
	Total Admissions to Neonatal Unit			Badger	16	28	31	36	22	34	30	33	41	37	29	22	22		
	Transitional Care Admissions: 34 – 36+6			Badger	2	3	1	4	3	2	1	5	7	11	8	5	1		
	Transitional Care Admissions: 37+			Badger	6	6	3	4	6	4	6	12	15	12	12	18	12		
	Total TC Admissions			Badger	8	9	4	8	9	6	7	17	22	23	20	23	13		
	Number of unexpected Term Admissions to NNU				6	17	18	18	16	15	11	11	11	11	14	13	15		
	Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)	**6%**	**≥ 4.5%**	**Maternity/Badger**	**2.56%**	**7.46%**	**8.45%**	**8.04%**	**9.41%**	**8.67%**	**5.82%**	**5.64%**	**5.72%**	**6.66%**	**6.66%**	**6.95**	**7.58**		
	Unexpected Term Admissions to NNU (*as % of Total Admissions*)			Badger/ NWNODN							36.66%	33.33%	26.80%	29.72%	50%	59.09%	68.10%		
	Mothers Eligible for AN Steroids (*< 34 Weeks*)			NNAP/ NWNODN	2	2	5	4	2	4	4	6	5	4	3	3	0		
	% of Mothers Who Received Full Course of Antental Steroids	**≥ 93%**	**< 89%**	**NNAP/ NWNODN**	**100%**	**50%**	**100%**	**50%**	**50%**	**75%**	**25%**	**100%**	**60%**	**25%**	**33%**	**33%**	**N/A**		
	Mothers Eligible for AN $MgSO_4$ (*< 30 Weeks*)			NNAP/ NWNODN	1	0	0	1	1	1	1	0	2	0	2	1	0		
	% of Mothers Receiving Antenatal $MgSO_4$	**≥ 85%**	**< 73%**	**NNAP/ NWNODN**	**100%**	**NA**	**NA**	**0**	**0**	**100%**	**100%**	**NA**	**50%**	**N/A**	**100%**	**100%**	**N/A**		
	Babies Eligible for Delayed Cord Clamping			NNAP/ NWNODN	2	2	6	6	2	3	4	6	8	4	5	3	0		

NNAP	**% of Babies Receiving Delayed Cord Clamping**	**≥ 85%**	**< 73%**	**NNAP/ NWNODN**	**100.00%**	**100.00%**	**66.67%**	**66.67%**	**0.00%**	**33.33%**	**25.00%**	**100.00%**	**75.00%**	**50.00%**	**60.00%**	**66.66%**	**N/A**		
	Babies Eligible for Temperature on Admission (*< 32 Weeks*)			NNAP/ NWNODN	2	1	1	1	2	2	1	6	8	4	5	3	0		
	% of Babies With Temperature Within First Hour of Admission (*< 32 Weeks*)			NNAP/ NWNODN	100%	100%	100%	0	50%	100%	100%	6	8	3	5	3	N/A		
	% of Babies With Temperature on Admission of 36.5°C – 37.5°C (*< 32 Weeks*)			NNAP/ NWNODN	50%	100%	100%	0	50%	100%	100%	6	7	3	5	3	N/A		
	Babies Eligible for Senior Review			NNAP/ NWNODN	11	23	27	28	21	27	15	18	22	18	21	14	19		
	Number of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	7	19	26	28	21	26	14	18	20	17	17	14	19		
	% of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	63.64%	82.61%	96.30%	100%	100%	96.29%	93.30%	100%	91%	94.40%	80.90%	100%	100%		
	Total Ward Rounds Where Parents Present			NNAP/ NWNODN	20	27	28	31	22	21	22	23	27	20	17	15	17		
	% of Ward Rounds Where Parents Present			NNAP/ NWNODN	100%	92.59%	100%	100%	95.45%	100%	95.70%	100%	96.30%	90%	85%	100%	89.50%		
	% of Eligible Babies Reciving Retinopathy Screening (*ROP*)			NNAP/ NWNODN	100%	N/A	33%	100%	N/A	N/A	33%	50%	50%	100%	100%	100%	67%		
	% of Babies With Central Line Blood Infections			NNAP/ NWNODN	0	0	0	0	0	0	0	0	0	0	0	0	0		
	Babies Eligible for Follow-Up At 2 Years			NNAP/ NWNODN	0	4	0	2	4	1	0	1	2	0	4	5	0		
	% of Babies Receiving Follow-Up At 2 Years			NNAP/ NWNODN	N/A	75%	N/A	50%	50%	100%	N/A	100%	50%	N/A	50%	60%	N/A		
Incidents	Number of Incidents Reported			Datix	11	12	15	17	16		23	9	23	2	11	11	8		
	Number of Network Exception Reports			NWNODN	1	0	2	2	2		1	0	0	3	2	0	0		
	Number of Concise Investigations	**0**	**≥ 1**	**Datix**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**		
	Number of StEIS Reported Incidents	**0**	**≥ 1**	**Datix**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**		
	Number of Complaints	**< 2**	**≥ 2**	**Datix**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**		
	Number of Letters of Claim Received	**0**	**≥ 1**	**Datix**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**		
ding	**% of Mothers Expressing Breast Milk in First 24 Hours Following Baby's Admission to NNU**			Unicef/ NWNODN	52.90%	35.70%	51.50%	50%	9.10%	17.60%	27.60%	8%	7.30%	17.40%	11.50%	50.00%	9.10%		
	% of Babies Receiving Human Milk in First 24 Hours Following Admission to Neonatal Unit			Unicef/ NWNODN	52.90%	28.60%	51.50%	38.90%	9.10%	17.60%	24.10%	12%	12.20%	17.40%	19.20%	40.90%	22.70%		
	% of Babies Receiving Human Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	77.80%	25%	69.70%	69.20%	9.50%	11.10%	31%	20.80%	0	8.70%	4%	58%	66.70%		
	% of Mothers Expressing Breast Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	72.70%	25%	63.90%	64.10%	9.50%	11.10%	25.00%	12.50%	0	8.70%	0	63.20%	42.90%		
	% of Mothers Breastfeeding on Discharge from Neonatal Unit			Unicef/ NWNODN	77.80%	14.30%	57.60%	48.70%	4.80%	3.70%	25.00%	16.70%	0	4.30%	0	31.60%	38.10%		

Breastfee	Number of Babies Eligible to Receive Breast Milk in the First Two Days of Life (*< 34 Weeks*)			NNAP/ NWNODN	2	3	6	6	2	3	4	6	8	3	5	3	0		
	% of Babies < 34 Weeks Receiving Breast Milk in First Two Days of Life			NNAP/ NWNODN	0	33.33%	50%	33.33%	50%	33.33%	50%	33.30%	75%	66.70%	100%	100%	N/A		
	Number of Babies < 34 Weeks Eligible for Breast Milk at Day 14			NNAP/ NWNODN	5	1	6	6	3	1	4	3	7	2	5	1	1		
	% of Babies < 34 Weeks Receiving Breast Milk at Day 14			NNAP/ NWNODN	80%	0	66.67%	100%	66.67%	100%	75%	66.70%	71.40%	100%	60%	100%	100%		
	Number of Babies < 34 Weeks Eligible for Breast Milk at Discharge			NNAP/ NWNODN	5	4	5	7	1	1	6	4	9	3	6	3	5		
	% of Babies < 34 Weeks Receiving Breast Milk at Discharge			NNAP/ NWNODN	80%	50%	60%	85.71%	0	100%	33.30%	50%	66.70%	33.30%	66.70%	66.70%	100%		
Activity	Care Days ICU (*HRG1*)			Badger	15	5	9	11	5	40	16	7	44	3	20	6	3		
	Care Days HDU (*HRG2*)			Badger	52	42	41	29	19	77	61	115	39	56	71	61	63		
	Care Days SC (*HRG3, HRG4, HRG5, and code9*)			Badger	173	173	251	198	101	173	237	172	270	214	198	203	128		
	Cot Capacity ICU %			Badger	48.39%	16.67%	29.03%	35.48%	17.86%	129%	53.30%	22.58%	146%	9.60%	64.50%	20%	9.67%		
	Cot Capacity HDU %			Badger	55.91%	46.67%	44.09%	31.18%	22.62%	82.70%	67.77%	123.60%	43.33%	60.20%	76.30%	67.77%	67.70%		
	Cot Capacity SC %			Badger	55.81%	57.67%	80.97%	63.87%	36.07%	55.80%	79%	55.48%	90%	69.03%	63.80%	67.66%	41.29%		
	Overall Cot Capacity %			Badger	55.30%	52.38%	69.35%	54.84%	31.89%	69.04%	74.70%	68%	84%	62.09%	71.40%	64.28%	44.70%		
	Care Days TC (*HRG3*)			Badger	0	0	0	0	0	0	0	0	0	0	0	0	0		
	Care Days TC (*HRG4*)			Badger	51	56	23	35	53	21	17	40	64	63	51	83	72		
	Care Days TC (*HRG5*)			Badger	8	1	0	3	2	0	0	0	0	0	0	0	0		
	Care Days TC (*code 9*)			Badger	4	10	5	2	2	0	0	0	0	2	0	4	3		
	Total TC Care Days			Badger	63	67	28	40	57	21	17	40	64	65	51	87	75		
	Overall TC Cot Capacity %			Badger	50.81%	55.83%	22.58%	32.26%	50.89%	16.93%	14.16%	32.25%	53.33%	52.40%	41.12%	70.16%	60.48%		
Training	**NLS Accrediated**	**≥ 70%**	**< 70%**	**WWL**	**94.44%**	**91.43%**	**91.43%**	**97.22%**	**94.74%**	**91.00%**	**92.30%**	**90%**	**92.10%**	**92.10%**	**94.74%**	**94.74%**	**94.74%**		
	NLS In-House	**≥ 90%**	**< 90%**	**WWL**	**97.56%**	**97.56%**	**97.56%**	**97.56%**	**97.56%**	**100.00%**	**100%**	**100%**	**100%**	**100%**	**97.56%**	**97.56%**	**97.56%**		
	Qualified In Speciality of Intensive Neonates	**≥ 70%**	**< 70%**	**WWL**	**84.21%**	**81.08%**	**81.08%**	**84.21%**	**85.00%**	**85.00%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**		
	Foundation In Neonates	**≥ 70%**	**< 70%**	**WWL**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**98.00%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**		
	Family Intergrated Care	**≥ 85%**	**< 85%**	**WWL**	**97.62%**	**97.62%**	**97.62%**	**97.62%**	**97.62%**	**90.00%**	**91.10%**	**93.30%**	**97.80%**	**93.30%**	**100%**	**98%**	**98%**		
	Unicef BFI	**100%**	**< 80%**	**WWL**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**98.00%**	**99%**	**99%**	**100%**	**100%**	**100%**	**100%**	**100%**		

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

Perinatal Quality Surveillance Dashboard 2023

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

	Safe	Effective	Caring	Well-Led	Responsive	CQC Overall Rating Good (August 2023)		
	Requires Improvement	Good	Good	Good	Good			
\	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Cardiotocograph (CTG) training and competency assessment	Midwives = 13 (94% rolling compliance) Consultant = 1 (100% rolling compliance) Registrars = 1 (90% rolling compliance)	Midwives = 22 (96% rolling compliance) Consultant = 1 (100% rolling compliance) Registrars = 1 (90% rolling compliance)	Midwives = 11 (98% rolling compliance) Consultant = 0 (91.6% rolling compliance) Registrars = 2 (100% rolling compliance)	Midwives = 21 (98% rolling compliance) Consultant = 2 (91% rolling compliance) Registrars = 1 (100% rolling compliance)	Midwives = 13 (98% rolling compliance) Consultant = 0 (91% rolling compliance) Registrars = 1 (100% rolling compliance)	Midwives = 16 (97.7% rolling compliance) Consultant = 4 (91% rolling compliance) Registrars = 0 (100% rolling compliance)	Midwives = 20 (98% rolling complaince) Consultant = 0 (82% rolling complaince) Registrars = 1 (87.5% rolling complaince)	**No CTG Training in August** Complaince remains as July 2023	Midwives = 17 (98.6% rolling complaince) Consultant = 2 (91% rolling complaince) Registrars = 1 (90% rolling complaince)	Midwives = 14 (97.4 % rolling complaince) Consultant = 0 (88 % rolling complaince) Registrars = 1 (100% rolling complaince)		
Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)	Midwives 11 attended (7%) rolling % 91% Obstetric consultants 1 attended (8%), rolling % 92% Obstetric registrars 0 attended (0%), rolling% 82% Anaesthetists 0 attended (0%) rolling% 100% MSW's 3 attended (8%) rolling % 92%	No PROMPT in February Midwives rolling% 85% MSW's rolling% 94% Obs consultants rolling% 91% Obs Registrar rolling% 64% Anaesthetists rolling% 100%	Midwives 11 attended rolling % 88% MSW 6% attended rolling% 88% Consultants 9% attended rolling 82% Registrars 8% attended rolling % 75% Anaesthetist 0 attended rolling % 100%	Midwives 15 attended (10%) rolling % 87% MSW 1 attended (3%) rolling % 86% Obs consultants 1 attended (8%) rolling% 91% Obs reg 0 attended rolling % 91% Anaesthetists 0 attended rolling % 84%	**PROMPT cancelled May** Midwives Rolling compliance 80% MSW Rolling compliance 75% Obstetric consultant rolling compliance 92% Obstetric registrar rolling compliance 64% Anaesthetists rolling compliance 65%	Midwives 17 attended (11%) Rolling % 82% MSW's 6 attended (17%) Rolling % 81% Obsteteric Consultants 0 attended Rolling % 83% Obs Registrars 2 attended (18%) 82% Anaesthetists 0 attended Rolling% 63%	Midwives 16 attended Rolling compliance 84% MSW 5 attended Rolling compliance 83% Obstetric Consultant 0 attended Rolling compliance 67% Obstetric Registrar 2 attended Rolling compliance 100% Anaesthetists 1 attended Rolling compliance 68%	**No Prompt Training in August** Complaince remains as July 2023	Midwives 23 attended (15%) Rolling % 86% MSW 4 attended (10%) rolling 78% Obstetric Consultants 2 attended (17%) rolling % 75% Obstetric registrars 2 attended (15%) rolling % 79% Anaesthetists 1 attended (5%) rolling % 68%	Midwives 18 attended (12%) Rolling % 84% MSW 5 attended (13%) rolling 87% Obstetric Consultants 1 attended (10%) rolling % 60% Obstetric registrars 2 attended (17%) rolling % 83% Anaesthetists 3 attended (16%) rolling % 74%		
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)	60	60	60	60	60	60	60	60	60	60		
1:1 care in labour	99%	99%	100%	100%	100%	100%	100%	100%	100%	99.30%		
Maternity Red Flags reported (>3)	4	1	4	1	0	2	5	3	4	12		
Diverts: Number of occasions unit unable to accept admissions(>1)	0	0	0	0	0	1	2	0	0	0		
Supernumeray Shift Co-ordinator	100%	100%	98%	100%	100%	100%	100%	100%	98.33%	98.39%		
The number of incidents logged graded as moderate or above (>5)	2	2	2	1	2	0	1	2	2	0		
All cases eligible for referral to HSIB.	1	0	1	0	0	0	1	1	1	1		
Number of Datix submitted when shift co-ordinator not supernumerary	0	0	0	0	0	0	0	0	1	0		

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

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

NWNODN Workforce Action Plan (2021/Year 3 with 2022/Year 4)

2023 (year 5) Update for Maternity Incentive Scheme Safety Standard 4 Neonatal Workforce Compliance. (Actions 9 & 10 remain ongoing

	Aims/ Targets/ Objectives	How this will be achieved	What expected outcome will be	What evidence will support this	Lead	Timescales	Monitoring/ Update
1.	Achievement of National Neonatal Nursing Standards: NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010)	Accurate data collection using: - National Nurse Workforce Tool (NNWT) for direct Patient/Cot side Care - NWNODN Quality Nursing Roles Calculator (QNRC)- For Quality Roles Ongoing discussion with appropriate Organisational leads e.g., Service & Finance Leads Ensure Neonatal Safety Champion is aware of any ongoing challenges/risks due to nurse staffing shortages	Identification of total nursing gap/deficit against cot base, activity & quality roles Organisational awareness of nurse staffing position, Generation of Action Plan for achievement of national standards Any challenges are escalated to Trust Board for information/action	Currently there is a national staffing review in place following the Neonatal Critical Care Review. Funding has been identified from NHSE where shortfalls have been identified, however it will be a 1–3-year process based on level of need. Supernumerary Shift coordinators to be appointed once internal staffing review completed	Cathy Stanford Divisional Director of Midwifery and Child Health	The overall outcome of regional and National review is awaited. It is expected that the staffing review will be achievable within the current funded establishment.	A staffing tool has been sent to all units to complete to identify staffing numbers to staff to 100% BAPM standards and cot base. The initial findings identified a small shortfall in staffing and these posts have now been recruited to. **July 2021 Update** Skill mix review in progress. **October 2022 Update** Staffing paper completed in Nov 21 and updated Feb 2022 following receipt of Neonatal Critical Care Funding.

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2.	Recruitment of registered nurses in line with BAPM recommendations with regards to safe staffing levels against patient ratios	On-going recruitment in place to establishment as post become vacant Regular meetings with recruitment team (Monthly)	Staffing levels to reflect these required for acuity. Recruitment in line with Trust standard recruitment time.	Reflected in compliance recorded by local system Incidents reports submitted where staffing shortfalls occur. All Nursing red flags reported as appropriate Staffing levels at budgeted establishment Current Staff in Post April 2021.docx NNU Staffing Paper.docx NNU STAFFING PAPER OCT 2022 .do NNU STAFFING PAPER July 2023 for Wigan Annual Meeting 04.05.23.pp	Ann Carey Matron Child Health Cathy Stanford Divisional Director of Midwifery and Child Health	Ongoing. A full staffing review will be undertaken in July 2021 to identify the requirements to meet the BAPM recommendations for: Supernumerary shift coordinator, Annual Staffing paper Annual NWNODN review Education and development Leads	**June 2022 Update.** Staffing reviewed completed and Band 7 posts recruited. Internal development and promotion to vacated Band 6 posts **October 2022 Update** Current staffing fully recruited. For Band 5/6. Some additional hours to be recruited to Band 7 vacancies **July 2023 Update** NNU Staffing paper completed and submitted to Board and Q&S Committee. BAPM standards met. Current vacancy shortfall of 1.31. recruitment in place. **July 2021 Update** Skill mix review in progress.

Last Updated October 2023 CS

NWNODN Workforce Action Plan (2021/Year 3 with 2022/Year 4)
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3.	Review of roles to manage skill mix and encourage innovative roles.	Regular Workforce meetings to discuss all issues. Introduction of New roles	Implementation of new roles and Quality improvement roles for unit leaders Such as • BFI Lead • FiCARE Lead • ATAIN Lead • TC Lead • Bereavement Lead • Developmental Care Sessions will be ring fenced neonatal time and allocated.	Role diversity New Unit manager appointed. Supernumerary shift coordinators to be introduced following additional funding received from the Critical Care review. full staffing review to be undertaken. All band 7 leaders will have a quality project to lead on. AB WWL Add Neonatal Funding 2	Ann Carey Matron Child Health	Ongoing	**October 2022 Update** Staffing paper completed in Nov 21 and updated Feb 2022 following receipt of Neonatal Critical Care Funding. **August 2023 Update** Additional recurrent funding received to increase Education and Governance/ Risk post. Practice Education lead post increased and 12 hr Governance lead Nurse post created.

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4.	Share Nurse staffing information, workforce strategy and action plans with NWNODN as stated in Neonatal Critical Care Review and Maternity Incentive Scheme Safety Standards Monitoring of Staffing levels to ensure levels are in line with acuity	Work with NWNODN team to complete NNWT and QNRC Workforce Strategy & Action Plan shared with NWNODN Monthly Review or by exception in periods of high demand and capacity	Completed tools to be held locally and by NWNODN NWNODN will use data, W/F Strategy and • Action Plans to: Identify gaps for NCCR funding • Inform ODN W/F and Education Strategy Clear review of staffing on a weekly basis. Report of staffing to workforce group.	Staffing tool completed. In house staffing review to be finalised. **Badger Staffing data** NNU staffing data numbers.xlsx **Q1&2 BAPM and QIS compliance** Neonatal Unit Report. BAPM compl	Cathy Stanford Divisional Director of Midwifery and Child Health Ann Carey Matron Child Health Simon Needham Neonatal Unit Manager	31 August 2021	Staffing tool completed and submitted as requested to NWNODN **<u>October 2022 Update</u>** Continue to work closely with NWNODN and submit staffing compliance as requested. Data is also received directly through BadgerNet. BAPM compliance monitored against acuity through BadgerNet **<u>October 2023 Update.</u>** BAPM compliance monitored monthly on NNU dashboard. And quarterly reports available

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5.	Retention Rate	To listen to staff and understand the key drivers that retain staff and how staff would value being recognized	Improved retention	Over 89% Target for retention. Staff report positive experiences of their membership of the workforce. Staff surveys to be repeated in line with SCORE culture survey utilised within MatNeoSip quality improvement programme	Ann Carey Matron Child Health Simon Needham Neonatal Unit Manager Cathy Stanford Divisional Director of Midwifery and Child Health	On-going	**October 2022 Update** Attrition rates remain low with minimal turnover of staff. Recent additional Band 7 posts have allowed for implementing quality projects to Shift Coordinators **October 2023 Update.** Score culture survey will be phase 2 of the Quadrumvirate Culture programmes, which commences in November 2023. Additionally, NNU will be involved in an inhouse culture programme.

Last Updated October 2023 CS

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6.	Training and development opportunities are taken up and positively evaluated by all staff	To promote ascending and aspiring Talent Review funding for continuing education. Ensure all staff are facilitated to maintain mandatory competencies and monitor compliance.	Yearly Training Needs analysis completed, and training delivered. All staff to remain up to date with core competencies.	Service specification of 70% staff QIS maintained. Compliance maintained across all areas of mandatory training All training requests are reviewed through the educational panel to ensure equity	Suzanne Faulkner Practice Education Lead	Monthly on-going review **October 2022 Update** Additional uplift required to baseline establishment to incorporate all additional training requirement/ Leave and sickness etc. **October 2023 Update** uplift to baseline staffing agreed in principle when July staffing paper presented, however funding at this present time is unavailable.	**October 2022 Update** Monthly mandatory Training 2 days in place with additional Difficult air way day. Compliance levels excellent and well received. **0ctober 2023 Update** Effective education panel in place. Training opportunities identified and places booked on NIPE course. 2 staff are also requesting to be considered for ANNP course in 2024

Last Updated October 2023 CS

NWNODN Workforce Action Plan (2021/Year 3 with 2022/Year 4)
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7.	Attendance to be monitored and in line with Trust target	Absence monitoring meetings as per trust policy Ensure sickness absence policy is being effectively undertaken and any themes or trends identified in regard to staff sickness.	Absence below the Trust 4% target	Absence levels below target **October 2023 Update** Sickness levels have significantly raised in 2023.	Simon Needham Neonatal Unit Manager Ann Carey Matron Child Health	Monthly on-going review	**October 2022 Update** Sickness levels monitored monthly. Expected levels no concerns identified **October 2023 Update** In depth review of sickness levels across the unit to be undertaken
8.	Robust and effective roster approval process	Review of current process against targets	Roster standards Met	Roster produced in correct time. Roster meet all Trust Standards **October 2023 Update** Roster templates and KPI's have been reviewed and are compliant with Budgeted establishment. Current Rota sign off by Dep DoM and Child health. Sign off level to be escalated to Div DoM level from next rota in November due to financial constraints and Nursing budget overspend.	Simon Needham Neonatal Unit Manager Ann Carey Matron Child Health	Monthly on-going review	**October 2022 Update.** Roster KPI remain compliant **October 2023 Update** Supernumerary shift coordinator monitored monthly and above the National average for compliance.

NWNODN Workforce Action Plan (2021/Year 3 with 2022/Year 4)

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9.	Review of AHP services and how they support and enhance the Neonatal workforce.	Review options for shared roles with neighbouring units. (Recruit on a session basis for shared posts)	Training and competency packages will be developed with support from the NWNODN. Job Descriptions to be developed	Recruit on a session basis as an option associated competencies, and training will be required Recruit to the following recommended posts. • Dietetics • Physiotherapy • Speech and Language therapists • Pharmacy Technician • Psychologist	Christos Zipitis Divisional Medical Director Consultant Paediatrician.	Ongoing	Currently no funding for Additional AHP roles as recommended **October 2023 Update** Will need to explore further funding for AHP roles as per recommendations. Currently compliant for Pharmacy support as designated senior paediatric pharmacist in post. Speech and Language and Dietetic support is on a request basis from WWL community Services. Physiotherapy is provided within the community following discharge from NNU
November 2023 Update Funding secured for part time Psychologist role to be shared with neighbouring unit, this is in addition to the existing pharmacist hours in place. Speech and language are available upon request. Physiotherapy is available in the community following discharge. Dietetic support remains difficult to achieve due to the training requirements of the existing Trust staff however the Neonatal service are actively pursuing this option with community service leads.							

Last Updated October 2023 CS

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10.	The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of medical staffing.	• Rota Gaps for Tier I added to risk register. • Outline business case to be resubmitted for additional ANNP and/ or medical trainees • Recruitment of staff to commence training as ANNP	Full rota cover remains an ongoing priority and vacant shifts are actively managed within the Division. There is an agreed plan within the Division to recruit to Advanced Neonatal Nurse Practitioners which will cover the shortfalls going forward and provide additional skilled senior support to the Neonatal unit. This is not an immediate solution as staff will need to be trained through accredited Training Programme which	Year 3 Maternity Incentive Scheme (CNST) action plan and compliance paper agreed and supported by Trust Board Preliminary Outline Business Case.docx BC2022-046 - Advanced Neonatal Funding required for additional ANNP training programme once approval received. AB WWL NWNODN 2022 10 28.pdf **October 2022 Update,** Funding received from NWNODN to support the Tier 1 Rota Gap and provide Tier 1 cover 24/7. However, the current gap is not fully addressed by allocated funding.	Cathy Stanford Divisional Director of Midwifery and Neonates Christos Zipitis Divisional Medical Director Consultant paediatrician	**September 2021** Full business case to be completed and sent for approval. Recruitment and selection for substantive additional ANNP with allocated funds and additional Divisional Top-up **October 2022 Update** Tier 1 neonatal cover – additional 3 new Clinical recruits, (long term staff grade locums)	**February 2022 Update** Funding was received in 2022 to increase Neonatal Nurse staffing and to support the Advance Neonatal Nurse recruitment **October 2022 Update.** Funding received from CCR to support the recruitment for an additional ANNP post. WWL will utilise any underspend to cover locum/agency gaps to help

Last Updated October 2023 CS

NWNODN Workforce Action Plan (2021/Year 3 with 2022/Year 4)
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			will take 2 years until completion.	WWL Example Template Action Plan **October 2023 Update** Rota review currently being undertaken to include in-post ANNP to provide night cover alongside additional Clinical Fellows posts. Current Deanery trainee allocation is predominantly GP trainees who cannot provide cover for NNU Outline Business Case ANNP V03 13.0		these will fill the Gaps from shortfall in allocated trainees and will allow for 1 SHO covering neonates 9 am to 9 pm weekdays and weekend and deliveries out of hours. Awaiting notification of places on January 2024 ANNP course for 2 existing members of staff as not been able to recruit to the fully funded ANNP post despite being out to	with safety until the additional ANNP post is recruited to. Overnight cover – there remains a shortfall as only one Tier 1 SHO covering both neonates and paediatrics. **October 2023 Update** Outline Business case completed to fund ANNP training and therefore increase the level of cover by an addition 2 x ANNP (Band 8a) to ensure compliance with a Tier 1 Rota 24/7 to cover the Neonatal Unit . Places requested for ANNP course for 2024

NWNODN Workforce Action Plan (2021/Year 3 with 2022/Year 4)
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						recruitment several times	

November 2023 Update
2 training places secured, and Interviews will take place w/c 27/11/23 for January 2024 start date

Rota cover improved with dedicated SHO covering 9-9 7 days per week. Existing ANNP also able to cover some weekend or night shifts as duties allow, once trained (12 months) additional 2 ANNP will be able to provide a more robust rota cover. Rota templates have been developed which will require approval which are inclusive of ACP (to free up Rainbow Ward SHO to cover neonates) and ANNP.