Board of Directors - Public Meeting

Wed 07 February 2024, 14:00 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

14:00 - 14:01
1 min

15. Declarations of Interest

Information *Mark Jones*

Verbal item

14:01 - 14:03
2 min

16. Minutes of Previous Meeting

Approval *Mark Jones*

16.Minutes_Board of Directors - Public meeting_061223.pdf (8 pages)
16a. Public Board Action Log - Dec 2023.pdf (1 pages)

14:03 - 14:18
15 min

17. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

14:18 - 14:33
15 min

18. Chief Executive's report

Information *Mary Fleming*

18. Board Report CEO Feb 2024_FINAL.pdf (3 pages)

14:33 - 14:48
15 min

19. Balanced Scorecard

Information *Abdul Ashish / Kevin Parker-Evans/Juliette Tait/Clare Wannell*

19. M9 Board of Directors Balanced Scorecard Report FINAL.pdf (6 pages)

14:48 - 15:03
15 min

20. System partnerships report

Information *Richard Mundon*

20. Partnerships Report 070224.pdf (5 pages)

15:03 - 15:13
10 min

21. Finance Report

Information

21. Trust Financial Report 23-24 December Month 9 Board.pdf (11 pages)

21.1. 2024/25 financial plan update

15:13 - 15:28
15 min

22. Maternity Reports

Information *Kevin Parker-Evans*

22.1. Outlying metrics report

- 22.1. Outlying Metrics Report final.pdf (97 pages)

22.2. Perinatal Quality Surveillance dashboard

- 22.2. Maternity Perinatal Quality Surveillance Q3 (For Board).pdf (25 pages)
- 22.2a. January 2024 - Perinatal Monthly Surveillance Dashboard.pdf (3 pages)

15:28 - 15:58
30 min

23. Committee chairs' reports

Information *Non Executive Directors*

23.1. Finance and Performance

Information *Julie Gill*

- AAA F&P - Jan 2024.pdf (2 pages)

23.2. Quality and Safety

Information *Francine Thorpe*

- AAAQ&Sdec23.pdf (2 pages)
- 23.2 AAAQ&Sjan24.pdf (2 pages)

23.3. Research

Information *Clare Austin*

- 23.3 AAA - Research - Dec 2023.pdf (2 pages)

15:58 - 16:03
5 min

24. Board assurance framework

Discussion *Paul Howard*

- 24. BAF Report Board February 2024 v2.pdf (28 pages)

16:03 - 16:08
5 min

25. Resolution - Delegation of authority to approve year-end documents

Decision *Paul Howard*

- 25. Report - Delegation of authority to approve year-end documents.pdf (2 pages)

16:08 - 16:13
5 min

26. Risk appetite statement FY2024/25

Approval *Paul Howard*

- 26. Risk Appetite 24-25.pdf (17 pages)

Consent Agenda

16:13 - 16:13
0 min

27. Safeguarding annual report

Information

- 27. Safeguarding Annual Report 2022 2023 Board of Directors Feb 2024.pdf (25 pages)
- 27. WWLTH CIC Annual report 2022-2023 for Board of Directors Feb 2024.pdf (22 pages)

16:13 - 16:13
0 min

28. Maternity dashboards

Information

- 28. Maternity Dashboard report Dec 23.pdf (7 pages)
- 28a. Maternity and Neonatal Safety Dashboard December 2023.pdf (3 pages)

16:13 - 16:13
0 min

29. Guardian of Safe working hours

Information

- 29. GOSWH Wrightington Wigan and Leigh Teaching Hospitals Trust April to June 2023 Quarterly Report.pdf (8 pages)
- 29a. GOWSH Quarterly Report April to June 2023.pdf (11 pages)
- 29b. GOSWH Quarter 2 Report July to Sept 2023.pdf (8 pages)
- 29c.GOWSH Quarterly Report 2 July to Sept 2023.pdf (11 pages)

16:13 - 16:13
0 min

30. Freedom to Speak up Guardian's report

Information

- 30. FTSU ETM Report 110124.pdf (2 pages)

16:13 - 16:13
0 min

31. Review of statutory and mandatory posts

Information

- 31. Statutory, mandatory and recommended posts - Feb 2024.pdf (10 pages)

16:13 - 16:13
0 min

32. Date, time and venue of the next meeting

Information

03 April 2024, 1:15pm Boardroom, Trust HQ

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

Attendees

Board members

Mark Jones (Chair), 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), Ian Haythornthwaite (Non-Executive Director), Paul Howard (Director of Corporate Affairs), Lynne Lobley (Non-Executive Director), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Mary Moore (Non-Executive Director), Richard Mundon (Director of Strategy and Planning), Silas Nicholls (Chief Executive), Juliette Tait (Chief People Officer), Francine Thorpe (Non-Executive Director), Rabina Tindale (Chief Nurse)

Absent: Sanjay Arya (Medical Director)

In attendance

Member of the public, Nina Guymer (Deputy Company Secretary (Minutes)), Cathy Stanford (Divisional Director of Midwifery and Neonates), Christos Zipitis (Divisional Director of Medicine for Surgery)

Meeting minutes

13. Declarations of Interest

Information

No declarations of interest were made.

Mark Jones

14. Minutes of Previous Meeting

Approval

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

Mark Jones

14. Minutes_Board of Directors - Public Meeting_04 10 23.pdf
14a. Public Board Action Log - Oct 2023.pdf

15. Chair's Opening remarks

Information

Mark Jones

The Chair began by noting that this meeting would be the last meeting for Ms R Tindale, Chief Nurse and Mr S Nicholls, Chief Executive, who would both soon be leaving their post at WWL. He expressed thanks to them both on behalf of the Board for all that they have achieved during their time at WWL and went on to summarised the interim arrangements for filling their positions. Arrangements for filling two of the resulting interim posts had begun by way of handover, being the Deputy Chief Executive acting as the Interim Chief Executive and that the Director of Operations for Surgery acting as the Interim Chief Operating Officer. He fed back positively on the work which both individuals had done in these roles thus far. He went on to explain that the Interim Chief Nurse position had just been filled by Mr K Parker-Evans, who brings a strong track record and a wealth of experience with him to WWL.

He went on to thank Dr T Hankin, WWL's outgoing Non Executive Director who had worked with the Trust for the pervious six months, welcoming Ms M Moore who would be filling this seat on a full term basis.

The Board received the update positively.

16. Chief Executive's report

Information

Silas Nicholls

The Chief Executive presented the report which had been shared in advance of the meeting. He acknowledged the current pressures on all staff and services and expressed gratitude for staffs' continued efforts in delivering safe care. He reminded the Board that this would be his final meeting as WWL's Chief Executive and thanked them as a team, as well as WWL's system partners, for the great work which they had done along side one another during his time at there.

The Chair expressed thanks to the Chief Executive on behalf of the Board and the Council of Governors.

16. Board Report_CEO_December_2023 FINAL.pdf

17. Committee chairs' reports

Information

Non Executive Directors

The Non-Executives presented their respective papers which had been shared in advance of the meeting.

17.1. Finance and Performance

Information

Julie Gill

The Chair added that there is currently a strong focus on finance across the organisation, particularly in relation to recent changes in the Trusts' governance structure to support financial grip and control and reporting to the regular meeting with the Greater Manchester Integrated Care Board (GM ICB) and consultant firm PwC.

AAA F&P - Nov 2023.pdf

17.2. People

Information

Lynne Lobley

Mr L Lobley as People Committee chair added that moving forwards, the people dashboard will provide a more divisional focus on the metrics reported upon.

The Chief People Officer advised that the main cultural development actions are proposed through the Workforce Race Equality Standards (WRES) report and the Workforce Disability Equality Standards (WDES) reports, being firstly signing up to the antiracism framework and secondly signing up to the Disability Confident Scheme.

The Board was in support of these initiatives.

The Chair recalled a recent meeting between himself and Mrs L Lobley who also holds the role of Deputy Chair, to consider how equality, diversity and inclusion (ED&I) can be ensured within WWL's Council of Governors and emphasised the importance of utilising any framework or approach agreed by the Board with the Council of Governors too. He noted the upcoming January board away day and that it would facilitate a develop session focussed on ED&I. The Board agreed upon the importance of ensuring that gender is weighted as equally as race and disability.

17.2. AAA People - November 23.pdf

17.3. Audit

Information

Ian Haythornthwaite

In response to the Chair's request for further detail around the arrangements for WWL's Freedom to Speak Up (FTSU) Guardian moving forwards, the Chief People Officer explained that, given the lack of success in WWL recruiting their own guardian, the organisation would be contracting to utilise an FTSU Guardian from NHS GM's FTSU service. The Board appreciated that this would not only emphasise the independence of the role but would also provide cover for WWL during periods of absence, since there are several guardians working within the service.

The Chair noted that himself, the Chief Executive and Prof C Austin, as the Non-Executive Director with oversight of FTSU arrangements, would like to review the arrangements and provide their views on the same prior to the service going live.

17.3 AAA - Audit Committee - 15 Nov 2023.pdf

17.4. Quality and Safety

Information

Francine Thorpe

In response to a query from the Chair on progress with work at the Sterile Services Decontamination Unit, Mrs F Thorpe confirmed that the specialist services division had been asked to provide an update on the issue with surgical equipment packs at the next Quality and Safety Committee (Q&S) meeting the following week but that, through the division's update to the Finance and Performance Committee, she was aware that they are working towards a solution.

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

17.4. AAAQSOct23.pdf

18. Board assurance framework

Discussion

Paul Howard

The Director of Corporate Affairs summarised the reported which had been shared prior to the meeting.

In respect of 'Patients', Mrs F Thorpe noted that she took assurance from the document, in terms of the improvements made in sepsis and other patients metrics, per what the Q&S Committee has seen through its papers.

Lady R Bradley asked how 'preferred place of death' is linked in to other related patient metrics, such as duty of candour.

The Director of Corporate Affairs advised that the risk to delivery of this corporate objective has now been escalated up from the Risk Management Group to sit on the board assurance framework itself and that now that this has happened, the process for review will be followed. A discussion ensued around how wide reaching this objective is and that it can be affected by so many different variables and parties involved in a patient's care.

In respect of 'Partnerships' the Chair noted the Board's previous discussion around the work that the Trust is doing with operational improvement firm, Newton Europe, which is a system led approach to change. He observed that the related report which had been reviewed within the private session, highlighted that the area which staff are most concerned about is communication and working between WWL and its system partners, he asked therefore whether this should be reflected in the revised set of corporate objectives for 2024/25.

The Director of Strategy and Planning advised that this is accounted for within the new draft and it is hoped that the three year financial strategy plan for the GM system, set out under the guidance of financial services firm PwC and due to be shared in 2024, will strengthen this moving forwards.

The Chair advised that he would be inviting Rochdale Care Organisation to one of the Board's upcoming workshops, to present their approaches to integrated and partnership working, following his and the Chief Finance Officer's positive feedback in this area on a recent visit there.

The Director of Corporate Affairs added that it is positive that the risk in respect of the 'Partnerships ' corporate objective is within tolerable range.

Mrs L Lobley asked whether there is an ICB assurance framework (BAF), which outlines risks at system level and those which cross over between Trusts and the ICB.

The Director of Corporate Affairs advised that WWL are working with place based partners to develop a local BAF and that a placed based risk register is being developed, with both documents currently in draft.

The Board received and noted the updates provided.

18. BAF Report Board December 2023.pdf

19. University teaching hospital update

Discussion

Richard Mundon

The Director of Strategy and Planning summarised the paper which had been shared prior to the meeting. In respect of the two outstanding University Hospital criteria, he was pleased to advise that WWL have now secured the relevant amount of research capability funding, being over £200k and that the organisation is confident that the requirement around the core number of university principle investigators will be met in 2024.

The Chair noted the significant amount of benefits which the organisation will have as a result of being a University Hospital, with the Chief Executive adding that ultimately, these will result in better outcomes for patients.

The Chair queried plans which were soon to be put forward in respect of facilitating additional car parking for staff.

The Chief Finance Officer advised that this had been delayed due to the suspension of several council planning committees recently and that, following initial discussion at the informal Non-Executive Directors' meeting in December, it is hoped that a proposal is able to be presented at the Finance and Performance Committee meeting in January 2024.

The Board received and noted the paper provided.

19. University Hospital Status AAA November 2023.pdf

20. Biannual staffing review

Decision

Rabina Tindale

The Chief Nurse presented the report, which had been shared in advance of the meeting.

Mrs F Thorpe noted that if WWL and its local system are to truly move to a model which focusses on community care and treating patients away from the acute site, more focus must be given to the staff that will work in these areas and how they will be supported.

The Chief Nurse advised the Board of a tool which is due to be released soon which will assess nurse staffing levels and aid reporting on safe staffing. The Chief People Officer added that she is aware of a tool which can identify additional, non-nursing, staff groups to ensure that the full model of care is considered.

The Board received and noted the paper provided.

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

21. Maternity

The Chief Nurse introduced the item, noting that if the Board feel that further assurance is required in respect of any of the papers provided, that these can be reconsidered and brought back for deferred sign off.

The Divisional Director of Midwifery and Neonates summarised the papers provided and advised that the local maternity and neonatal system (LMNS) are content that WWL are compliant with all of the 10 standards required.

Mrs F Thorpe noted the link with the board safety champions and that these individuals meet regularly with the Divisional Director of Midwifery and Neonates, who has conducted a number of walkabouts across the maternity wards with them. She affirmed that the information in the reports is reflective of what they had seen whilst visiting the wards.

Lady R Bradley noted the high level of assurance within the report, versus the recent negative publicity around maternity services and suggested that, to increase public confidence in maternity services, more of these positive messages are shared. Although no negative feedback had been observed around WWLs services specifically, the Board agreed that once the position is confirmed around February 2024, this could be considered and the power of the patient perspective was noted.

The Chief Nurse advised that there this is picked up through the ASPIRE programme, which will rate the maternity ward as it does with all wards but agreed that in antenatal and outpatient clinics it may be helpful for patients to be provided with more direct assurance.

The Chair noted the positive progress made across WWL's maternity services.

The Board **AGREED** to declare compliance against the 10 safety actions, as set out in the five year maternity incentive scheme, once members had received the January 2024 virtual update and on the condition that there were no concerns raised at that point. It was noted that virtual approval would be sought from Board members in this regard.

21.1. CNST presentation

Cathy Stanford

21.1. CNST BOARD REPORT UPDATE DECEMBER 2023.pdf

21.2. Maternity incentives scheme

21.2. Maternity Incentive Scheme Year 5 update report Dec 2023.pdf

21.3. Bi-annual maternity staffing

21.3. Maternity Staffing Paper November 2023.pdf

21.4. Board declaration form

21.4. MIS_SafetyAction_2024_V8.pdf

22. Finance Report

Information

The Chief Finance Officer presented the paper which had been shared prior to the meeting. She highlighted that the £12m deficit forecast outturn is now £10.7m and that this is a technical adjustment, with no resulting change to activity or services. She highlighted that the local authority had been supportive in terms of bringing forwards the date on which they make payments to the Trust, since they are unable to earn interest on funds, allowing WWL to now benefit from any additional interest earned as a result.

Mrs F Thorpe asked whether trusts will move back to a payment by results regime for both elective and non-elective cases.

The Chief Finance Officer explained that she could not advise definitively but that the WWL have not returned to completing the same level work which would have been done before the pandemic, highlighting an underperformance of £5m, driven by the reduced activity during the periods of industrial action.

The Deputy Chief Executive expressed thanks to the divisional teams for their work done to improve the financial position, as illustrated by the report.

Mrs L Lobley asked what, aside from strikes, has impacted on WWL's activity.

The Deputy Chief Executive advised that the ongoing high occupancy rates and inability to discharge at the required rate has resulted in areas being escalated for prolonged periods, coupled with staff shortages and the need to reallocate staff roles to accommodate this position, activity has been negatively impacted.

Mr I Haythornthwaite noted the potential for the system to ask WWL to achieve more as a result of these positive achievements. The Board agreed that a strong stance must be taken should this happen and that although the Trust would not be unwilling to help and will endeavour to increase activity, it would be unable to expose itself to any risk associated with this, through commitment to revised targets, or otherwise.

The Board received and noted the paper provided.

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

23. Balanced scorecard

Information

Christos Zipitis/Juliette Tait/Mary Fleming/ Rabina Tindale

WWL's Executive Directors presented their corresponding quadrants of the scorecard, which had been shared in advance of the meeting.

Mr I Haythornthwaite asked for further information around the issues with rate card adherence.

The Chief People Officer advised that this is monitored through the divisional assurance meetings and that most issues with higher rates being requested and/or paid are seen in the medical division. WWL will now amend its rate card to bring this in line with GM. She further described that a piece of work will be carried out to feed back to consultants who have refused to work should they not be paid above the rate, where their actions and response will be reviewed in line with their code of practice.

The Chief Finance Officer confirmed that guidance received from the ICB is that a hard line is to be taken on this and that organisations should not negotiate in this regard.

The Chief Executive provided an anecdote of his recent experience on call, where a senior manager described to him how they had pushed back where a doctor was asking to be paid above rate and sought his agreement to refuse to pay this. He noted that this would not have happened prior to the new approach being rolled out and felt that this may be showing how well the approach has been embedded.

The Divisional Director of Medicine for Surgery was clear that in some services such as paediatrics, there is a lack of opportunity for cross cover and in those cases the decision making can not follow the same process.

Mrs F Thorpe asked whether the potential risk around right care, right person had been picked up by WWL and the Deputy Chief Executive confirmed that this was the case.

The Board received and noted the paper provided.

23. M7 Board of Directors Balanced Scorecard Report FINAL.pdf

24. EPRR (emergency preparedness resilience and response) core standards

Approval

Mary Fleming

The Deputy Chief Executive presented the report, noting that the percentage is lower than it has been historically due to the increase focus on EPRR training, which many colleagues have failed due to a change in standards following the pandemic. She agreed to make sure that plans are in place to improve training and to monitor the plan with the incoming Interim Chief Operating Officer. Further assurance would be provided in a report which would be presented to the Board at the end of the following year.

The Board received and noted the paper provided.

24. EPRR Core Standards Board Report 2023.pdf

Consent Agenda

25.

The Board having agreed in advance to the following items appearing on the consent agenda, **RESOLVED** as follows:

26. Equality, diversity and inclusion annual report

Information

THAT the report be **APPROVED**.

26. EDI Annual Report 2022-23.pdf

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

Information

THAT the reports be **APPROVED** along with the associated draft action plans.

The Board supported and acknowledged the ongoing work on assessment frameworks for the North West BAME Assembly Anti-Racist Framework and Disability Confident Scheme, to address deeper inequalities highlighted by the WRES and WDES data.

27. People Committee WRES and WDES Report Nov 2023.pdf

27.1. Workforce Race Equality Standard - Action plan

Endorsement

27.1 Draft WRES Action Plan 2023 until Board approval with success indicators.pdf

Juliette Tait

27.2. Workforce Disability Equality Standard - Action plan

Endorsement

27.2 Draft WDES Action Plan 2023 until Board approval with success indicators.pdf

Juliette Tait

28. Committee effectiveness review findings

Endorsement

Nina Guymer

THAT the recommendations be **ENDORSED**.

28. Board report - Committee Effectiveness Review - findings and recommendations.pdf

29. Maternity Dashboards and Neonatal action plan

Information

THAT the dashboards and action plan be received and **ENDORSED**.

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

30. Date, time and venue of the next meeting

Information

Wednesday 7 February 2024, 12:15 to 4:15pm, Boardroom, Trust HQ

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.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	07/02/2024
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

At the beginning of January, I assumed the role of Chief Executive for an interim period, and I am immensely proud and honoured to lead this organisation through what is an intense and pressured time for our services across the community and within our hospitals. I want to thank all colleagues for their relentless commitment to our patients and each other as they continue to meet the service demands through delivering compassionate and safe care. There is a real opportunity in 2024 to make good progress towards our improvement goals that are focused on patient safety and quality, operational standards, staff experience, inclusion and financial sustainability.

As I take on this new role, I also welcome Claire Wannell as Interim Chief Operating Officer and Kevin Parker-Evans to the Interim Chief Nurse role. Claire brings a huge amount of knowledge and understanding to the role, she is an experienced NHS Leader, working across a number of portfolio areas during her time at WWL, including Human Resources, Transformation and Operational leadership. Kevin joins us from Tameside and Glossop Integrated Care NHS Foundation Trust and brings with him a passion to develop Nursing, Midwifery and Allied Health Professional teams to be able to lead on the delivery of excellent patient and service user care.

The first week of January is always busy but coupled with the longer period of industrial action carried out by Junior Doctors and the seasonal bank holidays, staff worked extremely hard to deal with the extraordinary pressures and challenges we faced. There were high attendances with patients of high acuity across our Urgent and Emergency Care services, which regretfully meant that our patients have experienced longer waits than any of us would want. At WWL we truly believe the best place for our patients to continue their recovery is in the place they call home. Unfortunately, while we aim to get our patients safely back home, 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. I would like to assure the public that we are continuing to actively work with our system partners on improvement plans to enable better flow within our hospitals and improving discharges out of hospital, working towards a “Home First” approach for our patients when safe to do so. Some of this intense improvement work is in collaboration with our system partners and the Emergency Care and Improvement Support Team.

Over the festive period we were delighted to be supported by a number of organisations and individuals who helped to bring seasonal cheer across our services. It was great to welcome players from Wigan Warriors Rugby League Club and Wigan Athletic Football Club, who brought presents to patients on our Paediatric Rainbow Ward at the Royal Albert Edward Infirmary (RAEI). Patients and staff on Rainbow Ward were also entertained by ‘Starlight Pantomime’ with a performance of Aladdin and received a visit from the Grinch, Cindy Lou and Mother Christmas as well as therapy dog, Mabel. Rainbow Ward also benefitted from donations from local businesses such as ASDA Warehouse, Aykroyds and Fairy Bricks. Staff and patients at the Jean Heyes Unit at Leigh Infirmary were pleased to welcome Manchester United’s Women’s Academy players for some board and festive games.

As we look ahead into 2024, it’s a time for change on our sites, as we have been given the green light and are continuing to progress on a number of planning projects. I am delighted that a few months ago we started to see the first patients at our Community Diagnostic Centre (CDC) at Leigh Infirmary. Recently we saw our first Cardiology patient be treated on the site and feedback from both the patient and colleagues was incredibly positive. Moving forward I am very much looking forward to seeing more and more of our patients receiving care at the state-of-the-art CDC as more of its new facilities continue to be completed alongside the new laminar flow theatre over the next few weeks. I am really pleased to see Leigh Infirmary developing and having a crucial role to play in the future of our services in particular, as it will also soon be the new home for breast surgery.

Other great news is that we have recently been granted funding to start construction on a new four-storey extension to our Endoscopy Unit at our RAEI site, as well as investment into endoscopy services at Leigh Infirmary, increasing the number of endoscopy rooms at the site from three to six. This is a great piece of news for the Trust and will help us to improve waiting times for our patients.

Endoscopy is an important diagnostic procedure, and this investment will support earlier diagnosis of conditions, including bowel cancer, as well as other gastrointestinal diseases, through providing quicker access to endoscopy procedures, leading to better outcomes for patients.

There have been many awards and nominations over the past few months, and congratulations must be sent to all of the teams and colleagues who are being recognised for their hard work and commitment to achieving such success. A number of colleagues have been shortlisted for categories at this year's Celebrating Forces Families Awards. The Patient Experience Team have been nominated in the Public Service Award category in recognition of their work with members of the Armed Forces, Veterans and their families. Leanne Cobham, Armed Forces Healthcare Lead and Interim Lead for Patient Experience and Engagement, has been nominated in the Armed Forces Advocate of the Year alongside colleague and Armed Forces Healthcare Navigator, Joanne Lee. Leanne has also been nominated for Social Media Influencer of the Year. WWL is incredibly proud of Leanne, Joanne and all those involved in helping to provide an incredible standard of care for our Armed Forces Community. Their work has helped WWL to maintain our Gold Standard, Forces-Friendly employer status as a Veteran Aware Trust and a member of the Veterans Covenant Hospital Alliance.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

M9 Balanced Scorecard

Board of Directors Meeting

7 February 24

M9 Scorecard

Quality and Safety (Chief Nurse & Medical Director)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
SHMI Rolling 12 Months	Sep-23	106.24	100			106.24
HSMR Rolling 12 months	Oct-23	89.27	100			89.27
Never Events	Dec-23	0	0			2
Number of Serious Incidents	Dec-23	5	10			66
STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers	Dec-23	1	0			9
STEIS Reportable Serious Falls	Dec-23	0	0			0
Methicillin-Resistant Staphylococcus Aureus (MRSA)	Dec-23	0	0			0
Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Dec-23	1	0			10
Clostridium Difficile (CDT)	Dec-23	3	4			41
Complaints Responses	Dec-23	81.5%	85%			72.91%
Patient Experience (FFT)	Dec-23	79.6%	N/A	N/A		88.71%

Performance (Chief Operating Officer)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Ambulance handovers 60+ minutes delay	Dec-23	346	0			1,152
Reduce 12-hour waits in EDs	Dec-23	17.3%	10%			15.15%
A&E waiting times : patients seen within 4 hours	Dec-23	67.58%	75.04%			69.10%
G&A Bed Occupancy - Acute Adult Inpatient Wards	Dec-23	97.42%	94%			98.44%
85% Paediatric Bed Occupancy	Dec-23	59.97%	85%			54.60%
85% Critical Care Bed occupancy for Adults and Children	Dec-23	48.03%	85%			58.50%
Virtual ward patients	In Dev.					
No Right to Reside Patients (excluding Discharges)	Dec-23	135	50			135
Cancer - waits longer than 62 days	Dec-23	76	35			76
Patients waiting over 78 weeks (except patient choice and clinically complex)	Dec-23	1	0			1
Total patients waiting over 65 weeks (except patient choice and clinically complex)	Dec-23	1,241	130			1,241
Reduce waits of over 52 weeks by 50% by March 2024	Dec-23	4,071	1,540			4,071
Percentage of patients waiting less than 6 weeks for diagnostic tests	Dec-23	61.85%	87%			61.85%
Diagnostic activity compared to 19/20 levels	Dec-23	14,316	14,860			133,721
Meet the cancer faster diagnosis standard by March 2024	Nov-23	82.00%	67.5%			79.45%
Reduction in outpatient follow-ups	Dec-23	18,589	15,104			18,589
Day case rate	Dec-23	82.31%	84%			83.91%
Elective Theatre Utilisation	Dec-23	88.03%	85%			83.95%
Elective Recovery Plan	Dec-23	93.72%	100%			94.69%
2-hour urgent community response	Nov-23	80.00%	70%			76.29%

People (Chief People Officer)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Leaders Forum reach (Number of Leaders attending the Forum)	Dec-23	89	110			1,218
FTSU contacts	Dec-23	4	-			45
Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog/Blog)	Dec-23	7	6			62
Mandatory training compliance	Dec-23	94.86%	95%			95.64%
Rostering timeliness	Dec-23	56.76%	75%			73.27%
Appraisal	Dec-23	79.08%	90%			80.57%
Rate card adherence (Medical)	Dec-23	45.85%	80%			46.91%
% Turnover Rate	Dec-23	9.08%	10%			9.26%
Vacancy rate	Dec-23	6.32%	5%			5.97%
Sickness - %age time lost	Dec-23	5.59%	5%			5.02%

Finance (Chief Finance Officer)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Cash (£'000s)	Dec-23	16,517	26,724			238,140
Cost Improvement Programme (CIP) (£'000s)	Dec-23	2,060	2,034			18,337
Capital Expenditure (£'000s)	Dec-23	2,220	1,682			16,314
Agency Expenditure (£'000s)	Dec-23	656	1,049			7,243
Better Payment Practice Code (BPPC)	Dec-23	91.98%	95%			93.55%
Agency % of Total Pay	Dec-23	2.18%	3.7%			2.69%
Adjusted Financial Performance (£'000s)	Dec-23	-1,460	-1,513			(8,154)
Surplus /Deficit (£'000s)	Dec-23	-1,477	-1,529			(8,208)

M9 Commentary (Page 1 of 2)

Quality and Safety (Chief Nurse & Medical Director)

Patient Safety

5 incidents were reported to StEIS in month. These related to 1 Pressure ulcer, 2 alleged abuse incidents, 2 delays in diagnosis incidents. A thematic review has been undertaken in relation to alleged abuse incidents and these have shown that improvements could be made in de-escalation at an earlier stage. A task and finish group has developed and begun implementing least restrictive practice training for frontline staff.

Complaints

Compliance with complaint responses increased to 81.48% which higher than previous months. This increases our in year performance and is now close to achievement of the 85% target set by our corporate objectives. Further work continues in education and training of values and behaviours and more complaints are being de escalated at an early stage by quicker communication with the complaint. There are still challenges in responding to complaints due to operational pressures but support is provided by the central complaints team where possible.

People (Chief People Officer)

Through collaborative working between the Division and the Recruitment Team, the average time to hire from vacancy to starting letter has reduced over a 3 month period by 4.5 days – now average of 54.4 days against a target of 65 days.

The 2023 National Staff Survey had a response rate 37%, which is an increase of 2% since 2022 demonstrating higher levels of engagement from staff at WWL. New sub divisional data breakdown will allow to effectively support areas with increased levels of sickness absence and turnover. Socialisation of results will begin from February/March 2024.

At 5.59%, the sickness absence rate in December 2023 remains above the Trust target of 5%. *Further commentary re: December absence to be included.*

Referrals into Staff Psychology Service remain high, however it is typical to see a drop in referrals during holiday periods (28 new referrals in December and inc Xmas period). 15 wellbeing drop in/pitstop sessions provided across divisions and 1 TRiM incident where assessments were offered by TRiM practitioners in ECC. Steps4Wellness team offered a promotional event in December across hospital and community sites providing psycho-education for staff about mental health and wellbeing support available.

There was a slight increase in MSK related absence, with 24 new referrals into MSK Staff Physio Service received in December, with 3 of those staff currently absent from work due to MSK related absence. Staff Physios are working collaboratively with the Steps for Wellness team to provide psycho-education to staff around MSK issues and preventative advice and guidance.

Turnover within divisions has remained stable overall, and continues to be below the Trust target.

There has been a slight reduction in Mandatory Training compliance % which has dropped under the Trust target of 95%. This is partially due to many mandatory training renewal dates taking place between Nov-Jan every year and was also predicted as a result of operational pressures during winter months. Activity is in progress g in collaboration with the Medical Education Team and Staff Experience team to improve compliance rates for Junior Doctors, which are particularly low, and an improvement plan is being developed.

Rate card adherence for Medical Staff remained below the Trust target of 80%, at 46%. Factors which have affected rate card adherence include industrial action and escalated rates in A&E. Improved reporting of rate card adherence is being developed. Weekly establishment control meetings are continuing, which include review and oversight of local pay variations.

M9 Commentary (Page 2 of 2)

Performance (Chief Operating Officer)

Unsheduled Care

A&E wait times and ambulance handover delay metrics deteriorated in month due to significant pressure on urgent care services, exacerbated by periods of industrial action and the various bank holidays over the Christmas period. G&A bed occupancy for December was 97.42%, and on many individual days was over 100%. The Trust has been asked to submit an early indication of ability to reduce bed occupancy to 92% by the end of March 2025 – this has not been signed up to, in recognition of our General and Acute bed base which is the lowest in Greater Manchester by a significant margin.

Paediatric and ICU bed occupancy remains on target, although ICU occupancy increased towards the end of the month and into January which will be reflected in Jan performance data.

The NRTR list appears to have increased significantly – this is partly due to a lack of discharges into residential and care homes over the Christmas period, and partly due to a change in recording of General and Acute beds requested by GM ICB which means that 24 beds on the Jean Heyes Reablement Unit are temporarily included within this figure and should be disregarded for monitoring purposes. The NRTR figure at the time of writing was 95. Daily discharge calls led at Deputy Chief Nurse / AHP level are ongoing to further reduce this number.

Scheduled Care

There was one 78 week breach in month which did not relate to patient choice or significant complexity – the patient was dated in month and had their surgery cancelled on the day due to bed pressures/staff sickness and has since been treated in January. Both 52 and 65 week waits improved in month. Patients on a cancer pathway waiting 62 days or more for treatment or step down increased in December, this was due to a combination of industrial action and Christmas annual leave impact on capacity, including MDT capacity. Divisions are working collaboratively on recovering this position and returning to plan by year end. We continue to meet the cancer faster diagnosis standard.

Elective theatre utilisation was above target in December for sessions that were utilised, however, industrial action and annual leave impacted the number of sessions utilised, resulting in reduced activity – more positively, once the impact of industrial action was accounted for, T&O returned to elective activity plan for the first time this financial year. We continued to perform above target for urgent community response times.

Finance (Chief Finance Officer)

Surplus/Deficit

The Trust reported an actual surplus of £1.5m in month 9 (December 2023), which is a favourable variance of £0.1m to the plan. Year to date, the Trust is reporting an actual deficit of £8.2m which is £3.8m adverse to plan.

Adjusted Financial Performance

The adjusted financial performance is a surplus of £1.5m which is £0.1m favourable to the plan.

Agency Expenditure

Agency expenditure is £0.7m in month 9. Year to date, agency spend is £7.2m which is £2.2m favourable to plan.

Agency % of Total Pay

The Trust is operating within the agency ceiling with agency representing 2.7% of the total pay bill year to date (compared to the ceiling of 3.7%).

Capital Expenditure

Capital expenditure against internal CDEL was £0.8m in month 9 which is £0.3m above plan. Year to date, capital expenditure is £2.0m below the internal CDEL plan. This is primarily due to Community Diagnostic Centre (CDC) and Leigh Laminar Flow Theatre being underspent against the original NHS Plan.

Cash

Cash is £16.5m at the end of month 9 which is £10.2m below plan. Cash has decreased by £3.2m 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 12 days at the end of November compared to 16 at the end of October.

Cost Improvement Programme (CIP)

In month 9, £2.1m CIP has been delivered which is on plan. CIP delivery remains on plan year to date due to non-recurrent measures put in place.

Better Payment Practice Code (BPPC)

BPPC for month 9 is 91.98% and 93.55% year to date. An action plan is in place to improve the BPPC to the target of 95.0%.

Holistic narrative

Triangulated Holistic Narrative

- Infection outbreaks (Norovirus and Flu (Strain A&B)) have led to the closure of a number of wards and capacity. This has had an operational impact on the number of patients within the Emergency Department awaiting beds and the length of time they are waiting within the ED to get admitted. Due to the nature of testing for Norovirus we have seen a small increase in the number of Clostridium Difficle cases being reported, which have been incidental findings associated with testing. The IPC outbreaks have seen an increase in staff absence and so increased reliance on temporary staffing towards the end of December ’23.
- Despite the operational pressures within the Emergency Department, the number of moderate and above harms within the Department has remained low. There have been no direct complaints associated with any of the escalation capacity during December to time. Executive presence within the ED has been well recognised and welcomed by the teams during the heightened pressures. The Interim Chief Nurse has introduced a Back to the Floor Walkaround every Friday that all of the NMALT team will participate in visiting wards and Departments.
- Junior Doctor Strike action commenced on the 20th December 2023 until the 23rd December 2023. The trust managed the strikes effectively despite both the operational and seasonal IPC pressures it was managing. SHMI and HSMR both saw further improvement in Month 9 and Never events and serious incidents reduced. Whilst there was slight increase in sickness in December no Industrial action trends were noted.

Change log

Ref	Metric	Change	Date	Requested by:
23/24 30	People metrics, 3 Your Voice metrics: Engagement; Psychological Safety; Well Being and Usefulness of Trust Wide Communication	Data no longer available; metrics removed	05/01/2024	Chief People Officer
23/24 29	Percentage of patients waiting less than 6 weeks for diagnostic tests	Changed the wording from 'Number of diagnostics received completed	17/11/2023	DAA
23/24 28	Clostridium Difficile (CDT)	Added an in month threshold in line with 23/24 agreed threshold	17/11/2023	DAA
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 26	All	Added sparklines for 6 months to show trends	18/09/2023	Executives
23/24 25	All	Change the format of the report from Word to PowerPoint	18/09/2023	DAA
23/24 24	All	Improve the visualisation of the report	19/07/2023	Executives
23/24 23	Change order of Quality & Safety metrics	Re-order metrics	03/07/2023	Medical Director
23/24 22	Sepsis - Screening and Antibiotic Treatment (In Dev.)	Remove metric	03/07/2023	Medical Director
23/24 21	2 hour urgent community response	Metric added	13/04/2023	Deputy Chief Executive
23/24 20	Day case rate	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 18	Meet the cancer faster diagnosis standard	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 16	Number of diagnostics received completed within 6 weeks	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 14	Patients waiting over 52+ weeks by 50% by Mar 24	Add metric	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 12	85% Critical Care bed occupancy for Adults and Children	Metric added	13/04/2023	Deputy Chief Executive
23/24 11	85% Paediatric Bed Occupancy	Metric added	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 09	Total Waiting List - RTT position	Remove metric	13/04/2023	Deputy Chief Executive
23/24 08	Virtual Outpatient Consultations	Remove metric	13/04/2023	Deputy Chief Executive
23/24 07	Outpatient DNA rates	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 05	Patients waiting over 104+ weeks (except patient choice or clinically complex)	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 03	Ambulance Handovers under 15 minutes	Remove metric	13/04/2023	Deputy Chief Executive
23/24 02	Ambulance Handovers under 30 minutes	Remove metric	13/04/2023	Deputy Chief Executive
23/24 01	Sickness Absence	Change target from 4% to 5%	22/05/2023	Deputy Chief People Officer

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Partnerships Report
Presented to:	Board of Directors
On:	7th February 2024
Presented by:	Richard Mundon, Director of Strategy and Planning
Prepared by:	Chris Clark, Director of Strategic Transformation
Contact details:	Email: chris.clark@wwl.nhs.uk

Executive summary

The latest version of the NHS Foundation Trust Code of Governance (published in April 2023) requires Trust to work effectively with our system partners and identifies a number of specific responsibilities for Trust Boards.

This report provides Trust Board with an overview of the Code of Governance principles which relate to system partnerships and an update on the work the Trust is doing in support of these.

Link to strategy
Working effectively with our partners across the Wigan Locality, Greater Manchester and beyond is identified as a key part of *Our Strategy 2030*.

Risks associated with this report and proposed mitigations
No specific risks linked to this report. Risk to partnerships included within the Board Assurance Framework (see PR12)

Financial implications
No financial implications to this report.

Legal implications
No financial implications to this report.

People implications
No financial implications to this report.

Wider implications
None noted.

Recommendation
The Board of Directors are requested to note this report.

Background

The latest version of the NHS Foundation Trust Code of Governance (published in April 2023) highlighted an expectation that "*providers will work effectively on all issues, including those that may be contentious for the organisation and system partners, rather than focusing only on those issues for which there is already a clear way forward or which are perceived to benefit their organisation. The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver high quality care and effective use of resources*"[1].

This update to the code reflects the establishment of Integrated Care Systems (ICSs) on a statutory footing. Each ICS now has: an Integrate Care Board (ICB) which bring NHS bodies together locally to improve population health and care and manage the financial allocation; an Integrated Care Partnership (ICP) which is statutory joint committee of the ICB and upper tier local authorities, with a focus on improving the care health and wellbeing of the population. The ICP and ICB, along with place-based partnerships (such as our Healthier Wigan Partnership) and provider collaboratives, are tasked with bringing together all partners within an ICS.

The principles underpinning the new code has several elements that relate directly to the need to work in partnership as shown in the table below.

Table 1 – Code of Governance Principles

1.1	Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust ***as part of the ICS and wider healthcare system in England***, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public.
1.2	The board of directors should establish the trust's vision, values and strategy, ***ensuring alignment with the ICP's integrated care strategy*** and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture.
1.3	The board of directors should give ***particular attention to the trust's role in reducing health inequalities in access, experience and outcomes***.
1.4	The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the ***trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners***, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions
1.5	For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and ***encourage collaborative working at all levels with system partners.***
1.6	The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.

This report provides a summary of the key ways in which we are seeking to work effectively as a system partner, specifically across Greater Manchester (GM) and the Wigan Locality.

Alignment of Strategy

[1] NHS Foundation Trust Code of Governance – Paragraph 2.3

As part of developing the Our Strategy 2030, the Trust engaged widely with partners across the Wigan locality and well as considering strategies at a Greater Manchester level. Delivery of the Trust's strategy is then focussed on an annual basis as part of the corporate objective setting and supporting divisional plans. In addition to Our Strategy 2030, several other drivers are considered as part of setting the annual corporate objectives including: changes in national planning guidance and/or expectations; and any new partnership strategies as they emerge. An example of this is the inclusion of the objectives in 2023/24 on: developing effective partnerships within the new statutory environment (Corporate Objective 14); and improving the health and wellbeing of the population we serve (Corporate Objective 15 within the objectives for 2023/24. Risks to achievement of these objectives are monitored through the Board Assurance Framework (BAF) with updates on Trust Board brought biannually.

Participation in NHS Greater Manchester ICB

All executive directors play an active role in their relevant sub-group or network across GM, as well as the GM wide programme boards such as Elective Recovery and Sustainable Services, which track system wide actions against priority areas.

Several of the Executive Team have key roles within the GM Trust Provider Collaborative including the Trust Provider Collaborative Director of Strategy and Planning who chairs the GM Directors of Strategy group, which help to shape the system response to challenges and develop future plans. Recently a GM Commissioning Oversight Group has been established, which we are represented at. The purpose of this group is to make recommendations on proposed NHS GM commissioning decisions. It will do this by undertaking a systematic assessment of services against an agreed set of outcome, efficiency, effectiveness and quality measures to determine which services must be maintained, those which need review and potentially transformed to a different delivery model and those which could be considered for disinvestment as no longer affordable or core to the NHS GM vision and aims. Inputs to the group will be from Place, Providers, Pan GM Functions and System Boards.

The Trust is an active participation in the GM planning group forums which convene to oversee the development of the system plan and ensure that as we develop our internal planning processes that these are aligned. In the planning round for the current financial year this included participating in a check and challenge process with a peer Trust.

Participation in the Healthier Wigan Partnership

WWL Executives play an active role in the Healthier Wigan Partnership Board which brings together key partners across the Wigan Locality including Wigan Council, WWL, the locality ICB team, Healthwatch and representation from the voluntary, community and faith sectors (VCFS). Key WWL stakeholders also contribute to the sub-groups to the Partnership Board including, such as the Planned Care Board and Urgent and Emergency Care Board.

The Interim Chief Executive co-chairs the Wigan Integrated Delivery Board with Director of Public Health from Wigan Council. Over the last twelve months this group has focussed on overseeing improvement plans against the three priorities identified by the locality: diabetes; discharge and flow; and children and young people.

The Wigan locality ICB team are currently developing a new locality plan, with input from key stakeholder including WWL. This will set the priorities for the partnership and confirm the governance arrangements. This follows on from the recent approval of the Joint Strategic Needs Assessment by the Wigan Health and Wellbeing Board in December.

Benefits from partnership working

Partnership working has supported delivery of several tangible benefits both for the Trust and the wider system. A number of these are outlined in this section. These are not comprehensive but give an overview of our partnership activities and their benefits.

Partnership working has a critical role in ensuring the clinical and financial sustainability of services for our community, as set out in both *Our Strategy* 2030 and the Clinical Services Strategy. A recent example of this is the implementation of a shared on-call model for urology with Bolton NHS Foundation Trust which is now embedded. Further work is being undertaken with the GM Trust Provider Collaborative on development of a Clinical Services Strategy focussed on sustainability. Aligned to this, discussions are also ongoing with Bolton about other opportunities to work together to deliver sustainable services.

Partnership working also supports the development of facilities which both bring investment into the Wigan Borough and enable provision of services which support the wider GM system, recent examples of which include:

- Development of a Community Diagnostic Centre at Leigh Infirmary as part of the GM diagnostics programme. Through increased diagnostic capacity, this will support earlier diagnosis, reduction in health inequalities both for residents of the Borough and GM.

- Development of our endoscopy facilities at both Leigh Infirmary and the Royal Albert Edward Infirmary to expand and improve endoscopy facilities in line with the GM Endoscopy network plans. This will further enhance the role of Leigh Infirmary as a diagnostic hub for GM.

- Development of Wrightington an elective orthopaedic hub for GM. This has included securing investment in a new theatre, refurbishing an existing theatre, and creation of a new discharge lounge, thereby increasing Wrightington's capacity to undertake elective activity and support the GM system. Wrightington has recently been accredited as a Surgical Hub by the national Getting It Right First Time Programme (GIRFT) following a review visit from NHS England in September 2023.

- Development of Leigh Infirmary as an elective surgical hub for GM. This has included securing investment in a new theatre which is due to be operational later in January. Following this, accreditation from the GIRFT team will be sought.

Partnership working has supported the Trust receiving mutual aid from other Trusts, as well as providing mutual aid to others, contributing to a sustainable reduction in the number of patients waiting a long time for surgery.

Partnership working is essential to addressing the challenges across the urgent and emergency care pathway and supporting our population to be supported to live within their own homes wherever possible. Across the Borough, a system diagnostic has recently been undertaken on urgent and emergency care with partners supported by Newton Europe. This will inform development of a system transformation which is owned by all key partners across the Wigan Locality.

Partnership working brings opportunities to focus not just on provision of health services, but also on tackling the wider determinants of health. One key approach to this is our role as active participant in the Wigan Community Wealth Building partnership, as one of the Anchor Institutions within the Borough. Through this, we are actively engaged in supporting improvements in the socio-economics of the Borough by leveraging the economic clout we have as the largest employer and our significant spending power. Examples of tangible benefits include: development of a central training facility in partnership with Wigan and Leigh College, Edge Hill University, Wigan Council and WWL (the Rushton building); an increase in the

number of T-level placements at WWL; increases in the number of apprentices. A landing page on our internet site has recently been developed (https://www.wwl.nhs.uk/anchor-institution). This highlights why our role as in Anchor Institution is important to us, and the work that we are doing. It will be further developed as part of a wider communications plan which will seek to create a golden thread, utilising case studies and stories, to highlight our role in health, wealth and wellbeing.

Health Inequalities

As previously reported to Trust Board, as part of the six-month review of corporate objectives, a number of reports have been commissioned to aid a greater understanding of health inequalities in relation to: patients who do not attend for appointments; attendances at A&E; emergency admissions and waiting lists. These have been shared with locality partners, and the HWP Integrated Delivery Board is planning to focus on health inequalities, including reducing inequity of access to care. A workshop was held with IDB members, with wider representation from across the locality, to inform development of a plan to reduce inequity of access to care. Increasingly, our internal performance reporting considers health inequalities.

Recommendation
Trust Board are requested to note this report.

Agenda item: [21]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 9 (December 2023)
Presented to:	Board of Directors
On:	7th February 2024
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 £8.2m year to date, which is £3.9m adverse to plan. The system has agreed a revised year end position with NHSE of £180m, of which the agreed WWL forecast is a deficit of £10.2m. This is £3.7m adverse to the original planned deficit of £6.5m. In addition, all providers were asked to include an estimate for the impact of industrial action for December and January, as this is outside the agreed system position of £180m. The estimated impact for WWL is £2.0m, which takes the revised forecast outturn to £12.2m. This has been reflected in the formal return to NHSE from month 9. Further clarity is awaited nationally on any additional funding settlement for the impact the industrial action for December and January. Based on the month 9 activity data, the Trust continues to be below the YTD elective activity target. The month 9 position includes an under performance of £4.0m YTD and includes the notified target reduction from NHSE for industrial action in month 1-7 but no target adjustment for December's industrial action. This has been calculated as a reduction in income of £0.4m. As advised by GM ICB, we have excluded the YTD over performance on unbundled activity (£1.7m) within our reported month 9 position. Escalation expenditure of £7.6m has been incurred year to date. Work continues to safely de-escalate the main hospital site; however, this remains challenging, and the trust was escalated to a business continuity incident during December. Engagement continues with external agencies (Newton Europe and ECIST) and the locality to reduce non elective length of stay, with opportunities from the diagnostic now being shared with the Trust. CIP delivery has been above plan for month 3 to 9, and the year-to-date slippage has now been recovered. The current forecast is full 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, £8.8m has been released through a full review of payables and deferred income. The most likely scenario includes forecast balance sheet support of £13.1m in year. There are significant risks to achievement of the agreed forecast outturn of £10.2m (excluding the industrial action impact) including ongoing escalation and Winter pressures and the delivery of the elective activity plan.
Activity	Achieve the elective activity plan for 2023/24.	Red	The Trust has under-performed against the NHSE ERF target by £4.1m YTD and this includes the notified target reduction from NHSE for industrial action for months 1-7. No adjustment has been made for the December industrial action and the impact of this based on internal calculations was £0.4m in lost income. As advised by GM ICB, we have excluded the YTD over performance on GM ICB unbundled activity (£1.7m) within our reported month 9 position.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Red	The cash balance continues to decline, with a closing balance of £16.5m at the end of month 9 which is £10.2m below plan. Cash has decreased by £3.2m from the previous month and £26.6m since the start of the financial year. The variance to plan relates to the revenue deficit, capital underspend and other timing differences. The operating cash days metric is 12 days at the end of December compared to 15 at the end of November, and 27 days at the beginning of the financial year. Based on the current run rate, external cash support will be required in quarter 1 of 2024/25.

Capital expenditure (CDEL)	Achieve CDEL for 2023/24.	Amber	Capital expenditure against internal CDEL was £0.8m in month 9 which is £0.2m above plan. Year to date, capital expenditure is £2.0m below the internal CDEL plan. This is primarily due to Community Diagnostic Centre (CDC) and Leigh Laminar Flow Theatre being underspent against the original NHSE plan. The Trust is anticipating confirmation of an additional £1.5m CDEL in this financial year to support schemes with a revenue benefit.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £24.4m, of which £19.7m is recurrent.	Amber	In month 9, £2.1m CIP has been delivered which is on plan. CIP delivery remains on plan year to date due to non-recurrent measures put in place. As at month 9, the in year target has been fully identified. The divisional recurrent CIP target includes £0.3m unidentified with a significant proportion remaining high risk. There are mitigations in place to offset this, however it should be noted that these are predominantly non-recurrent.
Temporary expenditure	To remain within the agency ceiling set by NHSE and reduce bank expenditure.	Amber	Agency expenditure is £0.7m in month 9, a £0.1 decrease from last month. The Trust is operating within the agency ceiling with agency representing 2.7% of the total pay bill year to date (compared to the ceiling of 3.7%). Bank expenditure within the divisions was £2.2m in month 9, 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 9 is 93.6% by volume and 92.1% 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	There are challenges to the delivery of the agreed revised deficit position which will be closely managed in quarter 4. This includes continued escalation into unfunded areas and recovery of elective activity. There is uncertainty about how the impact of industrial action for December and January will be treated nationally and whether there will be any additional funding. The Trust continues to engage with PWC and the turnaround director. The December meeting was stood down due to the improved financial position in month 8. The next meeting is scheduled for 25th January 2024.

Link to strategy

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

Risks associated with this report and proposed mitigations.

The proposed GM forecast outturn of £180m deficit has been agreed by NHSE, excluding the impact of industrial action in Dec/Jan. This reflects the trust most likely position will be £10.2m deficit, a variance of £3.7m to the original planned deficit of £6.5m. This is £0.5m better than the month 8 most likely scenario of £10.7m, due largely to the revenue benefit of additional capital expenditure. This change will be reflected in the Trusts financial reporting to NHSE in month 9. This will not trigger the NHSE 'protocol for changes to the in-year revenue financial forecast' or further SOF intervention as its part of the system wide changes to the forecast outturn. This increases to £12.2m with the impact of industrial action for December and January. The working assumption is that this will be externally funded although no formal commitments have been made at the time of writing.

There is a risk to delivery of the activity plan, primarily due to the loss of activity during industrial action. The agreed forecast outturn of £10.2m deficit (before the impact of industrial action in December and January) is predicated on reducing the overall API underperformance in year to £3.0m by the end of March.

The Trust's cash balance presents increasing levels of risk. At present the Trust's cash balance is below plan, but there remains sufficient cash to service the planned deficit and the planned capital programme within the current financial year, although external support is likely to be required in quarter

1 of 2024/25. A GM Capital and Cash group has been established with CFO representation, which will be supporting management of the cash position across providers within the system.

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 9, the Trust has reported an actual deficit of £1.5m, which is a favourable variance of £0.1m to the original plan.

Year to date, the Trust has reported an actual deficit of £8.2m, which is £3.8m adverse to the planned deficit of £4.4m.

A forecast deficit of £12.2m has been reported to NHSE. This is based on an agreed deficit of £10.2m as part of the system adjustments, plus £2.0m for the impact of industrial action in December and January.

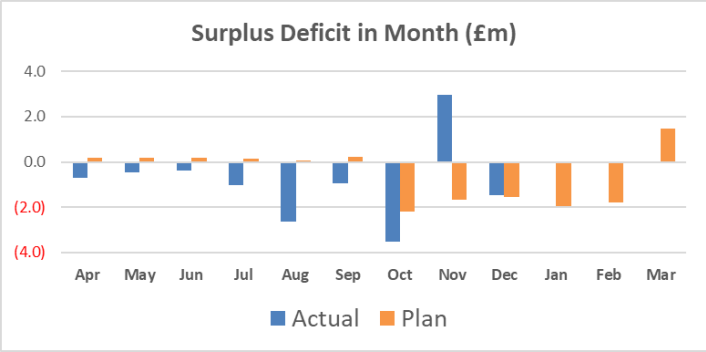
The Trust reported an actual deficit of £1.5m in month 9 (December 2023), which is a favourable variance of £0.1m to the plan. The month 9 position includes the balance sheet support of £0.5m in month, reported within income. Year to date, the Trust is reporting an actual deficit of £8.2m which is £3.8m adverse to the original planned deficit of £6.5m.

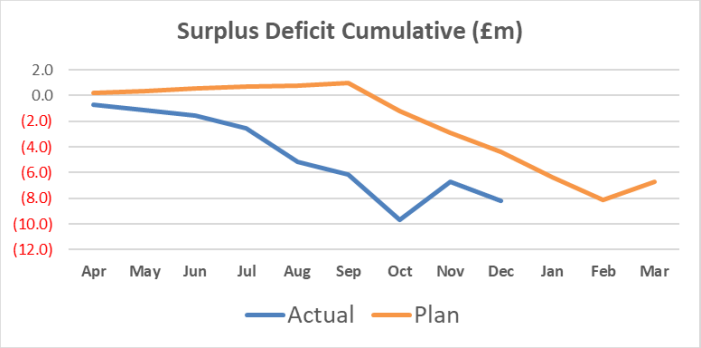
Year to date, GM providers are collectively reporting a deficit of £202.9m, which is £191.0m adverse to plan. The system remains in financial recovery with continued support from the Turnaround Director and PWC.

GM has agreed a forecast outturn of £180m deficit with Julian Kelly (before the impact of the December and January industrial action) to be reported from month 9. This reflects the trust most likely position of £10.2m deficit. The current estimate for the impact of industrial action is £2.0m. This means that the forecast outturn reported is £12.2m deficit.

The ERF/API underperformance is £4.0m YTD and £4.1m in the forecast outturn. This includes £1.1m of lost income due to industrial action in December and January, pending clarification on further national funding to address this.

Escalation expenditure of £7.6m above plan has been incurred YTD and there is £1.8m of pay expenditure associated with the industrial action within the YTD position.





Key Financial Indicators

Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Financial Performance							
Income	43,077	41,997	1,080	378,149	380,751	(2,602)	506,768
Pay	(30,114)	(29,996)	(118)	(269,223)	(263,891)	(5,332)	(351,791)
Non Pay	(12,961)	(11,697)	(1,264)	(101,487)	(105,062)	3,574	(139,842)
Financing / Technical	(1,479)	(1,833)	354	(15,646)	(16,206)	560	(21,829)
Surplus / Deficit	(1,477)	(1,529)	52	(8,208)	(4,408)	(3,800)	(6,693)
Adjusted Financial Performance *	(1,460)	(1,513)	53	(8,154)	(4,263)	(3,891)	(6,500)
Memo Items							
CIP	2,060	2,034	27	18,337	18,295	42	24,404
Bank Expenditure	2,235	1,165	(1,070)	22,513	8,640	(13,873)	12,136
Agency Expenditure	656	1,049	393	7,244	9,444	2,201	12,593
Cash Balance	16,517	26,724	(10,207)	16,517	26,724	(10,207)	30,403
Capital Spend - CDEL	773	482	(291)	8,341	10,369	2,028	11,640
Capital Spend - PDC	1,447	1,200	(247)	7,974	6,950	(1,024)	13,150

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

Financial Performance

- Income is £1.1m favourable to plan in month and £2.6m adverse to plan year to date.This includes £4.0m of activity underperformance YTD.
- Operating expenditure is £1.3m adverse to plan in month 9. Pay expenditure is £0.1m adverse plan in month. Year to date, operating expenditure is £1.8m adverse to plan.

Temporary Spend

- Bank spend £2.2m in month and £22.5m year to date.
- Agency spend for the Trust is £0.7m in month and £7.2m year to date. Currently below the agency ceiling at 2.7% of total pay bill (ceiling 3.7%).

CIP

- £2.1m transacted in month, which is on plan.
- £18.3m transacted year to date, which is on plan.
- Split in month: Divisional £1.2m; Centralised £0.9m.

Cash

- £16.5m cash balance, redcution of £3.2m on last month.
- £10.2m worse than plan.

Capital

- Capital spend of £2.2m against a plan of £1.6m in month.
- CDEL exependiture £0.8m which is £0.2m above plan in month.
- PDC expenditure £1.4m which is £0.5m above plan in month.

Divisional Performance

Medicine

- (£0.8m) Adverse to plan in month
- (£0.7m) Escalation
- (£0.2m) Unachieved CIP
- (£0.1m) Industrial action costs
- £0.2m Vacant posts

Surgery

- (£0.4m) Adverse to plan in month
- (£0.2m) Clinical supplies and drugs
- (£0.1m) Industrial Action costs
- (£0.1m) CIP

Specialist Services

- On plan
- (£0.3m) Clinical supplies
- £0.1m Private patient income
- £0.2m CDC expenditure

Community

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

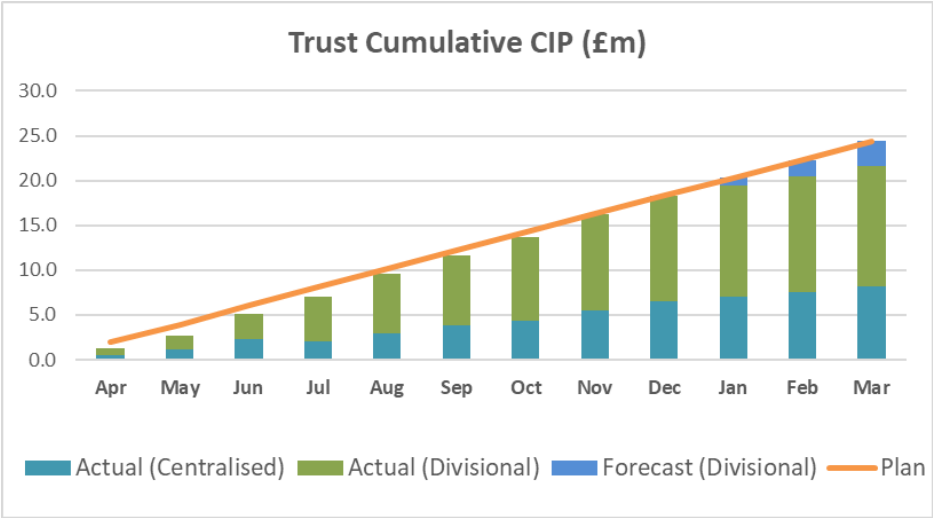
Estates & Facilities

- (£0.2m) adverse to plan in month
- (£0.1m) Estates maintenance
- (£0.1m) Other smaller items

Corporate Divisions

- £0.1m Favourable in month
- £0.1m Small items IM&T and S&P

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 9, actual CIP of £2.1m has been transacted which is on plan. £1.2m has been transacted against the divisional CIP target (including the divisional stretch). £0.9m has been transacted through the Centralised CIP.

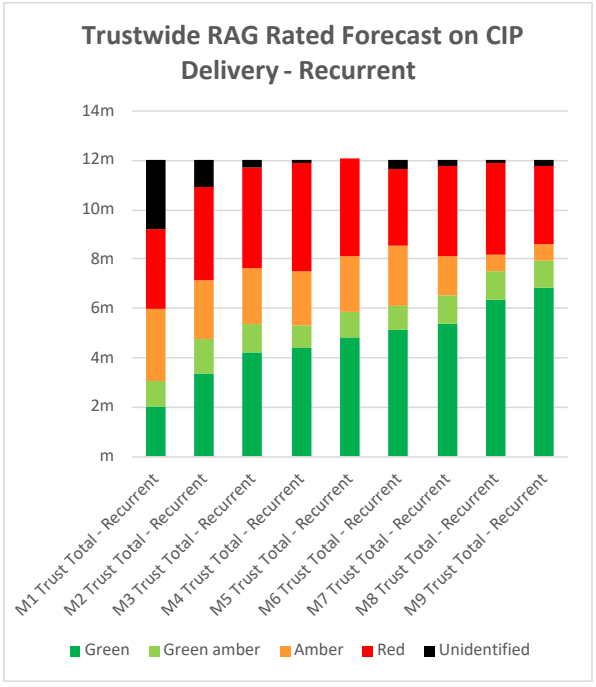
The Divisional CIP transacted in month is split £1.0m for transactional schemes and £0.2m for transformational schemes.

The chart on the right shows the RAG rated forecast for the divisional CIP of £12.0m. As at month 9, the in-year unidentified gap is now £1.1m (8%), which has been mitigated through non-recurrent measures. The recurrent CIP gap is now £0.3m.

£6.8m 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/ National 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

The Trust is completing the formal actions from the Financial Performance and Recovery meeting held on the 7th December 2023. This work focuses on ERF over performance, recognition of unbundled activity performance and quantifying the opportunities presented by Newton Europe. The month 9 Financial Performance and Recovery meeting is scheduled for 25th January 2024.

The BMA have not announced any further dates for industrial action at the time of writing. Consultants are currently voting in a referendum as to whether to accept the government pay offer. SAS doctors have voted in favour of industrial action. They too have a pay offer from the government which the vote opens on 29th January 2024.

To support the financial recovery of the trust, two improvement directors have been appointed, one for finance and one with an operational portfolio. These appointments are initially to the end of the financial year.

Financial planning is underway for the 2024/2025 financial year. National planning guidance has been delayed from December to January; however the trust continues to work on its 2024/25 plan. The GM system has requested two returns on the 19th January. The first is a high level bridge template from 2023/24 exit run rate to initial 2024/25 revenue plan. The second is a capital planning return to support the ICB led prioritisation process for allocation of the CDEL envelope between providers.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	WWL Outlying Maternity Outcome Metrics Report
Presented to:	Board of Directors
On:	7 February 2024
Presented by:	Kevin Parker Evans Interim Chief Nurse
Prepared by:	Cathy Stanford Divisional Director of Maternity and Child Health
Contact details:	01942 773107 cathy.stanford@wwl.nhs.uk

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Contents

Executive Summary

At WWL the maternity dashboard was first introduced in 2012 and it has grown and been modified many times over the years. The maternity dashboard enables clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement.

Better Births (2016), the report of the National Maternity Review, recommended that a nationally agreed set of indicators should be developed to help local maternity systems track, benchmark, and improve the quality of maternity services. In response, NHS England, and NHS Improvement, in partnership with NHS Digital, produced a National Maternity Services Dashboard for maternity services to use.

Within Greater Manchester and Eastern Cheshire (GMEC) The local Maternity and Neonatal System (LMNS) additionally collate data from all service providers to produce a regional set of metrics for gaining assurance that local maternity services are providing safe, quality care and taking a proactive approach to learning from incidents and shared lessons across all the maternity providers within the region.

Some measures, including stillbirth rates, have increased during the pandemic and these have not returned to pre-pandemic levels or aligned with national averages for some providers within Greater Manchester and these are being closely monitored through the regional governance processes.

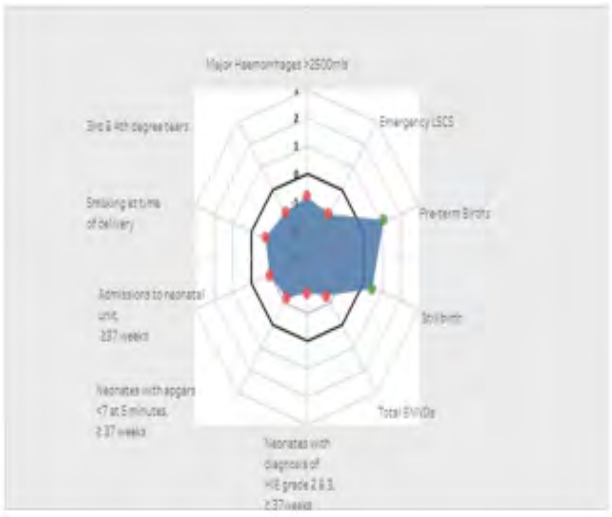
Data collected from Q3 2022 to Q3 2023 has identified WWL as having deteriorating metrics in a number of the clinical indicators monitored.

These will be discussed in detail within the report and corresponding appendices and assurance given as to what measures are in place to address these going forward to demonstrate sustainable improvements.

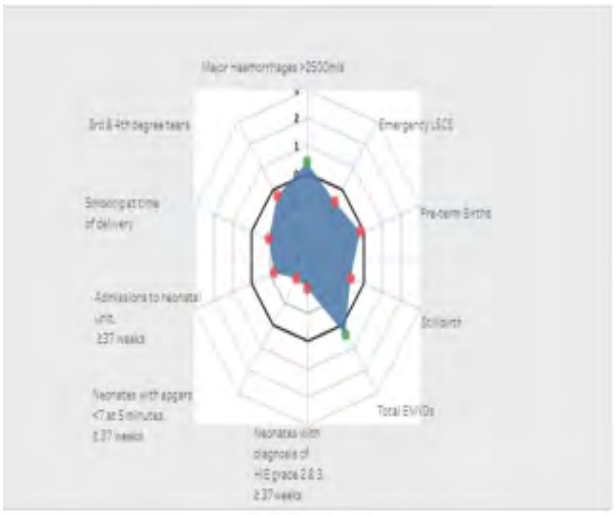
The GMEC LMNS collates data within the Tableau Maternity Analysis Toolkit and produces a Perinatal Quality Surveillance Dashboard which bench marks all providers within GM against the GM average. This is captured within spider graph charts as detailed below.

Of the 10 indicators being measured WWL were noted to be outside of the GMEC mean against 9 of these in comparison to other GM providers. Each of these will be detailed below to demonstrate performance throughout the time period and what measures are in place or will be put in place to show improvements.

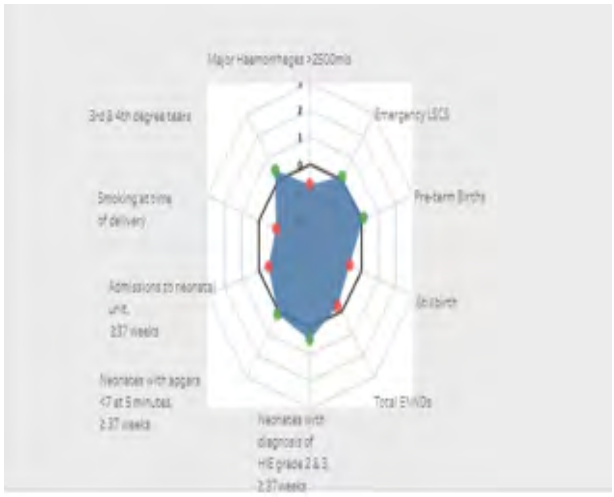
22/23 Q3



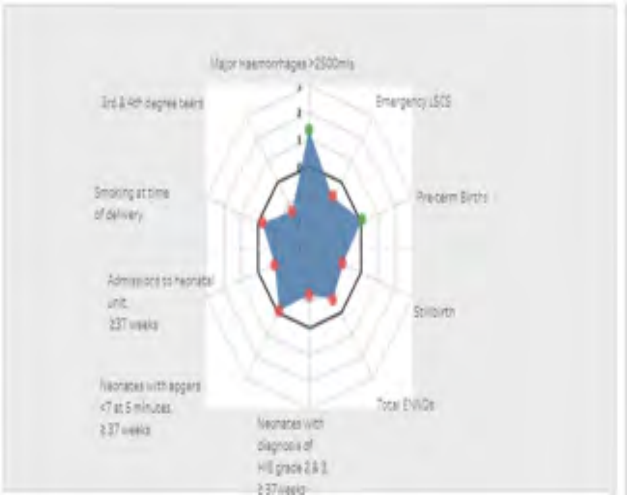
22/23 Q4



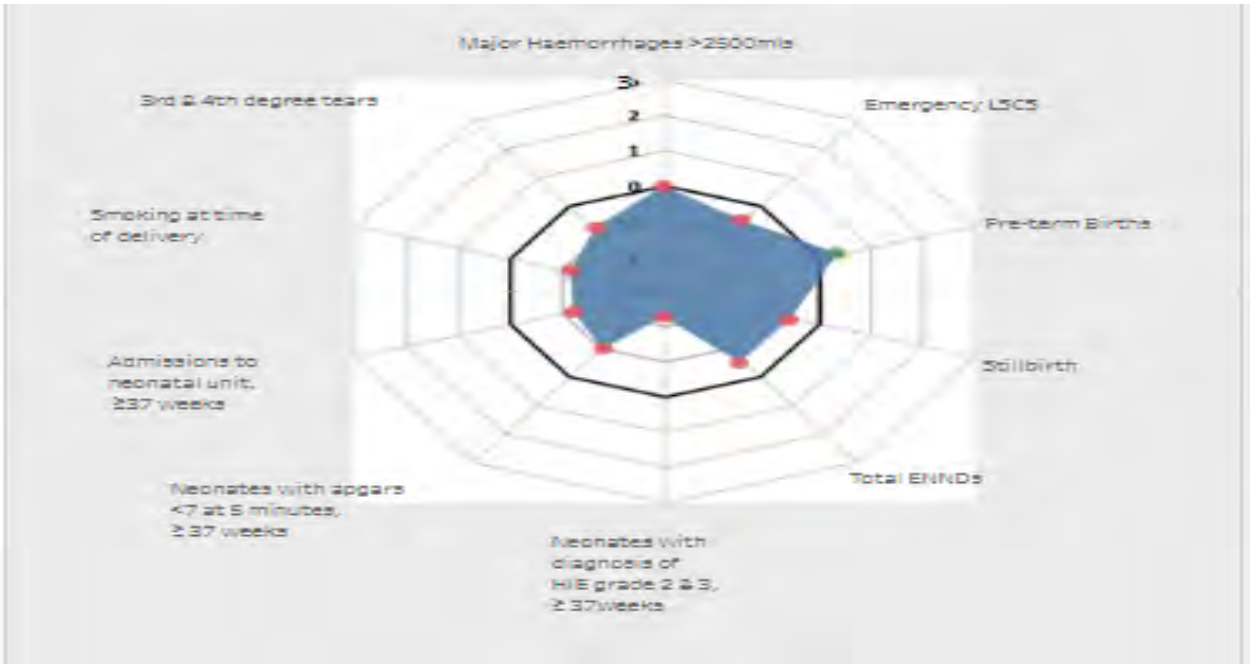
23/24 Q1



23/24 Q2



Full Year October 2022 – September 2023

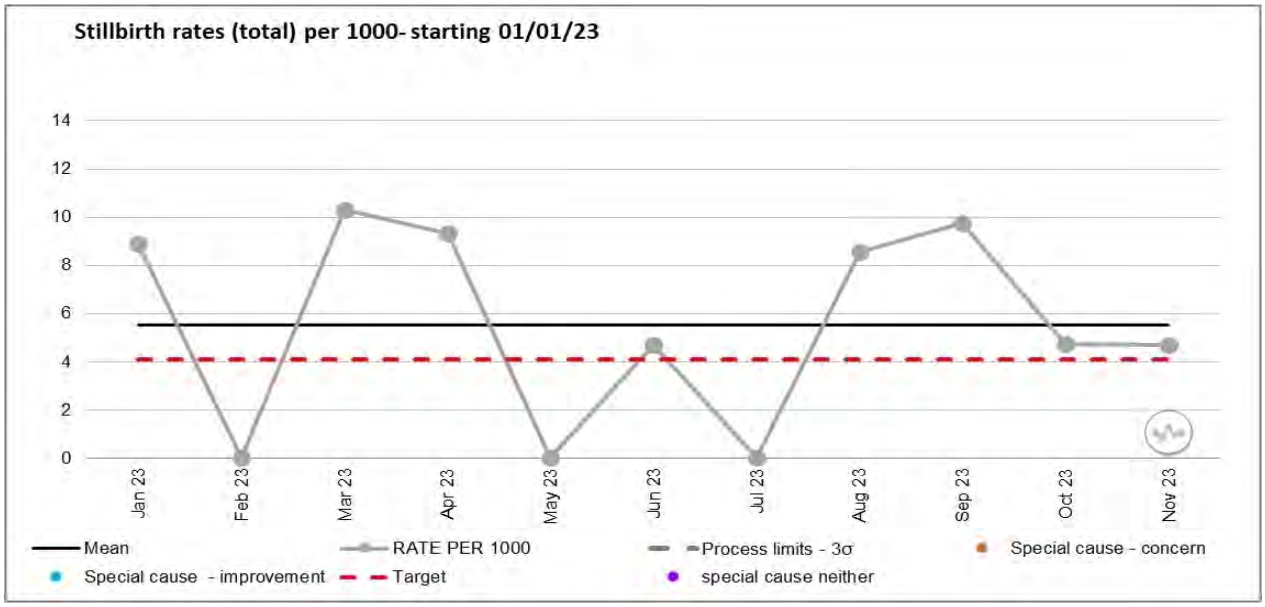


Report

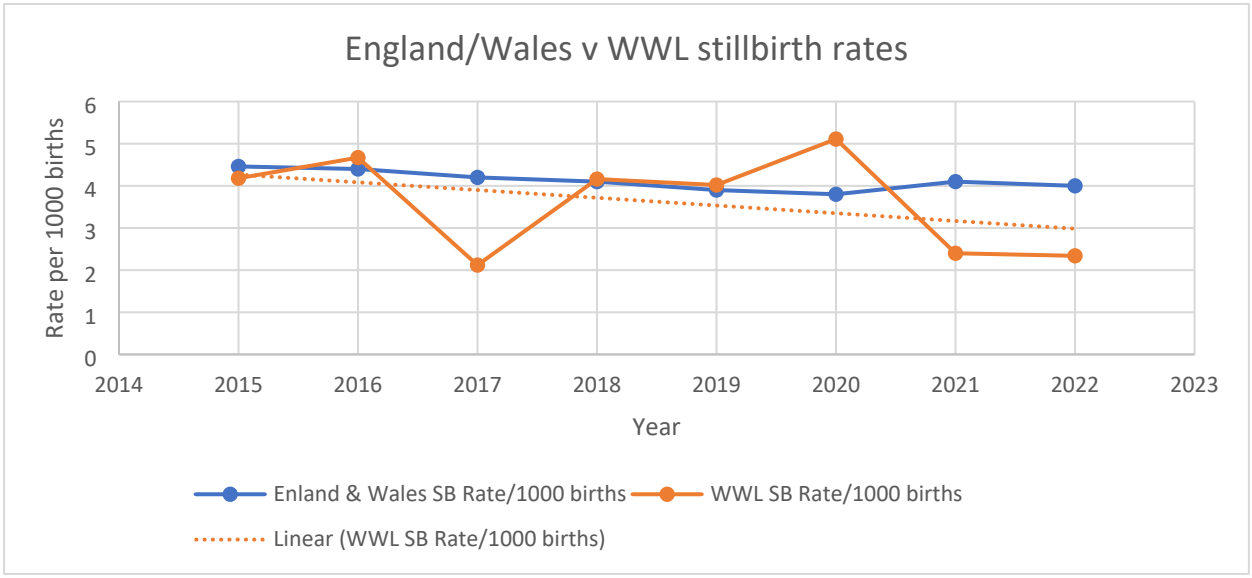
Stillbirths

The Department of Health (2016) and NHS England (2016) mandated that Maternity Services should work toward halving the number of stillbirths by 2030 and achieve a 20% reduction by 2020. The NHS Long Term plan (2019) has set a target of reducing stillbirths by 50% by 2025 (based on 2010 data). That would require England and Wales to reduce its stillbirth rate to 2.6 stillbirths per 1000 births.

The Office for National Statistics (ONS) has confirmed that rates of stillbirth in England and Wales increased from 3.8 per 1000 births in 2020 to 4.1 per 1000 in 2021. There was a slight decrease in 2022 to 4 per 1000 births but this remains higher than pre-Covid-19 rates in 2019. The data also shows that there continues to be significant variation in stillbirth rates across different parts of England and Wales.



Stillbirth rates are calculated as rates per 1000 births. Where spikes are seen in the chart above this equates to 2 still births in the month. The national rate currently stands at 4.1 / 1000 and the GM rate is 4.47 / 1000. Our rolling average so far in 2023 is 4.84 / 1000.



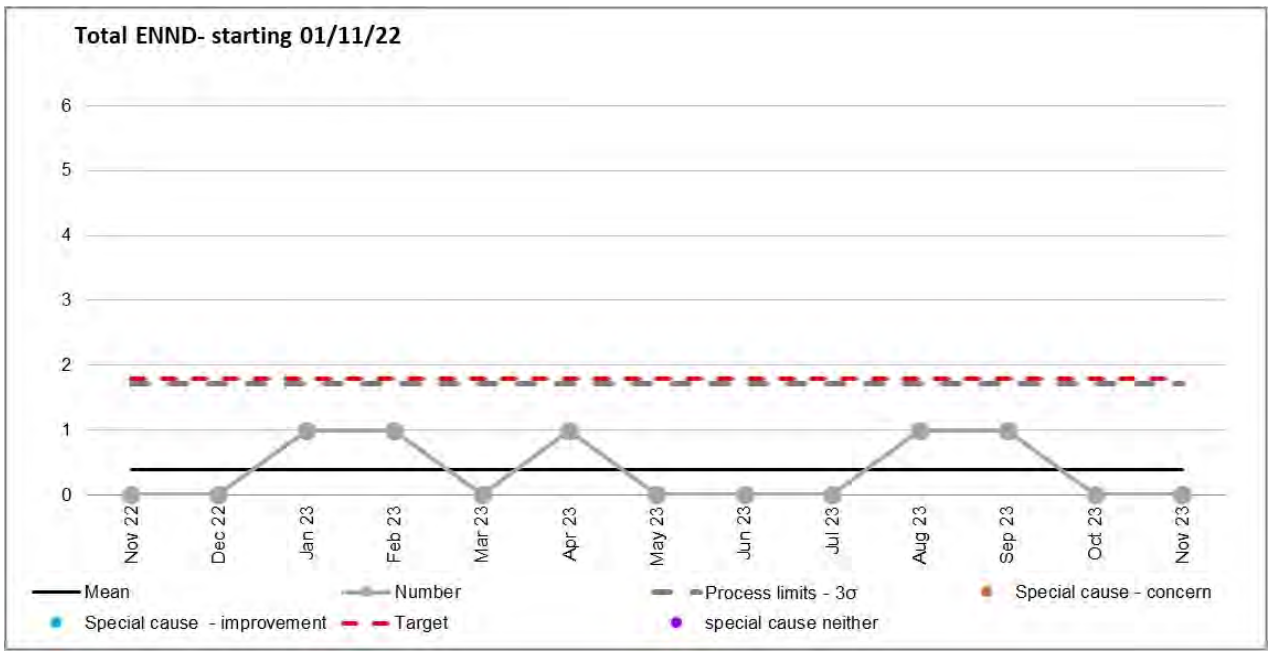
Between 2015 and 2022 WWL has seen a downward trajectory for the rate of stillbirths and, with the exception of 2020, have either been in line with, or significantly below ONS reported rates of stillbirth across England and Wales.

2023 to date has since an increase in both the number and rate per 1000 births of stillbirths at WWL and we have been an outlier for rates of stillbirth in GMEC for the last 3 quarters.
12 babies have been stillborn between January-October 2023, with an adjusted figure for MTOP of 10 babies and an adjusted figure for fetal anomalies of 9 babies. 25% of babies stillborn had known anomalies. Furthermore 2 babies (twins) were stillborn following known complications of MCDA twin pregnancy, with specialist care from the tertiary fetal medicine unit.
There were no known cases of intrapartum stillbirth.

A review of all 12 cases has identified strong themes around raised and significantly raised BMI, social deprivation, and white British ethnicity with 50% of white British mothers living in deciles 1 or 2 and having a significantly raised BMI at booking, compounding the risk.

Please see (Appendix 1). Learning from Mortality: A review of stillbirths at WWL in 2023 January – October, which details all stillbirths and identifies any additional learning and recommended actions.

Total Early Neonatal Deaths (ENND)



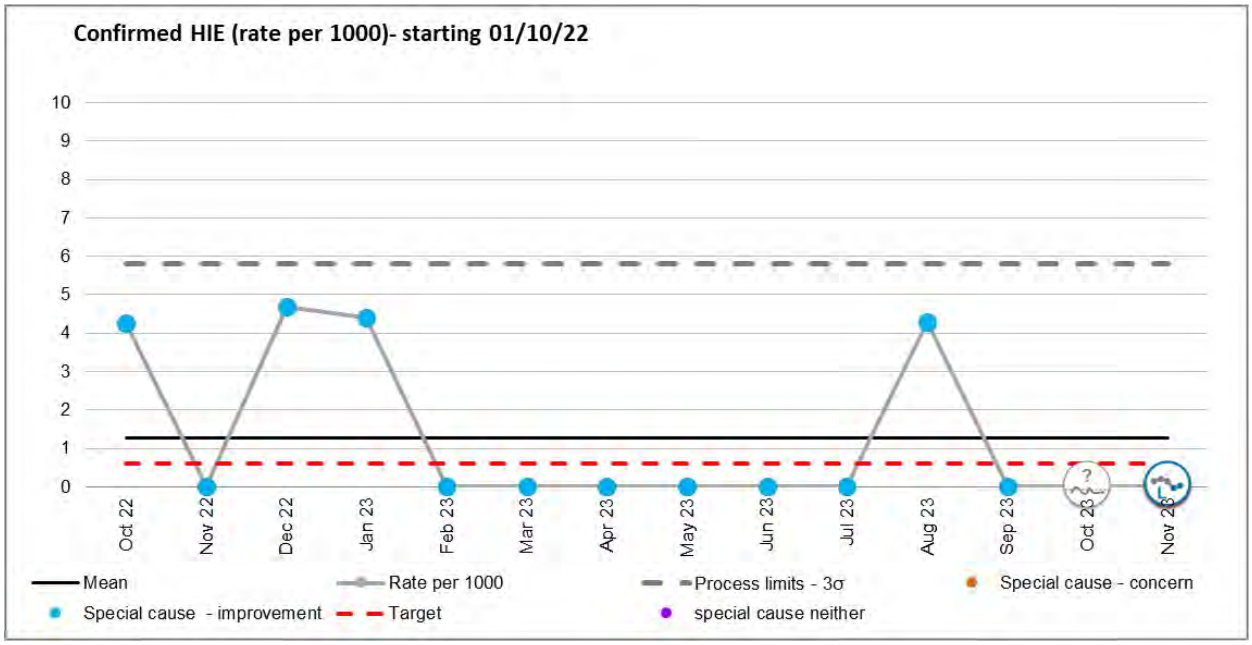
A neonatal death is the death of an infant aged under 28 days. In England, the government has an ambition to halve the 2010 neonatal mortality rate for babies born at a gestational age of 24 weeks or over by 2025. The neonatal mortality rate ambition in England is 1.0 deaths per 1,000 live births of babies born at 24 weeks or over.

A review of the neonatal deaths that occurred at WWL during October 2022 – September 2023, has been undertaken to identify learning. *(Information only will be included for any neonatal deaths of babies born at WWL during this time but required transfer to a tertiary level 3 unit and died outside of the trust).*

During the time frame October 2022 to September 2023 the total number of births at WWL was 2526. There were 8 recorded early neonatal deaths during this time, ranging from 18 weeks to 24+6 weeks gestation **(0.32%).** There were no recorded late neonatal deaths at WWL. (There were 6 neonatal deaths outside WWL, which underwent/undergoing a shared PMRT review)

Please see (Appendix 2). Learning from Mortality: A review of Early Neonatal Deaths(ENND) at WWL October 2022- September 2023, which details all ENND's and identifies any additional learning and recommended actions

Neonates with a diagnosis of HIE 2&3 ≥ 37 weeks gestation



Hypoxic-ischaemic encephalopathy (HIE) may be diagnosed if a baby's brain does not receive enough oxygen and/or blood flow around the time of birth.

Low oxygen and/or blood flow to a baby's brain happens most commonly before or during birth, but it can also happen shortly after birth.

HIE affects the brain, but the effects of low oxygen or blood flow can also cause problems in the lungs, liver, heart, bowel, and kidneys.
When diagnosed, HIE is graded as mild, moderate, or severe. Where HIE is graded as moderate or severe (HIE 2 and 3), it can result in long-term disability and, in some cases, can sadly result in death.

In spite of an overall slight downward trajectory in both suspected and confirmed cases of HIE 2 and 3 in babies ≥ 37 weeks, WWL are outliers across GMEC for the number of babies with confirmed HIE on MRI at term. Utilising Tableau data over the last 12

months, at the end of October 2023, WWL mean rate per 1000 births is 1.75 compared to GMEC mean rate of 0.6 per 1000 births.

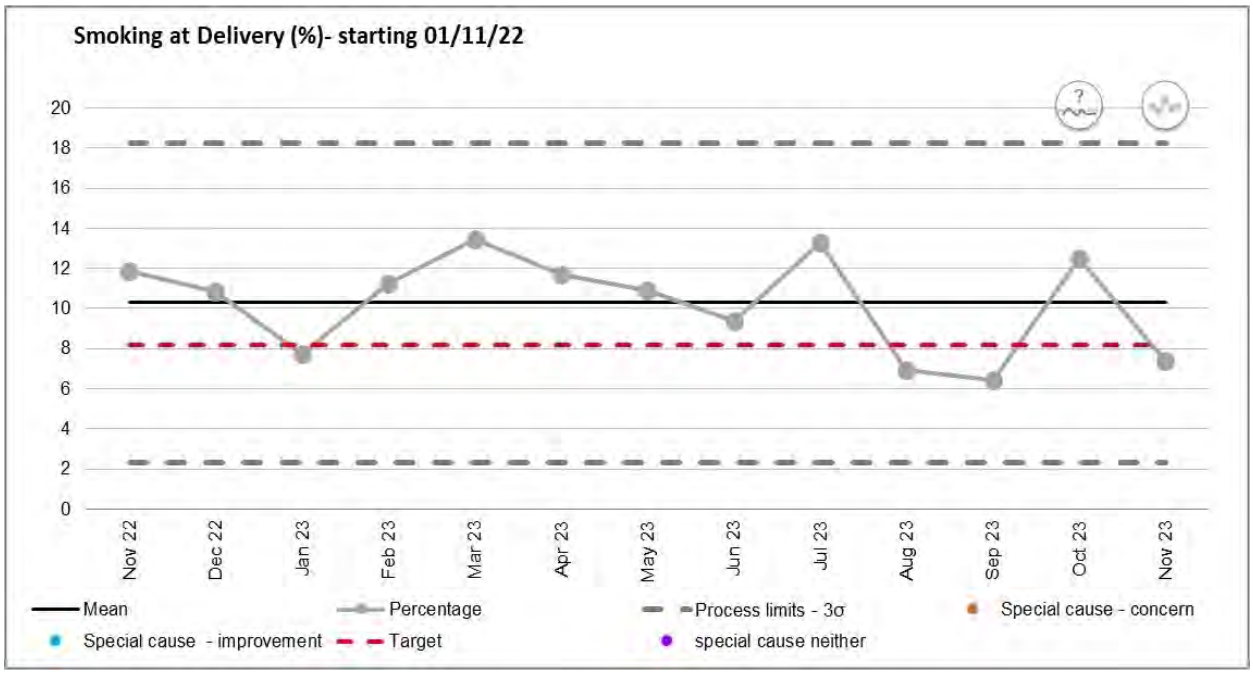
WWL monitors the numbers of babies with both suspected and confirmed HIE 2 and 3, collate all learning from reviews and identify themes and trends in care and service delivery.

All cases of suspected and confirmed HIE are subject to review and appropriate referrals are made to HSIB/MNSI.

A review of the suspected and confirmed cases of HIE that occurred at WWL during April 2022 – October 2023, has been undertaken to identify learning.

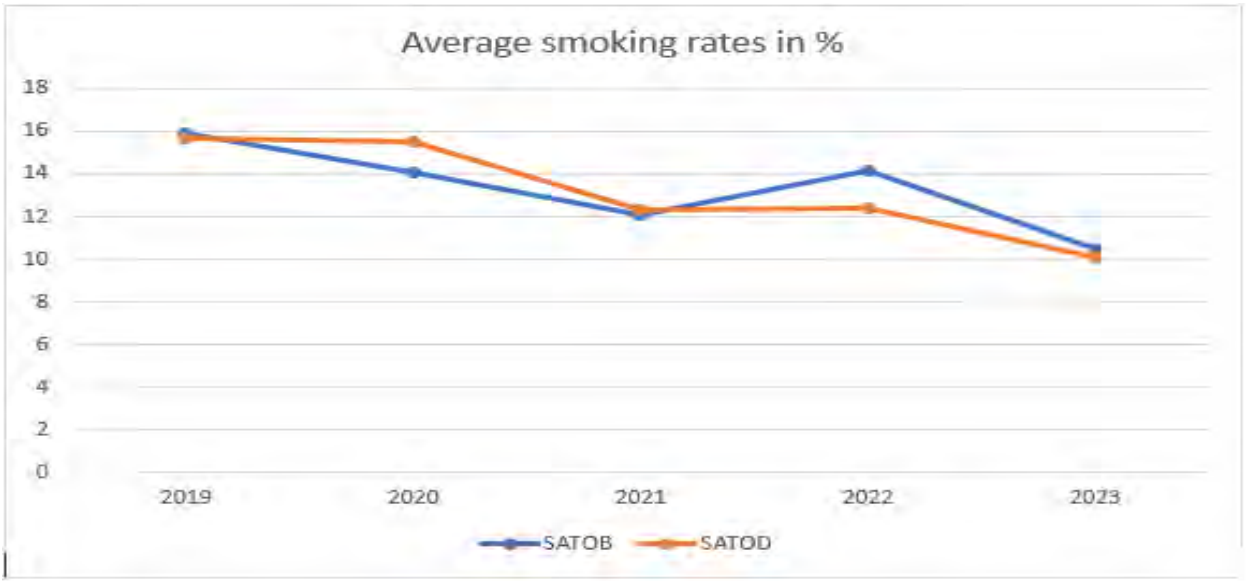
Please see (Appendix 3)Learning from Data: A review of babies born with HIE 2 and 3 at WWL April 2022 - October 2023 which details all cases and identifies any additional learning and recommended actions

Smoking at Time of Delivery



A review of the data at WWL from October 2022 – October 2023 has been undertaken as the trust has been identified as an outlier within Greater Manchester (GM) for smoking at time of delivery rates (SATOD)

Smoking at time of delivery at WWL with the exception of three months is continually above the GM target rate. This could be influenced by the high % of women who are smoking at time of booking (SATOB).



WWL rates over the last 5 years apart from 2022, demonstrate a downward trajectory with the rates of smoking at time of delivery.

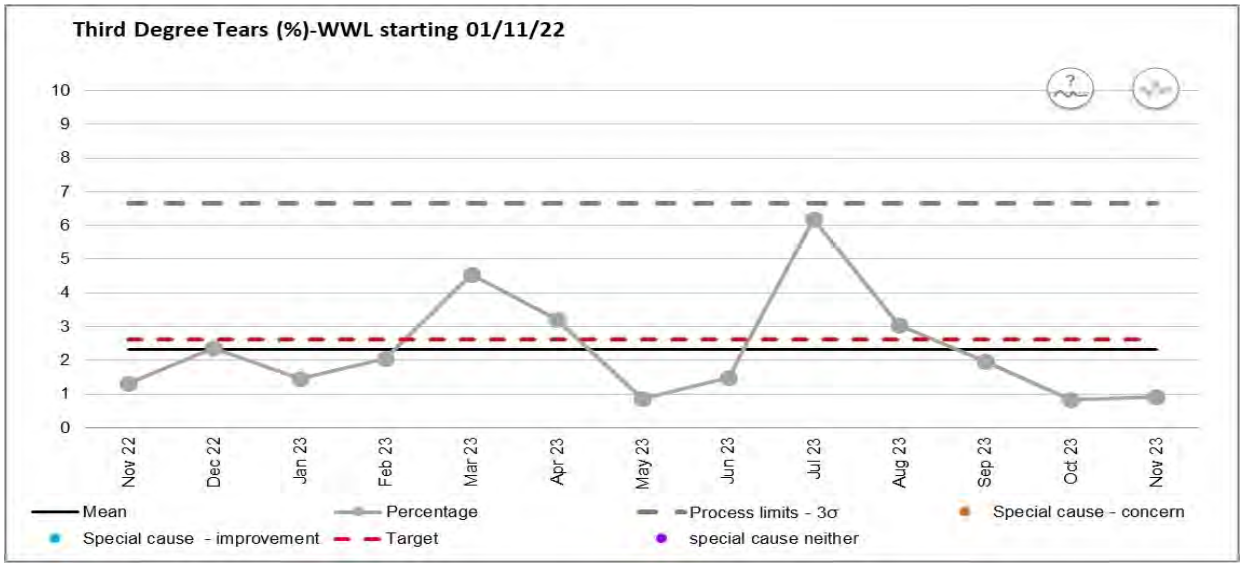
The Wigan in-house Smokefree Pregnancy Team launched on 26th January 2021. This service commenced with one midwife and one maternity tobacco dependency advisor, which has since developed. In June 2023, the service at WWL expanded, and two band 4 Maternity tobacco dependency advisors joined the service. The team started to issue Vapes as a nicotine replacement therapy (NRT). Face to face appointments resumed where possible to improve engagement and outcomes, this is reflected in the 2023 downward trajectory of % of women smoking at time of delivery.

With support from GM smokefree pregnancy programme the service has continued to evolve to meet the needs of pregnant women who are tobacco dependent. During covid restrictions the team primarily worked from home to provide support by telephone, which is reflected in the 2022 increase, as engagement with women was not as successful.

The Borough has a high number of postcodes that are within the lowest Deciles of deprivation (Decile 1 & 2). This has identified a theme within review, 73% of women resided in these deciles. Women in decile 1 are captured by the community enhanced team Fern who offer continuity of care to these ladies. 15% of the women living in decile 1 were cared for by the Daisy team midwives (enhanced team for the most vulnerable women in the area). This demonstrates the complexity of the women who were identified as still smoking at the time of delivery within these deciles.

Please see (Appendix 4) A review of Women Smoking at Time of Delivery at WWL October 2022- October 2023 which provides a full review and identifies any additional learning and recommended actions

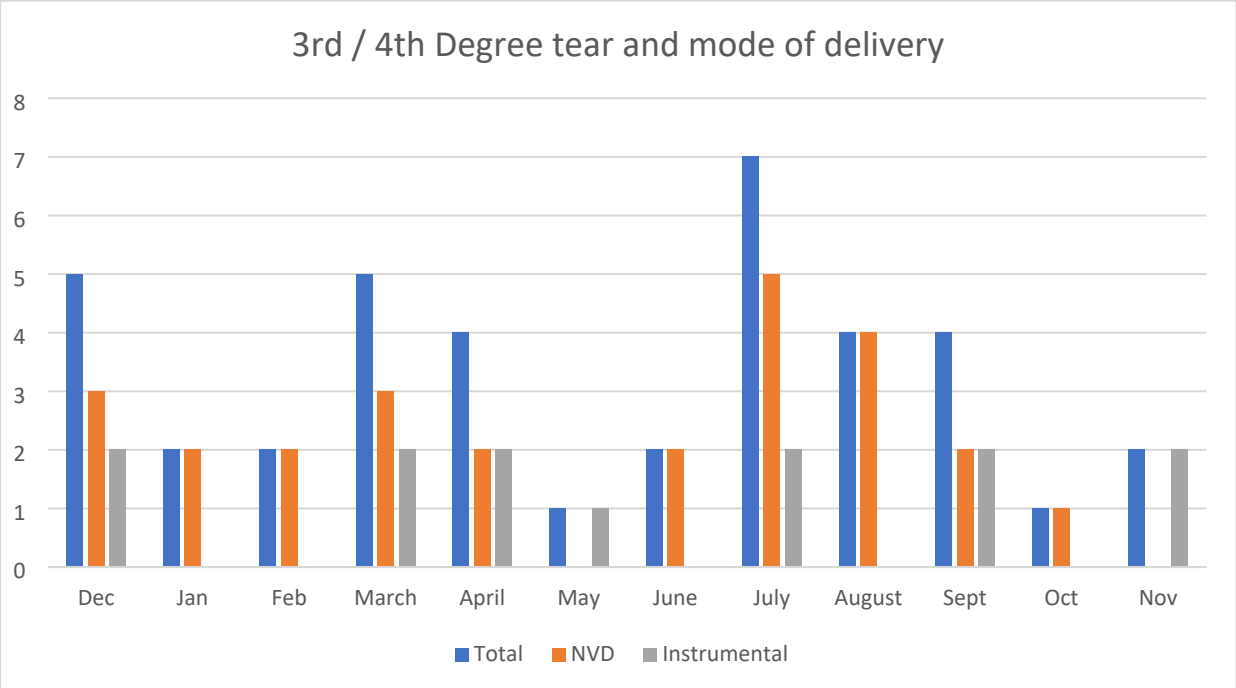
3rd and 4th Degree tears



It is difficult to determine why WWL is currently considered to be an outlier for anal sphincter injury as the above SPC chart demonstrates a downward trajectory, nevertheless, it is noted that there were 2 episodes which were above the usual range, however on average the third- and fourth-degree tear rates remain within target range.

The graph below identifies the mode of delivery with unassisted vaginal births having the highest rates.

A review of the data has identified that there are no staff who are flagging as having multiple episodes as they are all single occurrences, however there is a significantly large number of student Midwives included within these numbers and work will be undertaken by the practice education team to incorporate an additional training package for all midwifery students into the training that is already in place.



Please see (Appendix 5). Obstetric Anal Sphincter Injuries (OASI) - Third and Fourth-Degree Tears. Data analysis of OASI between May-July 2023.

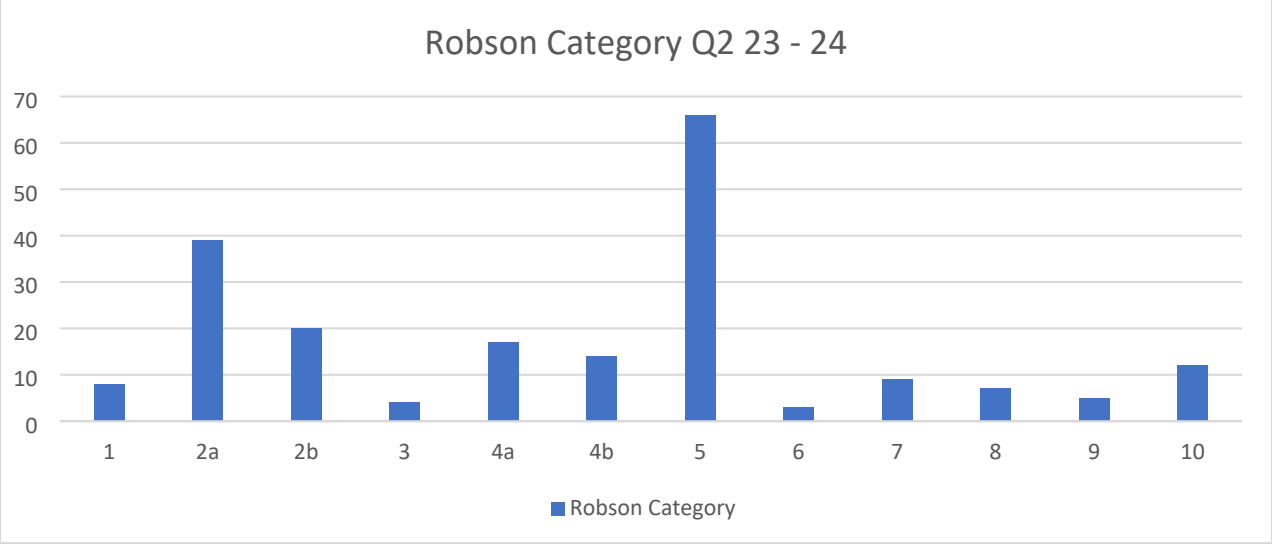
Emergency Caesarean Sections

Donna Ockenden in her first Report in 2020 recommended that all Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

It was recommended that targets for caesarean section rates should be removed and instead Trusts should use the Robson criteria as detailed below which provides an expectation of rates in relation to associated risk factors and parity.

By utilising this criteria, it would be expected that women who have had a previous caesarean birth and women undergoing an induction of labour would account for the highest numbers. (Categories 2,4 &5)

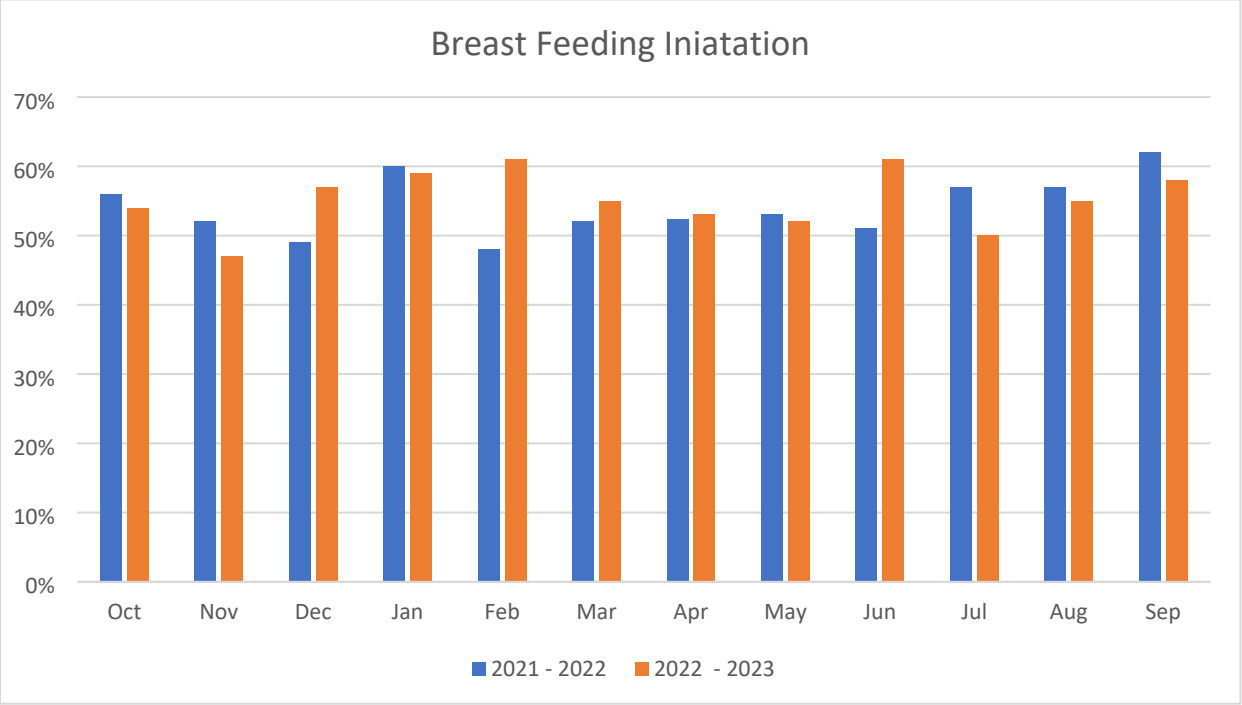
Group	Obstetric population
1	Nulliparous women with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour
2	Nulliparous women with a single cephalic pregnancy, ≥37 weeks gestation who had labour induced or were delivered by CS before labour
2a	Labour induced
2b	Pre-labour CS
3	Multiparous women without a previous CS, with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour
4	Multiparous women without a previous CS, with a single cephalic pregnancy, ≥37 weeks gestation who had labour induced or were delivered by CS before labour
4a	Labour induced
4b	Pre-labour CS
5	All multiparous women with at least one previous CS, with a single cephalic pregnancy, ≥37 weeks gestation
5.1	With one previous CS
5.2	With two or more previous CSs
6	All nulliparous women with a single breech pregnancy
7	All multiparous women with a single breech pregnancy including women with previous CS(s)
8	All women with multiple pregnancies including women with previous CS(s)
9	All women with a single pregnancy with a transverse or oblique lie, including women with previous CS(s)
10	All women with a single cephalic pregnancy < 37 weeks gestation, including women with previous CS(s)



The above chart demonstrates the main Robson groups for WWL women which is consistent with the expected findings as detailed in the table above

Breastfeeding.

Wigan as an area has strong local identity, particularly around traditional industries and the rich ecological value of unique habitats created by former industrial activities. This has led to a deeply embedded culture where bottle feeding is the Norm.
It is acknowledged that over the past 10 years there has been a 10% increase in Breastfeeding which is of commendation to those involved. Changing the culture of formula feeding brings challenges and this is a difficult workstream to address as it involves a whole system approach, however it is hoped that a Borough wide strategy will be in place and discussions are taking place with Public Health and partner agencies.

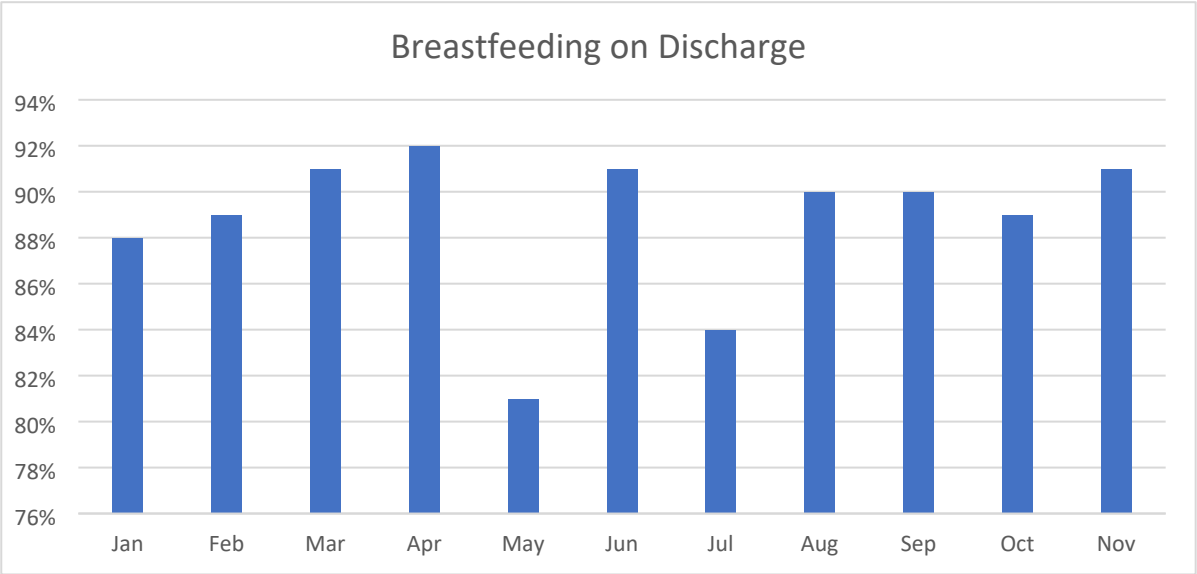


The maternity unit at Wigan was accredited as a Gold Baby Friendly service in March 2019 and revalidated in July 2023.

We are currently the only maternity unit in Greater Manchester with any Baby Friendly award.

One of the requirements of the GOLD award is that we must have further data collection points as well as initiation.

The infant feeding team monitor monthly the discharges from the maternity ward. The graph below shows the percentage of women who have initiated breastfeeding at delivery are still feeding on discharge from the maternity unit. So, whilst our initiation rates are low, we do manage to keep those who have started feeding still feeding on discharge.



During the antenatal period conversations around infant feeding are initiated at the 16-week appointment and at regular intervals during the antenatal period. As a minimum, 28 weeks and 36 weeks gestation are key touchpoints for discussions around infant feeding choices which is audited.

WWL have recommenced face to face parentcraft workshops in June and this will include a breastfeeding workshop. Hopefully, this will help some way to increasing the initiation rates further.

The partnership with Maternity Voices (MVP) has been strengthened. They have undertaken a survey on infant feeding which has given useful feedback and recommended actions

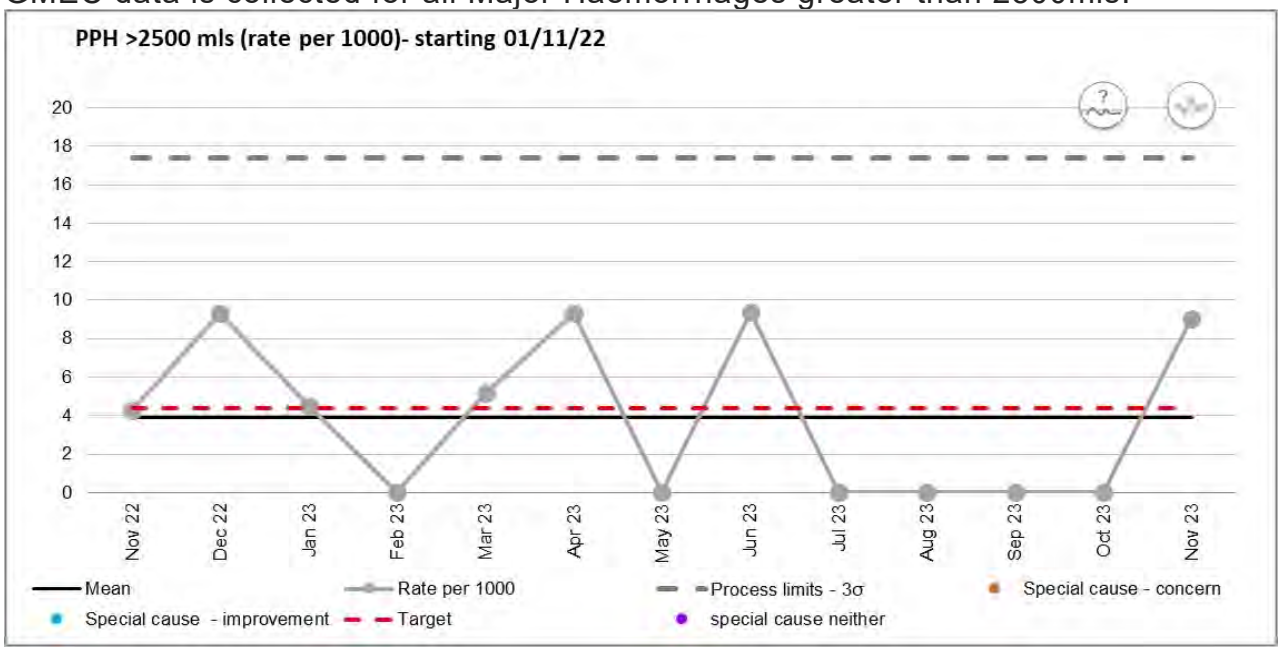
Quarterly compliance reports to the Board are tabled through the Safety Champions Forum and are also included within the Maternity dashboard . This group has challenged the low initiation rates in Wigan and the skin contact rates, however it is acknowledged by the members that any cultural shift involves a multi-agency approach and will take time to embed.

The health visiting service has gained gold accreditation and sits under the acute service. The Start Well centres have also gained gold accreditation. This provides the opportunity for continued collaborative working, ensuring a seamless pathway of care for babies, mothers, and their families and will remain a focus for improvement across the Borough.

Major Obstetric Haemorrhage (>2500ml)

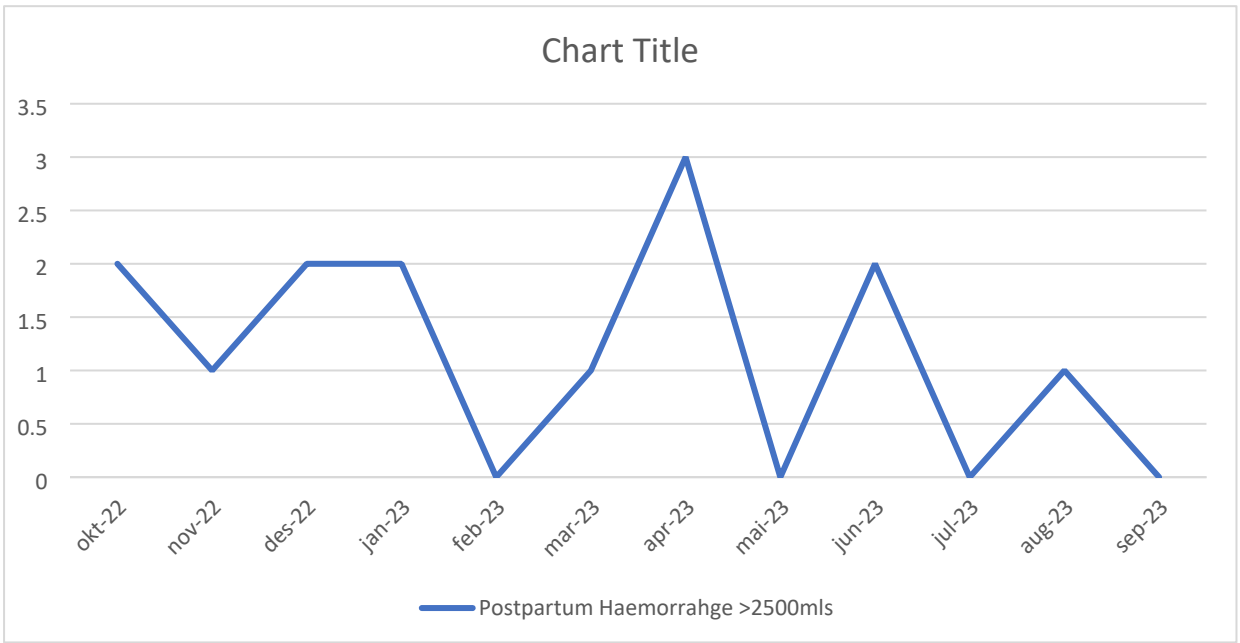
Post Partum Haemorrhage (PPH) is the most common form of major obstetric haemorrhage. The traditional definition of primary PPH is the loss of 500 ml or more of blood from the genital tract within 24 hours of the birth of a baby. PPH can be minor (500–1000 ml) or major (more than 1000 ml). Major could be divided to moderate (1000–2000 ml) or severe (more than 2000 ml).

GMEC data is collected for all Major Haemorrhages greater than 2500mls.



In the 12-month period, October 2022 – September 23, of the 14 cases of Major Obstetric Haemorrhage > 2500mls identified, 2 of the 14 cases were not reported via the maternity dashboard as the initial blood loss following birth was less than 2500mls.

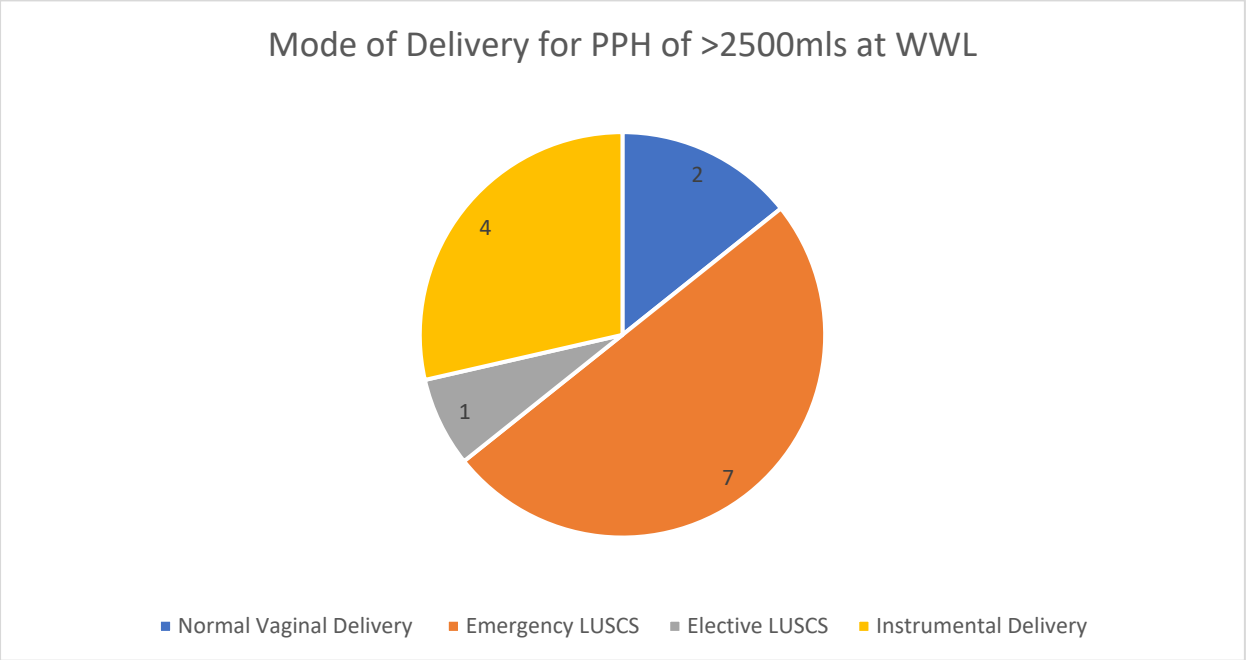
This gives a rate of 5.5 per thousand births. The regional average is 4.41.



A thematic review of all major Haemorrhages was undertaken in January 2023 and was presented at the WWL Safety Summit. Data from January – December 2022 was reviewed and the rate for major haemorrhages greater 2500mls was 6.2 per 1000 births.

4 serious incidents were reviewed from 2022,
Themes identified:

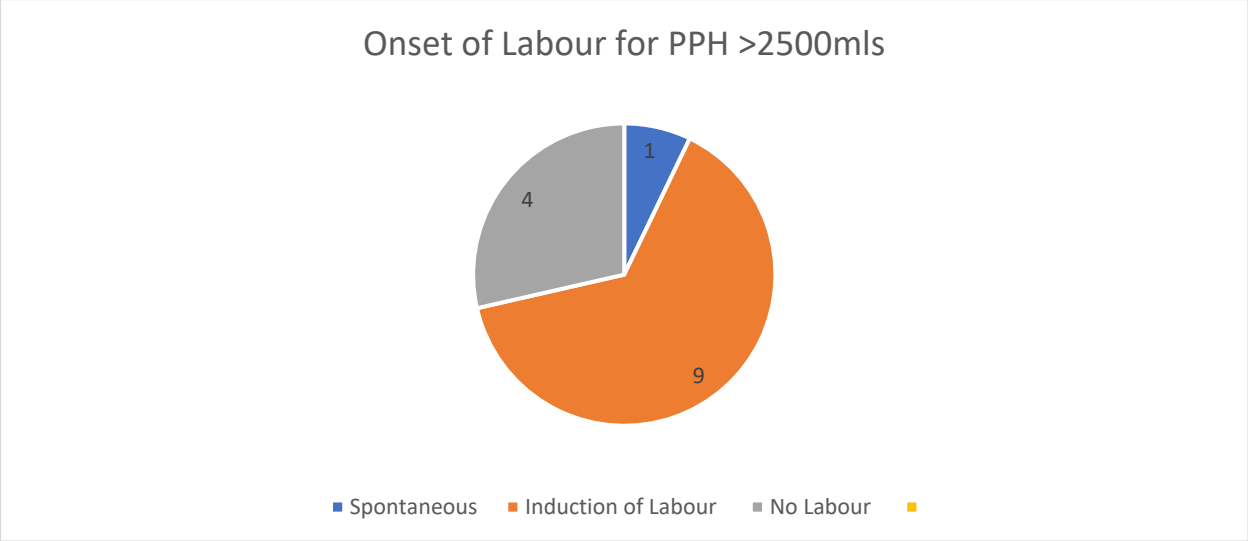
- Lack of multi-professional team working between the maternity theatre team and delivery suite team in maternity theatre
- No clear lead in massive obstetric haemorrhage in maternity theatre
- Lack of emergency documentation available in maternity theatre
- Process for ordering blood and blood products not robust
- Total blood loss to be weighed and any subsequent losses recorded appropriately (ensuring any loss under the patients drapes and in the 'suction' is accounted for)



8 women (57%) at WWL who experienced a post-partum haemorrhage had a caesarean section, 2 of the emergencies were for an abruption, the total estimated blood loss for these women was including both antenatal and postnatal blood loss.

1 woman was a known placenta praevia who was an inpatient for antenatal observation, during admission at 34+3 gestation had fresh red blood loss and required a category 1 LUSCS.

4 of the 8 women who had a C/S who had a major haemorrhage were induced (IOL)

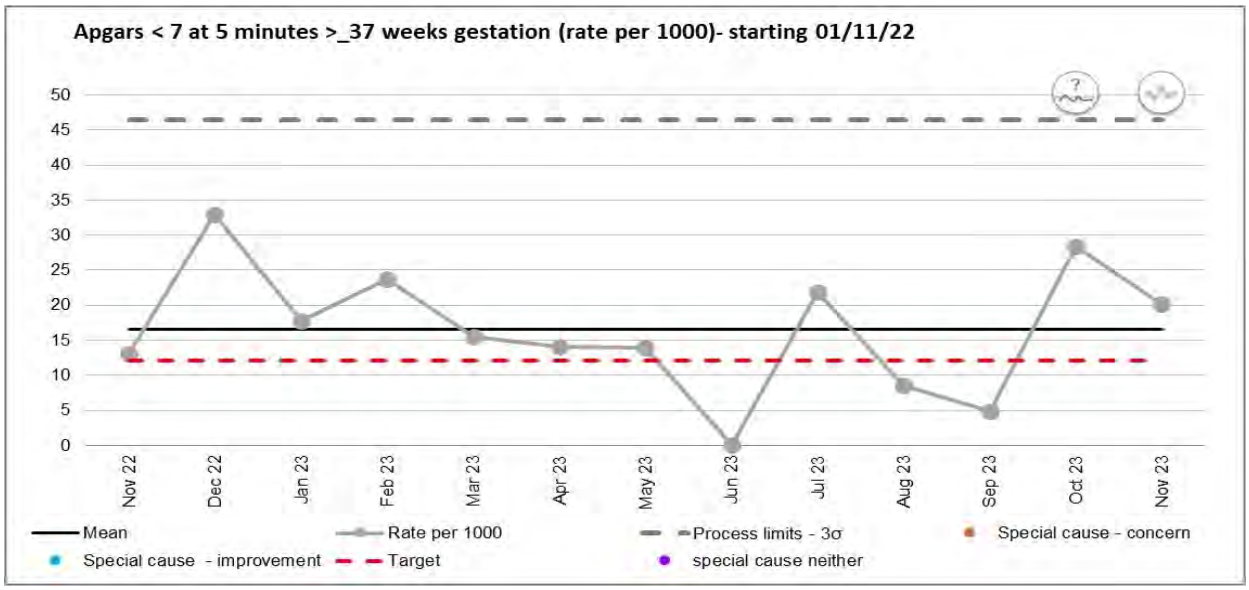


9 women (64%) who had a PPH were induced.
29% of the women did not labour (one woman had a placental abruption, one woman had an elective section for previous caesarean section and two women had pre-term caesarean sections for obstetric reasons).

Only 1 woman went into spontaneous labour but did require an instrumental birth.

Neonates with Apgar's <7 at 5 minutes ≥ 37 weeks gestation

The Apgar score is performed soon after birth, and observations are made of a baby's heart rate, breathing, colour, muscle tone and response to stimulation. These are performed at 1 minute and 5 minutes of age, with a third assessment at 10 minutes. The five observations are each given a score of 0. 1 or 2. The total of these scores is referred to as the Apgar score If a baby requires resuscitation, the aim is to see the score rising and the baby's condition improving.



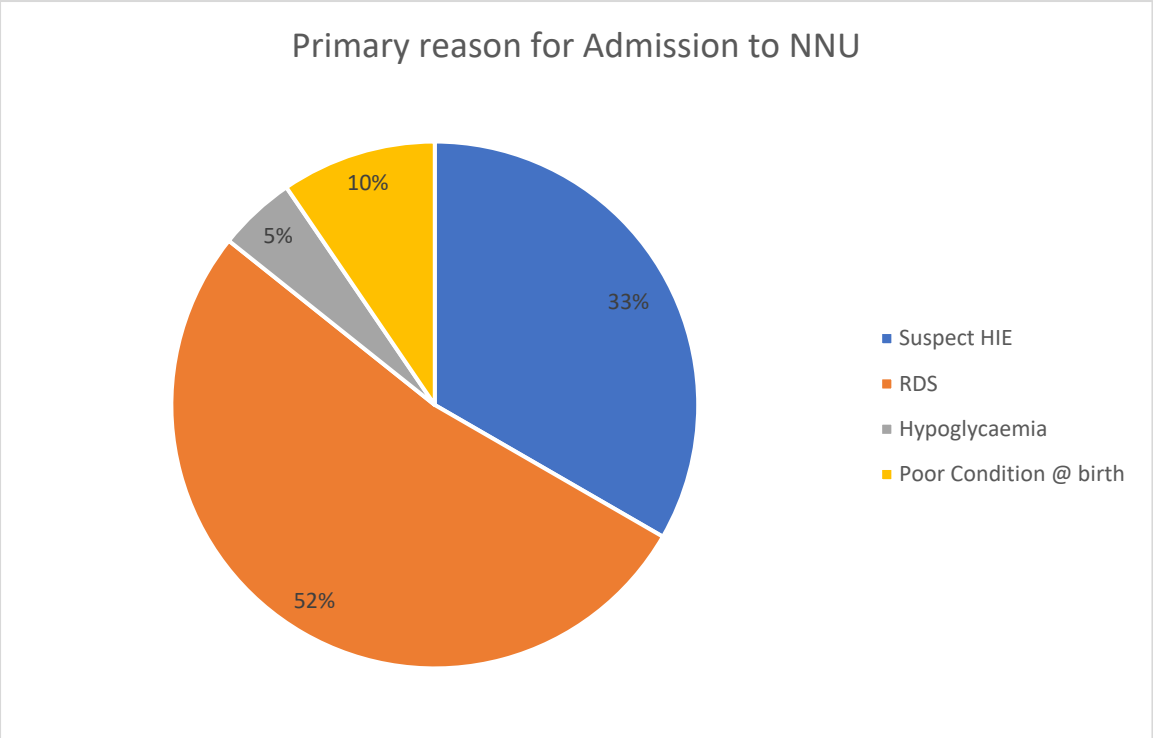
The WWL target range for 2023 was set at below 3 babies per month to ensure that we identified and collated themes for improvement if this figure was exceeded. This target aligned with the previous year's 2022 data. From 2024 our target range will be benchmarked against the GMEC average for 2023.

Regionally our metrics are aligned per 1000 total births for Apgar's less than 7 at 5 minutes at 37 weeks gestation.

There were 36 babies in 12 months who had Apgar's less than 7 @5 minutes This equates to a rate of 1.42 per 1000 Births during the period October 2022 – September 2023

36% (n=13) were admitted directly after birth to the postnatal ward

64% (n=23) were admitted to the neonatal unit All babies have had an ATAIN review

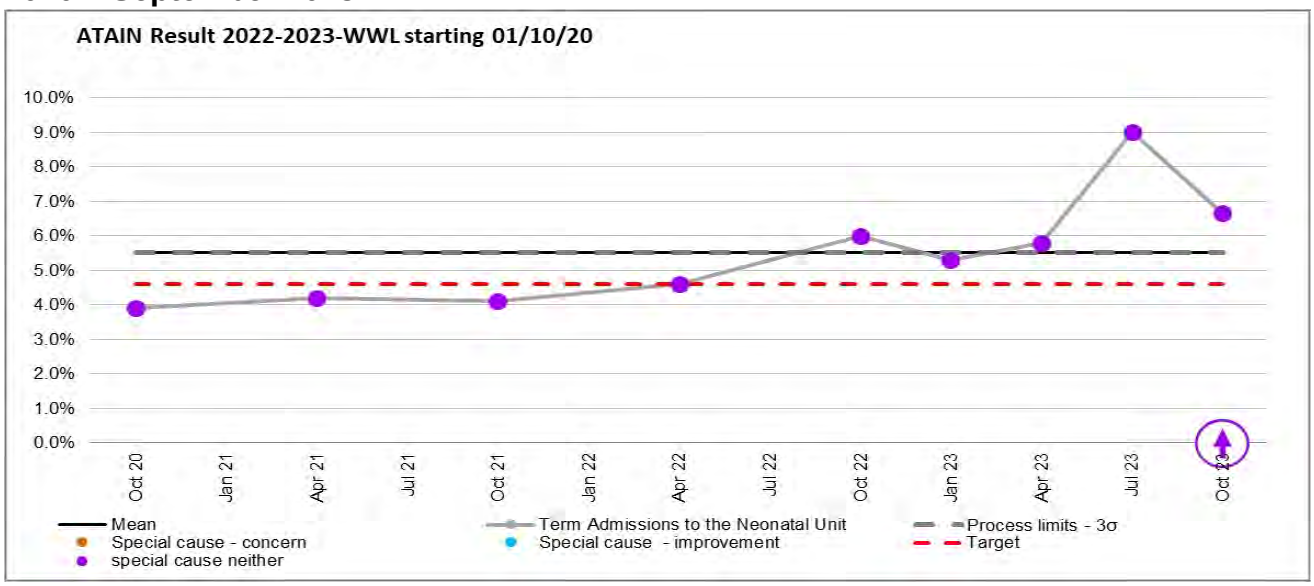


Admissions to NNU ≥ 37 weeks gestation

Between 2022 and 2023 WWL has seen an upward trajectory for the rate of unexpected and avoidable term admissions to the neonatal unit, this is significantly higher than the expected national accepted rate. WWL is currently an outlier for rates in GMEC and the regional rates in the last 4 quarters have highlighted this.

This has prompted an additional deep dive into the themes and trends of these admissions and what actions can be put in place to improve upon this.

The total number of term admissions to the neonatal unit at WWL from October 2020 – September 2023.



The mean data point for WWL across Greater Manchester for year 2022/23 was 6.5%. It is acknowledged that this was the highest score across the rolling year 2022/2023 in Greater Manchester.

The role of transitional care plays an integral part of the pathway for reducing term admissions to the neonatal unit and supports families to stay together and be part of their baby's care.

When the Avoiding Term Admissions into Neonatal (ATAIN) initial document was published in 2017 the national figures were showing a decrease in the birth rate and an increase in term admissions to the neonatal unit. **Term admissions are defined as pregnancy beyond and including 37 weeks (NICE 2023)**

Between 2011 and 2014, the number of term live births in England declined by 3.6%, but the number of admissions of term babies to neonatal units increased by 24% with a further increase of 6% in 2015 (NHS England 2017).

NHS England (2017) released its document on: reducing harm leading to avoidable admission of full-term babies into neonatal units, as part of the national focus on maternity safety, demonstrated through the combined work of the National Maternal and Neonatal Health Safety Improvement Collaborative, the Maternity Transformation Programme and the government's Maternity Safety Action Plan.

They focused on 4 main themes for admission but acknowledge there will be other factors affecting admission.

- hypoglycaemia,
- jaundice,
- respiratory conditions, and
- asphyxia (hypoxic–ischaemic encephalopathy,

Clinical multi-professional reviews of these cases were a recommendation (NHS England 2017) to form trends in admissions at local maternity units and themes to identify learning from practice and support quality improvement initiatives to form safe and effective care that helps reduce separation of babies from their mothers.

WWL undertakes a multi-professional review of all term admissions to the neonatal unit, this is undertaken on a weekly basis.

In quarter 2, 2023/24 the service introduced a new process whereby we use the Local Maternity and Neonatal System (LMNS) ATAIN audit tool to log the antenatal, intrapartum, and postnatal lessons learned, this identifies themes from practice and strong actions to identify areas for improvement.

The total of unexpected term admissions to the neonatal unit in this period was 160 of 2527 registrable births. Equating to 6.33% of all births at WWL in this timeframe.

1 baby was excluded from the ATAIN audit due to a suspected fetal anomaly. **The regional target figure stands at less than 4.6%, WWL recognises the work we need to do to reach the national and regional target.**

Please see (Appendix 3) Avoiding Term Admissions to the Neonatal Unit at WWL October 2022 – September 2023 Report

Summary

It is acknowledged that WWL is an outlier in the GMEC metrics for the period October 2022- September 2023 and work has been undertaken and remains ongoing in light of this information within the Trust to understand if any themes or Trends have been identified.

2023 to date has seen an increase in both the number and rate per 1000 births of stillbirths at WWL and we have been an outlier for rates of stillbirth in GMEC for the last 3 quarters.

All aspects of the Saving Babies Lives Care Bundle V2&3 have been implemented as recommended with additional work continuing in regard to Pre-Term Births. The overall trajectory for a 50% reduction by 2025 was on track to be achieved prior to the significant spike seen this year. With the exception of 2020, WWL stillbirth rates had been in line with or significantly below the rates across England & Wales.

A review of all cases has identified strong themes around raised and significantly raised BMI, and social deprivation. Additionally, 50% of the white British mothers lived in deciles 1 or 2 and had significantly raised BMI at booking, compounding the risk.

In spite of an overall slight downward trajectory in both suspected and confirmed cases of HIE 2 and 3 in babies ≥ 37 weeks, WWL are outliers across GMEC for the number of babies with confirmed HIE on MRI at term. Utilising Tableau data over the last 12 months, at the end of October 2023, WWL mean rate per 1000 births is 1.75 compared to GMEC mean rate of 0.6 per 1000 births.

WWL monitors the numbers of babies with both suspected and confirmed HIE 2 and 3, collating all learning from reviews and identifying themes and trends in care and service delivery. All cases of suspected and confirmed HIE are subject to review and appropriate referrals are made to HSIB/MNSI.

There were 8 recorded early neonatal deaths during the time period under review, ranging from 18 weeks to 24+6 weeks gestation **(0.32%).** There were no recorded late neonatal deaths at WWL.

It is clear that all cases were extremely premature with 5 of the cases occurring following a medical termination of pregnancy (MTOP) for a fetal anomaly or compassionate IOL for maternal / fetal reasons, this equates to 63% of the neonatal deaths that occurred at WWL. All infants demonstrated signs of life for a significant period despite the extreme premature gestation and all were below the cut off for offering KCL prior to commencing termination.

Whilst WWL is an outlier for Smoking at time of delivery and breastfeeding it should be noted that both of these are improving rates. Within the Wigan and Leigh Borough, the rates for smoking have been high and the initiation of Breastfeeding has been low for many decades and ongoing work is seeing a cultural shift in both of these metrics. It is acknowledged that this will take time to see significant improvements in line with national and regional rates but the multi-agency approach and changes in demographics and public health awareness across the borough is now showing signs of significant improvements.

A full review of all Anal Sphincter injuries has taken place and the OASI Care Bundle will be fully introduced in the new year when the Community Education Lead commences in post. This will be rolled out to all staff and offered at parent education sessions. Additional training packages will be in place for Students Midwives on their delivery suite placements to enhance the theoretical packages offered within universities. OASI champions have been identified and leads are in place to commence this ongoing quality improvement measure.

It was recommended that targets for caesarean section rates should be removed and instead Trusts should use the Robson criteria which provides an expectation of rates in relation to associated risk factors and parity.

By utilising this criteria, it would be expected that women who have had a previous caesarean birth and women undergoing an induction of labour would account for the highest numbers. (Categories 2,4 &5) The main Robson groups for WWL women is consistent with the expected findings

Unexpected term admissions to the Neonatal has seen a significant increase over the last 2 years where previously WWL had low numbers of term admissions.

Multi-professional ATAIN reviews take place weekly in a more structured and systematic way utilising the audit tool provided by the LMNS. this has identified themes and trends for shared learning, the MatNeoSip optimisation metrics are monitored monthly and are showing sustained improvements across all metrics especially in thermoregulation which is a main contributor to the term admissions

Linked to the term admissions is the babies who have an Apgar score of <7 at 5 minutes of these it has been identified that a significant proportion of these babies do not require an admission to the NNU or require only minimal or no resuscitation and work is ongoing around ensuring babies are correctly positioned to ensure airway occlusion is not occurring whilst in skin to skin, and that strong opioids are not given near to delivery wherever possible.

Of the babies who are admitted to NNU at term significant numbers of these births are either by Caesarean section or the Birth was induced. These incidental findings will be examined in more detail to ensure that any arears for improvements are recognised. Induction of labour (IOL) as a theme has been seen in many of the outcomes and it needs to be determined that all IOL's are undertaken within the recommended guidelines and time frames and based on clinical need. A full audit incorporating all of these factors is currently being undertaken.

Major Post Partum Haemorrhage was the themes for a recent safety summit with multi-professional presentation around the main themes identified and the management of these challenging cases. Work is ongoing in regard to this, and the Trust has recently introduced a Pack System which should enable a timelier approach to availability of blood products and replacement of blood loss. Additionally, the trigger point for activation of the major haemorrhage protocol is not in line with other GM trusts and this is currently under review with Obstetric Colleagues.

It is clear there is still much work to be done in providing enhanced levels of care to women who are socially deprived and have existing co-morbidities for poor outcomes as these groups feature heavily within all metrics. WWL now has 2 dedicated teams who provide enhanced care for the most vulnerable and those living in the most deprived areas.

The impact of increased numbers of women undergoing induction of labour and requiring a caesarean section is also adding to the higher numbers of poor outcomes for both mothers and babies
WWL continue to evaluate outcomes and put improvement measures in place and will remain committed to ensuring women, babies and families have the best possible care and unavoidable harms are minimised through continuous improvement methodologies.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Learning from Mortality: A review of stillbirths at WWL in 2023

January – October.

Eve Broadhurst Divisional Head of Governance for Maternity and Child Health

Joanne Birch Specialist Matron / Fetal Surveillance Lead.

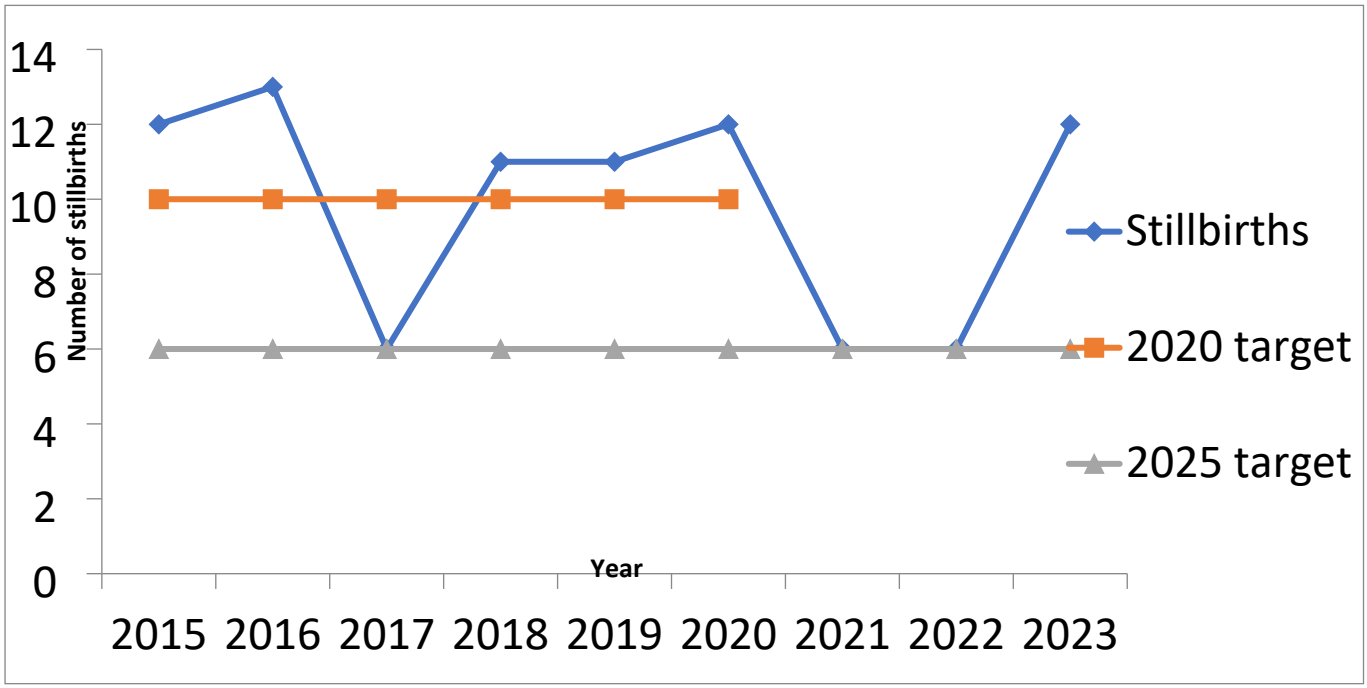
Contents

1. Background

The Department of Health (2016) and NHS England (2016) mandated that Maternity Services should work toward halving the number of stillbirths by 2030 and achieve a 20% reduction by 2020. The NHS Long Term plan (2019) has set a target of reducing stillbirths by 50% by 2025 (based on 2010 data). That would require England and Wales to reduce its stillbirth rate to 2.6 stillbirths per 1000 births.

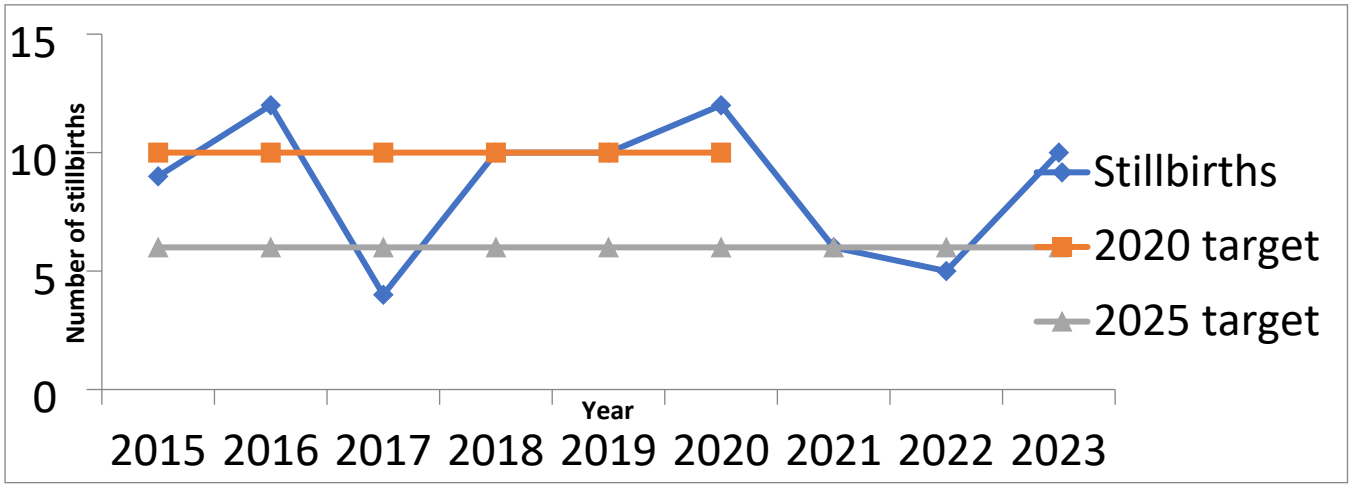
The Office for National Statistics (ONS) has confirmed that rates of stillbirth in England and Wales increased from 3.8 per 1000 births in 2020 to 4.1 per 1000 in 2021. There was a slight decrease in 2022 to 4 per 1000 births but this remains higher than pre-Covid-19 rates in 2019. The data also shows that there continues to be significant variation in stillbirth rates across different parts of England and Wales.

1.1 Total number of stillbirths at WWL since 2015 against National targets (up to October 23)



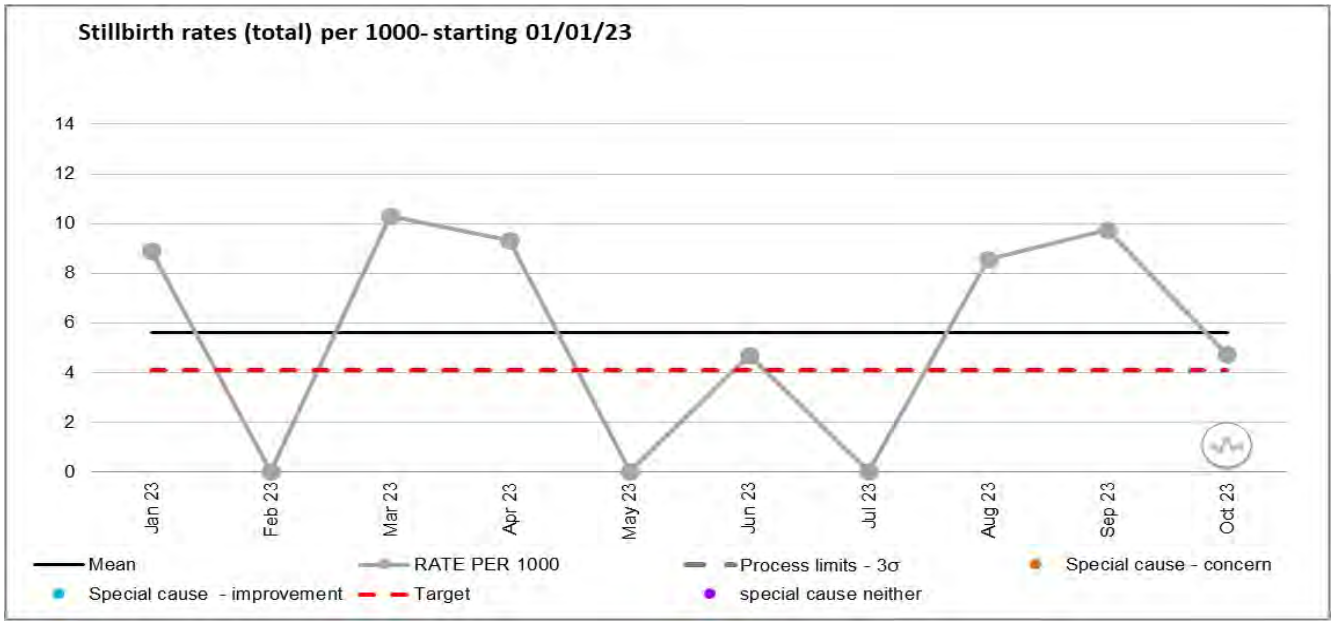
The graph above shows the fluctuating numbers of stillbirths over the last 9 years at WWL. In 2020 the number of stillbirths increased during the Covid-19 period in line with the national picture, following which, WWL saw a downward trend emerge over the following 2 years. However, in 2023 there has been a steep increase in the trajectory prompting a deep dive into all of these cases to provide assurance that the learning from stillbirth reviews is being identified and actions are in place.

1.2 Number of stillbirths – Adjusted for MTOP – at WWL since 2015 against National targets (up to October 2023)



From July 2023 GMEC data submission includes the adjusted rate of stillbirth for medical termination of pregnancy (MTOP). The adjusted number of stillbirths from 2015 is provided in the graph above. All stillbirths are eligible for rapid review, however MTOPs are not eligible for review via the Perinatal Mortality Review Tool (PMRT).

1.3 Rates of stillbirth (total) in 2023 at WWL



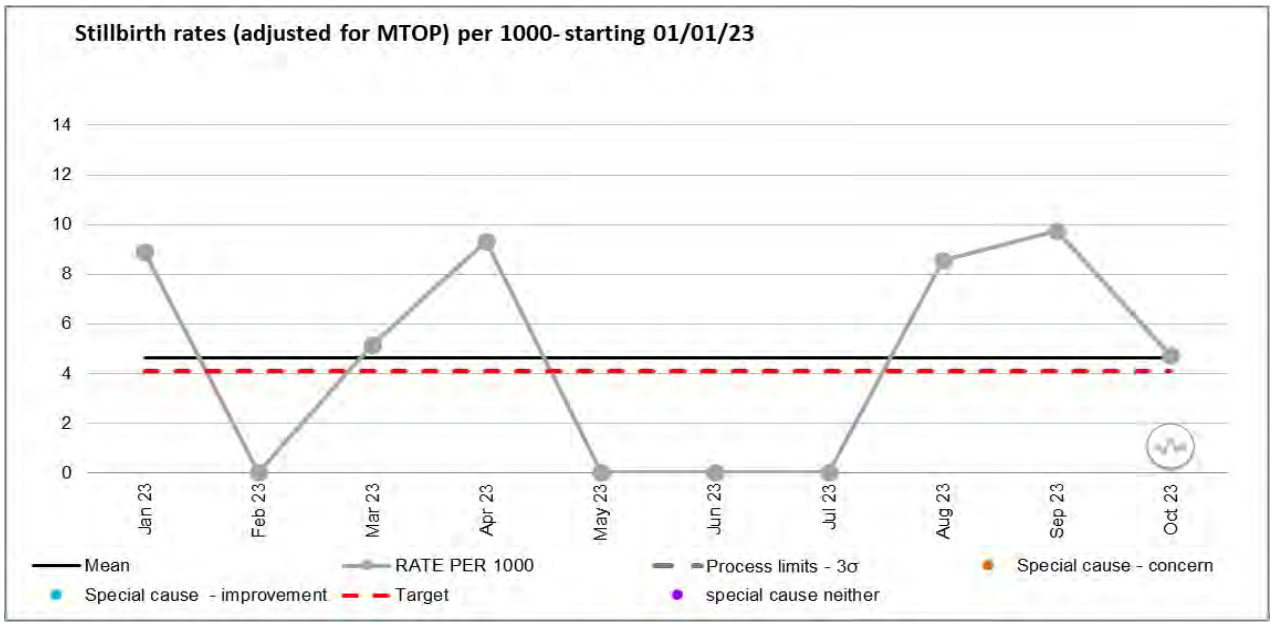
Data pull 8.11.2023 – source Tableau

Black line - WWL mean

Red line - GMEC mean

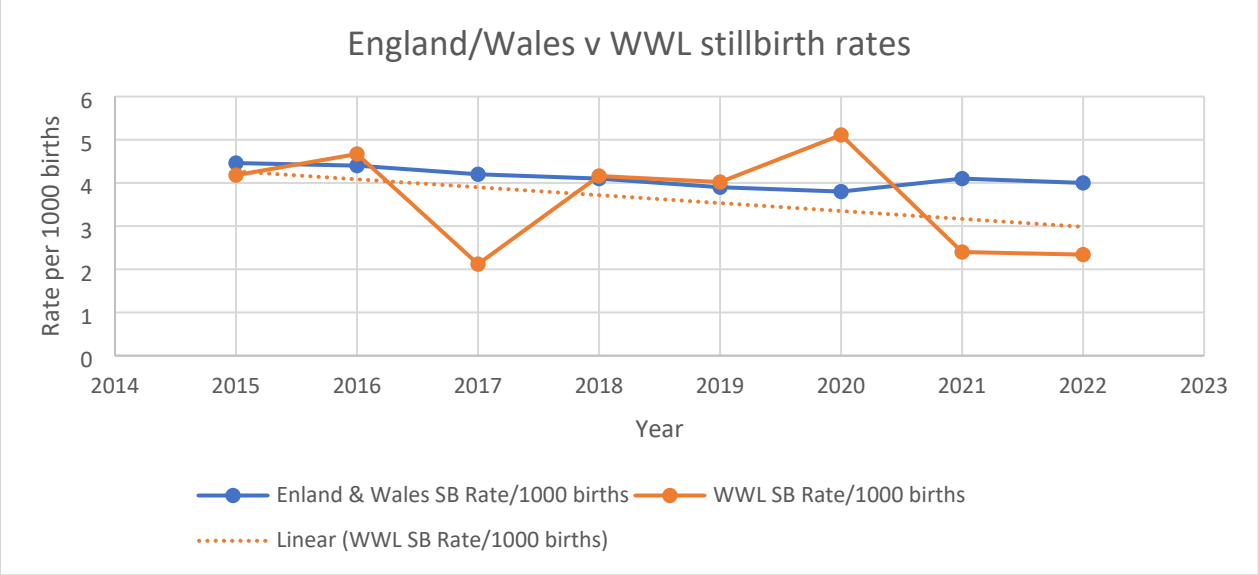
GMEC rate at the time of the data pull in 2023 (YTD) was 4.1/1000 births. WWL rate at the time of the data pull in 2023 (YTD) was 5.81/1000 births. WWL has been an outlier for rates of stillbirth in GMEC for the last 3 quarters.

1.4 Rates of stillbirth (adjusted for MTOP) in 2023 at WWL



Data pull 28.11.2023- source Euroking

1.5 ONS stillbirth rates England & Wales as compared to WWL stillbirth rates 2015 - 2022



(Office for National Statistics, 2023)

The graph above provides assurance that year on year, with the exception of 2020, WWL stillbirth rates have been in line with or significantly below the rates across England & Wales.

2. Overview of stillbirth cases 2023 (January – October 2023)

2023	Type of Stillbirth	Gestation	Ethnicity	Decile	Maternal Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues identified	PMRT grading
January	Antenatal	33+1	White British	9	24	23.5	No	No	52.9	Yes	B, A
January	Antenatal	36+1	White British	2	28	36.5	No	GDM	0	No (known anomaly)	A, A
March	MTOP	25+6	White British	2	29	23.6	Yes	No	-	No	-
March	Antenatal	35+5	White British	1	32	45.7	Yes	No	5.5	Yes	B, B
April	Unknown pregnancy	?29	White British	1	41	-	Yes	No	-	No	-
April	Antenatal	32+4	White British	1	34	34.4	No	No	36	Yes	B, B
June	MTOP	24+4	White British	1	33	46.6	No	No	76.7	No	-
August	Antenatal	35	White British	9	27	27.4	No	No	0.1	Yes	Final PMRT 4.12.2023
August	Antenatal	41	White British	2	27	37	No	No	31.7	No	In progress
September	Antenatal (twins)	26+5	Black African	2	29	33.2	No	No	4.5 0.0	No	In progress (joint)
October	Antenatal	39+2	White British	4	29	33	No	Declined GTT	92.3	Yes	In progress (joint)

3. Themed analysis of stillbirths at WWL in 2023 (January to October 2023) 11 mothers (12 babies)

Sources

Detailed timelines

72-hour reviews

PMRT reports (4 case reviews still in progress)

Case notes

0 complaints have been received

Tableau

Euroking

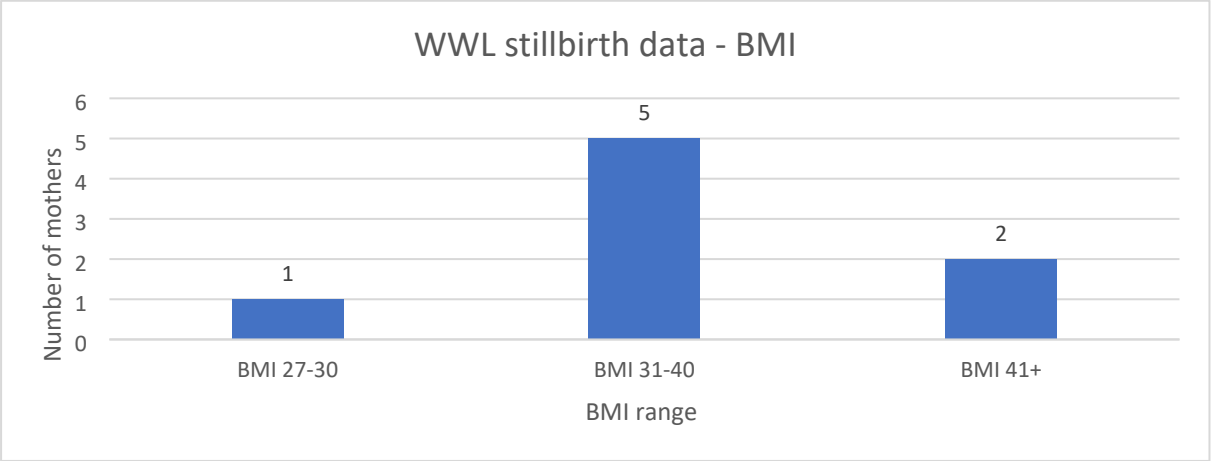
DATIX

GMEC dashboard

BMI

In women with a high BMI (> 26) the risk of stillbirth increases by around 20% with every 5 extra BMI points on the scale (Tommy's, 2023).

In WWL almost 73% of mothers who experienced a stillbirth had a BMI >26.



Raised BMI is a public health issue wider than the scope of maternity services however local guidance recognises that women with a raised BMI are at increased risk of various pregnancy complications including stillbirth. It provides guidance to support women with a BMI >25-30 to self-refer to the Community Weight Management service where free Slimming World classes are available, and to offer women with a BMI of 30 or more a referral to the Specialist Weight Management service.

The PMRT gathers data on folic acid, aspirin, diabetes screening (GTT) and scan pathways, however, does not reference care around weight management. This is something future local reviews should look at in light of this data. 1 review of care stated that a BMI of 27.4 was normal, which illustrates well how our perception of what is a high BMI has altered over time.

100% of eligible women were offered high dose folic acid, aspirin, GTT and were on the correct scan pathway.

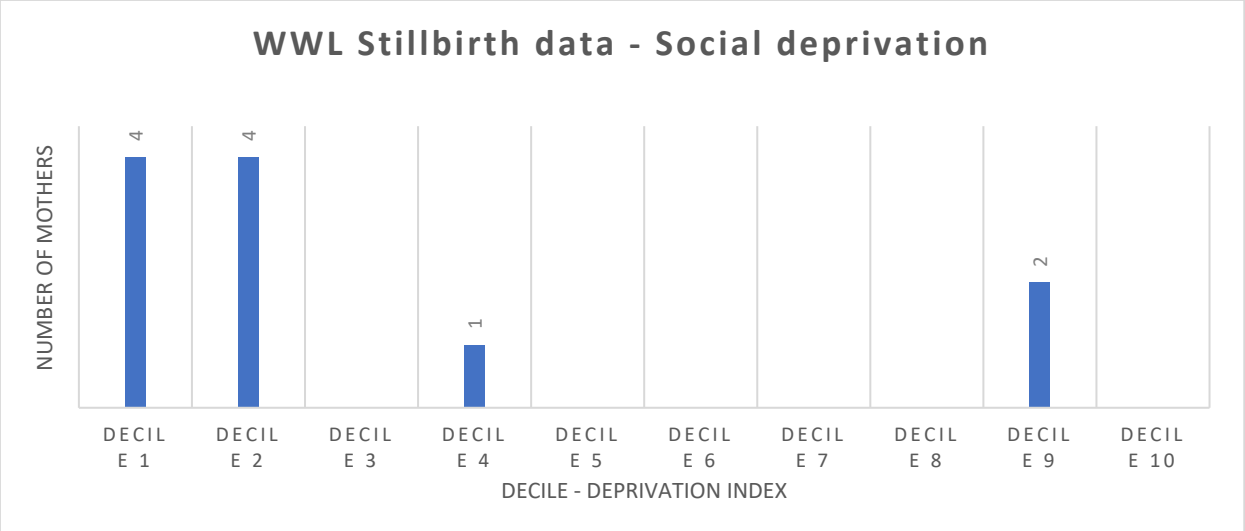
1 woman declined a GTT, and we are currently looking at our processes of follow up when women decline, cancel, or do not attend a GTT appointment to ensure women are fully informed to make a decision by the appropriate professional at the earliest opportunity.

At WWL there was a link between the mothers with a raised BMI and social deprivation with 75% of those living in Deciles 1 and 2 having a BMI of at least 27. 50% of those living in Deciles 1 and 2 had a BMI >30, and 25% had a BMI >40.

Social Deprivation

In 2021, in the UK there were notable increases in stillbirth rates for babies born to mothers from the most deprived areas (from 4.29 per 1,000 total births in 2020 to 4.69 per 1,000 total births in 2021), representing widening inequalities (MBRRACE, 2023).

At WWL almost 73% of mothers who experienced a stillbirth lived in areas with a postcode in the bottom 20% of the deprivation index.

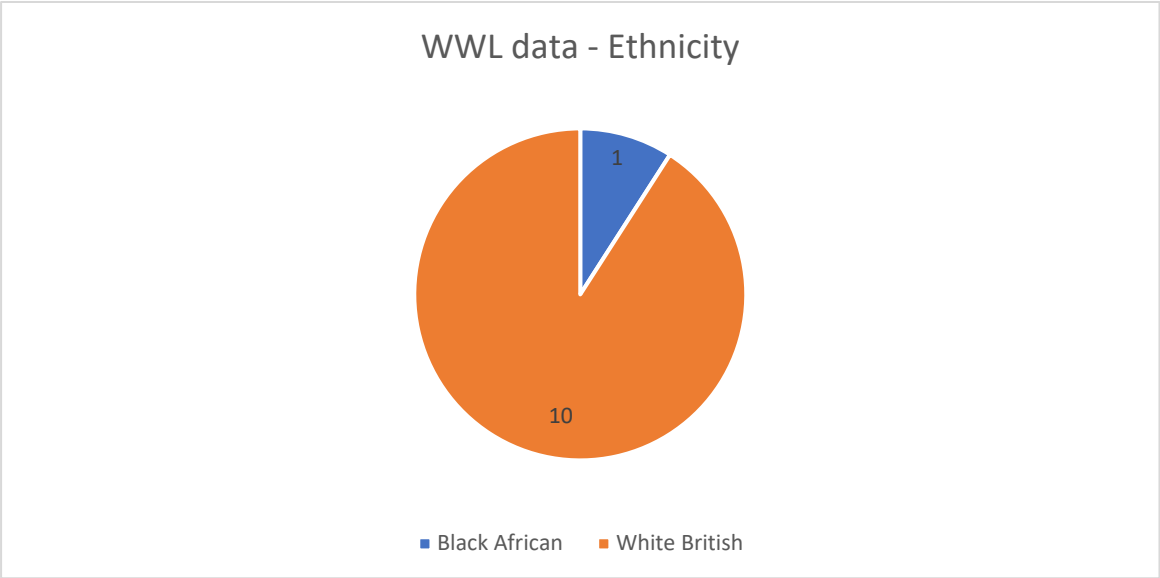


Ethnic Origin

In 2021, in the UK there were notable increases in stillbirth rates for babies born to mothers of Black ethnicity (from 6.42 per 1,000 total births in 2020 to 7.52 per 1,000 total births in 2021), representing widening inequalities (MBRRACE, 2023)

In WWL the mothers who experienced a stillbirth were predominantly white British (90%). This may be in part due to the demographic in the Borough. 1 Black African

mother experienced the stillbirth of twins due to a known complication of an MCDA twin pregnancy. There were no issues identified with the care



MBRRACE (2023) recognises not only the effect of deprivation on the stillbirth rate but also the compounding effect of ethnicity and social deprivation. WWL has recently implemented a dedicated midwifery team called the Fern team which provides enhanced midwifery care to all women who live in Decile 1 (lowest 10% of the deprivation index) and to all none-English speaking women regardless of decile.

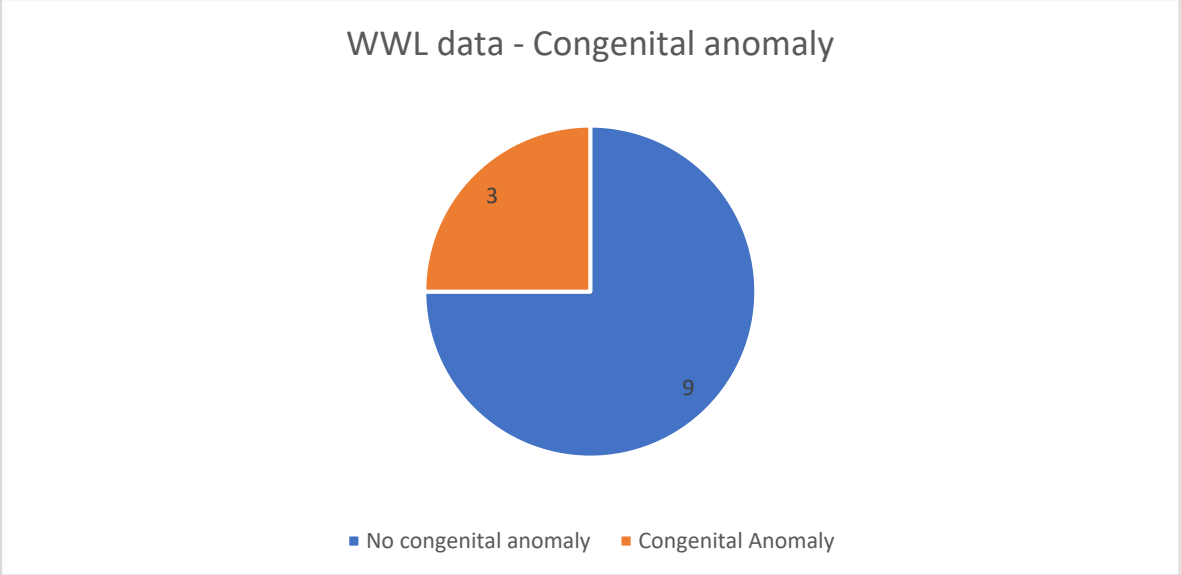
Furthermore, the Daisy team is a dedicated team providing enhanced care to the most vulnerable and complex families and has been recognised nationally. WWL has the highest rate of domestic abuse in the country and a population with some of the highest deprivation, substance misuse, red flag mental health (risk of suicide), and proportionally high number of babies / children subject to a child protection plan in Greater Manchester. 2 women were under the care of the Daisy team. 1 woman had complex social issues and had an MTOP due to fetal anomalies. The Daisy team supported 1 woman due to not attending several appointments. The mother's case was complicated by smoking (declined referral to stop smoking services), BMI >40 and social deprivation.

It is evident from the data that monitoring outcomes for women in the lowest 20% of the deprivation index is pivotal to tailoring future service provision.

Congenital Anomaly

In the UK in 2021, congenital anomaly accounted for 9.3% of stillbirths and this figure has remained consistent as one of the leading causes of stillbirth (MBRRACE, 2023).

At WWL congenital anomaly accounted for 25% of stillbirths. There were no issues identified with the care. It is worth noting that when MBRRACE collate our rates of stillbirth, the figure will be adjusted for all congenital anomalies.



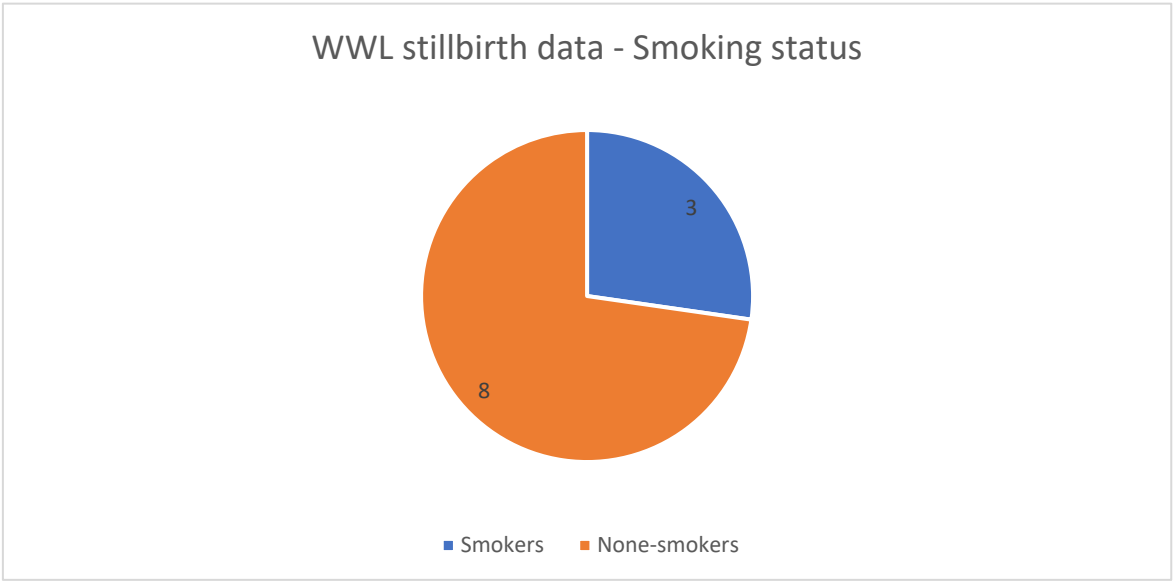
Maternal Age

Maternal age 35 or over is associated with an increased risk of stillbirth (NHS, 2021). 1 mother who had a stillbirth at WWL was aged over 40. This was an unknown pregnancy and therefore the mother did not access maternity services. There was no strong theme identified of women aged over 35.

Smoking status

Mothers who smoke during pregnancy are at increased risk of stillbirth, with those who smoke over 10 a day increasing the risk by 52% (Tommy's, 2023).

At WWL 27% of mothers who experienced a stillbirth were known smokers. Of these 3 mothers, 1 was an unknown pregnancy and therefore the mother did not access maternity services, 1 mother declined stop smoking services (antenatal stillbirth at 35+ weeks) and 1 mother was referred appropriately to stop smoking services (MTOP). There were no care or service delivery issues identified in relation to these cases in relation to smoking.



At WWL there is now a Band 7 lead on Element 1 of the Saving Babies Lives 3 care bundle. Elements 1 has been submitted for validation and meets the Maternity Incentive Scheme Year 5 Standard with 70% progress towards full implementation.

Fetal Growth Surveillance

Fetal growth restriction accounts for a 7-fold increase in the risk of stillbirth (Perinatal Institute, 2018).

All mothers were on the correct care pathway.

5 babies had a birthweight under the 10th centile on the customised growth chart.

3 babies were expected to be small due to fetal anomaly and twin-to-twin transfusion.

2 babies were undiagnosed as small for gestational age (SGA).

The 1st mother had a BMI of 45.7 and on ultrasound the growth was estimated to be normal. Maternal obesity is a known limitation of ultrasound imaging. The mother presented with reduced fetal movements for 22.5 hours; information regarding reduced fetal movements had been given. WWL is in the top 10 hospitals in the country at detecting SGA pregnancies. Recent improvements in the service are noted with the addition of extra scan slots in order to achieve the targets of the Saving Babies Lives 3 care bundle.

The 2nd mother was on the midwifery-led pathway. Fundal height measurements were plotted accurately on the chart at the correct intervals. The addition of a more formalised approach to the practical assessment of fundal height measurement in

the mandatory training package from September 2023 will increase assurances of a standardised approach.

Intrapartum Stillbirth

In the UK around 7% of all stillbirths occur in the intrapartum period (MBRRACE 2021).

There were no intrapartum stillbirths at WWL. It is noted that 1 stillbirth was unable to be confirmed as either antenatal or intrapartum stillbirth as the pregnancy was unknown to the mother, she did not access maternity services and she delivered at home with no medical professional present.

Themes identified from review of care and service delivery

Theme	Occurrence
Good care	
No learning identified	3
Documentation	
Community – No documentation of mother's presentation/rationale for OC screen	1
Triage – documentation not available at review – delays in filing process	2
Triage – no documentation of fetal movements following telephone triage	1
Missed/incomplete tests	
Incomplete cholestasis screen – omitted bile acids	1
Missed MSU (should test every visit)	1
Delayed care/treatment	
VTE 4 – commenced LWMH at 28 weeks	1
Persistent missed appointments	
Missed appointments for cervical length screening – pregnancy continued to term	1
Missed appointments – referred to Daisy team for support	1
Cancelled/missed/declined GTT – processes are being strengthened to ensure speak to DSM / RM at earliest opportunity	1
Lack of senior review	
Triage - Attended with known PPROM & 1st episode of reduced movements – plan by ST3	1
Induction of labour booked after 41 weeks	
Booked at 41+1. Presented with IUD prior to induction date	1
Inappropriate plan of care	
Plan made for fortnightly follow up for PPROM – should be weekly – guideline needs clarifying. This did not affect the outcome.	1
Consultant-on-call did not attend to confirm SB and family had to wait until following day.	1

4. Summary

Between 2015 and 2022 WWL has seen a downward trajectory for the rate of stillbirths and, with the exception of 2020, have either been in line with, or significantly below ONS reported rates of stillbirth across England and Wales. 2023 to date has since an increase in both the number and rate per 1000 births of stillbirths at WWL and we have been an outlier for rates of stillbirth in GMEC for the last 3 quarters.

12 babies have been stillborn between January-October 2023, with an adjusted figure for MTOP of 10 babies and an adjusted figure for fetal anomalies of 9 babies. 25% of babies stillborn had known anomalies. Furthermore 2 babies (twins) were stillborn following known complications of MCDA twin pregnancy, with specialist care from the tertiary fetal medicine unit.
There were no known cases of intrapartum stillbirth.

A review of all 12 cases has identified strong themes around raised and significantly raised BMI, social deprivation, and white British ethnicity with 50% of white British mothers living in deciles 1 or 2 and having a significantly raised BMI at booking, compounding the risk.

WWL has a dedicated team for mothers who live in decile 1 and for non-English speaking women regardless of decile. There is also a dedicated team providing care for the most complex and vulnerable families. The Saving Babies Lives team has developed in 2023 with the appointment of Band 7 midwifery leads specialising in Elements 1, 5 and 6 of the care bundle (Smoking, Pre-term birth and Diabetes in pregnancy).

Themes from care and service delivery have identified issues in Triage regarding appropriate level of obstetric review, documentation omissions and delays in filing the records which poses a risk. A new interim matron with a background in intrapartum patient safety has been appointed and has been involved in collating the learning from reviews.

The management of persistently missed appointments is a challenge for maternity services and pathways have been strengthened in 2023 at WWL to ensure a robust process of follow-up. Recent learning from a 72-hr review has identified that improvements can be made when women cancel/miss or decline GTT appointments and with immediate effect the Diabetes Specialist Midwife will have oversight of these women to ensure they have had the correct information to make an informed choice at the earliest opportunity. Robust processes of documentation are pivotal.

4 cases have been through the PMRT process and incidental learning only was identified. 4 cases are ongoing. Themes from review will continue to be collated and governance processes followed.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Learning from Mortality: A review of Neonatal Deaths at WWL

October 2022- September 2023

Joanne Birch Specialist Matron / Fetal Surveillance Lead

December 2023.

Contents

1. Background

A neonatal death is the death of an infant aged under 28 days. In England, the government has an ambition to halve the 2010 neonatal mortality rate for babies born at a gestational age of 24 weeks or over by 2025. The neonatal mortality rate ambition in England is 1.0 deaths per 1,000 live births of babies born at 24 weeks or over.

A review of the neonatal deaths that occurred at WWL during October 2022 – September 2023, has been undertaken to identify learning. *(Information only will be included for any neonatal deaths of babies born at WWL during this time but required transfer to a tertiary level 3 unit and died outside of the trust).*

During the time frame October 2022 to September 2023 the total number of births at WWL was 2526. There were 8 recorded early neonatal deaths during this time, ranging from 18 weeks to 24+6 weeks gestation **(0.32%).** There were no recorded late neonatal deaths at WWL. (There were 6 neonatal deaths outside WWL, which underwent/undergoing a shared PMRT review)

Neonatal Deaths at WWL (Oct 2022 – Sept 2023)

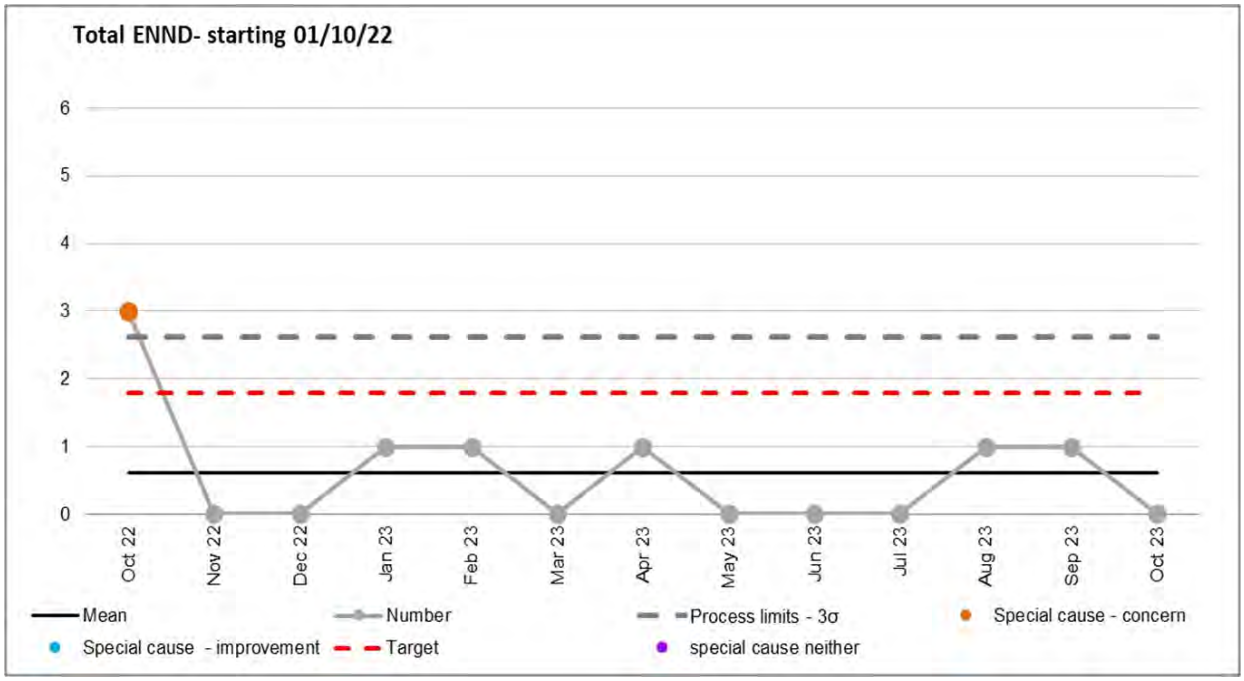
Gestation	Number of Neonatal Deaths	Medical termination of Pregnancy (MTOP)
Gestation <20 weeks	1 (12.5%)	1
Gestation 20 – 23+6 weeks	6 (75%)	4
Gestation >24 weeks	1 (12.5%)	0
Total	8	5

63% of the neonatal deaths that occurred at WWL were following a medical termination of pregnancy (MTOP) for a fetal anomaly or compassionate IOL for maternal / fetal reasons

Neonatal Deaths outside WWL (Oct 2022 – Sept 2023)

Gestation	Number of Neonatal Deaths	Medical termination of Pregnancy (MTOP)
Gestation <20 weeks	0	
Gestation 20 – 23+6 weeks	3	• 1 ENND (22 weeks) • Twin 1 LNND at 14 days • LNND at 19 days (22+6)
Gestation >24 weeks	3	• 2 ENND following cooling for abruption • 1 LNND at 18 days for undiagnosed heart defect

1.1 Total number of neonatal deaths of babies who died at WWL October 2022 – September 2023



Data collected – 08.11.23 (Tableau) – Red Line = GMEC mean target

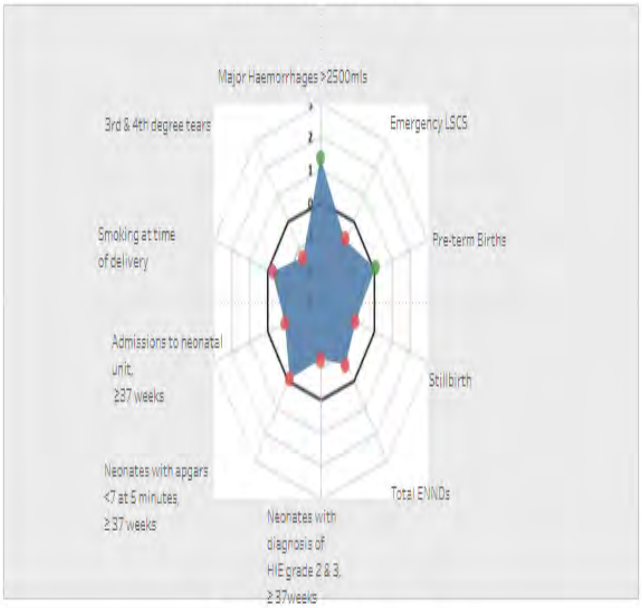
Black Line = WWL mean target

Table 1.1 illustrates the number of early neonatal deaths at WWL over a twelve-month period against the GM average rate. Except for October 2022, when there were 3 recorded neonatal deaths, WWL have remained under the GM mean target per month.

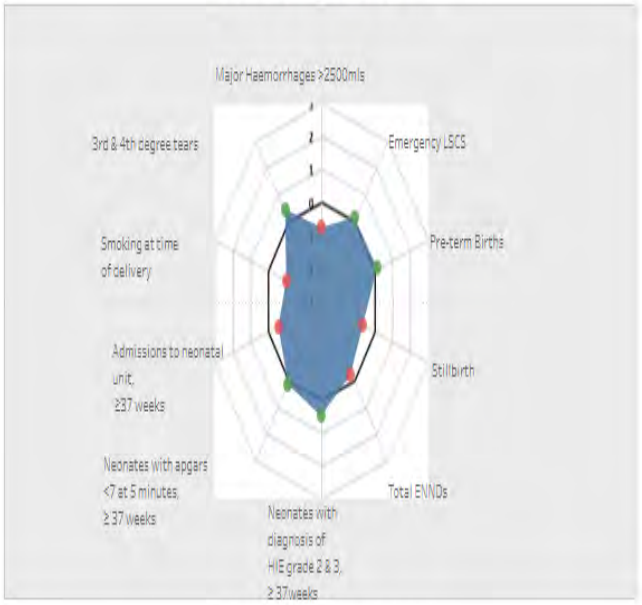
Data from Greater Manchester Tableau demonstrates over a 12-month period, apart from Q4 in (2022/2023) that WWL have been an outlier for neonatal deaths with a rate of 2.78 per 1000 births compared to the GM rate of 1.87 per 1000 births.

1.2 Greater Manchester quarterly comparison spider graphs for WWL

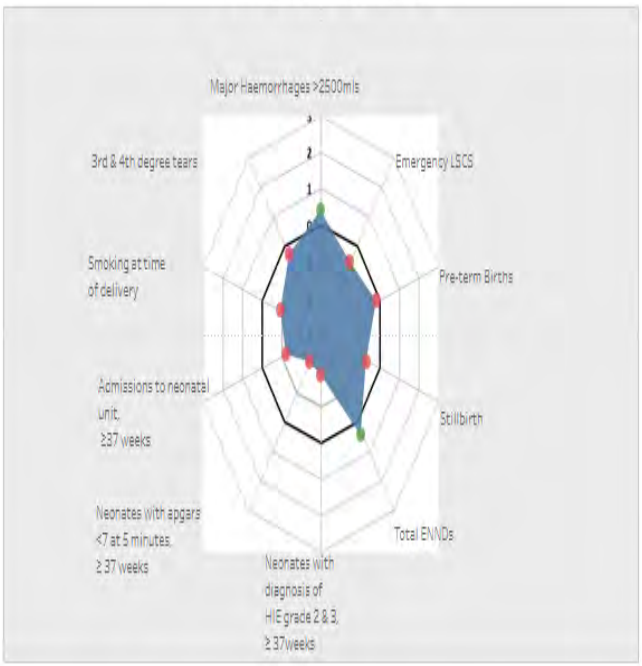
FY 2023/24 Q2 (Jul'23 -Sept'23)



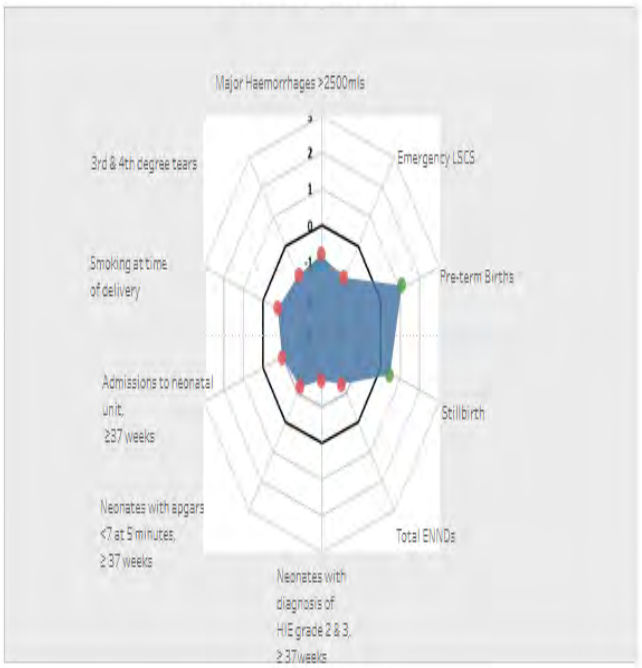
FY 2023/24 Q1 (Apr'23 -Jun'23)



FY 2022/23 Q4 (Jan'23 -Mar'23)



FY 2022/23 Q3 (Oct'22 -Dec'22)



2. Overview of NND cases at WWL 2022/2023 (October -September)

2022 - 2023	Type of NND	Gest	Ethnic Origin	Decile	Maternal Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues identified	PMRT grade
Oct	Compassionate IOL	23+2	White British	7	33	21.2	No	No	57.9	No	For info only on PMRT
Oct	Emerg LUSCS	24+6	Indian	4	34	22.1	No	No	0.5	Yes	B, B
Oct	Compassionate IOL	20+5	Asian	5	34	30.3	No	Yes	-	Yes	For info only on PMRT
Jan	MTOP	18+5	White British	9	34	23.3	No	No	-	No	<20 weeks
Feb	MTOP	21+1	White British	2	31	25.8	No	No	-	No	For info only on PMRT
Apr	Spontaneous Labour	22	White /Latvian	2	26	23.5	No	No	-	No	A A A
Aug	MTOP	21+6	Black African	2	34	29	No	No	-	No	For info only on PMRT
Sept	Spontaneous Labour	20+6	Black African	2	34	32.8	No	No	-	No	For info only on PMRT

For the 8 Early Neonatal Deaths reviewed at WWL, information was Sourced from:

Detailed timelines

72-hour reviews

PMRT reports

Case notes

0 complaints have been received

Tableau

Euroking, Maternity Information System

DATIX Incident Reports

GMEC dashboard

1 STEIS

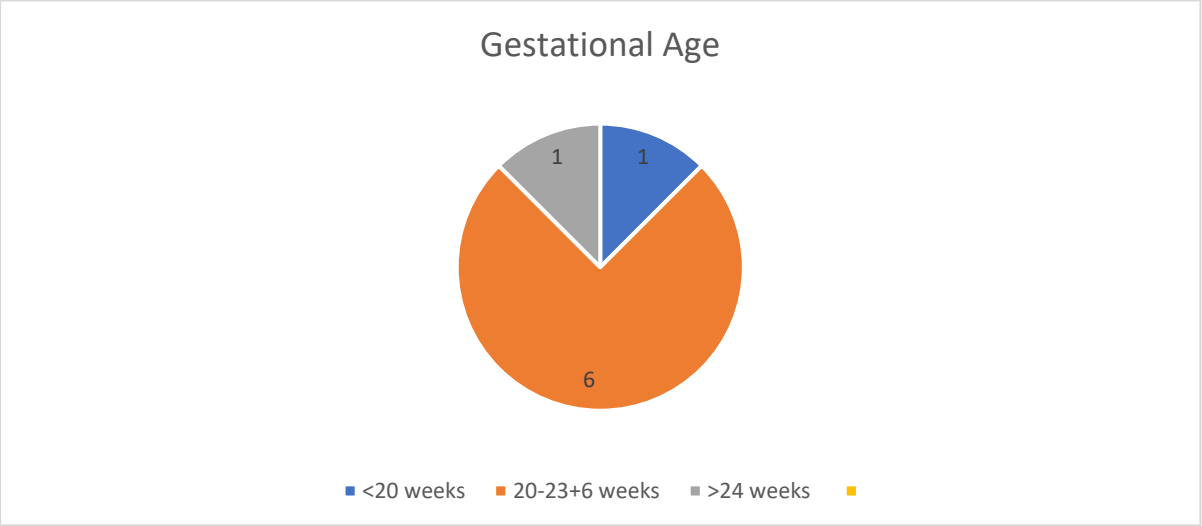
3.Themed analysis of neonatal deaths at WWL October 2022 – September 2023

The Office for National Statistics (ONS, 2021) report there are known risks for neonatal mortality and these risk factors that have been considered within this review, the risks include:

- Gestational Age
- Cause of Death
- Birthweight
- Ethnicity
- Maternal Age
- Deprivation

Gestational Age

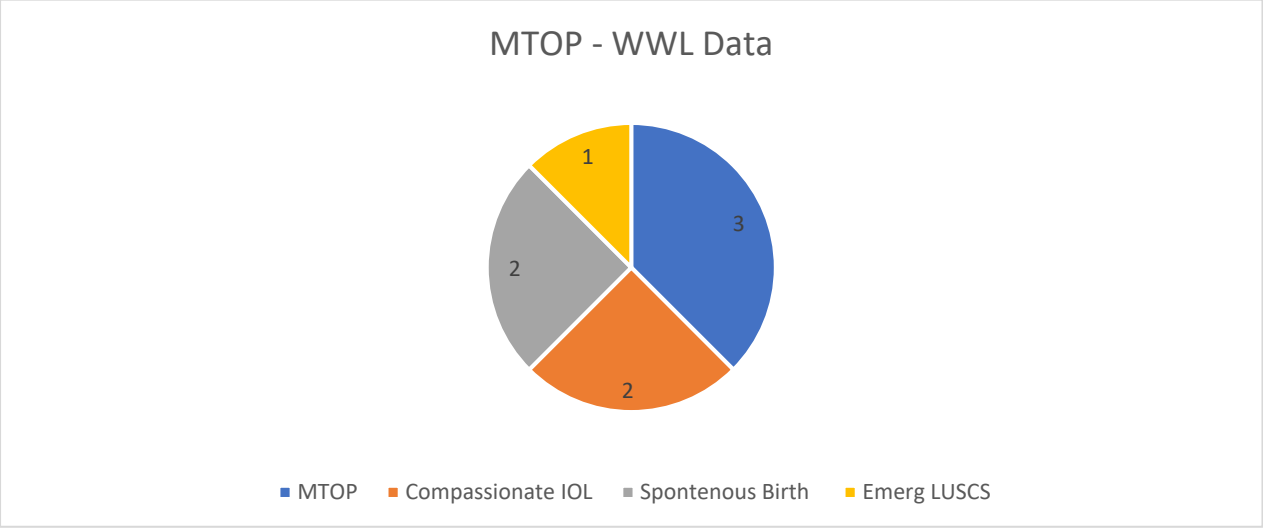
Babies born at earlier gestations have a higher mortality rate than babies born at term. 75% of the ENND at WWL were of babies born between 20 – 23+6 weeks gestation.



Medical Termination of Pregnancy (MTOP) for Anomaly

A MTOP will be offered at WWL for any women with a confirmed fetal anomaly of the fetus. Women >21+6 who choose to undergo a MTOP, will be offered feticide to end the life of a fetus prior to birth. This is offered to spare the families of the extremely difficult experience of their baby being born alive. 37.5% of neonatal death at WWL were following MTOP of fetus under 22 weeks. At this gestation feticide has not been offered.

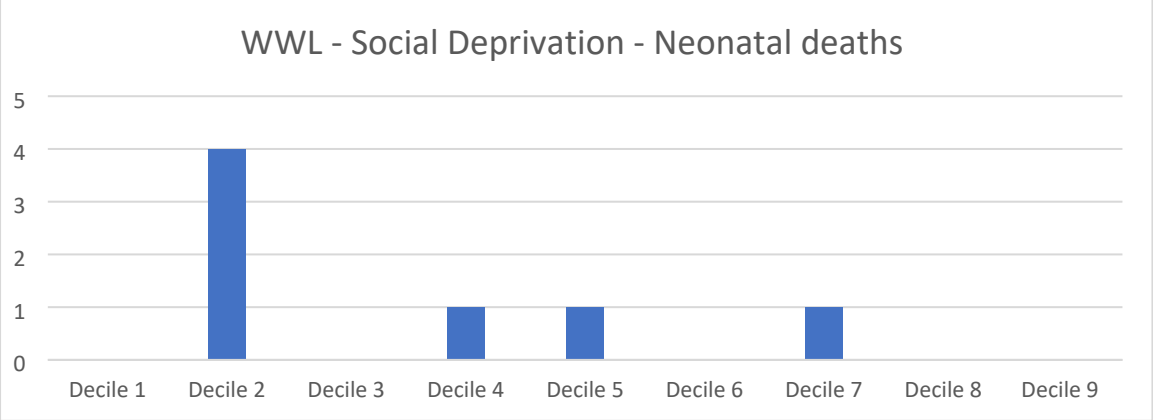
25% of the neonatal deaths at WWL were following compassionate induction of labour (IOL) following the pre-term prelabour rupture of membranes (PPROM) or for maternal wellbeing (sepsis). A compassionate IOL is when labour is brought on artificially when the prognosis of continuing the pregnancy is poor or there are significant risk factors for mother or baby.



Social Deprivation

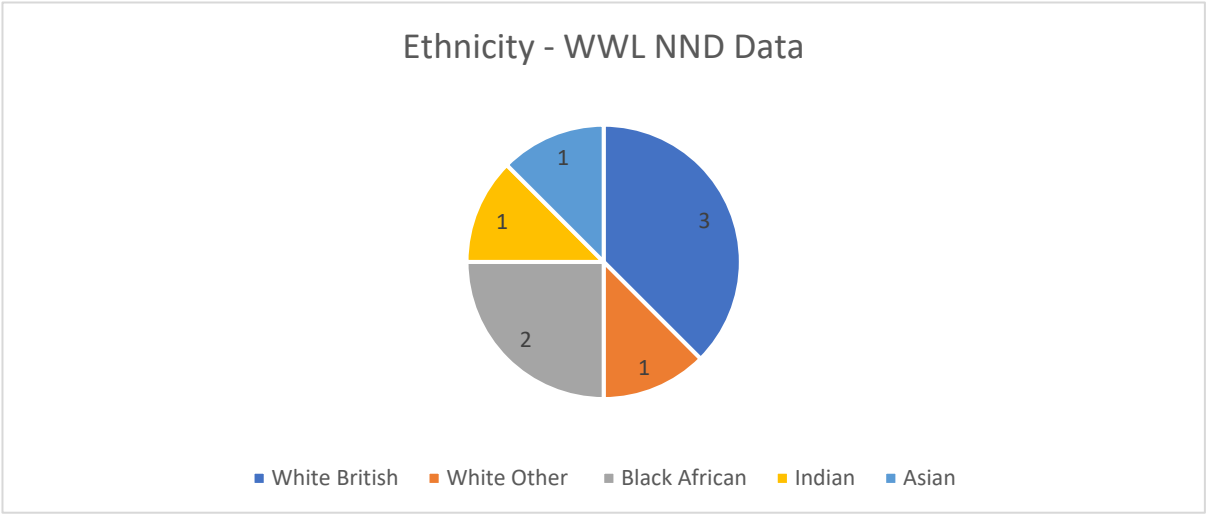
Infant mortality risk varies by socio-economic background. In 2021, the 10% most deprived areas in England had higher infant mortality rates compared with the 10% least deprived areas.

50% of the neonatal deaths at WWL occurred in families who lived in areas with a postcode in the bottom 20% of the deprivation index. WWL have two community teams which provide enhanced care for vulnerable families. In line with the stillbirth data from WWL decile 2 is significant, whilst care is provided for vulnerable women and women in decile 1, at the time of the report there is no dedicated team for women in decile 2 unless they meet criteria for one of the enhanced teams (Daisy or Fern)



Ethnicity

At WWL the mothers who suffered a neonatal loss were predominantly White British (37.5%). This may be in part due to the demographic in the Borough. 2 Black African mothers experienced neonatal deaths, one of those was following a medical termination of pregnancy (MTOP). No themes with ethnicity were highlighted within this review



Maternal Age

The ONS (2021) reported in 2021, babies born to mothers aged 30 to 34 years had the lowest risk of infant mortality and babies born to mothers aged under 20 years had the highest risk of neonatal death. Maternal age >35 or over is associated with increased risk of neonatal death (NHS, 2021).

All women who suffered a neonatal death at WWL were under 35 years old. (87.5%% in the 30-34 category). There was no strong theme identified with maternal age.

BMI

Even modest increases in maternal BMI were associated with increased risk of neonatal death. Weight management guidelines for women who plan pregnancies should take these findings into consideration to reduce the risk of neonatal death.

Raised BMI is a recognised public health issue and maternity guidelines provide guidance to support women with a BMI >25-30 to self-refer to the Community Weight Management service where free Slimming World classes are available.

Women with a BMI of 30 or more should be offered a referral to the Specialist Weight Management service.

In WWL 50% of mothers who experienced a neonatal death had a BMI >25, two of those women with a BMI >30 at booking

4. Themes identified from review of care & service delivery for ENND at WWL

Theme	Occurrence
Good care	
No learning identified	6
Documentation	
Booking Risk Assessment does not identify need for cervical length scans	1
Missed/incomplete tests	
Cervical Length scans / missed opportunity for cervical suture	1
Community midwife appointments for routine care outside obstetric care	1
Missed midstream urine test during antenatal period	2
Delayed care/treatment	
Reviewed in A&E ? delay in recognising pre-eclampsia due to BP limits	1
Misdiagnosis of pre-eclampsia	1
Missed opportunity to commence MgSo4 for neurological protection	1
Lack of recognition of deteriorating fetal heart rate with intermittent auscultation	1
Delay in performing ultrasound scan following eclamptic seizure	1
Lack of senior review	
On recognition of deteriorating fetal heart rate, no face-to-face consultant review	1
Inappropriate plan of care	
Initial risk assessment did not recognise high risk pathway	1

Summary

2022 – 2023 at WWL has seen no spikes in the number of monthly neonatal deaths. With the exception of October 2022, the monthly rate of neonatal deaths has been below the GM mean rate. However, the annual rate from Oct 2022 – September 2023 has seen WWL as an outlier in GM for 3 of the last 4 quarters (exception Q4 2022/2023).

8 neonatal deaths have occurred at WWL during the time frame (further 6 neonatal deaths in babies born at WWL who have died at another Trust). 63% were following a MTOP or Compassionate IOL all under 24 weeks. The routine use of feticide is only used for pregnancies over 21+6 weeks undergoing MTOP, all 3 MTOP's and 1 compassionate IOL at WWL were under this gestation and therefore did not receive it. On review of the case notes all babies born should signs of life for longer than 10 minutes and therefore were classified as livebirths.

A review of all 8 cases which occurred at WWL has identified strong themes around gestational age, cause of death and social deprivation of mothers living in decile 2. 87.5% of neonatal deaths were in babies under 24 weeks gestation.

WWL has a dedicated team for mothers who live in decile 1 and for non-English speaking women regardless of decile. There is also a dedicated team providing care for the most complex and vulnerable families. However, there appears to be a gap in the care provided to women in decile 2.

Learning from care and service delivery has identified several issues. Documentation at booking on the risk assessment form, led to one woman being on the incorrect antenatal pathway and missed cervical length scans, although this may not have prevented a pre-term birth and neonatal death it potentially could have reduced the risk and allowed early recognition of cervical shortening and a cervical suture to be performed.

The Trust has now employed a Pre-Term Lead Midwife as recommended within Saving Babies Lives V3 (Element 5), to support the triage of women who are at high risk of pre-term birth, a new assessment form is under development which will be completed at booking and forwarded to the pre-term lead to ensure women are on the correct pathways and appropriate scans and consultant follow ups are arranged. Women at risk of pre-term birth will be seen in a one stop clinic with the obstetrician and midwifery lead.

Face to Face senior obstetric reviews should occur for women who are high risk, there was a missed opportunity to recognise pre-eclampsia for a significant period, as the woman presented in Accident & Emergency with an unclear history. This led to a delay in commencing magnesium sulphate for neurological protection for the fetus and delays in arranging an ultrasound scan. The combination of extreme prematurity (24+6) and intrauterine growth restriction (IUGR) however, were significant risk factors for neonatal death and the outcome may not have been avoided despite earlier intervention. Holistic overview of women who present with more than one risk factor or unclear presenting history must be clearly documented by a senior obstetrician.

Throughout the review, incidental learning has been identified and any themes from reviews will continue to be collated and governance processes followed.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Learning from Data: A review of babies born with HIE 2 and 3 at WWL in 2022/2023

April 2022 - October 2023

Eve Broadhurst Divisional Head of Governance for maternity and Child Health

Contents

5. Introduction

Hypoxic-ischaemic encephalopathy (HIE) may be diagnosed if a baby's brain does not receive enough oxygen and/or blood flow around the time of birth.

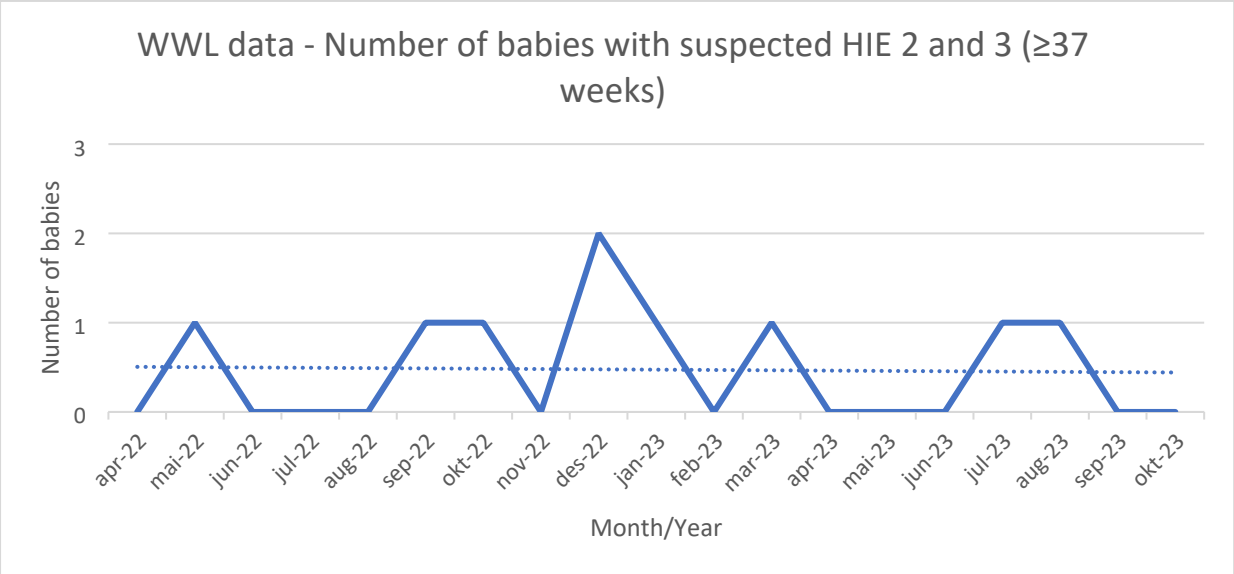
Low oxygen and/or blood flow to a baby's brain happens most commonly before or during birth, but it can also happen shortly after birth.

HIE affects the brain, but the effects of low oxygen or blood flow can also cause problems in the lungs, liver, heart, bowel, and kidneys.
When diagnosed, HIE is graded as mild, moderate, or severe. Where HIE is graded as moderate or severe (HIE 2 and 3), it can result in long-term disability and, in some cases, can sadly result in death.

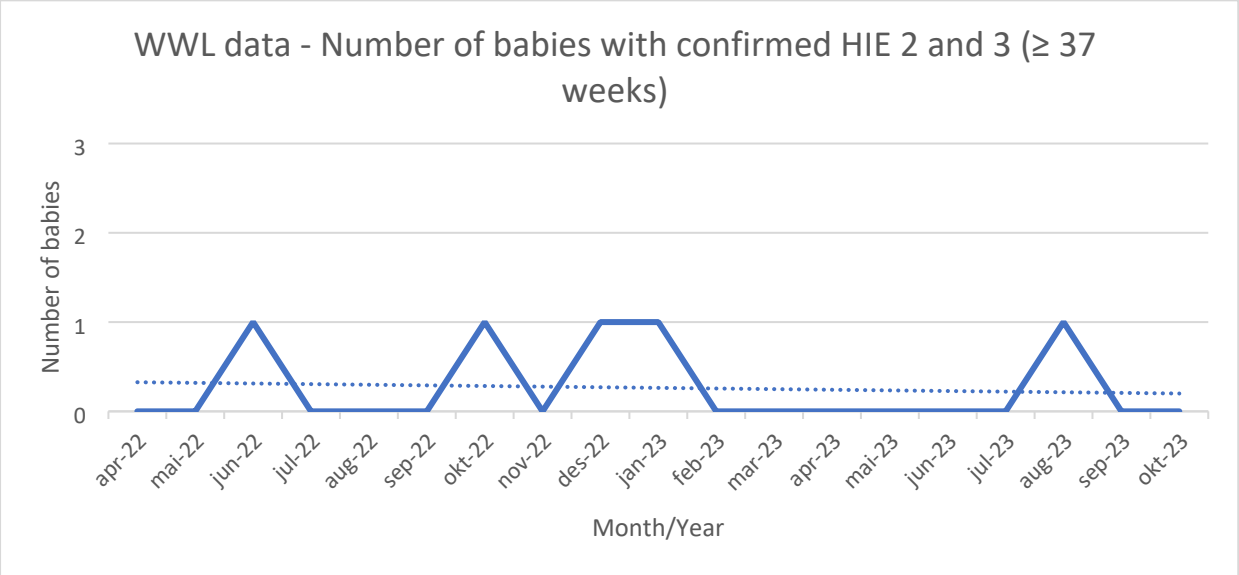
If a baby has moderate to severe HIE, there is a risk of death or long-lasting damage to the brain. To reduce this risk, babies with moderate or severe HIE are likely to receive a treatment called therapeutic hypothermia or cooling, which needs to be started within the first six hours after birth.
An MRI scan uses magnetism to build up a detailed picture of areas of your baby's brain. It is used to see if any damage has been done to your baby's brain. It is usually performed after cooling treatment.

2. WWL Data

2.1 Number of babies with suspected HIE 2 and 3 (1.4.2022 - 31.10.2023)

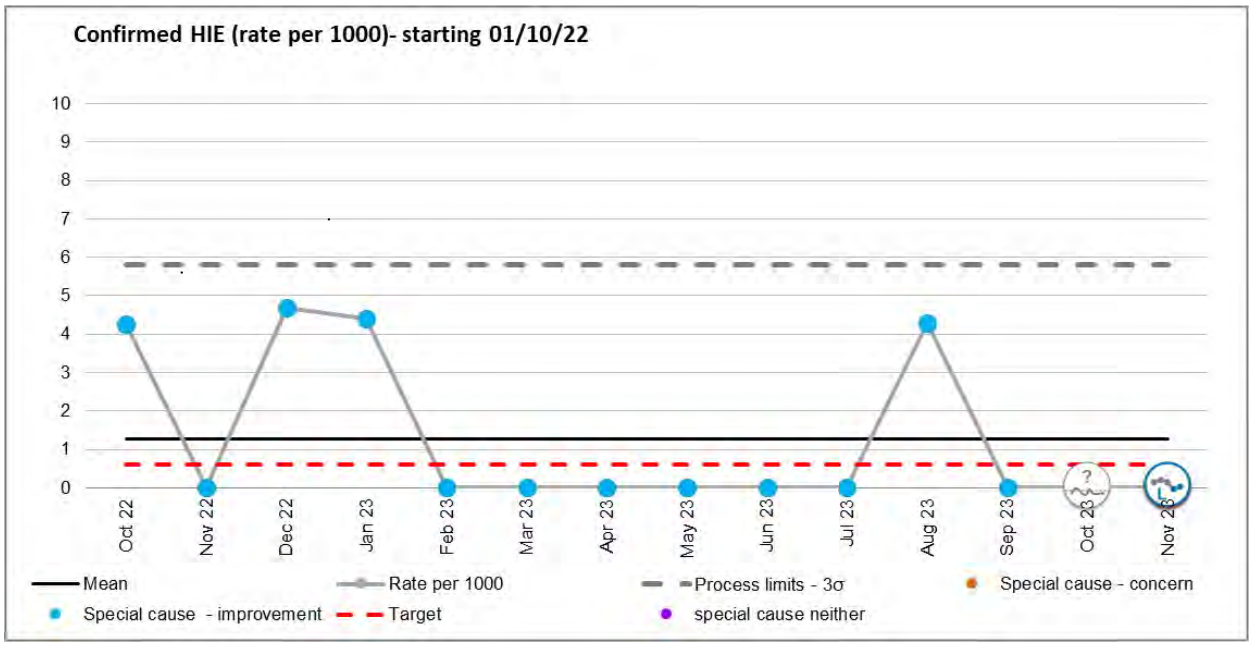


2.2 Number of babies with confirmed HIE 2 and 3 (1.4.2022 - 31.10.2023)



*Includes 1 baby with diagnosis of HIE 1 (changes on MRI)

2.3 Rate of confirmed HIE 2 and 3 ≥ 37 weeks per 1000 births - 1.10.22–31.11.23



---- GMEC mean **——— WWL mean**

In spite of an overall slight downward trajectory in both suspected and confirmed cases of HIE 2 and 3 in babies ≥ 37 weeks, WWL are outliers across GMEC for the number of babies with confirmed HIE on MRI at term. Utilising Tableau data over the last 12 months, at the end of October 2023, WWL mean rate per 1000 births is 1.75 compared to GMEC mean rate of 0.6 per 1000 births.

WWL monitors the numbers of babies with both suspected and confirmed HIE 2 and 3 and collates all learning from reviews to identify themes and trends in care and service delivery.

All cases of suspected and confirmed HIE are subject to review and appropriate referral to HSIB/MNSI.

3. Overview of HIE 2 and 3 cases April 22- October 23

Date	Number of neonates assessed as HIE 2 or 3	Therapeutically cooled	Outcome of MRI	HSIB/MNSI	Comments/learning
Q1 22/23 April 22	0	0	-	-	-
May 22	1	1	No evidence of HIE	HSIB referral accepted	Learning re importance of holistic risk assessment and not reviewing a CTG in isolation.
Jun 22	0	1	Evidence of HIE	HSIB referral rejected – no consent	HIE 1. Learning re 'fit for labour assessment' in presence or abnormal CTG and transferring to Theatre directly from Triage rather than to Delivery Suite.
Q2 22/23 July 22	0	0	-	-	-
Aug 22	0	0	-	-	-
Sep 22	1	1	No evidence of HIE	HSIB referral rejected - no consent	Learning re: Importance of documentation of position of fetal head during vaginal examination to determine progress in labour and anticipate any concerns with descent of the fetal head and delay in labour. 5 – 6 contractions in 10 minutes with Syntocinon – this is hyperstimulation and requires the syntocinon to be reduced to allow for recovery of the fetus in utero between uterine activity.
Q3 22/23 Oct 22	1	1	Chronic HIE	HSIB referral accepted	Complicated by maternal opiate use, un-booked. Baby had microcephaly. HSIB findings – Intrapartum rather than Antenatal CTG interpretation criteria was used when mother not in labour. Decision to Delivery Time (DDT) not met. No safety recommendations.
Nov 22	0	0	-	-	-
Dec 22	2	2	No evidence of HIE	HSIB referral rejected - at triage	Women with pre-labour SROM at term should be offered immediate (as soon as possible) induction of labour or conservative management. No documentation in the notes regarding this. This learning is incidental and would not have affected the outcome. It is important to document whether chest-rise and fall seen during resuscitation. Delay from decision to delivery time (1hr 3 mins). 30 minutes is the target delivery time from decision to delivery. This is unlikely to have affected the outcome.
		-	NA (NND)	HSIB referral rejected – does not meet criteria	Early neonatal death at term following antepartum haemorrhage at home – no labour. No care or service delivery issues found affecting the outcome. Incidental learning only - Take care when documenting 3rd /5th centile and plotting on the small scale on the customised growth chart as this could potentially affect the management plan
Q4 22/23 Jan 23	1	1	NA (NND)	HSIB referral accepted.	Early neonatal death at term following placental abruption on the ward. HSIB investigation – no findings or safety recommendations
Feb 23	0	0	-	-	-
Mar 23	1	1	No evidence of HIE	HSIB referral accepted	Use FSE if unable to auscultate FH up to point of birth. Respond to alarms on CTG. Utilise maternal pulse oximeter to assist differentiation between maternal and fetal heart rates.
Q1 23/24 April 23	0	0	-	-	-
May 23	0	0	-	-	-
June 23	0	0	-	-	-
Q2 23/24 July 23	1	1	No evidence of HIE	HSIB referral accepted	Draft copy received. Learning re: effective Risk Assessment and handover of risk, availability of wireless CTG monitoring, appropriate recognition, and management of hyperstimulation
August 23	1	0	Evidence of HIE	HSIB referral accepted	Investigation in progress. Difficulty assessing neurology due to pain from shoulder ? missed opportunity to cool
Sept 23	0	0	-	-	-
Q3 23/24 Oct 23	0	0	-	-	-

4. Breakdown

9 babies were diagnosed with suspected HIE 2 or 3 in the 19-month period between April 2022- October 2023.

7 of the 9 babies were eligible for MRI.

2 of the 9 babies died before MRI (HIE 3).

5 of the 7 MRIs showed no evidence of HIE.

2 of the 7 babies were diagnosed with HIE on MRI.

A further 1 baby was diagnosed with HIE 1 but has been included in the table below as was therapeutically cooled and there was evidence of HIE on MRI.

Total – 5 cases of confirmed HIE in the 19-month period.

There were 3 cases of confirmed HIE following MRI in the 19-month period April 2022 - Oct 2023 and 2 neonatal deaths (HIE 3).

Case 1 - there was learning re need for 'fit for labour assessment' before artificial rupture of membranes (ARM) in the presence of an abnormal CTG and the need to transfer to Theatre directly from Triage rather than to Delivery Suite.

Case 2 - the woman was un-booked, opiate user – some incidental learning regarding using intrapartum CTG interpretation when the mother was not in labour and the decision to delivery time was not met but NO safety recommendations were made by HSIB (now MNSI).

Case 3 – still under review by MNSI. The 72-hr review identified that the shoulder dystocia was well managed. The interpretation of the neurological picture was complicated by pain and there may have been a missed opportunity to commence therapeutic cooling within the timeframe.

Both neonatal deaths were following placental abruption/APH and **NEITHER** case had any learning that would have affected the outcome.

5. Themes

Learning themes identified include

- CTG management
- Decision to delivery time not met
- Management of syntocinon and hyperstimulation
- Holistic review and ongoing risk assessment.

5.1 CTG Management

Robust actions have been undertaken in response to investigations and actions are monitored via SIRI. It is worth noting that HSIB have recognised fetal monitoring management as a theme nationally. As such this is reflected as a risk on the WWL risk register. Robust, proactive measures put in place by WWL in line with national guidance are in place and improvement work continues with GMEC.

In 2018 the GMEC Fetal Monitoring Group was developed to ensure Trusts within GM work to the same standards and approach based on national guidance. WWL monitoring reports to ensure we are achieving standards set out in national directives such as the Saving Babies Lives Care Bundles and the Maternity Incentive Scheme are submitted to Trust Board quarterly. Currently we are achieving the standards required. As part of the GMEC Fetal Monitoring Network, WWL Fetal Surveillance leads have worked in conjunction with the regional team on the new GMEC Intrapartum and Antenatal Fetal Monitoring guidelines which are now in use. The GMEC fetal physiology training package has been updated with relevant information and the 'complex pregnancies' antenatal CTG package has been completed and is delivered to all maternity staff at the annual mandatory training session. The new intelligent intermittent auscultation package is now embedded at WWL.

A 'fresh eyes' sticker has been developed in line with NICE fetal monitoring criteria and embedded to support with national directives on hourly fresh eyes CTG monitoring and ongoing risk assessment.

In line with SBL >90% of MDT staff are compliant with the full day fetal physiology training, which includes:

- GMEC fetal physiology package and online assessment
- Intermittent Auscultation Package & assessment
- Human Factors
- Dawes Redman
- Overview of CTG related incidents at WWL in 2022 and 2023

Furthermore, additional intrapartum CTG training via the Baby Lifeline CTG Masterclass has been facilitated for Delivery Suite staff and Band 5 midwives as part of their preceptorship.

5.2 Decision to delivery time (DDT) not met

Monthly data is gathered and reviewed via the GMEC maternity dashboard with regular 6-monthly audit undertaken. Recent audit has identified areas for improvement with DDT standard met for 80% of patients. There was a slight decline in performance as compared to previous audit where 84% DDT was achieved. Recommendations from the audit are made.

- Careful documentation for time and calculation of delay in all cases.
- Appropriate documentation for the reason for delay (if any) and indication of Caesarean Section on Euroking.
- To ensure the ‘Indications for Caesarean Section’ documented in midwives notes and doctors’ notes are the same.
- Consider incorporating Robson Classification for Caesarean Section on Euroking to identify areas of improvement.

5.3 Management of syntocinon and hyperstimulation

WWL are currently in the process of reviewing and ratifying GMEC Induction of Labour guidance to ensure a standardised approach across the region. On review of both GMEC and NICE Induction of Labour and Intrapartum Fetal Monitoring guidance it is apparent that definitions of hyperstimulation are not clear and are contradictory. This is currently under review by GMEC. As an interim measure local guidance has been updated to guide staff to no more than 4 contractions in 10 minutes. Learning bulletins at WWL have focussed on the ‘No More Than 4’ message in response to cases where syntocinon has not been reduced or stopped when contractions have exceeded 5 in 10 minutes.

5.4 Holistic review and ongoing risk assessment

The importance of holistic review and ongoing risk assessment is incorporated into annual Fetal Surveillance mandatory training. Tools such as the Fresh Eyes CTG assessment sticker have been updated to ensure hourly ongoing risk assessment. Paperwork is in the process of being streamlined in order to avoid the need to duplicate documentation of risk and therefore avoid unnecessary omissions and communication of risk between teams.

6. Summary

WWL are currently an outlier across GMEC for babies confirmed with HIE 2 or 3 at birth. There were 3 cases of confirmed HIE following MRI in the 19-month period April 2022 - Oct 2023 and 2 neonatal deaths (HIE 3). All cases are monitored and learning, and themes collated and shared with the MDT by the governance team. Action plans are reviewed and monitored via the Trust Serious Incidents Requiring Investigation (SIRI) panel and discussed at the HSIB/MNSI quarterly review meeting. Work continues.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

A review of Women Smoking at Time of Delivery at WWL October 2022- October 2023

Joanne Birch Specialist Matron / Fetal Surveillance Lead.

December 2023.

Contents

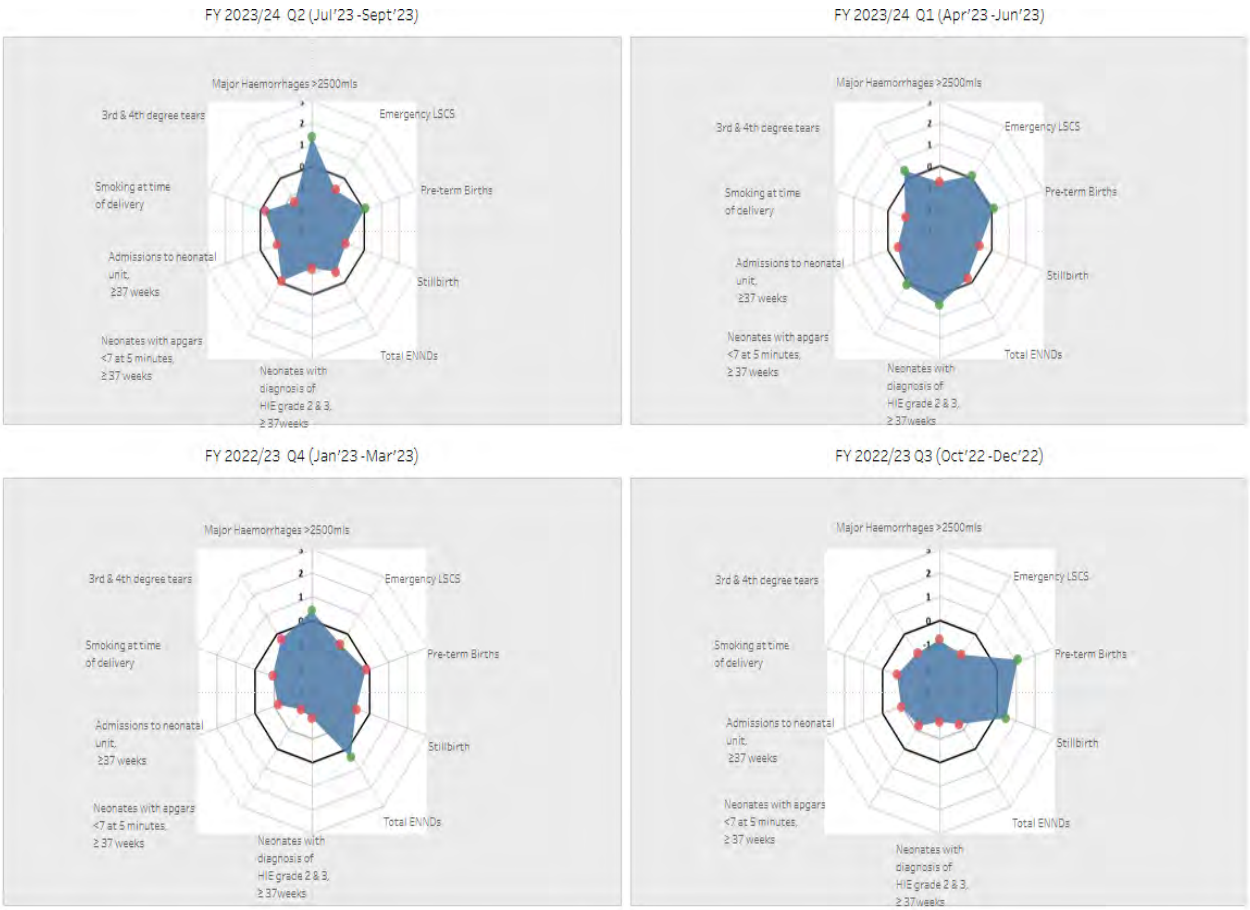
1. Background

Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birthweight, and sudden unexpected death in infancy.

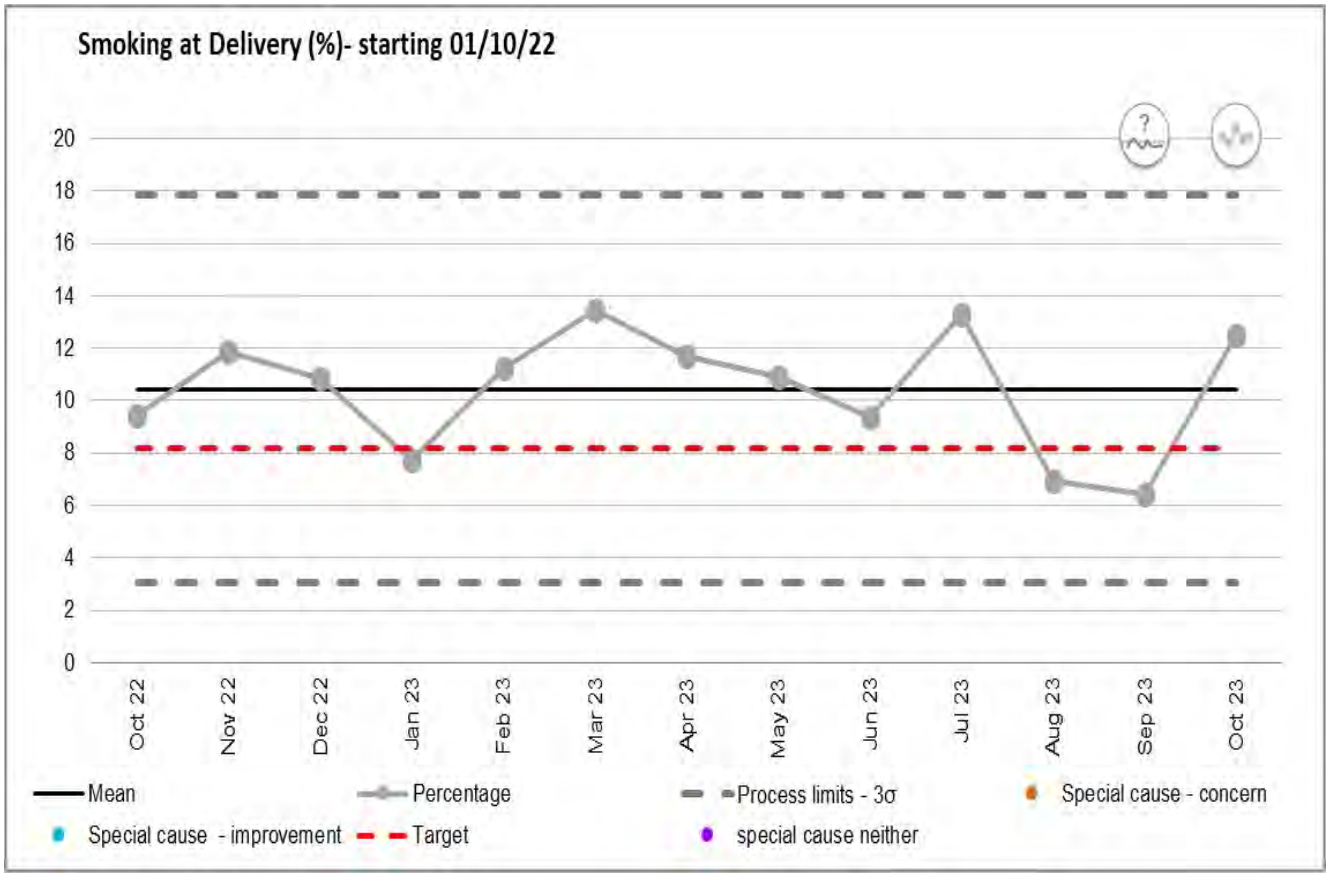
Reducing smoking during pregnancy is one of the three national ambitions in the Tobacco Control Plan published in July 2017, “reducing smoking amongst pregnant women” (measured at time of giving birth). In England (2023) 8.8% of pregnant women were known to be smokers at the time of delivery.

A review of the data at WWL from October 2022 – October 2023 has been undertaken as the trust has been identified as an outlier within Greater Manchester (GM) for smoking at time of delivery rates (SATOD) (see spider-graphs below.) An overview of the latest data submitted (October 2023) has been undertaken to identify themes and trends for learning.

1.1 – Greater Manchester quarterly comparison spider graphs for WWL



1.2 Smoking rates at WWL October 2022 – October 2023



1.2 demonstrates that WWL has consistently been above the GM average rate for SATOD (75% of the rolling of 12 months). The current rate at WWL is 10.21 per 1000 births in comparison to the GM mean rate of 9.4 (however, data submission by all GM trusts in 2022 was not completed and this % may not be 100% accurate.

1.3 GM Tableau Data for % of Women smoking at time of booking (SATOB)

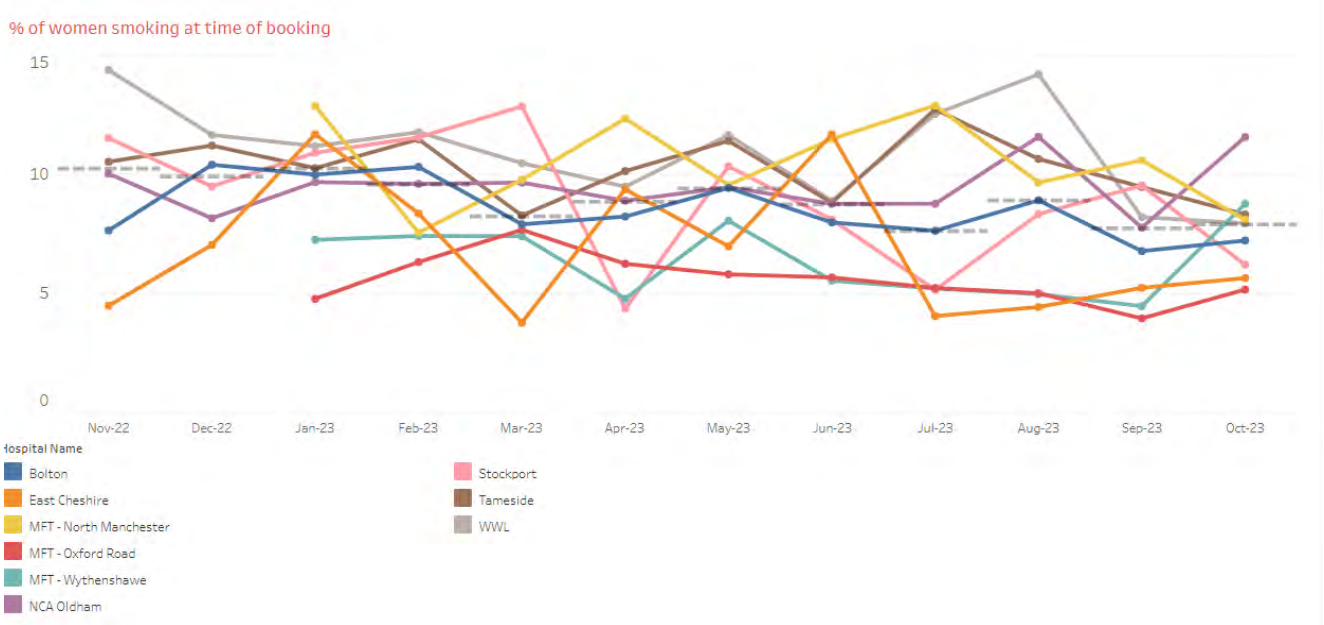
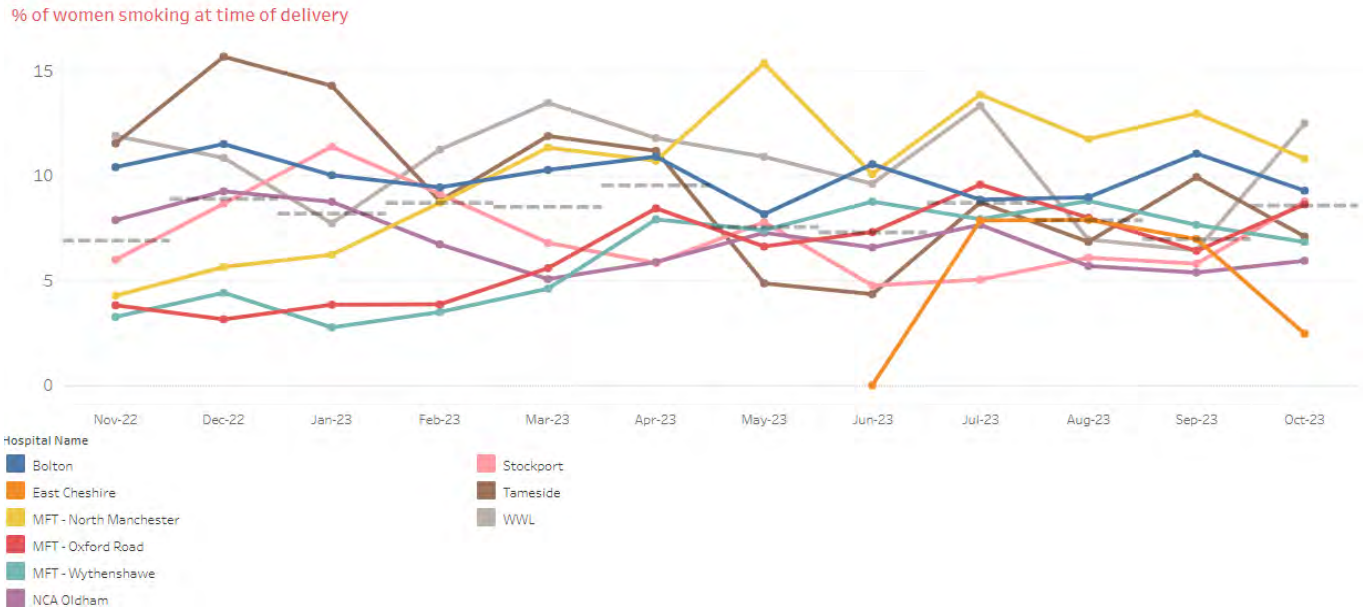


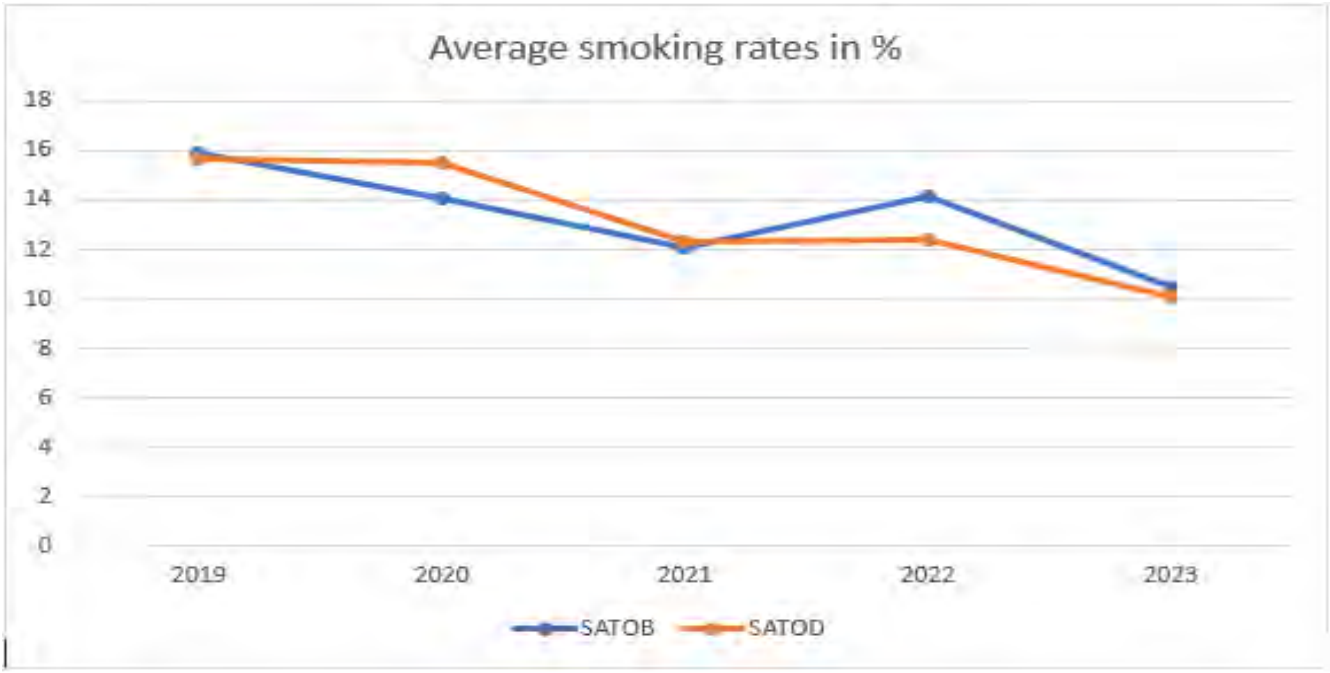
Figure 1.3 shows the percentage of women at WWL who are smoking at time of booking (SATOB) *(smoking at time of booking is classified as any woman who is currently smoking or was smoking on confirmation of pregnancy)*. WWL have an increased % of SATOB in comparison to trusts within GM, which is consistently above the GM mean rate.

1.4 GM Tableau Data for % of Women Smoking at time of delivery (SATOD)



Smoking at time of delivery at WWL with the exception of three months is continually above the GM target rate. This could be influenced by the high % of women who are SATOB.

1.5 WWL - Smoking at Time of Delivery Average Rate (2019 – 2023)



WWL rates over the last 5 years apart from 2022, demonstrate a downward trajectory with the rates of smoking at time of delivery.

The Wigan in-house Smokefree Pregnancy Team launched on 26th January 2021. This service commenced with one midwife and one maternity tobacco dependency advisor, which has since developed. With support from GM smokefree pregnancy programme the service has continue to evolve to meet the needs of pregnant women who are tobacco dependent. During covid restrictions the team primarily worked from home to provide support by telephone, which is reflected in the 2022 increase, as engagement with women was not as successful.

In June 2023, the service at WWL expanded, two band 4 Maternity tobacco dependency advisors joined the service. The team started to issue Vapes as a nicotine replacement therapy (NRT). Face to face appointments resumed where possible to improve engagement and outcomes, reflected in the 2023 downward trajectory of % of women smoking at time of delivery.

2. Demographics of Borough

			Ethnicity within decile at Booking 2021							
Deciles	No of women	% of total women	Black background - no	Black background as %	Asian Background - no	Asian Background as %	Mixed background - no	Mixed background as %	total as % in decile	Total in No
1	595	21.82%	15	2.52%	27	4.53%	3	0.50%	7.56%	45
2	490	17.97%	9	1.83%	13	2.65%	2	0.40%	4.88%	24
3	287	10.52%	5	1.74%	9	3.13%	2	0.69%	5.56%	16
4	161	5.90%	3	1.86%	6	3.72%	1	0.62%	6.20%	10
5	222	8.14%	11	4.95%	12	5.40%	4	1.80%	12.15%	27
6	169	6.19%	1	0.59%	2	1.18%	0	0.00%	1.77%	3
7	129	4.73%	3	2.32%	1	0.77%	1	0.77%	3.86%	5
8	237	8.69%	5	2.10%	2	0.84%	1	0.42%	3.36%	8
9	270	9.90%	4	1.48%	8	2.96%	0	0.00%	4.44%	12
10	115	4.21%	0	0.00%	2	1.73%	0	0.00%	1.73%	2
Unknow	36	1.32%	0	0.00%	0	0.00%	1	2.70%	2.70%	152

There are 1429 Postcodes within the Wigan and Leigh Borough that are within the Lowest Decile of deprivation (Decile 1). These postcodes fall predominantly into 6 demographic areas. It is recognised that women who are most likely to continue smoking throughout pregnancy are generally of lower socio-economic status or lower maternal age.

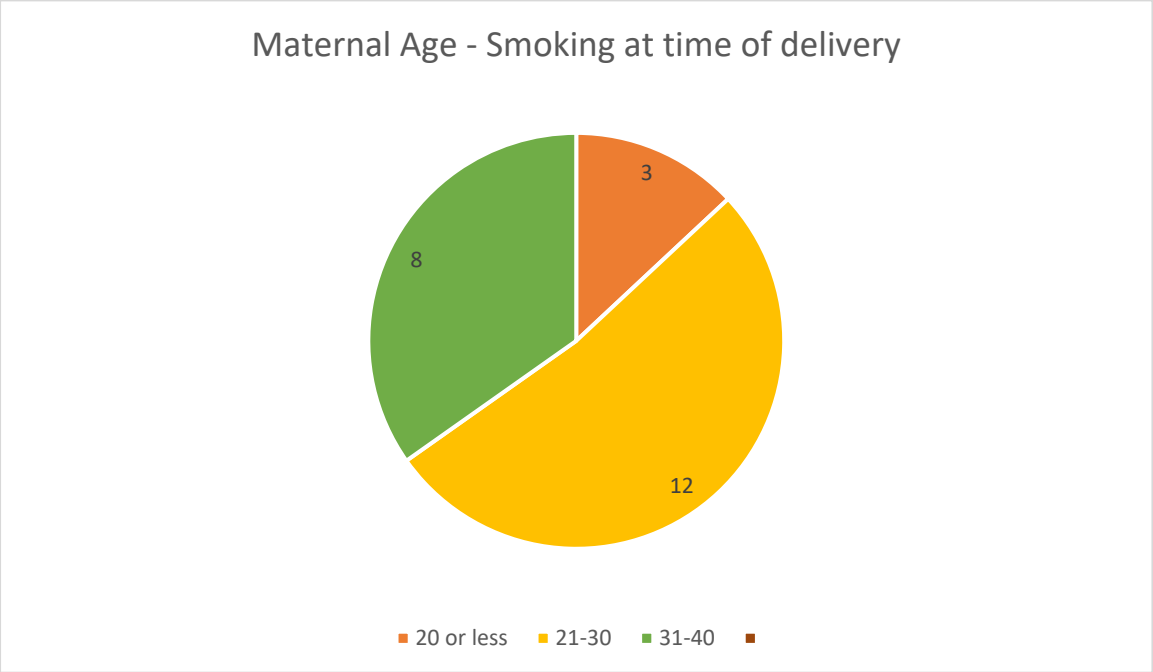
WWL data for October 2023, identifies the smoking at time of delivery rate to be 12% (an increase compared to 2 previous months). 26 women smoking at time of delivery.

53 women who birthed in October 2023 were identifed as smokers at time of booking, with 26 still smoking at time of delivery – this demonstrates a 51% sucessful quit rate for the month.

Of the 26 women SATOD, 12 lived in Decile 1 (46%) and 7 lived in decile 2 (27%), a total of 73% of women living in the most deprived 2 deciles within the Borough.

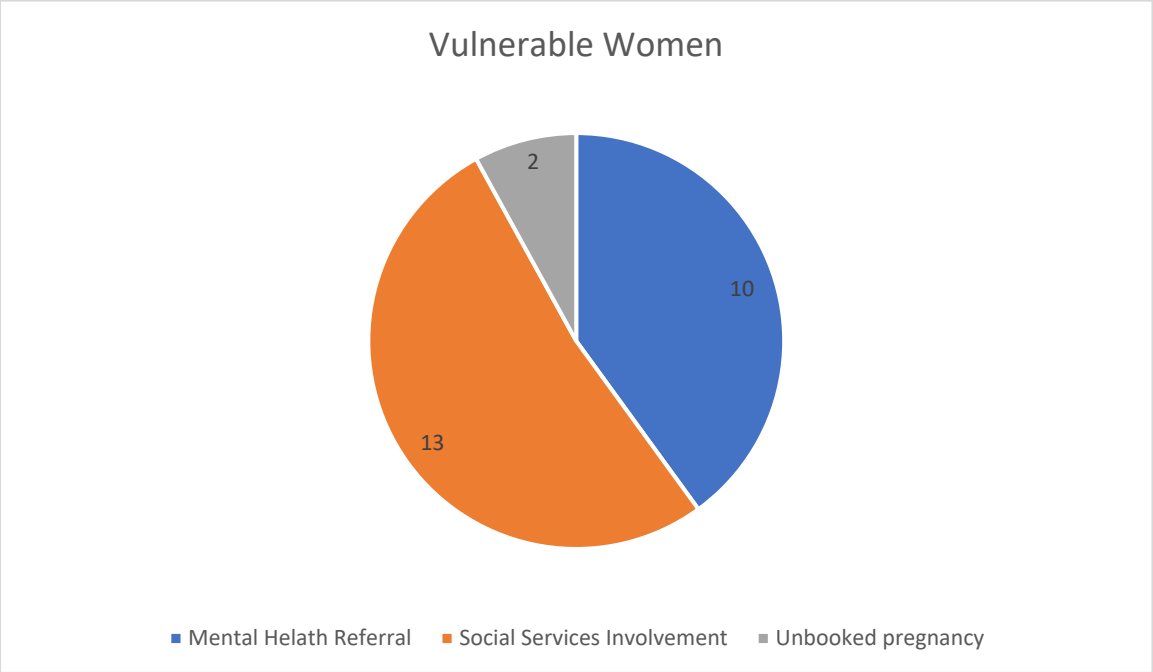
3.Themed Analysis of the smoking at time of delivery data at WWL

Maternal Age



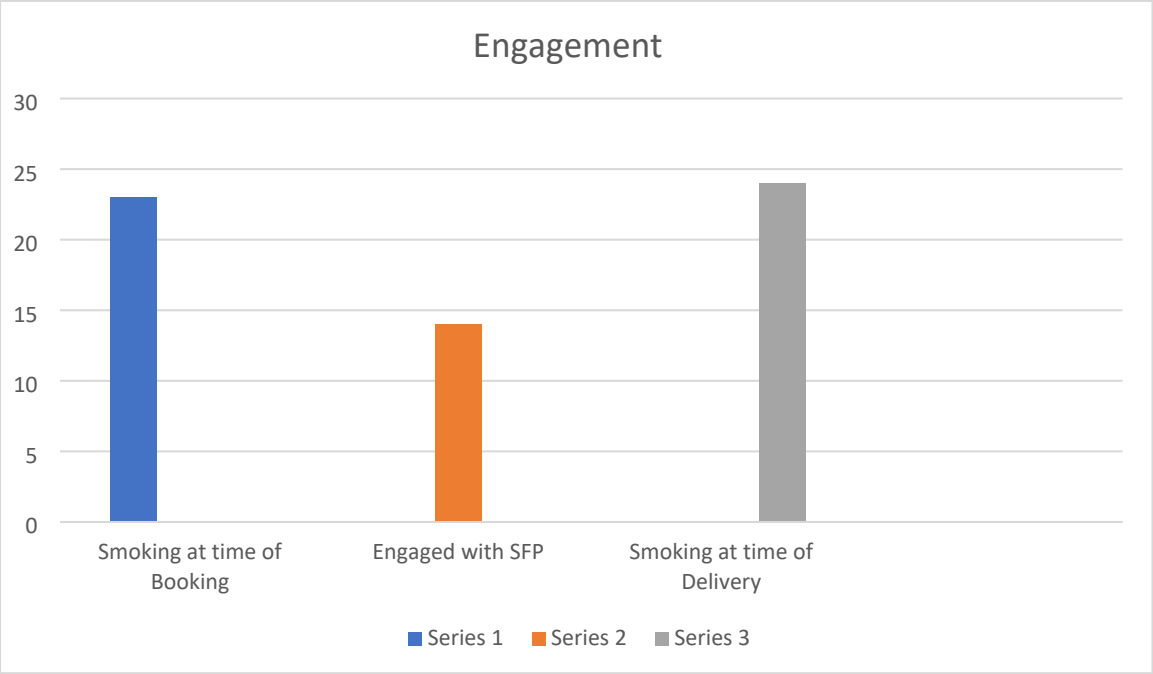
The average age of the 26 women smoking at time of delivery in October at WWLwas 21-30 years old (46%). There were no clear themes associated with maternal age and smoking in the review.

Vulnerable Women



92% of the 26 women had been under the care of social services or been referred to the mental health team for additional support. 46% of the women were under the care of the Daisy Team at WWL (enhanced community midwifery team for vulnerable women). Women can use smoking to reduce stress and anxiety levels and it is acknowledged within reports that women smoke to help control their mood. Vulnerable women may be at a pre-disposed risk to continue smoking in pregnancy and caution must be given with the management of these women when supporting them to quit smoking to prevent psychological harm. Despite several women not quitting smoking at time of delivery, the number of cigarettes smoked per day may have seen a significant reduction and although this is not reported it could be considered.

Engagement



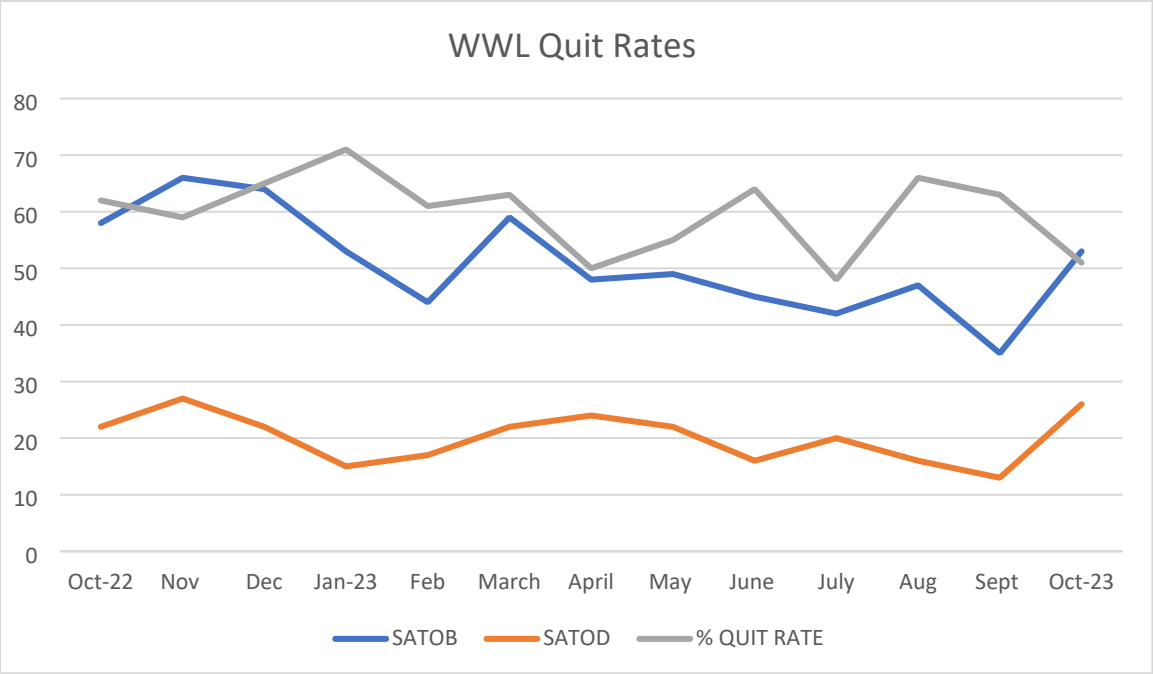
17 (65%) of women initially engaged with the smokefree pregnancy service but disengaged during pregnancy and continued to smoke. 2 women were unbooked, 1 suffered a miscarriage, 1 was uncontactable and 5 women declined support.

Of the 17 women who engaged, 11 of women had a family member who smoked in the home, increasing their risk of relapse. Work is currently under discussion within GM to actively offer support and NRT to the family members of pregnant women to mitigate this risk moving forward, this action should see a positive impact on quit rates for women who are smoking at the time of booking.

Staffing issues within the smokefree pregnancy team at WWL were an issue in March and April 2023, this negatively impacted the ability to have face to face appointments for women who were SATOD in October. One midwife was working solo, whilst the funding and recruitment of two band 4 tobacco depency advisors was underway. During this time a number of appointments were by telephone or virtual.

Additionally, Risk Perception Intervention (RPI) was not embedded due to staffing. RPI (health behavioural change interventions to sucessfully engage women to quit smoking) is now being completed more consistently in antenatal clinic by the smokefree pregnancy lead midwife which should reflect in the upcoming months data. Two antenatal clinic midwives are now trained to deliver RPI with plans in place to train more to support the service.

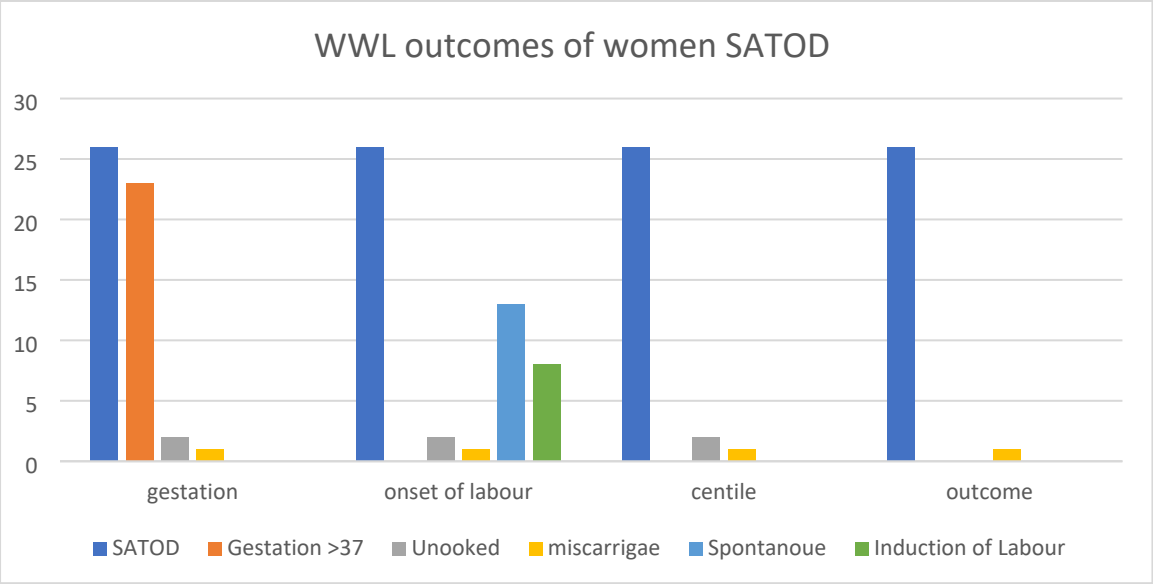
Quit rates for women smoking at time of booking



Quit rates at WWL are consistently above 50% (apart from July 2023 when the rate was 48%), this demonstrates the positive impact the smoke free team are having on supporting women to successfully quit smoking during pregnancy.

4 Outcomes for women smoking at time of delivery

Outcomes for the 26 women who were smoking at time of delivery were reviewed for learning from care and service delivery.



One woman suffered a miscarriage of pregnancy prior to 20 weeks gestation which is a known risk factor for smoking during pregnancy. Smokefree intervention had been accepted however, she was a vulnerable adult who was homeless and under the care of the Daisy team, additional factors which increase the risk of smoking.

There were 25 livebirths in October, all over 37 weeks gestation (which is classified as a term pregnancy). 60% of women went into spontaneous labour and 32% required an IOL for various reasons (small for gestational age and prolonged rupture of membranes).

60% of the babies born were of a birthweight between the 10th – 50th centile and 16% were below the 10th centile which is a significant risk factor for women who smoke during pregnancy. The women were on the correct antenatal pathways and attended for growth scans per guidance.

5 Summary

The review has identified that over the last twelve months smoking at time of booking has been consistently above the GM average rate. This has a significant impact on the number of women who are still smoking at the time of delivery which is reflected in WWL being a persistent outlier within the GM. WWL can demonstrate that the work undertaken by the specialist smoke free pregnancy team is having a positive impact for the women under their care by their successful monthly quit rates (which are over 50% quit rate per month).

The Borough of WWL has a high number of postcodes that are within the lowest Deciles of deprivation (Decile 1 & 2). This has identified a theme within review, 73% of women resided in these deciles. Women in decile 1 are captured by the community enhanced team Fern who offer continuity of care to these ladies. 15% of the women living in decile 1 were cared for by the Daisy team midwives (enhanced team for the most vulnerable women in the area). This demonstrates the complexity of the women who were identified as still smoking at the time of delivery within these deciles.

Women in decile 2 at this current time receive routine antenatal care unless they are non-English speaking, it has been identified within a number of recent reports at WWL that this cohort of women are having poor outcomes and further work is needed to support them.

Vulnerability and smoking at time of delivery shows a clear link with women at WWL. Enhanced care provided by the Fern and Daisy Team is offered to these women, in conjunction with the smoke free pregnancy team. A more in-depth review of the data may be required to look at how this cohort of women can be further supported to quit smoking. It must be acknowledged, for some women despite smoke free pregnancy services and numerous support networks available they may choose not to quit smoking. Education must be offered to these women and families to ensure an informed decision has been made.

The introduction of vapes in June 2023, should be reflected in the successful quit rates for women who birth in 2024 as engagement has been positive. A future initiative is to involve partners and family members with NRT. Quitting smoking is more achievable with the support of partners and family members. WWL are currently in collaboration with Wigan Councils “Be Well” service who have recently launched a vape programme,

offering NRT for partners, this will positively impact on the women being successful in quitting smoking.

Learning from this review has recognised that monitoring successful quit rates can offer an insight into the work undertaken by the smoke free pregnancy team. Monthly data will continue to be submitted onto the smoke free pregnancy platform with a clear overview by the smoke free pregnancy lead midwife.

Evidence submitted to the LMNS for SBLV3 (Element 1) will also offer assurances that WWL are successfully achieving the required standards and acting timely and appropriately when we are not.

Throughout the review, learning has been identified and the themes highlighted to allow close monitoring over the next 6-12 months. Learning from reviews will continue to be collated by the smoke free pregnancy lead midwife and governance processes followed appropriately.

Obstetric Anal Sphincter Injuries (OASI) - Third and Fourth-Degree Tears. Data analysis of OASI between May-July 2023.

Eve Broadhurst
Divisional Head of Governance for maternity and Child Health

Executive Summary

What is an OASI?

An OASI is an obstetric anal sphincter injury that can occur during vaginal birth, also referred to as severe perineal tearing or third and fourth-degree tears. Most women and birthing people who have an OASI detected and repaired at birth recover well, although it can take some time.

The long-term consequences of OASI include increased risk of chronic pain, sexual dysfunction and difficulty or inability to control the bladder, bowels, or the passing of wind. These consequences can significantly affect mental health, the ability to carry out everyday activities and personal relationships.

If an OASI is not diagnosed and repaired immediately following childbirth, women are at greater risk of experiencing these symptoms and miss their best opportunity for improved long-term outcomes.

Third-degree tear: Injury to perineum involving the anal sphincter complex:
Grade 3a tear: Less than 50% of external anal sphincter (EAS) thickness torn.
Grade 3b tear: More than 50% of EAS thickness torn.
Grade 3c tear: Both EAS and internal anal sphincter (IAS) torn.

Fourth-degree tear: Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.

Obstetric anal sphincter injuries (OASI) encompass both third- and fourth-degree perineal tears.

(RCOG, 2015).

Background

The Royal College of Obstetricians and Gynaecologists report that between 2000 and 2012, OASI rates increased three-fold in England (1.8-5.9%).

This trend towards an increasing incidence of OASI did not necessarily indicate poor-quality care.

Tearing is a complex issue influenced by a range of factors including increased use of forceps during birth, advanced maternal age at first birth, and increased birth weight. Furthermore, as clinicians improve their detection of OASI, it can make it appear as if rates are increasing.

However, OASI can dramatically affect the short- and long-term health of women and birthing people. As it also affects decisions about future births, prevention, and management of OASI is a priority in maternity care.

Experiences in some maternity units in England highlighted that some of the underlying problems related to this rise in OASI include:

Inconsistencies in approaches to preventing OASI
Inconsistencies in training and skills
Lack of awareness of risk factors and long-term impact of OASI
Variation in practice between health professionals

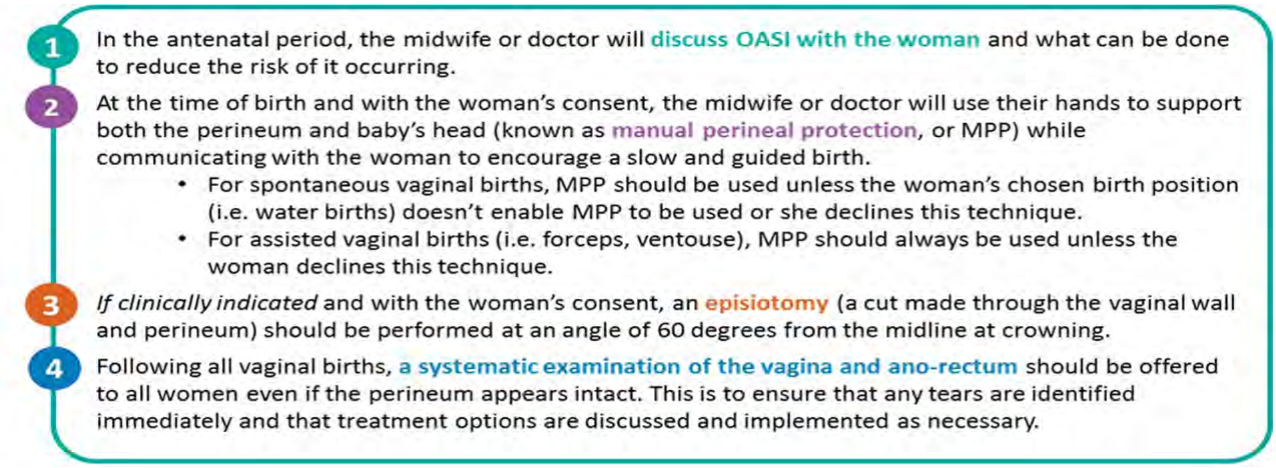
The following risk factors have been identified. There is, however, considerable difference in the reported risks for the same risk factor (RCOG, 2015).

- Asian ethnicity
- Nulliparity (first baby)
- Previous OASI
- Birthweight of baby – over 4kg is considered a risk
- Shoulder Dystocia
- Occipital-posterior position (baby lying back towards mother's back)
- Prolonged second stage of labour
- Instrumental Delivery, particularly instrumental delivery without episiotomy.
- Maternal Position
- Advancing maternal age at first birth

Risk factors for sustaining recurrent OASIS in the subsequent pregnancy include

- Asian ethnicity
- Forceps delivery
- Birthweight more than 4 kg

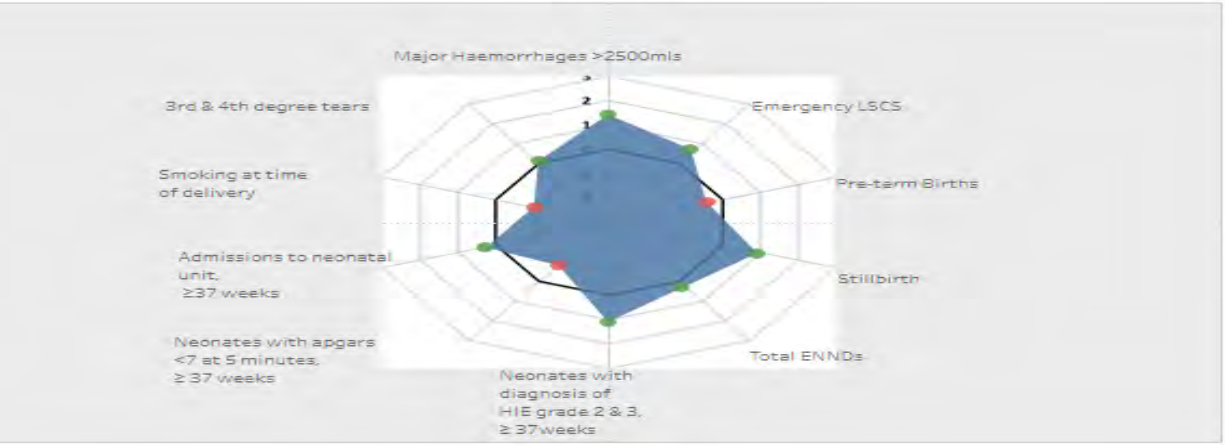
Recommendations of the OASI bundle (RCOG,



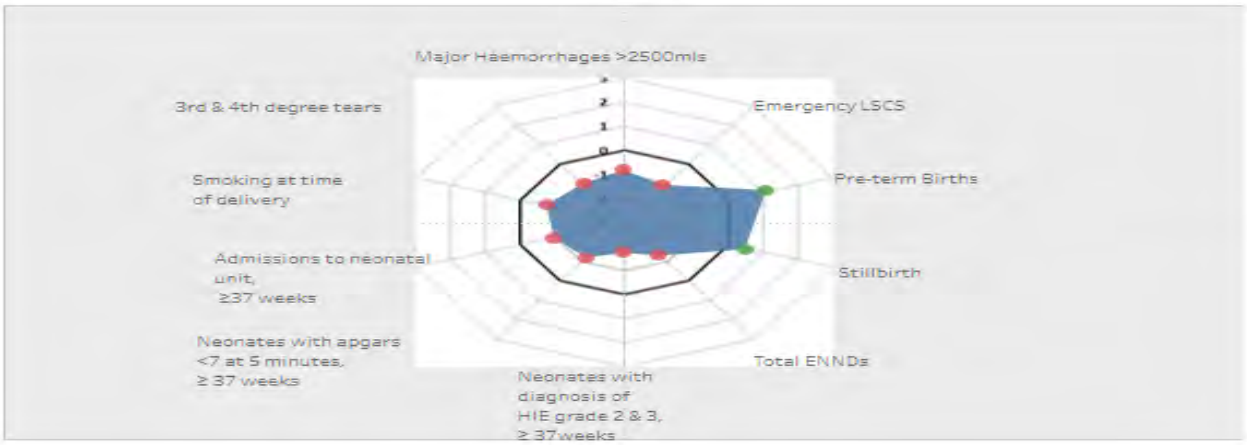
WWL

OASI rates at WWL have ranged between 0.46%-4.54% of vaginal births each month between 1.7.22 and 30.6.23 with a mean of 1.58%. Whilst the numbers appear relatively low, data published on Tableau indicates that WWL (with the exception of Q2 Financial Year 2022- 2023) are outliers across Greater Manchester for the rate of third- and fourth-degree tears.

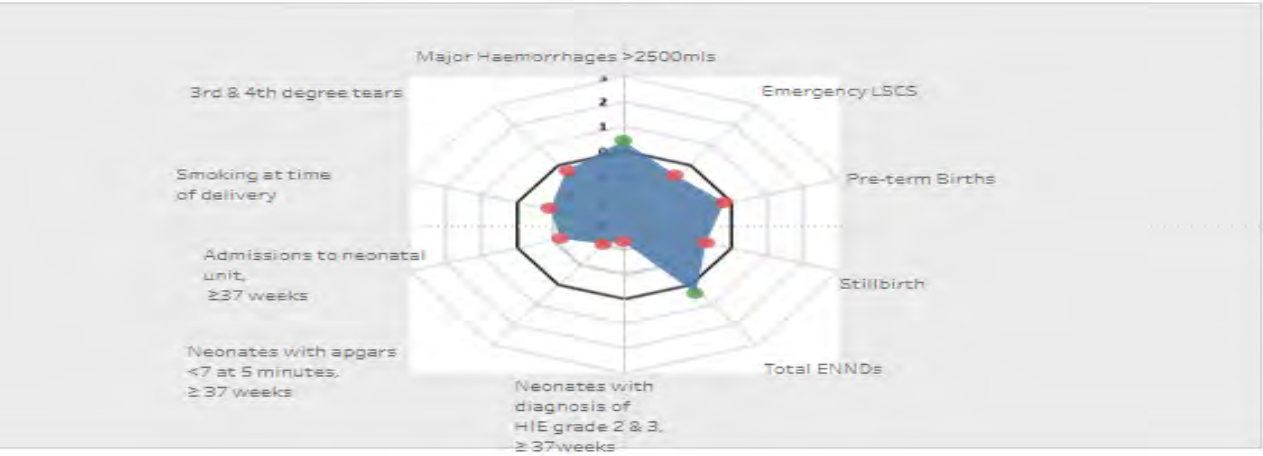
FY2023 Q2



FY2023 Q3



FY2023 Q4

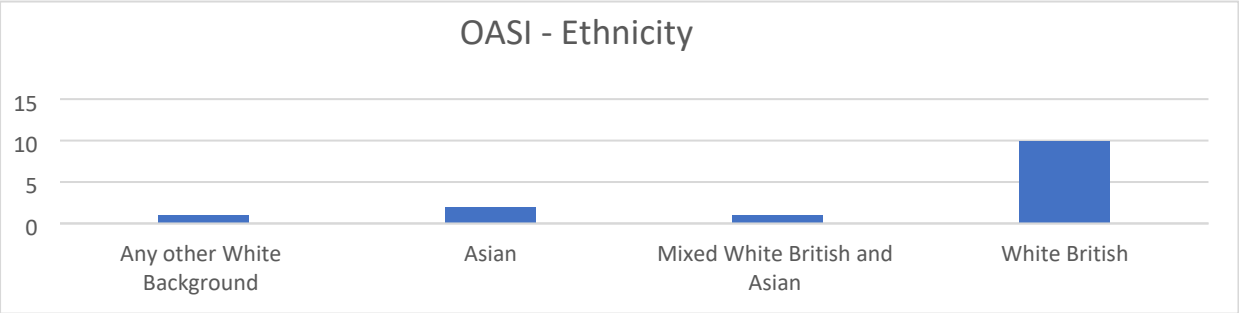


Analysing the Data – WWL 1.5.23 – 31.7.23

The following information has been gathered to support our understanding of the cases of OASI in terms of risk factors and prevalence of those women experiencing third and fourth-degree tears at Royal Albert Edward Infirmary.

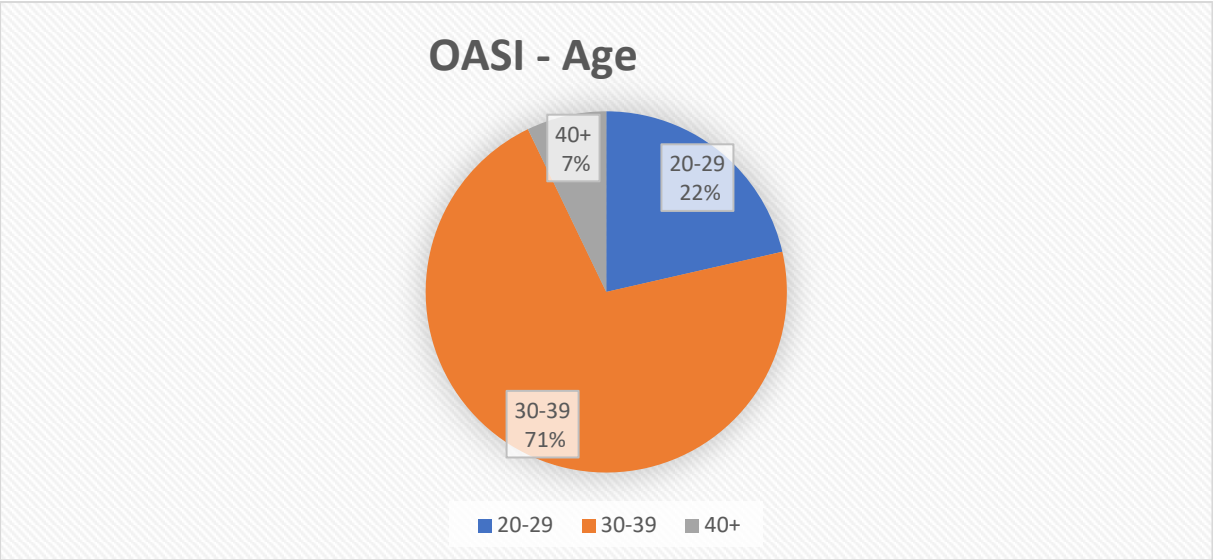
14 cases of OASI have been identified between 1.5.23-31.7.23, in which 14 women have experienced a third-degree tear during labour. There were 0 cases of fourth-degree tear (the most severe grading of perineal ear).

Ethnicity



The most common ethnicity sampled was white British (71.42%), which makes up approximately 94% of the local pregnant population in Wigan. 3 women (21.42%) were of Asian heritage (or mixed Asian heritage) compared to a local Asian population of <5%.
Of these 3 women of Asian background, 2 were primigravid, and all 3 women were over the age of 35 compounding the risk of OASI.

Age
Of the 14 cases, the age of mothers ranged from 20 to 40 years of age. In 10 cases, the mother was aged between 30 – 39 years of age, making it the most prominent age bracket within these identified cases.



Second stage of labour
Of the 3 women who had previously given birth, in 2 cases we were unable to identify the time spent in second stage of labour. This is because documentation was not fully completed for one case, and because baby was born via an unplanned, unassisted homebirth in another. As a result, further analysis on labour times in these women who have previously birthed is unavailable.

Second stage of labour varied across all remaining 12 cases, with the shortest time being 6 minutes, and the longest being 3 hours 43 minutes. Only 2 cases exceeded 3 hours in the second stage of labour. The first case (KT) was converted to an

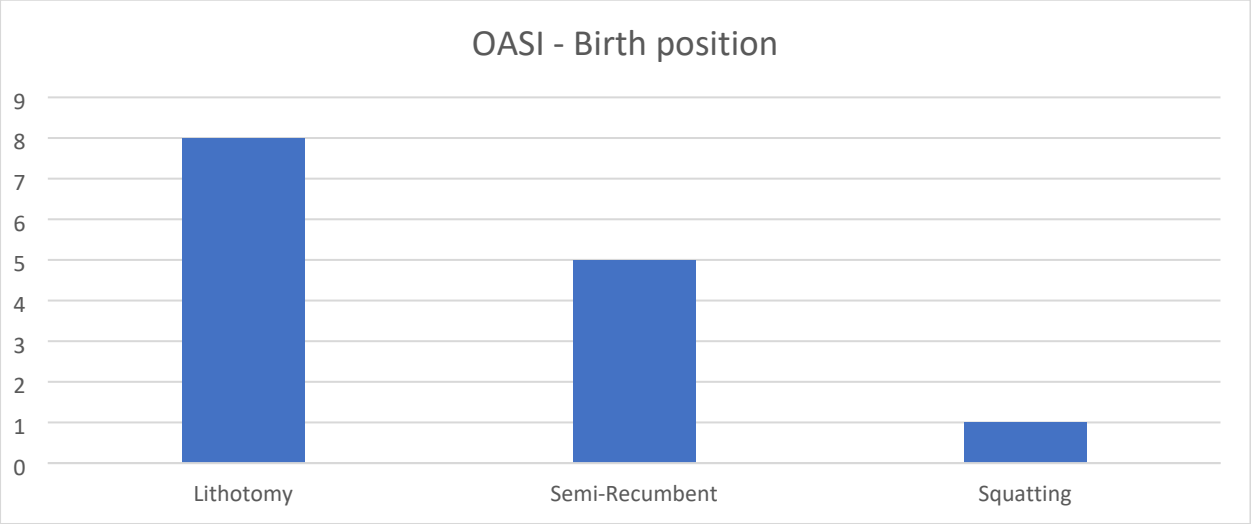
instrumental birth (forceps) as a result of the recognised delay during this second stage. The second case (PYC) was a failed ventouse delivery that required forceps.

Birth weight
No women birthed a baby heavier than 4kg, and there were no cases of shoulder dystocia.

Fetal position
There were 2 cases where the position of the baby was unable to be determined from the case notes, due to a lack of documentation. All other cases had occipital-anterior positioning. No known babies in occipital-posterior position.

Mode of delivery
The majority of cases (64.28%) did not require instruments to assist in the delivery, though there were 5 cases (35.71%) of requiring forceps to assist in delivery (with one of these having converted from a ventouse delivery, due to failure of the cap to attach.) Outside of these five cases where an instrumental delivery was required, no other woman had an episiotomy (it was considered in one case, though review of the notes indicate that baby delivered quickly before the Epi-scissors could be provided.)

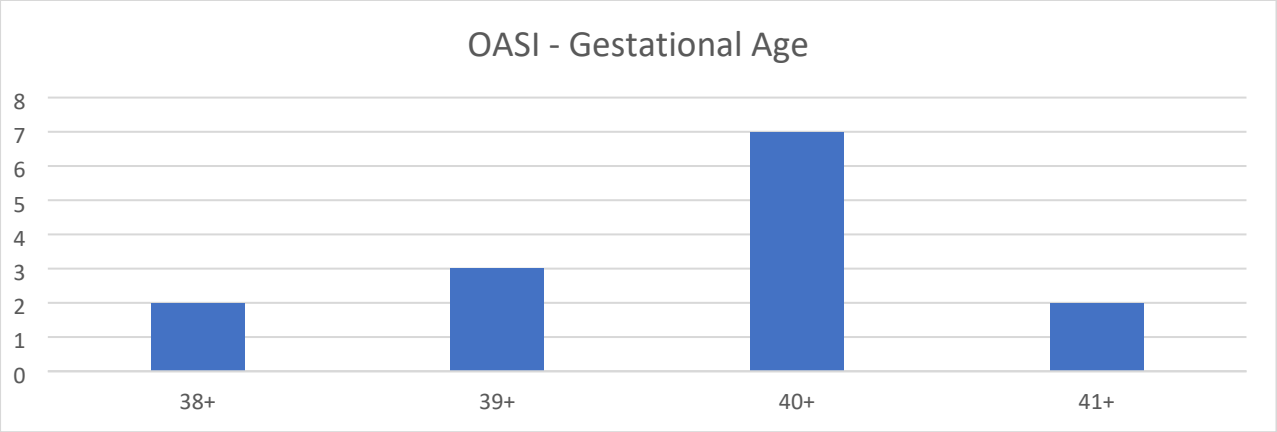
Maternal birth position



This identified that in 8 cases (57.1%), women were placed in the lithotomy position. Of those 8 cases, 5 (62.5%) required instruments to assist in delivery. Lithotomy position has been shown to increase the risk of OASI in both nulliparous and parous women.

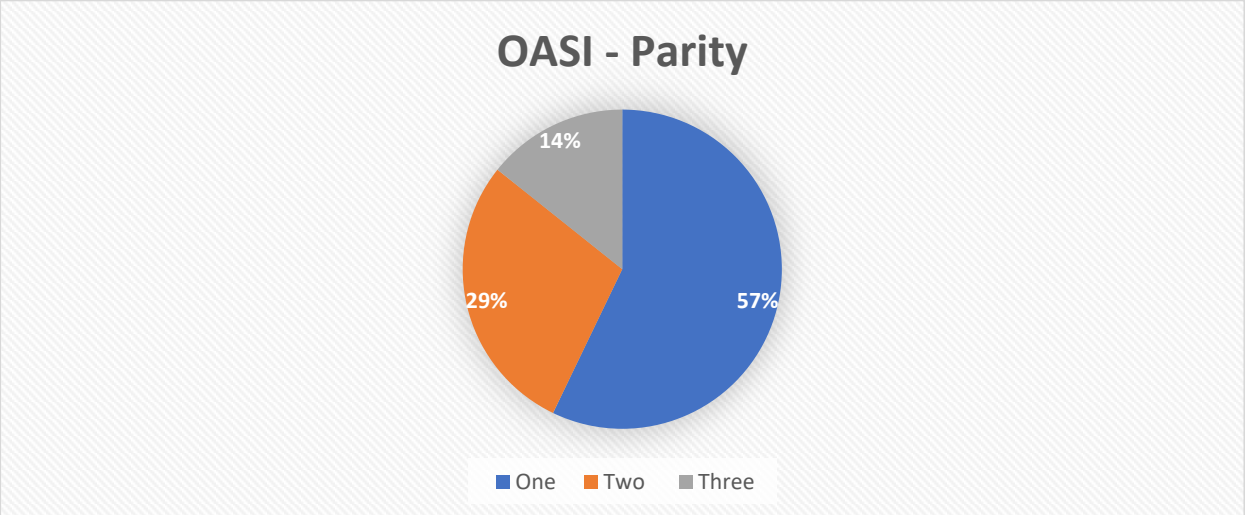
Gestation

All 14 cases occurred after gestational age of 38 weeks, with no premature births.



Parity

3 women had previously birthed, with the remaining 11 women being primigravid.



Previous OASI

8 women experiencing a third-degree tear within their first pregnancy. This accounts for 57% of the cases reviewed.

Antenatal Preparation

There was no evidence of perineal massages being discussed antenatally. No documented evidence of information leaflet being provided. The RCOG produce an information leaflet which is available for use.

Care in the 2nd stage of labour

There was 1 one case where manual perineal pressure was noted in the case notes as being utilised. It is likely that this is being used in most cases, though documentation does not currently support this.

In addition, there was no documented evidence of a warm compress being utilised during the second stage of labour to facilitate in the stretching of the perineal tissues. Again, this may be a more a symptom of current documentation requirements. A Cochrane review has found the application of warm compresses during the second stage of labour to have a significant effect on reducing OASIS The analysis, comprising two studies (1525 women), found that warm compresses significantly reduced the risk of third- and fourth degree tears (RR 0.48, 95% CI 0.28–0.84). The intervention involves holding the compress on the perineum continuously during and between contractions.

Conclusion and Recommendations

All but 2 women (86%) had at least 1 pre-existing risk factor for OASI.

1 of these 2 women received a ‘hands on’ delivery as recommended by OASI.

Current practice in documentation does not allow full review against the OASI recommendations.

Recommendations

OASI champions/leads

Program of mandatory training based on RCOG OASI bundle principles (in line with Core Competency Framework)

Program of antenatal parental education

Utilise RCOG perineal massage leaflet antenatally and upload to website

Ensure all staff are aware of increased risk of OASI in lithotomy position.

Review accessibility of Episcissors and ensure in birth room

Support effective documentation of OASI recommendations

- Antenatal advice and information
- Type of episiotomy – i.e. Right medio-lateral
- Type of scissors
- Use of warm compresses in 2nd stage of labour
- Hands on delivery technique

Review of Major Post Partum Haemorrhage September 2022 – October 2023

Joanne Birch Specialist Matron & Fetal Surveillance Lead

Eve Broadhurst Divisional Head of Governance for Maternity and Child Health.

Post Partum Haemorrhage (PPH) is the most common form of major obstetric haemorrhage. The traditional definition of primary PPH is the loss of 500 ml or more of blood from the genital tract within 24 hours of the birth of a baby. PPH can be minor (500–1000 ml) or major (more than 1000 ml). Major could be divided to moderate (1000–2000 ml) or severe (more than 2000 ml).

GMEC data is collected for all Major Haemorrhages greater than 2500mls.

In the 12-month period, October 2022 – September 23, of the 14 cases of Major Obstetric Haemorrhage > 2500mls identified, 2 of the 14 cases were not reported via the maternity dashboard as the initial blood loss following birth was less than 2500mls.

This gives a rate of 5.5 per thousand births. The regional average is 4.41.

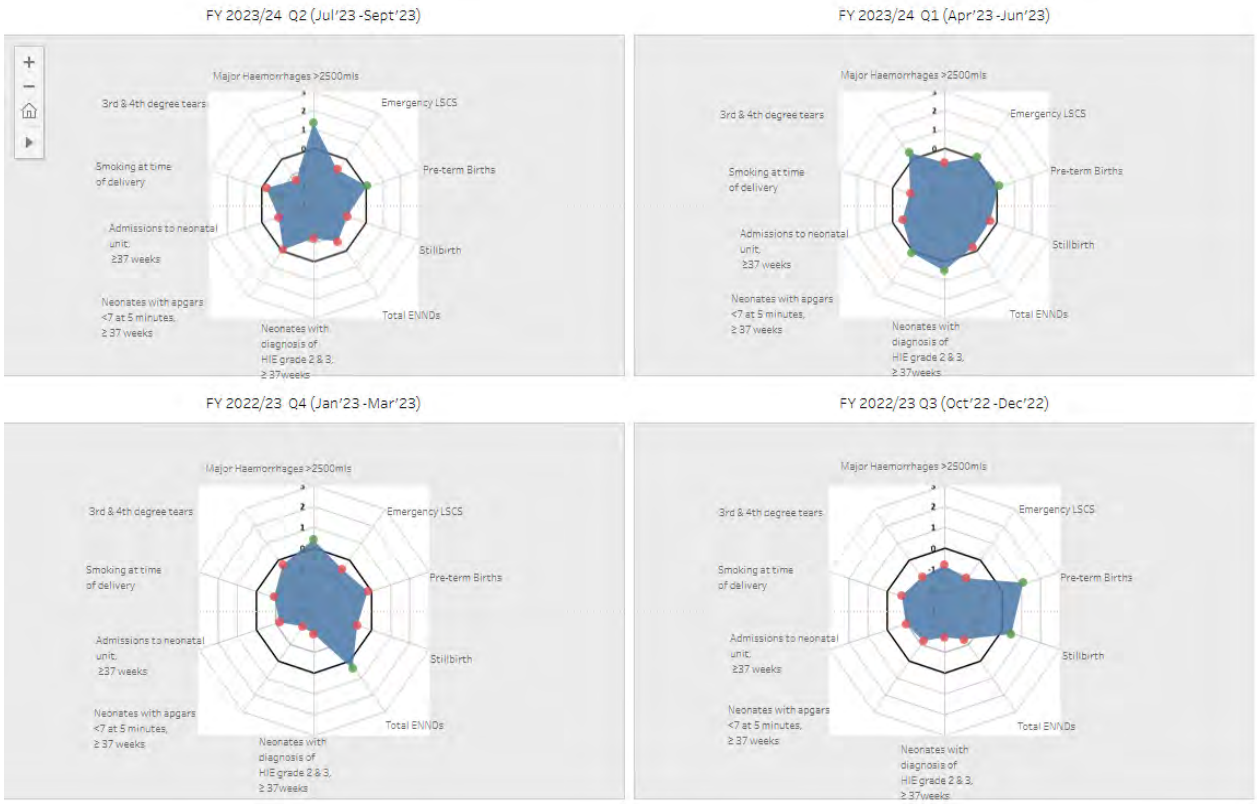
A thematic review of all major Haemorrhages was undertaken in January 2023 and was presented at the WWL Safety Summit. Data from January – December 2022 was reviewed and the rate for major haemorrhages greater 2500mls was 6.2 per 1000 births.

4 serious incidents were reviewed from 2022,

Themes identified:

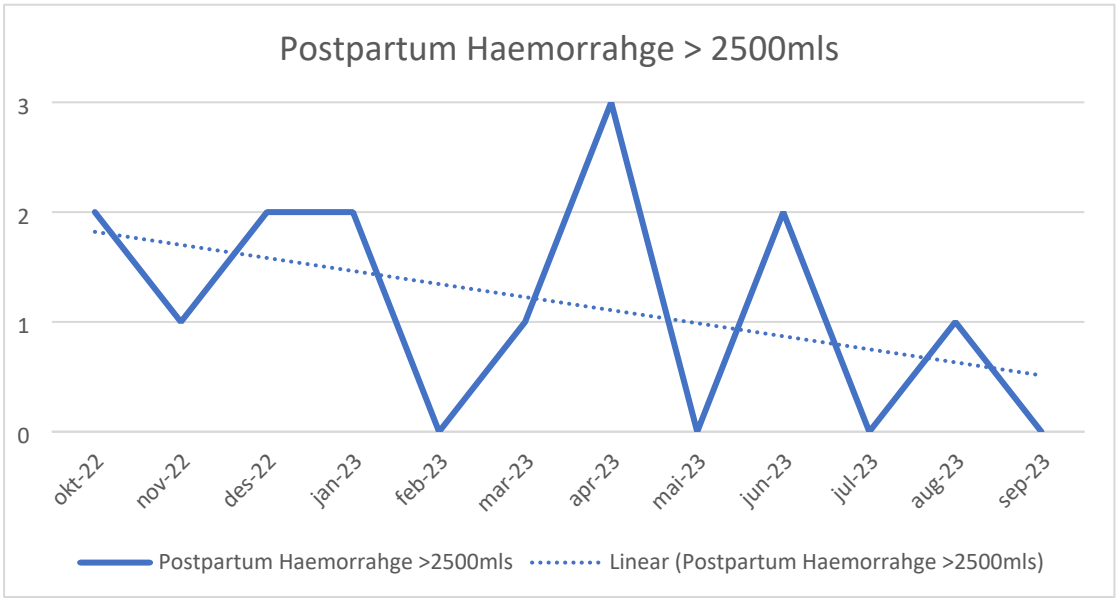
- Lack of multi-professional team working between the maternity theatre team and delivery suite team in maternity theatre
- No clear lead in massive obstetric haemorrhage in maternity theatre
- Lack of emergency documentation available in maternity theatre
- Process for ordering blood and blood products not robust
- Total blood loss to be weighed and any subsequent losses recorded appropriately (ensuring any loss under the patients drapes and in the ‘suction’ is accounted for)

GM Quarterly Spider graphs for WWL (October 2022 – September 2023)



In Q3 22-23 and Q1 23-24, WWL were outliers for PPH >2500L.

Major Haemorrhage >2500mls at WWL October 2022 – September 2023

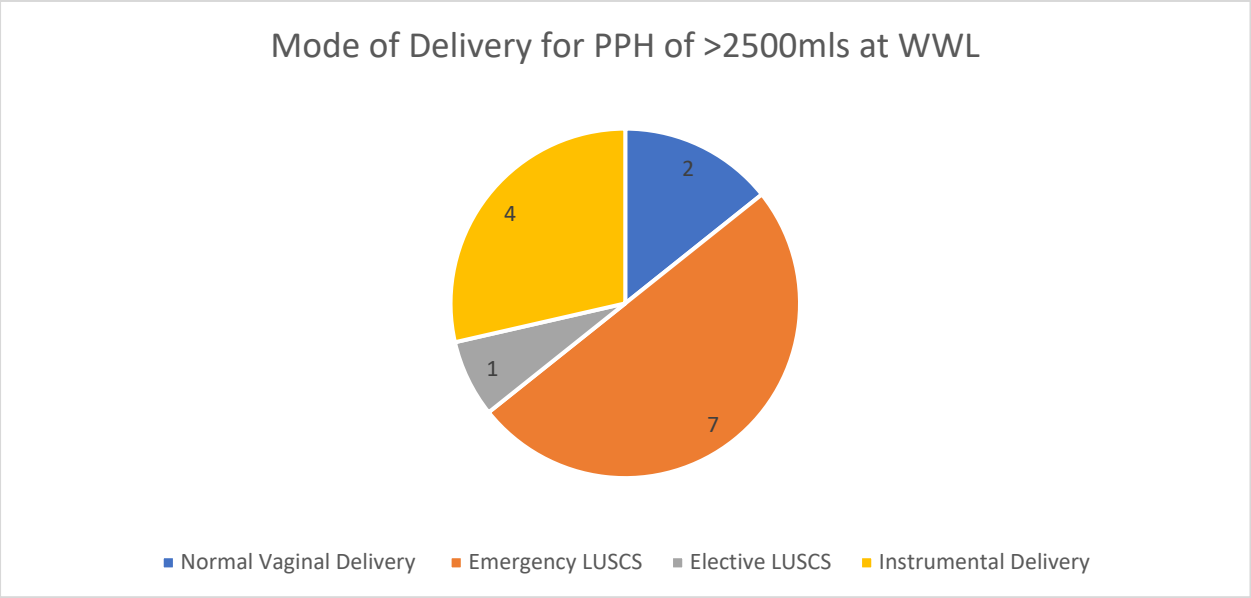


The data above demonstrates the fluctuating rates of major haemorrhage. In April 2023, three women had a blood loss greater than 2500mls, all three women had undergone an induction of labour (IOL) and required high dependency care (HDU) care on the

delivery suite for a period of 24 hours. There is a downward trajectory of PPH >2500l from October 2022 – September 202

Month	Blood Loss	Type of Birth	Outcome	Learning
October **2022**	2723mls	Neville Barnes Forceps Delivery (NBFD) (Spontaneous labour)	Episiotomy 3rd degree tear	Contemporaneous record of blood loss not maintained in documentation
October	2662mls	Emergency Lower Uterine Segment Caesarean Section (LUSCS) (No labour)	Abruption – GA Section at 39+3	No Learning
November	6000mls	Emergency LUSCS (Failure to progress) Induction of Labour (IOL)	ICU admission LUSCS prior to full dilatation	No Learning
December	3000mls	Emergency LUSCS (Failure to progress) Induction of Labour (IOL)	LUSCS prior to full dilatation	Emergency documentation may support effective documentation of uterotonics
December	2774mls	Elective LUSCS (No Labour)	Elective LUSCS	Datix should be completed for all PPH >1500mls
January **2023**	4000mls	Emergency LUSCS for abruption IOL	Cooling & NND - HSIB	Abruption – APH & PPH. Prompt management & no safety recommendations
January	2550mls	Ventouse for delay in second stage/IOL	Instrumental with Episiotomy (kiwi)	Escalate to shift coordinator when complications arise in third stage
March	3000mls	Normal Vaginal Delivery / IOL	ICU admission /? Disseminated intravascular coagulation. (DIC) Return to theatre for third stage	No Learning
April	3000mls	NBFD / IOL	4 units blood transfused. HDU care on delivery suite	No Learning
April	2700mls	Normal Vaginal Delivery / IOL	Return to theatre.	No Learning
April	3000mls	Emergency LUSCS /IOL		No Learning
June	4000mls	Emergency LUSCS (Cat 3). No Labour 34+2 gestation	HELLP syndrome /	Good management of PPH. Excellent contemporaneous documentation throughout emergency. Good involvement of wider MDT.
June	3000mls	NBFD suspicious 2nd stage CTG (IOL)	Shoulder dystocia < 2minutes Episiotomy	Ensure all drugs administered are prescribed and recorded in notes
August	4000mls	Emergency LUSCS – No Labour 34+3 gestation		Delay in return to theatre due to lack of teamwork between delivery suite and theatre teams

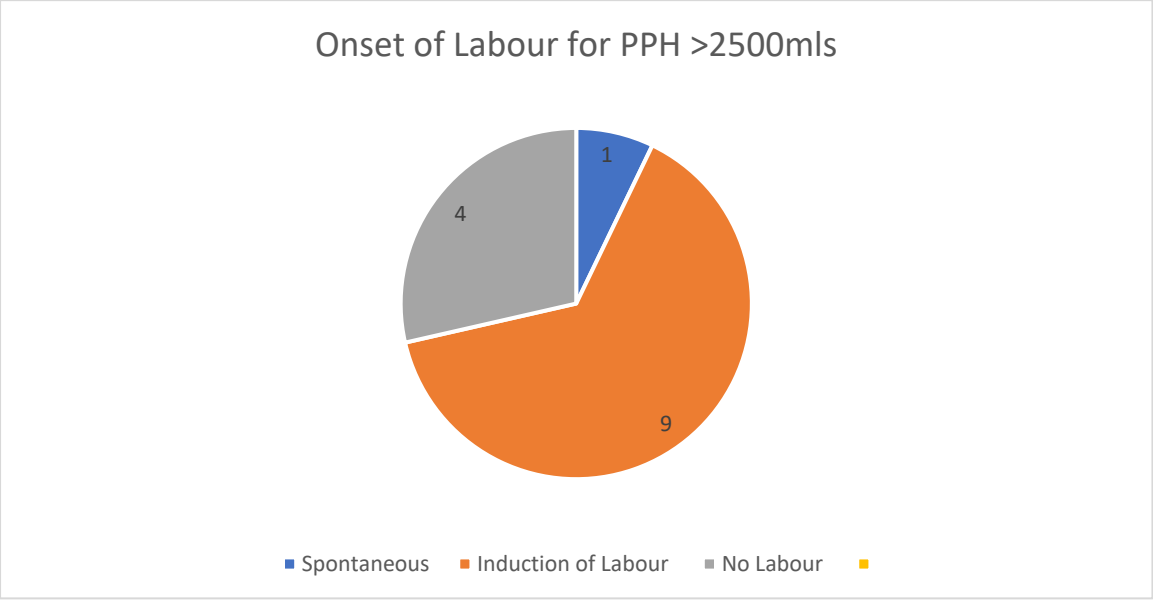
WWL Data October 2022- September 2023



8 women (57%) at WWL who experienced a post-partum haemorrhage had a caesarean section, 2 of the emergencies were for an abruption, the total estimated blood loss for these women was including both antenatal and postnatal blood loss.

1 woman was a known placenta praevia who was an inpatient for antenatal observation, during admission at 34+3 gestation had fresh red blood loss and required a category 1 LUSCS.

4 of the 8 women who had a C/S who had a major haemorrhage were induced (IOL)



9 women (64%) who had a PPH were induced.

29% of the women did not labour (one woman had a placental abruption, one woman had an elective section for previous caesarean section and two women had pre-term caesarean sections for obstetric reasons).
Only 1 woman went into spontaneous labour but did require an instrumental birth.

Summary

In Q3 22-23 and Q1 23-24, WWL were outliers for PPH >2500L.

WWL has a process for monitoring, reviewing and collating learning from incidents which is shared with the MDT.
Whilst no new themes have been identified since the Safety Summit held in January 2023 issues including lack of teamwork between maternity and delivery suite staff, issues around emergency documentation and lack of a robust system for ordering blood and blood products have not been completely resolved and actions are ongoing.

From November 30th, 2023, a new ‘pack’ system was introduced at WWL to improve the system of administration of blood products in the event of Major Obstetric Haemorrhage.

WWL has been selected to partake in a research project called ‘Obs UK’ with a view to improving the timely management of PPH.
A new initiative to improve culture and teamwork has seen the development of an MDT leading on QI in relation to PPH across midwifery, theatre and anaesthetic teams and have designed visual prompt boards in maternity theatre to support management of PPH.

It has been identified that the threshold for Major Obstetric Haemorrhage at WWL is not in line with other Trusts in GMEC and this is currently under review to ensure a standardised approach across GMEC.

Avoiding Term Admissions to the Neonatal Unit at WWL October 2022 – September 2023 Report

Lyndsey Banks Quality and Safety Midwife December 2023

Contents

1. Background

NHS England (2017) released its document on: reducing harm leading to avoidable admission of full-term babies into neonatal units, as part of the national focus on maternity safety, demonstrated through the combined work of the National Maternal and Neonatal Health Safety Improvement Collaborative, the Maternity Transformation Programme and the government's Maternity Safety Action Plan.

This work aligns with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030, recommendations in Better Births - taken forward in the NHS England-led Maternity Transformation Programme, reducing harm through learning from serious incidents and litigation claims and improving culture, teamwork, and improvement capability within maternity units.

This work recognised the importance of keeping babies and mums together in improving bonding, breastfeeding success, and supporting emotional wellbeing.

Transitional Care

The role of transitional care plays an integral part of the pathway for reducing term admissions to the neonatal unit and supports families to stay together and be part of their baby's care.

When the Avoiding Term Admissions into Neonatal (ATAIN) initial document was published in 2017 the national figures were showing a decrease in the birth rate and an increase in term admissions to the neonatal unit. Term admissions are defined as pregnancy beyond and including 37 weeks (NICE 2023)

Between 2011 and 2014, the number of term live births in England declined by 3.6%, but the number of admissions of term babies to neonatal units increased by 24% with a further increase of 6% in 2015 (NHS England 2017).

They focused on 4 main themes for admission, −

- hypoglycaemia,
- jaundice,
- respiratory conditions, and
- asphyxia (hypoxic–ischaemic encephalopathy,

but acknowledge there will be other factors affecting admission.

Clinical multi-professional reviews of these cases were a recommendation (NHS England 2017) to form trends in admissions at local maternity units and themes to identify learning from practice and support quality improvement initiatives to form safe and effective care that helps reduce separation of babies from their mothers.

Between 2022 and 2023 WWL has seen an upward trajectory for the rate of **unexpected** and **avoidable** term admissions to the neonatal unit, this is significantly higher than the expected national accepted rate. WWL is currently an outlier for rates in GMEC and the regional rates in the last four quarters have highlighted this.

This has prompted an additional deep dive into the themes and trends of these admissions and what actions can be put in place to improve upon this. This report will discuss the themed analysis of both **avoidable** admissions and **unexpected** admissions at term.

The local statistics highlight there is an increased chance of a baby being admitted to the neonatal unit for respiratory distress syndrome (RDS) if a caesarean section has been performed. Furthermore, babies being admitted with hypoglycaemia is on an upward trajectory.

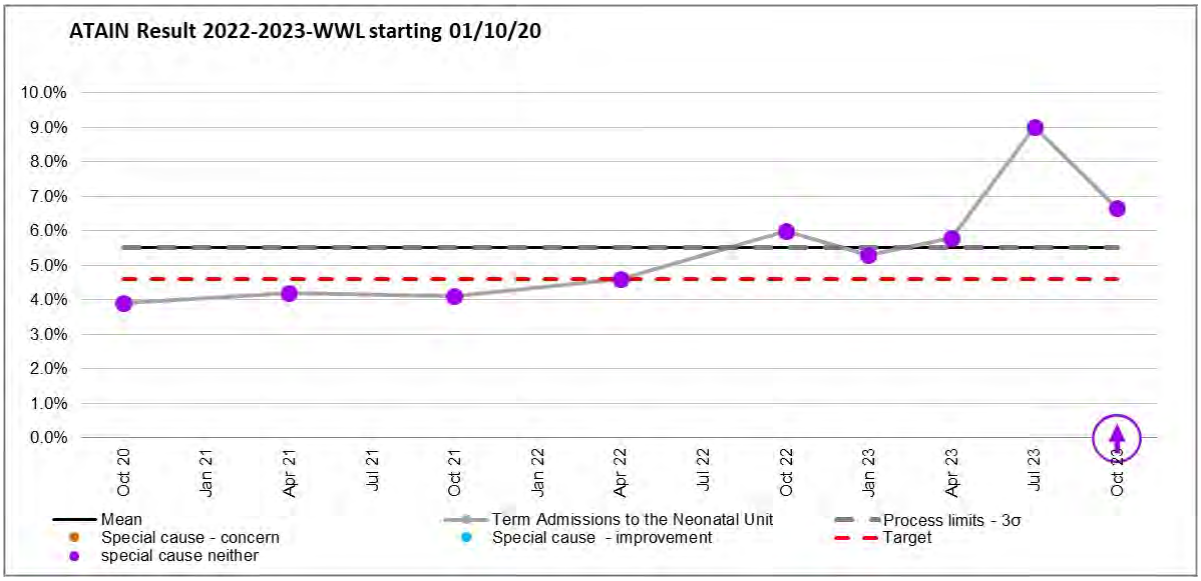
Measures have been taken to explore the care and communication to women and babies antenatally and at the time of birth to establish themes as communication and documentation are pivotal in supporting women to make clear informed choices around their care.

Guidelines, clinical documentation, and tools to support assessment e.g., NEWTT 2, have been reviewed, and this has founded the basis of the ongoing action plan.

The Quality and Safety Committee are requested to review the report and subsequent recommendations and actions prior to submission to the ICB and Regional Chief Midwife for assurance that appropriate actions are in place that will demonstrate an improving picture going forward.

Report.

The total number of term admissions to the neonatal unit at WWL from October 2020 – September 2023.



The mean data point for WWL across Greater Manchester for year 2022/23 was 7.0%. It is acknowledged that this was the highest score across the rolling year 2022/2023 in Greater Manchester.

Process for multi-professional Review at WWL

WWL undertakes a multi-professional review of all term admissions to the neonatal unit, this is undertaken on a weekly basis. In quarter 2, 2023/24 the service introduced a new process whereby we use the Local Maternity and Neonatal System (LMNS) ATAIN audit tool to log the antenatal, intrapartum, and postnatal lessons learned, this identifies themes from practice and strong actions to identify areas for improvement.

This multi-professional review is open to all midwives and is now attended by specialist midwives to enable them to understand themes relevant to their areas of expertise. The infant feeding team oversee areas for improvement within ATAIN reviews where hypoglycaemia or feeding issues has had an impact on unexpected admissions to the neonatal unit. The diabetic specialist midwife is invited when we are reviewing care of a woman with diabetes.

Postnatal and delivery team leaders are invited to attend to support the oversight of themes for improvement relevant to their team's practice and develop and communicate these effectively.

Our lines of communication ensure an embedded approach to quality and improvement work, and midwifery teams receive these via the governance newsletter, the quality and safety information board, quality improvement work and mandatory training sessions. Compliments are fed back to staff via individual emails, core huddles and a governance newsletter.

The communication process now involves a new quality improvement bus, which reflects pieces of quality improvement work. This new approach and visibility within clinical areas will enable WWL to sustain improvement across all areas.

Development of the ATAIN Action Plan

An ATAIN action plan has been developed and updated accordingly as actions have been completed. This is discussed and updated monthly with an ATAIN working group via a team's meeting.

With the recruitment of a new Quality and Safety Lead Midwife to oversee this metric the action plan has been reviewed and aligned with the new LMNS audit tool and the themes and strong actions generated from reviews. This oversight allows for actions to be completed within appropriate timeframes, clear understanding of who is identified as the lead for an action and provides reassurance through evidence collected that actions are progressing or completed.

The ATAIN action plan is submitted to Trust board on a quarterly basis. The quarterly presentations and audit report are shared at Board subcommittee. (Quality and Safety) and Safety Champions forums.

Overview of Unexpected Term admissions to the neonatal unit from October 2022 to September 2023.

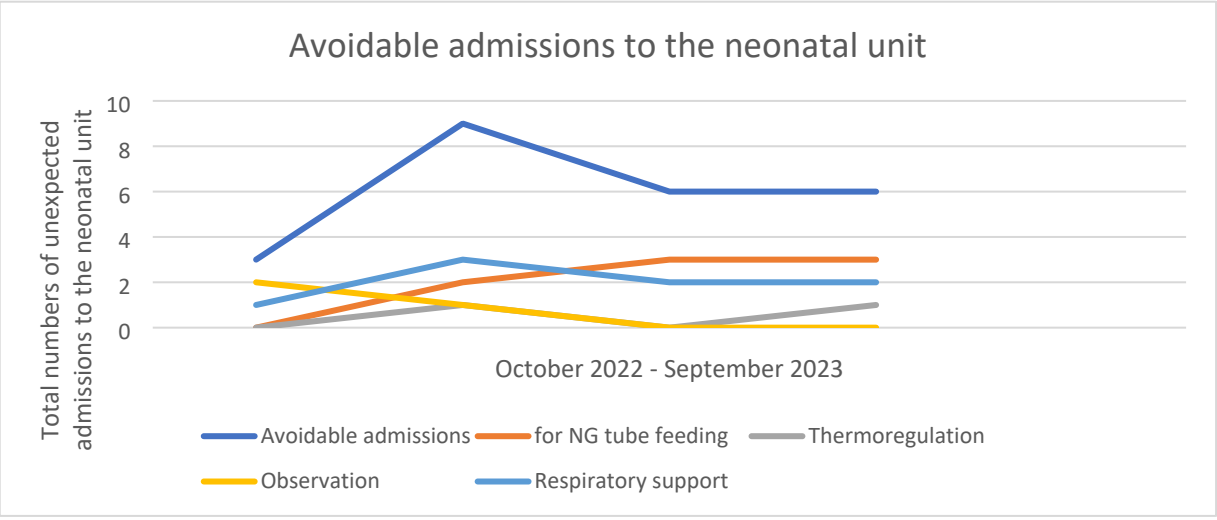
The total of unexpected term admissions to the neonatal unit in this period was 160 of 2527 registrable births. Equating to 6.33% of all births at WWL in this timeframe.

1 baby was excluded from the ATAIN audit due to a suspected fetal anomaly. **The regional target figure stands at less than 4.6%, WWL recognises the work we need to do to reach the national and regional target.**

Themed Analysis of the avoidable unexpected term admissions to the neonatal unit from October 2022 to September 2023.

Sources

ATAIN quarterly reviews
ATAIN quarterly reports/presentations
Euroking
Badgernet
GMEC ATAIN dashboard
GMEC Transitional Care audit tool
Case notes



The main themes from the avoidable admissions are presented in this line chart.

NG Tube Feeds

Rolling actions plans over the past 12 months have focused on improving the pathways for transitional care and provision of the WWL vision for transitional care, including a dedicated transitional care nurse to be visible and leading on care in the transitional care environment, however it is recognised that BAPM compliance and acuity within the Neonatal unit can affect this from time to time and support is provided from the Midwifery staff .Throughout this 12-month period NG tube feeding was not offered as part of the Transitional Care (TC) provision. A TC working group with a strong action plan have identified areas for improvement within this provision. A Standard operating procedure has been developed to sit alongside the TC guideline and offers a clear approach to our WWL model for transitional care, with clear roles and responsibilities for the collaborative team and an escalation process for when BAPM acuity is high within the neonatal unit.

Completed Actions

NG tube feeding is now offered within the transitional care provision and additional training is being provided to the maternity support workers to enable further support for parents as the primary carer for their babies. This has been effective from 7th December 2023. Implementing a midwife as second checker for neonatal antibiotics ensures babies are always kept with their mother, providing additional training for maternity support workers, to assist the transitional care nurse in supporting parents with nasogastric tube feeding and being the main carer for their babies. The transitional care audit reviews the provision and

identifies areas for continuous improvement and communicates the findings across maternity and neonates.

Thermoregulation

Thermoregulation has been a theme throughout the action plans over the past 12 months. From the avoidable admissions, 2 were avoidable due to thermoregulation, care could have been provided within the ward environment.

Respiratory

From the avoidable admissions, babies being admitted for respiratory support is a steady theme. These babies were found to not require respiratory support once admitted to the neonatal unit, it was highlighted these babies were often admitted quickly following birth and therefore a deeper dive into this data has been commenced.

Other Observations

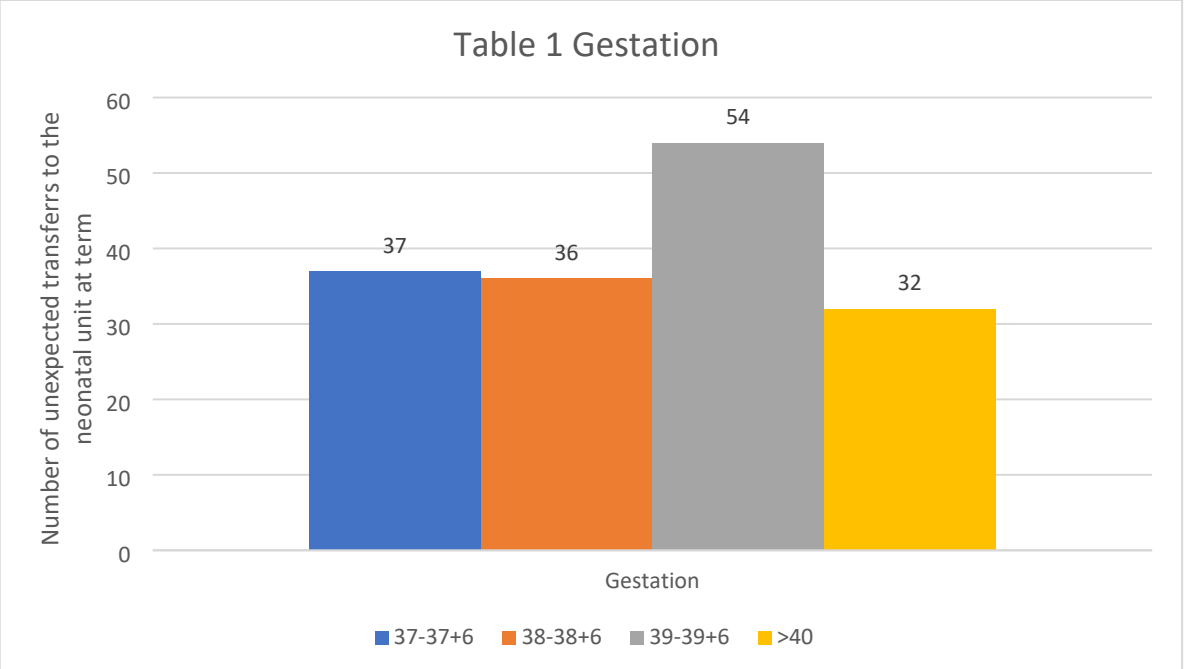
Other observations is a category nationally when reviewing ATAIN babies. There has been a positive decline in this category, routine observation that could have been supported on the ward or TC did not correlate with one single factor. Moderate resuscitation and poor feeding with normal BM's were identified.

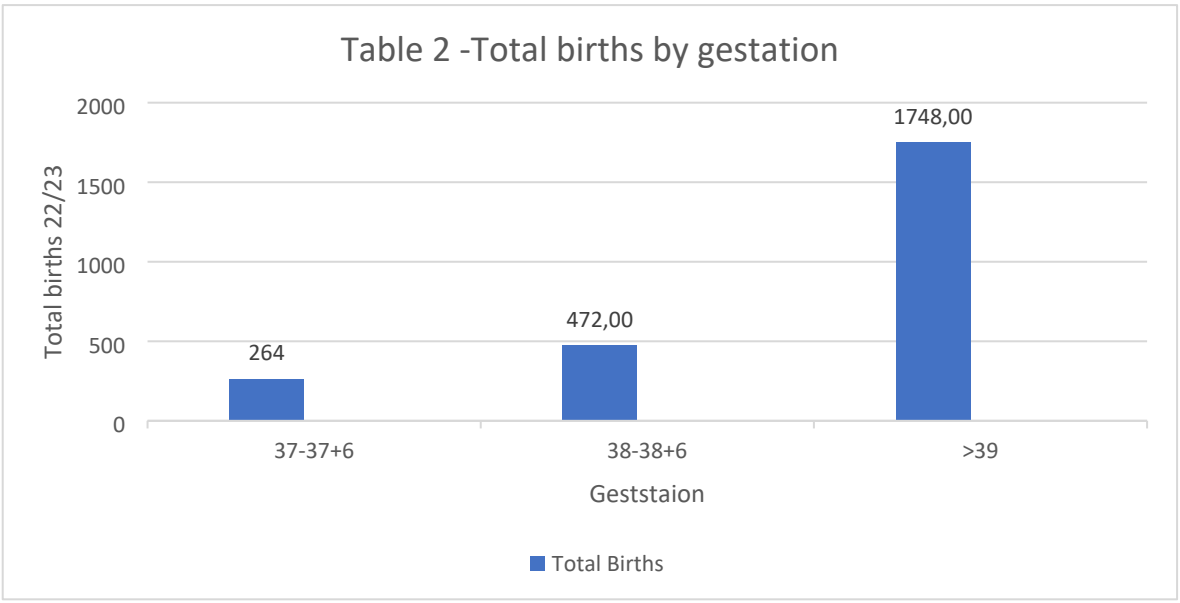
Themed Analysis of all the Unexpected Term Admissions to the Neonatal Unit

Gestation

Gestation at birth and impact on admission to the neonatal unit has been explored,

Table 1 highlights at WWL fewer babies that are born at a lower gestation to term are admitted to the neonatal unit.





Consideration was given to the number of total births undertaken at each gestation (Table 2).

Table 3

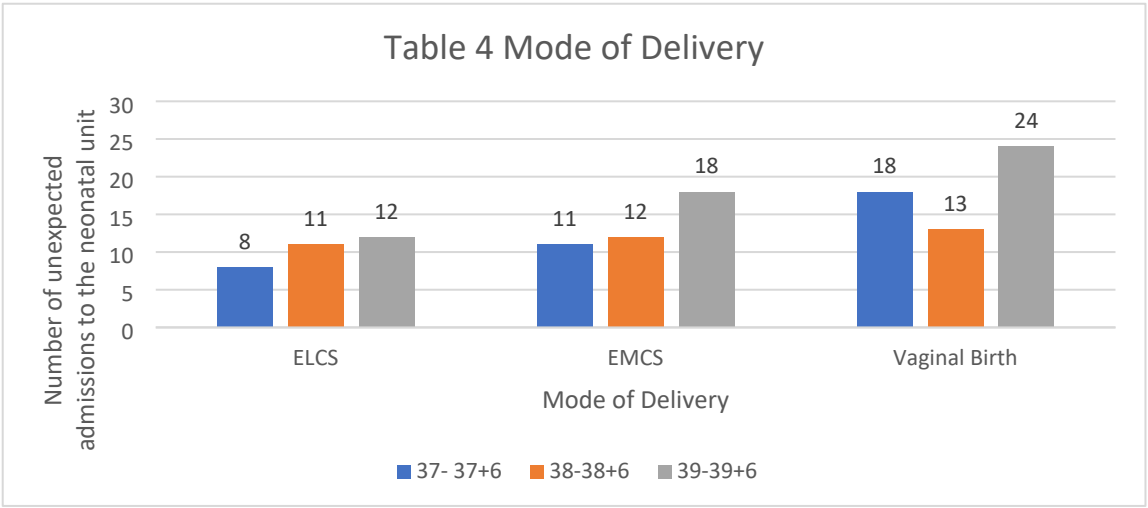
Gestation	Prevalence %
37-37+6	**14.1**
38-38+6	**7.62**
≥39	**4.91**

Table 3 shows the prevalence rate. 14.1% of babies born at 37-37+6 weeks were admitted to the neonatal unit, 7.62% of births at 38-38+6 weeks were transferred to the neonatal unit and 4.1% of babies born on or after 39 weeks were admitted to the neonatal unit.

Mode of Delivery

Mode of delivery and admission to the neonatal unit has been explored.

Table 4 below details the rate of admission comparing mode of delivery with gestation at birth.



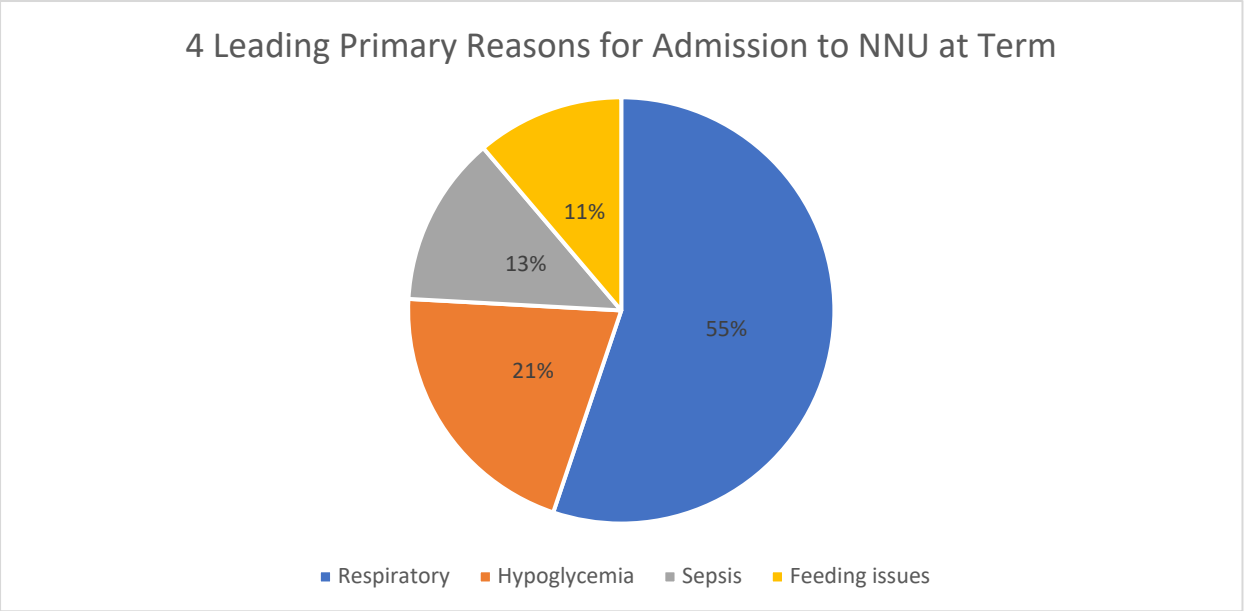
The local WWL ATAIN action plan reflects these findings. The process for counselling women re caesarean section, and the risks v's benefits has been considered and the RCOG leaflets for antenatal steroid therapy, considering caesarean section birth leaflet and Birth options after previous caesarean section have been reviewed, this has identified that there is contradictory information within these leaflets detailing the risks of respiratory distress syndrome and the potential for increased admission to the neonatal unit, this has been highlighted to the Regional ATAIN Group for further review.

This review and amendment of the documentation will ensure there is a robust process in place for counselling women regarding mode of delivery and gestation and risks and benefits of each.

Primary Reasons for admissions and Quality Improvement

The leading primary cause for unexpected term admissions to the neonatal unit locally is:

Respiratory distress syndrome (RDS).

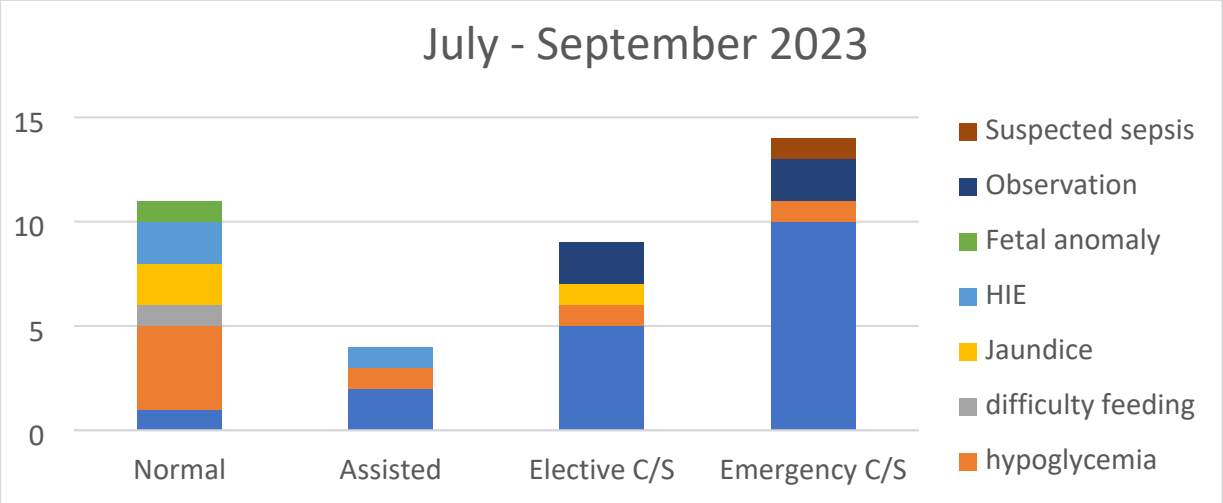


In the latest quarter, the action plan has focused on the primary reasons for admission. There has been a focus on antenatal education of the risks associated with RDS, early delivery and mode of delivery.

Thermoregulation is identified as a risk factor for RDS, a deep dive into this data is being undertaken, including temperature at birth and ambient temperature of the birth environment, and care in the golden hour to support thermoregulation.

Quality improvement work is being delivered and embedded and, a thermoregulation sticker has been agreed for use at all births, a sterile thick blanket in theatre to support during delayed cord clamping and cot warmer training for new equipment for all maternity staff.

Local audits have identified RDS as the lead cause for admission to the NNU at term when a baby is delivered by caesarean section.



Additional information has been added to the weekly ATAIN audit tool, to identify themes around resuscitation. Resuscitation in O2 is not routinely recommended (Neonatal Life Support 2021). This and time of transfer to the neonatal unit following birth have been added to identify learning.

Additional training for staff is planned as part of yearly mandatory training for ATAIN, the focus will be RDS and Transient Tachypnoea of the Newborn (TTN.) Learning will be developed collaboratively between the neonatal team and maternity team and displayed and communicated via the quality improvement bus.

Hypoglycaemia

The second highest primary reason for admission to the neonatal unit at term is hypoglycaemia. It has been identified that the local maternity policy for hypoglycaemia slightly differs from the neonatal policy for hypoglycaemia and this has the potential for confusion for paediatricians when reviewing babies over two care settings.

Learning through the infant feeding team and diabetic specialist midwife at ATAIN review has highlighted the importance of antenatal education to women in preventing hypoglycaemia to those most at risk.

Actions

- Await BAPM guidance to ensure we have a standard and robust approach to preventing, identifying, and managing hypoglycaemia.
- Antenatal education regarding colostrum harvesting is pertinent to prevention. The specialist diabetes midwife has a process in place whereby all women under the service are provided with this information. With the new GMCA essential parent app information regarding colostrum harvesting will be added to this information sharing tool.
- Parenting education has been recommenced from 2023, this offered to all women in wigan and facilitated collaboratively, this now incorporates information on colostrum harvesting.

Sepsis

The local guidance for management of sepsis in pregnancy and the postnatal period uses the regional sepsis tool. There is a robust process in place for identifying and treating potential sepsis.

The local Neonatal guideline for neonatal sepsis has a clear flowchart for how to manage newborn infants at risk of early onset sepsis on the postnatal ward. Reviews of babies who were admitted due to suspected sepsis have not identified any learning.

Tools for observation

The Newborn Early Warning Trigger and Track 2 (NEWTT2) tool has recently been implemented into practice. This enables the multi professional team to identify at risk babies, observe them according to guidance, care plan and recognise deterioration, and escalate appropriately.

Summary

Whilst it is recognised that WWL has considerable work to do to improve the rates for term admissions to the Neonatal unit there are robust plans in place to deliver the quality improvement measures

Themes from care and service delivery have enabled the WWL ATAIN working group to deep dive for further learning and detail a clearly defined action plan, with adequate timeframes and responsible owners. The inclusion of specialist midwives and nurses within this working group will enable continuous improvement within this metric.

Additional measures have been added for the weekly ATAIN review to explore correlations with clinical practice and admission to the neonatal unit. In this period 22/23 46% of admissions at term were from labours that were induced. We will explore this finding and consider the gestations at which we undertake induction of labour and caesarean section and the clinical reasons and identify learning from resuscitation and observation following birth.

We are confident with these measures in place we will sees a reduction in our avoidable and unexpected admissions to the neonatal unit in time.

Learning from Data: A review of babies born with Apgar's less than 7 at 5 minutes over 37 weeks

Rosie Robinson Governance and Risk Midwife
Maternity and Child Health.

6. Background

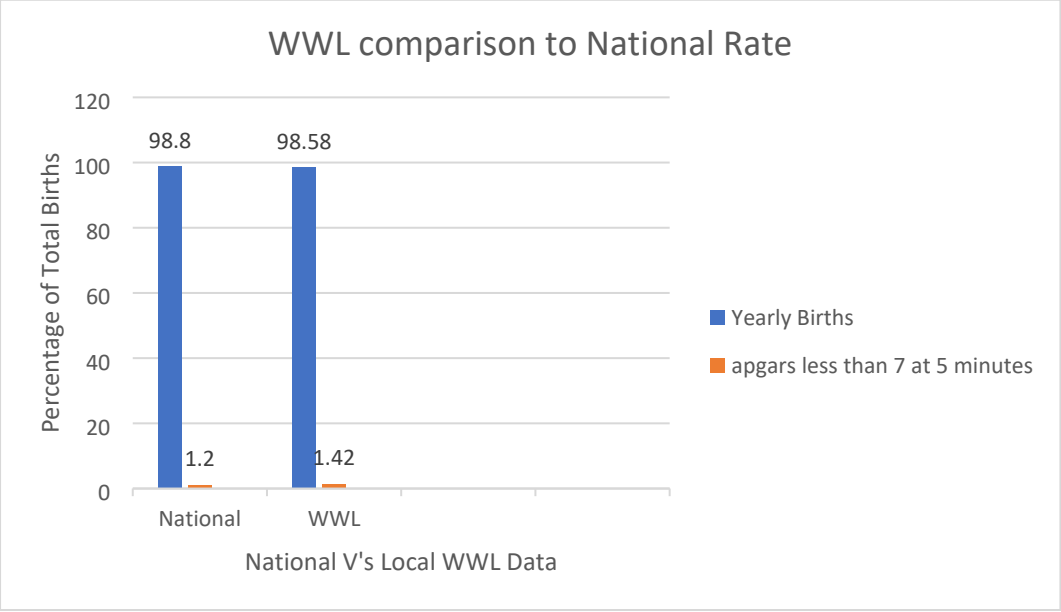
The Apgar score is performed soon after birth, and observations are made of a baby's heart rate, breathing, colour, muscle tone and response to stimulation. These are performed at 1 minute and 5 minutes of age, with a third assessment at 10 minutes. The five observations are each given a score of 0. 1 or 2. The total of these scores is referred to as the Apgar score If a baby requires resuscitation, the aim is to see the score rising and the baby's condition improving.

Time since birth	Heart rate	Colour	Tone	Reflex	Respiratory effort	Score
1 minute						
5 minutes						
10 minutes						

If the baby is born in poor condition (for example with abnormal breathing, heart, or tone) the Apgar will potentially be less than 7 at 5 minutes.

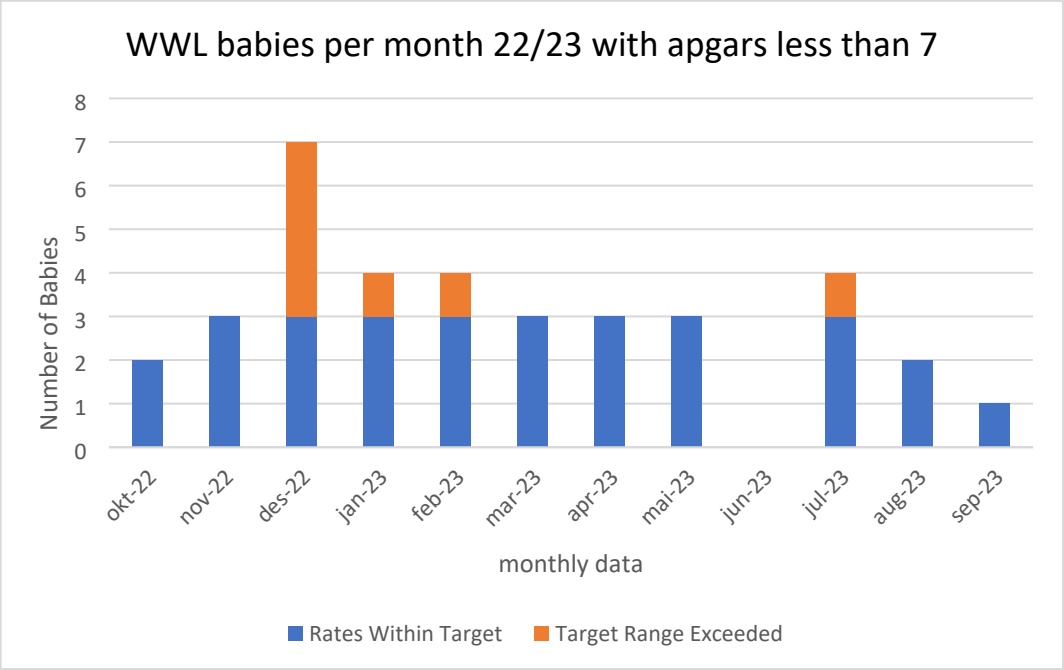
National and Local WWL Data

Apgar score less than 7 at 5 minutes for live born term babies, 2022-23 (MSDS)



This chart identifies local rates of babies born with Apgar scores of less than 7 at 5 minutes from 37 weeks are similar to national rates. With a 0.22% increase within our local WWL data.

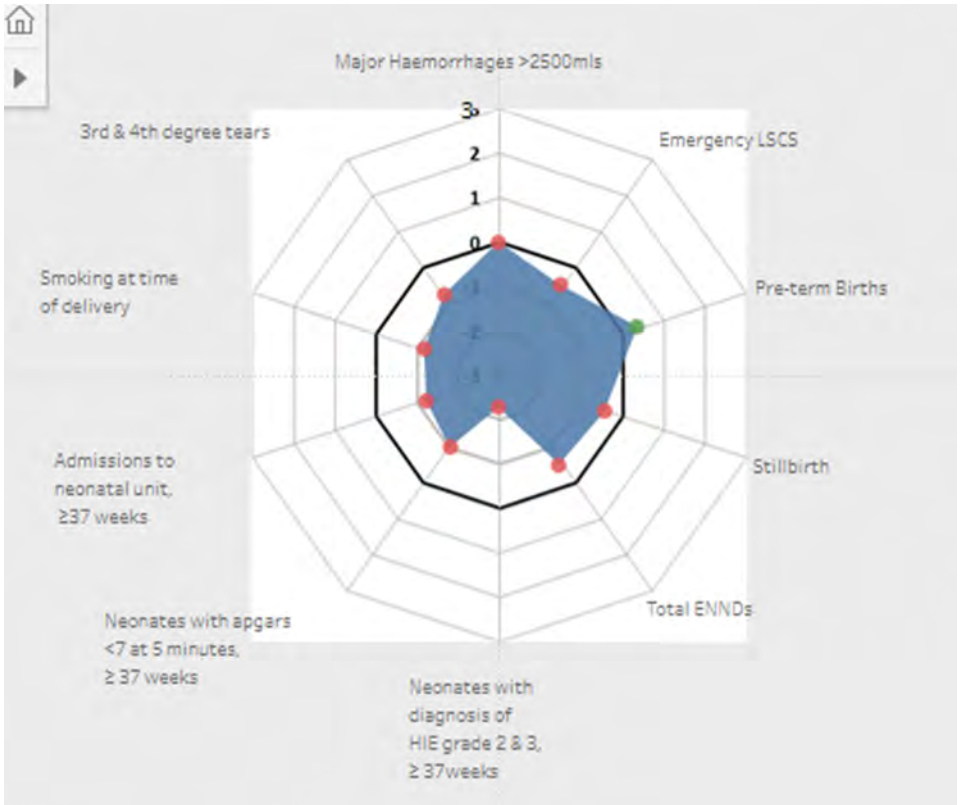
Total number of babies born with an Apgar less than 7 @ 5 minutes



The WWL target range for 2023 was set at below 3 babies per month to ensure that we identified and collated themes for improvement if this figure was exceeded. This target aligned with the previous year's 2022 data. From 2024 our target range will be benchmarked against the GMEC average for 2023.

Regionally our metrics are aligned per 1000 total births for Apgar's less than 7 at 5 minutes at 37 weeks gestation.

Regional data 2022-23 as below. (GM Tableau)



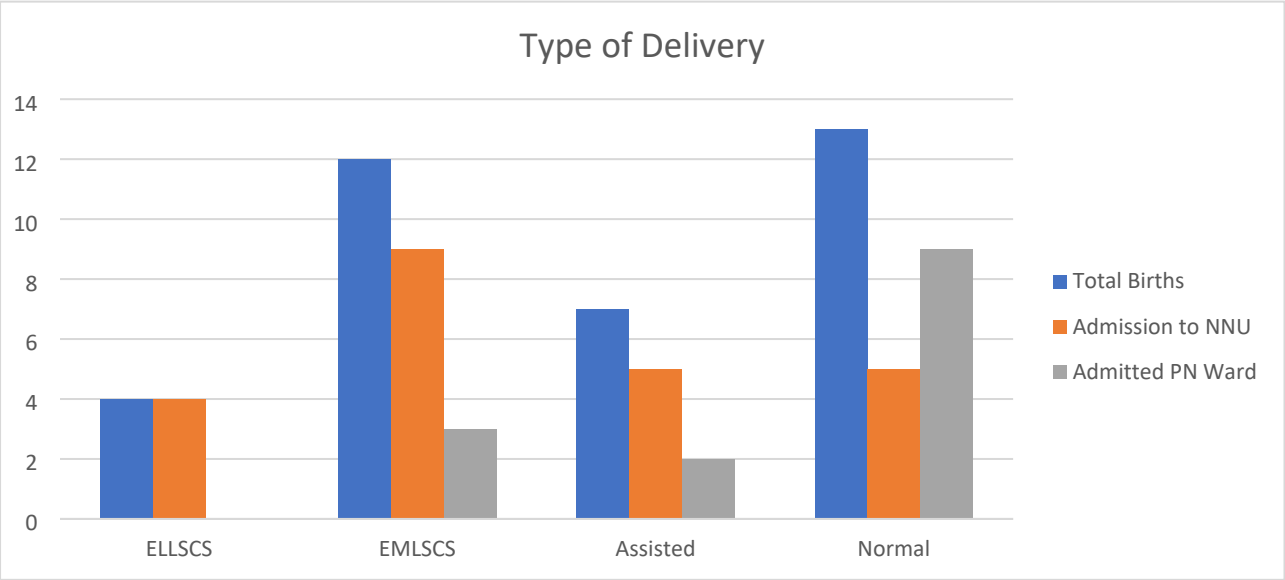
Overview

There were 36 babies in 12 months who had Apgar's less than 7 @5 minutes This equates to 1.42% of all registrable deliveries (2,527) during the period October 2022 – September 2023 Rate per 1000 Births = 1.42.

36% (n=13) were admitted directly after birth to the postnatal ward

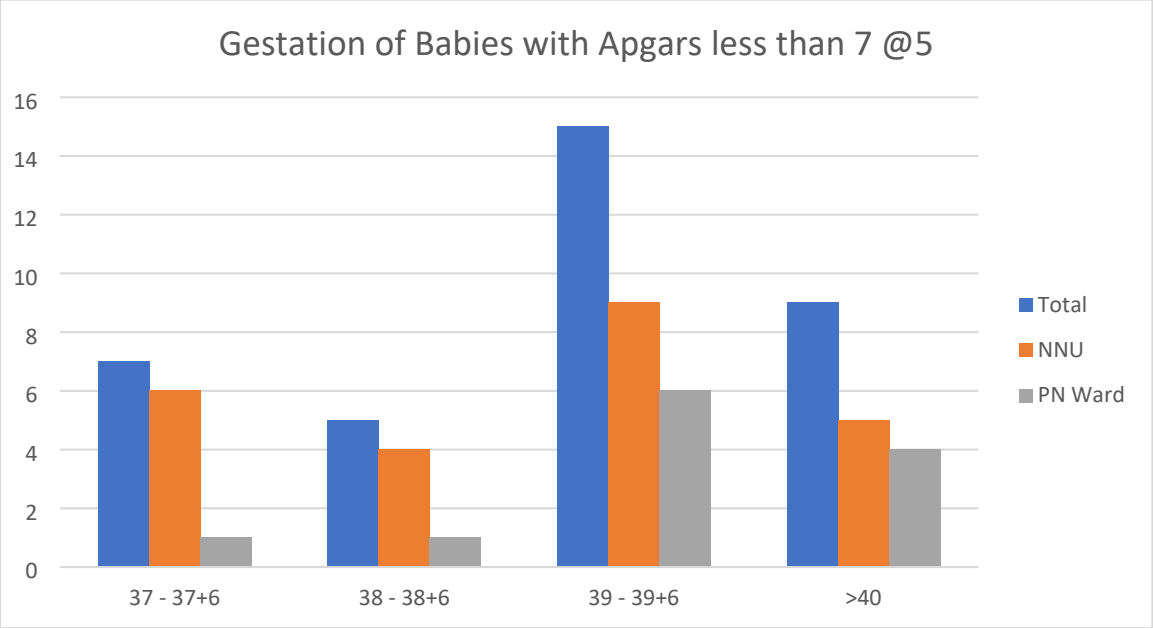
64% (n=23) were admitted to the neonatal unit All babies have had an ATAIN review

Mode Of Delivery and Post Delivery Admission



Of the babies born with Apgar's less than 7 @5 they are more likely to be admitted to the Neonatal Unit if born by Caesarean Section. Normal deliveries were more likely to be admitted to the postnatal ward.

Gestation At Delivery



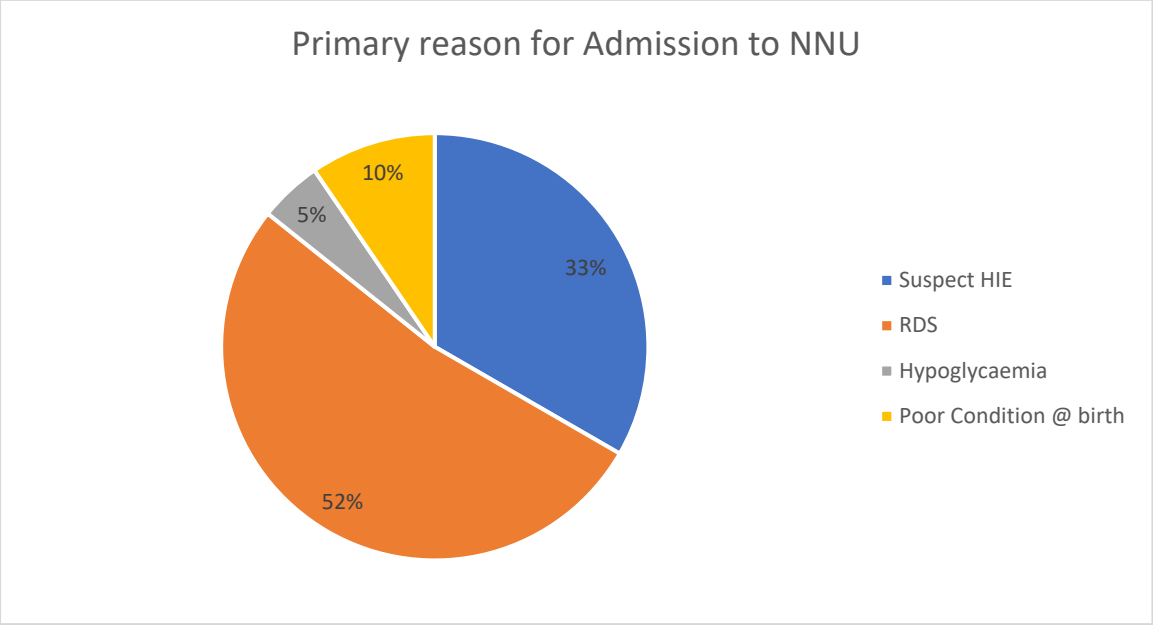
2.65% of births between 37 – 37+6 weeks

1.39% of births between 38 – 38+6 weeks

1.37% of all birth over 39 weeks

The review highlighted that babies who were between 37 – 37+ 6 weeks were more likely to have Apgar's less than 7 which correlates with the Atain audit which found that babies between 37 – 37+6 weeks were more likely to be admitted to the NNU

Primary Reason for Transfer to the NNU



Respiratory Distress Syndrome is the leading cause for Apgar's less than 7, this has been explored through the ATAIN review and audit tool. This is part of CNST Action 3 and monitored by the LMNS

Babies Transferred to The Postnatal Ward

14 babies with Apgar's less than 7 at 5 minutes were transferred directly with Mother to the postnatal ward. The majority of these babies had minimal or no resuscitation.

In this group of babies, the main themes for Apgar's less than 7, were maternal diamorphine in labour, a longer period of physiological adaption from intrauterine life to extrauterine life following birth, incorrect documentation of Apgar score and skin to skin and position of baby.

THEMES OF BABIES WITH APGARS LESS THAN 7

- **Respiratory Distress Syndrome (RDS)**

11 babies were admitted to the NNU with RDS. There has been a focus on antenatal education of the risks associated with RDS, early delivery and mode of delivery.

Thermoregulation is identified as a risk factor for RDS, a deep dive into this data is being undertaken via the ATAIN review, including temperature at birth and ambient temperature of the birth environment, and care in the golden hour to support thermoregulation.

Quality improvement work is being delivered and embedded and, a thermoregulation sticker has been agreed for use at all births, a sterile thick blanket in theatre to support during delayed cord clamping and cot warmer training for new equipment for all maternity staff.

Additional training for staff is planned as part of yearly mandatory training for ATAIN, the focus will be RDS and Transient Tachypnoea of the Newborn (TTN.) Learning will be developed collaboratively between the neonatal team and maternity team and displayed and communicated via the quality improvement bus.

- **Use of Diamorphine in labour**

6 babies with Apgar scores less than 7, had a prolonged period of physiological adaption from intrauterine life to extrauterine life following birth and diamorphine had been given in labour for analgesia. Midwives must ensure women are informed of the side effects to her baby such as short-term respiratory depression and drowsiness, (NICE 2023) A review of the information provided to women currently being undertaken.

- **Holistic Risk Assessment and CTG management**

Babies who have Apgar scores less than 7 who have been investigated either through internal or external investigations (HSIB) found a common theme with holistic risk assessment and CTG management.

The importance of holistic review and ongoing risk assessment is incorporated into annual Fetal Surveillance mandatory training. Tools such as the Fresh Eyes CTG assessment sticker have been updated to ensure hourly ongoing risk assessment. Paperwork is in the process of being streamlined in order to avoid the need to duplicate documentation of risk and therefore avoid unnecessary omissions and communication of risk between teams.

There is currently MDT training for all staff on fetal physiology with > 90% compliance and the training package includes the complex pregnancies CTG package with the reginal GMEC Intrapartum and Antenatal Fetal Monitoring guidelines now in use.

- **Documentation of Apgar scores**

The importance of the correct Apgar score to provide an accurate condition of baby in the immediate postnatal period and its implications with ongoing monitoring is required. 3 babies who had Apgar score less than 7 at 5 minutes did not relate to baby's condition at the time and cord gases where taken. Shared learning through the Quality and Safety Board on correct Apgar scoring will be shared with staff.

- **Position of baby in skin-to-skin**

2 babies had an Apgar score less than 7 at 5 minutes of age which on review could potentially be associated with airway position especially in skin to skin. 2023 NICE

Intrapartum NG235 incorporated further guidance to prioritise optimal baby airway positioning, ensuring the head is supported so the airway does not become obstructed during skin-to-skin contact Learning has been shared with maternity staff.

Incident Reporting of a baby with an Apgar score less than 7 @5 minutes
13 out of the 36 babies did not have an initial Datix incident reported for immediate review and to identify any shared learning The digital midwife provides a weekly report allowing the governance team to cross check and input any missed incidents onto the Datix system. This will reduce the workload on clinical staff.

7. SUMMARY

The number of babies with an Apgar score less than 7 @ 5 minutes will be reviewed through the Datix system and there is a robust system in place to ensure that they are all incident reported. The majority will be reviewed as part of ATAIN.

The weekly ATAIN audit tool will continue to identify themes, quality improvement projects and continuous improvements to care.

Findings from the incident report and ATAIN will be shared with staff through the Quality and Safety Board

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Perinatal Quality Surveillance Full Report (Q3 2023-2024, Oct-Dec 23)
Presented to:	Board of Directors
On:	7 February 2024
Presented by:	Kevin Parker-Evans Interim Chief Nurse
Prepared by:	Eve Broadhurst Head of Governance Maternity and Child Health for Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	T: 01942 772993 E: eve.broadhurst@wwl.nhs.uk

Executive summary

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

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

Incidents and investigations

In Q3 there were 1 incident with moderate harm or above in maternity/obstetrics.

1. Massive PPH-hysterectomy

In addition, 1 incident was reported to the Trust via Alder Hey Hospital due to a failure to refer a baby with fixed bilateral talipes which occurred earlier in the year. Moderate harm

Duty of Candour – 1 moderate and 1 severe, 2 DoC served –- 100% compliance

4 incidents were StEIS reported.

Undiagnosed SGA is the highest reported incident in both Q3 and in 2023. WWL remains in the top 10 Trusts in the country for diagnosis of SGA on scan. All scans with >10% discrepancy between estimated fetal weight and birth weight have been reviewed by the Sonography team and the images were of good quality and no learning has been found. The SBL team have strengthened training and now individual assessment of fundal height measurement is undertaken as part of mandatory training to ensure a standardised approach.

Term admissions to the NNU are reported by reason for admission – if amalgamated they account for highest reported incidents in 2023. QI work continues.

Exceptions - 138 DATIX incidents are under investigation. This has been escalated to the Senior Leadership Team and will be reviewed and monitored. A weekly incident support meeting has been instigated to support staff. A Risk has been added to the Corporate Risk Register and all incidents need to be closed by **March 2024.**

Feedback and complaints
The MNVP undertook the 15 steps walk-round on the 10th November. Lots of positive feedback regarding being Welcoming and Informative, Safe and Clean, Friendly, Personal, and Organised and Calm.

Areas to focus on included – Information boards for patients, concerns re the birth pool and room, lack of signage, promotion of birth plans and other antenatal information for patients, consistent infant feeding support and celebrating re-accreditation of BFI status.

In Q3, 7 formal complaints have been received for maternity services. 0 formal complaints received for neonatology services.
Themes in Q3 were clinical treatment and communication.
Exceptions - There has been an upward trend in the number of formal complaints for maternity services.

Risks
The Risk Register has been included for maternity and neonatal services.
At the end of Q3,
0 new risks under review.
1 risk awaiting approval - MAT 3880 Daisy Team future funding uncertain.
1 risk approved - MAT 3782 Maintenance of Maternity Equipment
2 risks closed
MAT 3819 Fetal Medicine Scanning
MAT 3656 Inability to transfer maternity patients to and from the unit as required due to NWAS strike action.
Risks continue to be pro-actively managed within the Division. Risks scoring 15 and over are monitored through RMEG. The risk register is tabled at the relevant monthly Clinical Cabinet for over-sight.
Exceptions - A number of risk actions are now overdue. Governance team to continue to support staff and progress is monitored via Divisional and Trust Risk meetings. Several risks have been mitigated to target levels – to review for closure (tolerate risk).

Ockenden 2
Q3 has seen progress against the 15 IAE Ockenden Actions. Where actions require national/regional input an action plan has been put in place to ensure IEAs are mitigated within our capabilities in the interim.
Exceptions - 5 actions remain, all are in progress. Note – there has been no given timeframe on the actions. They are red as they have surpassed the time that was initially allocated for completion.
(Progress against Ockenden 1 is monitored via the LMNS).

Maternity Incentive scheme Year 5
The technical guidance for the Year 5 scheme was launched on 31st May 2023. The relevant time period is 30th May 2023 to the 7th December 2023.
Ready for Trust Board sign off with 2 action plans, compliant.

ATAIN
Q2 23-24 audit found unexpected term admission rate to the neonatal unit to be **5.94%.** There is still work to be done, with 6 (16.2%) admissions thought to be avoidable on review and QI work is ongoing. The national target is <6% with the NWNODN setting the target at <4.5%. ATAIN action plan oversight by Board.
No exceptions

Mortality and PMRT
Q3 - 2 stillbirths and 1 neonatal deaths were recorded. Some immediate incidental learning has been identified and shared.

No completed PMRT in Q3. All on track.
Themes
100% of stillbirth cases had associated social deprivation (decile 2)
66% of the mortality cases were of Asian origin
Diabetes screening after 34 weeks not in line with GMEC practice. Under review.
No exceptions

Saving Babies Lives 3
SBL Tool completed for December submission 2023. Feedback from the LMNS rated WWL evidence as offering 'Significant Reassurance' with the evidence submitted. Overall compliance with 6 elements was **80%**
No exceptions – on track, areas of improvement recognised and SBL action plans provided.

GMEC LMNS Ambition
• Reduction in still births to a rate of 3.85 per 1000 registerable births in 2023/24
• Reduction in still births to a rate of 3.5 per 1000 registerable births in 2024/25
• Reduction of serious intrapartum brain injury to a rate of 1.0 per 1000 live births in 2023/24
• Reduction of serious intrapartum brain injury to a rate of 0.70 per 1000 live births in 2024/25

WWL will monitor its progress against the GMEC ambition.

Mandatory training
All but 1 staff group are over 90% compliant with mandatory training.
Exception 8 out of 9 eligible Consultants (excluding sickness/maternity leave) are compliant with mandatory fetal physiology training (89%). Training to be scheduled at earliest opportunity.

Workforce/ Safe staffing
At the end of Q3 there were 5.2 WTE midwifery vacancies and 1.07 WTE MSW vacancies.
There is 1 WTE Band 5 neonatal nurse vacancy and 1.73 WTE HCA vacancies.

GMEC data
This report looks at WWL/GMEC data, with a focus on outlier status and opportunities for learning.
See separate report for detailed themed analyses.
In Q2 2023, WWL has performed better than the GMEC average in rates of major haemorrhage >2.5 litres and pre-term births.
In Q2 2023 WWL has performed worse than the GMEC average in rates of smoking at the time of delivery, term admissions to NNU, stillbirth, early neonatal death, neonates with diagnosis of HIE 2 or 3 at term, 3rd and 4th degree tears, neonates with Apgars <7 at 5 at term, smoking at time of delivery and emergency Caesarean Section.
No exceptions – Improvement work already underway

Recommendations
It is requested that the Board of Directors review the contents of this paper to be aware of the recommendations within the quarterly report and gain assurance of the progress towards compliance in reaching the Ockenden essential actions (IEAs) from both reports which are continuing to be considered and implemented within the Division and that the Maternity Incentive scheme standards for MIS Year 5.

Contents

Maternity Perinatal Quality Surveillance Full Report

CQC RATING	Overall	Safe	Effective	Caring	Well Led	Responsive
	Good	Requires Improvement	Good	Good	Good	Good

1. Obstetrics/Maternity incidents in Q3 – NPSA Severity (data pull **04/01/2024** - DATIX)

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
No Harm	84	59	82	67	79	81	91	67	69	66	80	40
Low	5	7	8	8	8	3	7	7	5	7	5	4
Moderate	1	0	2	1	0	1	1	1	1	0	1	0
Severe	0	0	0	0	0	0	0	0	0	1	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total	**91**	**66**	**92**	**76**	**87**	**84**	**99**	**75**	**75**	**74**	**86**	**44**

In Q3 there was 1 incidents with moderate harm or above in maternity/obstetrics.

1. Massive PPH-hysterectomy

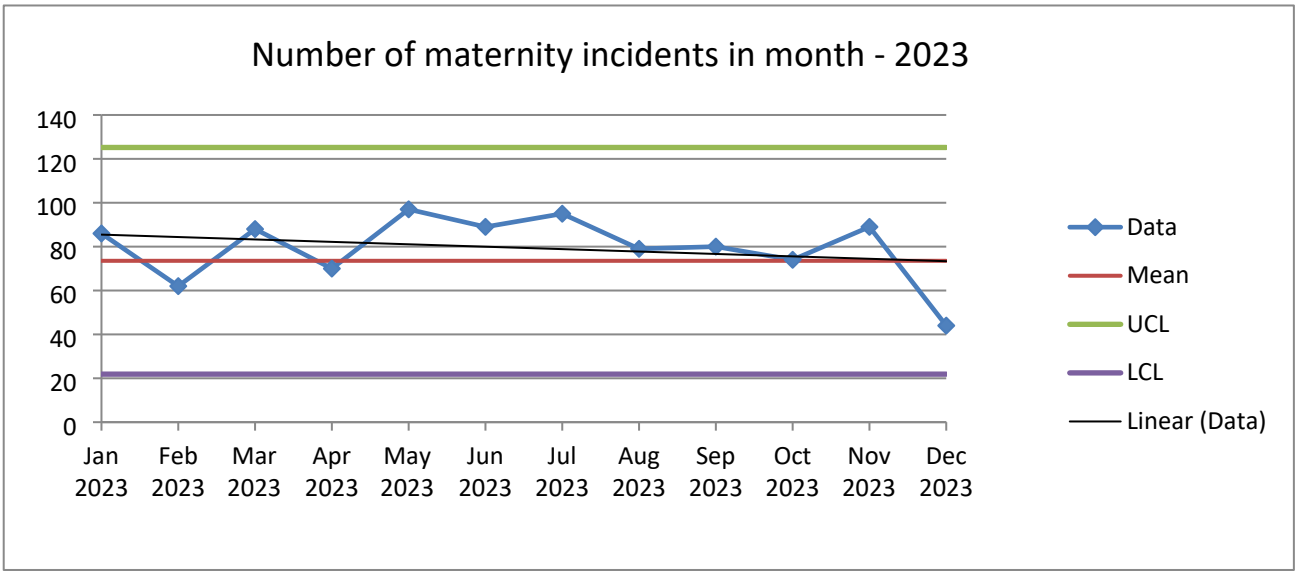
In addition, 1 incident was reported to the Trust via Alder Hey Hospital due to a failure to refer a baby with fixed bilateral talipes which occurred earlier in the year. Moderate harm

Duty of Candour 1 moderate and 1 severe harm incident – 2 DoCs served in Q3 - 100% compliance

NHS Resolution All cases accepted by MNSI are reported to NHSR.
In Q3 0 cases were accepted by MNSI for investigation – 1 referred to NHSR – 100% compliance.

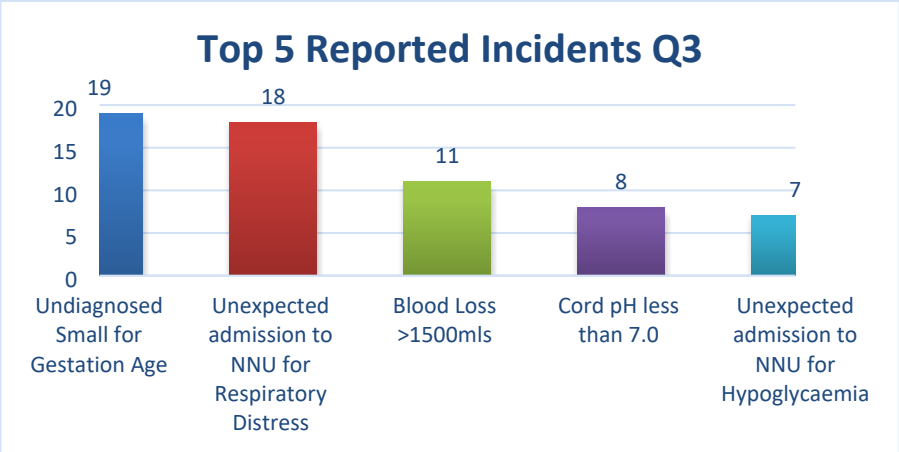
Exceptions - 138 DATIX incidents are under investigation. This has been escalated to the Senior Leadership Team and will be reviewed and monitored. A weekly incident support meeting has been instigated to support staff. A Risk has been added to the Corporate Risk Register and all incidents need to be closed by March 2024.

1.1 Maternity/obstetric incidents in 2023 by Month

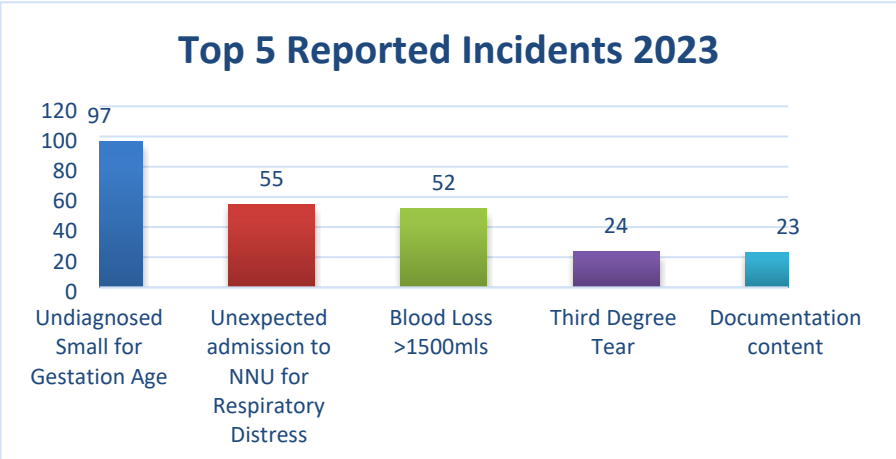


The mean number of incidents which occurred per month in 2023 was 74.

1.2 Top 5 Reported Incidents Obstetrics/Maternity– Q3



1.3 Top 5 Reported Incidents Obstetrics/Maternity 2023



Undiagnosed SGA is the highest single reported incident in both Q3 and in 2023. WWL remains in the top 10 Trusts in the country for diagnosis of SGA. For assurance, all scans with >10% discrepancy between estimated fetal weight and birth weight are now reviewed by the Sonography team and the images have been found to be of good quality and no learning has been found. The SBL team have strengthened training and now individual assessment of fundal height measurement is undertaken as part of mandatory training to ensure a standardised approach.

Unexpected Term Admissions to NNU are reported separately by reason for admission, if amalgamated they would account for 109 incidents in 2023 and be the highest reported sub-category.

1.4 Serious Incidents Q3

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Incidents reported to StEIS	0	1	2	1	0	1	3	1	0	1	3	0
HSIB referrals	1	1	1	0	0	0	1	1*	1	1	1	0
Accepted HSIB referrals	1	0	1	0	0	0	1	1	1	0	0	0
Cases referred to NHS R	1	0	1	0	0	0	1	0	1	0	0	0

StEIS
4 incidents have been reported to StEIS in Q3.
1.WEB147679 – Neonatal seizures. Immediate learning - Interpretation of neurological picture complicated by pain following shoulder dystocia ?missed opportunity to cool. Escalated to ESG. MNSI accepted. StEIS 2023/18407.

2.WEB117402 – Meconium aspirate. **Historic case** – initially rejected by HSIB. Family contacted MNSI to request investigation. Trust investigated at the time and there was learning re CTG interpretation. Re-escalated to ESG. MNSI accepted. StEIS 2023/20166.

3.WEB149717 – Difficult maternal GA and prolonged neonatal resuscitation. Immediate learning re length of time taken in theatre before induction of GA, use of Oxford pillow to support positioning head with women with large BMI. Escalated to ESG. MNSI rejected as did not fit criteria. StEIS 2023/21638 – for internal investigation.

4.WEB151872 – Massive PPH and hysterectomy. Immediate learning re lack of robust Major Obstetric Haemorrhage protocol and blood loss threshold for activation of MOH not in line with GM. Escalated to ESG. StEIS 2023/21628

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

MNSI/NHSR

Q3 has seen a decrease in the number of cases referred to MNSI when compared to Q2.
2 incidents have been referred to MNSI of which 0 have been accepted for investigation.

MNSI Ref	WEB	Criteria	Incident date	Referral Date	Accepted	Outcome
MI-035498	WEB149717	?Brain injury	06.10.2023	20.10.2023	No	Does not fit criteria
MI-036156	WEB149131	?Brain injury	15.09.2023	02.11.2023	No	Does not fit criteria

No exceptions

1.5 MNSI overview Q3

January 2019- December 2023	Cases to date	
	Total number referrals	23
	Cases rejected	10
	Total investigations to date	13
	Total investigations completed	10
	Current active cases	3
	Exception reporting	**No exceptions**
0 cases finalised in Q3		

1.6 MNSI /NHSR assurance slide 2023 (CNST Yr. 5 reporting period)

Patients

Advise, Resolve, Learn – MNSI / NHSR

MIS Year 5 reporting period 6.12.2022-7.12.2023

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	REJECTED	NA	NA
MI-036156	Seizures/?brain injury	15.9.2023	3.11.2023	REJECTED	NA	NA

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

1.7 Learning from completed investigations

In Q3, 2 investigations were finalised at ESG/SIRI.

WEB number	Date	Incident	Learning
WEB133593 StEIS 2022/24460	28.10.22	Missed cervical length scans – extreme pre-term birth – NND.	The 'risk' documentation requirements need streamlining to avoid omissions. Importance of dedicated pre-term specialist leads. Importance of dedicated pre-term specialist clinic.

			Importance of robust clinic processes and oversight when women present with more than one complex issue, to ensure holistic care planning.
WEB149131	15.09.23	Neonatal seizures	Optimum contractions with syntocinon ' No More than 4'

1.8 Investigation progress – overview of open investigations

At the end of Q3, 9 serious incident investigations are open.

WEB number	Date	Incident	Progress	Stage	Plan
WEB131310	Sep 2022	Therapeutically Cooled (rejected by MNSI)	Received in Division	Reviewed in Division – not complete	To work with investigators to complete
WEB136351 StEIS 2023/2503	Dec 2022	Neonatal stroke (MNSI)	Final report received	Action plan complete	Send to SIRI for final approval
WEB139693 StEIS 2023/6632	Mar 2023	Therapeutically Cooled (MNSI)	Final report received	Action plan complete	Send to SIRI for final approval
WEB145544 StEIS 2023/13640	Jul 2023	Therapeutically Cooled (MNSI)	Draft report received – Trust Fac Acc	With family for Fac Acc	Await final report
WEB145195 StEIS 2023/16382	Aug 2023	Neonatal death (22+6) (PMRT)	Preliminary PMRT held	Final PMRT scheduled	Await grading
WEB117402 StEIS 2023/20166	Oct 2021	Therapeutically Cooled (MNSI)	Draft report received	Trust Fac Acc	Await final report
WEB147679 StEIS 2023/18407	Aug 2023	HIE 2-3 (MNSI)	Information sent to MNSI	MNSI Report Panel	Await final report
WEB149717 StEIS 2023/21638	Sep 2023	Difficult maternal GA and prolonged neonatal resus	Rejected by MNSI – for further internal investigation	To meet with team for AAR	Invites to be sent
WEB151872 StEIS 2023/21628	Nov 2023	Massive PPH/hysterectomy	Presented at ESG – for Divisional Concise.	Authors informed – in progress	Immediate action to bring MOH guidance in line with regional guidance

2. Patient Experience - MVP and Service-user Feedback

The MVP completed the 15-steps walk round on 10th November.

Lots of positive feedback regarding being Welcoming and Informative, Safe and Clean, Friendly, Personal, and Organised and Calm.

Areas to focus on included – Info boards for patients, concerns re the birth pool and room, signage, promotion of birth plans and other antenatal info, consistent infant feeding support and celebrating re-accreditation of BFI status.

FFT feedback

Some FFT responses for Maternity & Child Health

Maternity Services - Unspecified

- I am very happy with how I have been taken care of.
- Excellent support from the midwives. They are on hand at all times 24/7.
- Very kind and helpful.
- The staff are very friendly and helpful.
- Supported all the way through by the midwives.

Antenatal

- Tina has been my absolute rock this pregnancy and afterwards. She never once judged me because of my personal circumstances. I wouldn't have gotten to where I am now without her support.
- I couldn't have asked for anything better. Thank you for everything.
- Everyone is absolutely amazing. They were always there for my need and took my mental health into consideration
- Amazing support and I was made to feel comfortable all of the time.

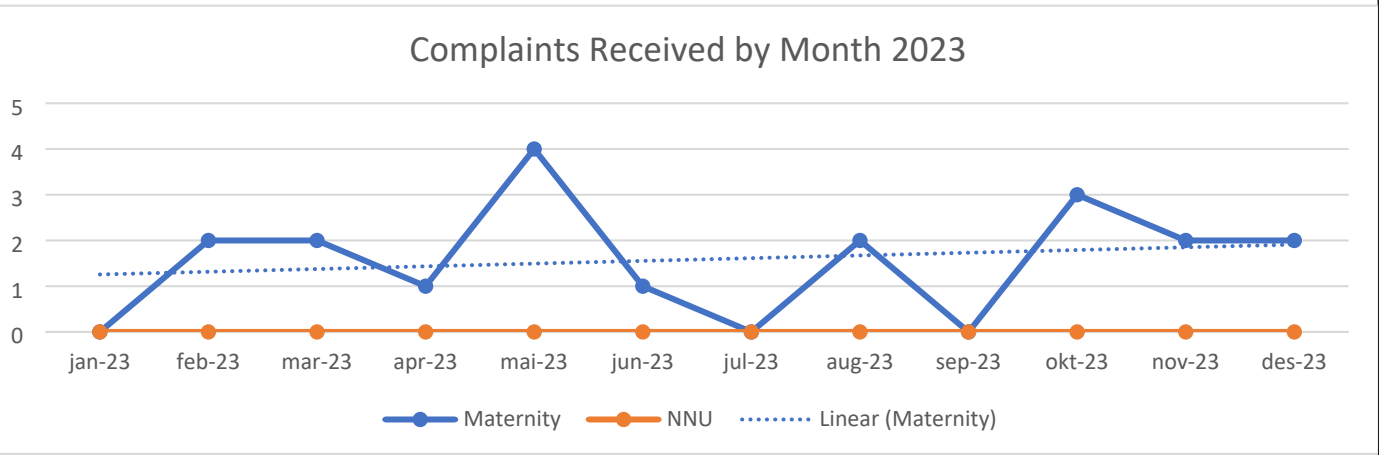
Postnatal

- I had all of the support when I needed it.
- Amazing support and I was made to feel comfortable all of the time.
- They helped me through everything. I really enjoyed having you as part of my journey. You helped me so much and I couldn't ask for more.
- They looked after me and Mia, absolutely amazing.

The Governance Team are currently awaiting feedback on training in January 2024 for the Envoy system, which will allow us to review and analyse FFT feedback – both positive and negative.

2.1 Complaints

Formal Complaints	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Maternity	0	2	2	1	4	1	0	2	0	3	2	2
NNU	0	0	0	0	0	0	0	0	0	0	0	0



In Q3, **7** formal complaints have been received for maternity services with the maternity matrons and managers continuing to meet with women and their families before discharge to deal with any immediate concerns. The maternity service offers a debrief service which women can access to discuss their care. A Birth Thoughts group is available where women can self-refer.

No formal complaints have been received for the NNU.

Q3	Oct	Nov	Dec	Total
Clinical treatment	2	1	1	4
Communication	1	1	1	3

Clinical treatment:
1. Patient has concerns over her Emergency Caesarean section and subsequent wound care due to slow healing of wound.
2. Concerns raised around the requirement for, and healing of an episiotomy wound.
3. Patient is concerned over the care provided postnatally, following issues with Caesarean wound healing.
4. Patient unhappy with her elective Caesarean experience, due to perceived haste of staff involved.

Communication
1. News was communicated with the patient in an unprofessional manner, and incorrect information was additionally provided over telephone and e-mail about another patient.
2. Incorrect wristband provided to patient, who only noticed the error following her delivery and discharge.
3. Concerns raised over postnatal care and a perceived lack of communication between teams to support health and safety of patient and baby.

Exceptions It is important to recognise that the number of complaints remains low, and the compliments received far outweigh concerns. However, an upward trend of complaints received by month has been noted over the year in Maternity services.

3. Risk register – Maternity and neonatal services

Live Risk Register	Significant (15+)	High (8-12)	Moderate (4-6)	Low Risk (1-3)
	2	16	10	0

Under review	-	-	-	-
Awaiting approval	MAT	3880	Daisy team future funding uncertain	9
Approved	MAT	3772	Euroking System Error	20
	MAT	3604	Obstetrics and Gynaecology On-Call Availability Risk	15
	MAT	3802	Obstetrics/Gynaecology Tier 2 Staffing Shortages	12
	MAT	3616	Compliance with Maternity Incentivisation Scheme Year 5	12
	MAT	3605	Obstetricians and Gynaecologists on call rotas not allocating compensatory rest	12
	MAT	3362	Midwifery Staffing Shortages	12
	NEO	1977	Specialist AHP services should be available in all units for neurodevelopment and family integrated care	12
	MAT	3780	Maternity Ligature Risk	10

	MAT	3727	Euroking To PAS Error Risk	9
	NEO	1978	Access to a Neonatal Dietician competent in Neonatal nutrition	9
	MAT	3732	Entonox Risk	9
	MAT	3756	Medical Devices Training	8
	MAT	3667	Emergency Evacuation from Maternity Birthing Pool	8
	MAT	3659	Insufficient number of Resuscitaires within the Delivery Suite for New-born resuscitation	8
	MAT	2581	Sustainability of Maternity Services	8
	NEO	2281	There are a significant number of staff who do not have current accreditation for NLS course	8
	MAT	3669	Potential inability to undertake more than 1 emergency delivery at a time due to number of theatres available.	8
	BOTH	3725	Junior Doctors Strike	6
	MAT	3672	Lack of availability of NLS accredited training resulting in potential risk to quality of new-born life support.	6
	MAT	1758	Delivery suite coordinator should be supernumerary at all times.	6
	MAT	3400	Screening for GBS at 36 weeks gestation in women with a history of GBS (group B beta-haemolytic streptococcus) infection	6
	MAT	140	Backflow of raw sewage due to blocked drains	6
	NEO	1975	BAPM staffing guidelines - Staff shortages on the Neonatal unit	6
	MAT	1037	CTG Misinterpretation	6
	MAT	1469	The risk of abduction from the maternity unit	5
	MAT	3426	Out of area women cared for under different SGA/FGR guidance	4
	MAT	2459	Transportation and supply of Entonox (Nitrous oxide 50% and oxygen 50%) by Community Midwives for use at Homebirths	4

At the end of Q3,

0 new risks **under review.**

1 risk **awaiting approval**
MAT 3880 Daisy Team future funding uncertain.

1 risk **approved**
MAT 3782 Maintenance of Maternity Equipment

2 risks **closed**
MAT 3819 Fetal Medicine Scanning
MAT 3656 Inability to transfer maternity patients to and from the unit as required due to NWAS strike action.

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

Exceptions - A number of risk actions are now overdue. Governance team to continue to support staff and progress is monitored via Divisional and Trust Risk meetings.

- Several risks have been mitigated to target levels – to review for closure (risk tolerated).

4. Ockenden 2 progress update

Q3 Update		Local Actions			N/A	Trust Corp Action	National/ regional Action
		Red	Amber	Green			
EA1	Workforce planning and sustainability	1	0	7			3
EA2	Safe staffing	0	0	9			1
EA3	Escalation and accountability	0	0	5			
EA4	Clinical governance-leadership	1	0	5		1	
EA5	Clinical governance – incident investigation and complaints	0	0	7			
EA6	Learning from maternal deaths	0	0	2			1
EA7	Multidisciplinary training	1	0	6			
EA8	Complex antenatal care	1	0	3			1
EA9	Preterm birth	0	0	4			
EA10	Labour and birth	1	0	3	2		
EA11	Obstetric anaesthesia	0	0	7			1
EA12	Postnatal care	0	0	4			
EA13	Bereavement care	0	0	4			
EA14	Neonatal care	0	0	5			3
EA15	Supporting families	0	0	3			
	Total	5	0	74	2	1	10

There are a total of 15 immediate and essential actions and 92 sub actions from the Ockenden 2 report. Q3 has seen progress against the 15 IAE Ockenden Actions. Where actions require national/regional input an action plan has been put in place to ensure IEAs are mitigated within our capabilities in the interim.

Exceptions - 5 actions remain, all are in progress. Note – there has been no given timeframe on the actions. They are red as they have surpassed the time that was initially allocated for completion by the Maternity team.

5. Maternity Incentive Scheme Year 5

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. The technical guidance for the Year 5 scheme was launched on 31st May 2023. The relevant time period is 30th May 2023 to the 7th December 2023. Ready for Board approval with 2 action plans.

Safety Action		Required standard	RAG
1	PMRT	a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	Data available on MBRRACE
		b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	Data available on MBRRACE
		c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	Data available on MBRRACE
		d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.	PQSR
2	MSDS	a) Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.	Embedded
		b) July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).	Embedded
		c) Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics.	Embedded
		If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information).	Carried out as failsafe
		d) Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.	Complete
		e) Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.	2 submitters in BI.
3	TC/ATAIN	a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Guideline

		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.	ATAIN meetings ATAIN action plan TC/ATAIN audits (LMNS)
		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.	Guideline
4	Clinical Workforce Planning	a) Obstetric medical workforce	Action plan approved
		b) Anaesthetic medical workforce	
		c) Neonatal medical workforce	Action plan approved
		d) Neonatal nursing workforce	
5	Midwifery Workforce Planning	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	Birthrate+
		b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	
		c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.	
		d) All women in active labour receive one-to-one midwifery care.	
		e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.	
6	SBL3	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.	
		2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.	
7	Listening to women / MNVP	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.	
		2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	
		3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.	
8	Multi-professional Training	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.	
		2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. 3. The plan is developed based on the “How to” Guide developed by NHS England.	
9	Board assurance process	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.	

		b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.	
		c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.	
10	HSIB/NHSR	A) Reporting of all qualifying cases to HSIB/CQC//MNSI from 30 May 2023 to 7 December 2023.	Embedded
		B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 until 7 December 2023.	Embedded
		C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Embedded

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q2

Q2	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU
July - Sept 2023	622	38 (6.1%)	37 (5.94%)	**6 (16.2%)**

In Q2, the unexpected term admission to NNU rate was 5.94% of total term live births. This is a slight increase from Q1. There is still work to be done with 6 (16.2%) of admissions potentially avoidable. Weekly MDT ATAIN meetings are led by the Quality and Safety Midwife and are scheduled to enable timely review, oversight, recognise themes and monitor the ATAIN action plan. Specialist midwives and team leaders are now part of this review process and provide a collaborative approach to enable improvement and service development specific to their team's practice.

Avoidable Admissions

3 babies required NG tube feeding; they had to be transferred to the NNU as this provision was not offered within the TC environment at that time. This has now been reintroduced in Q3 and we hope to see a reduction in avoidable admissions in the next quarter.

2 babies were transferred for a period of observation due to suspected transient tachypnoea of the newborn, these babies did not require respiratory support on admission to the neonatal unit. A more reasonable period of observation and early support for a grunting baby following birth may have supported these babies to stay with their mothers.

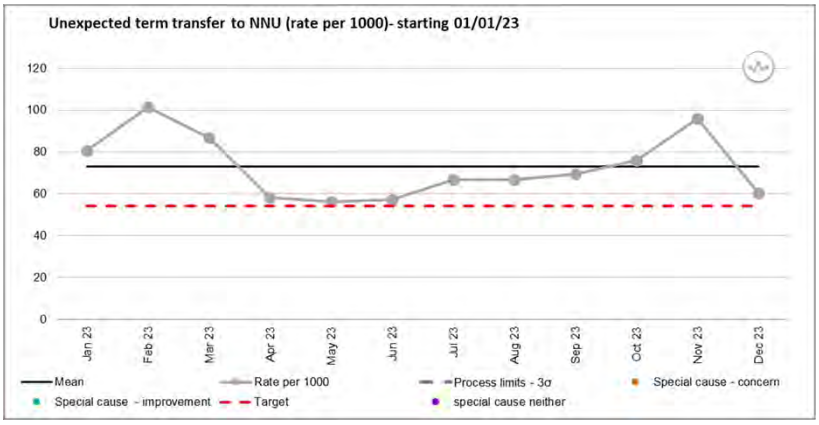
1 baby was admitted for hypoglycaemia. For one baby at risk of hypoglycaemia. It was found that optimisation of thermoregulation and initiating septic screening may have prevented separation of mother and baby and transfer to the NNU.

Unexpected Admissions

The principal reason for admission to the NNU continues to be respiratory distress. The working group are actively working on the ATAIN actions. These will focus on quality improvement initiatives for thermoregulation and embed the 'Warm Care Bundle' into practice to support staff to optimise care of the neonate in the first hour of life. The Neonatal Team Leader and Quality and Safety midwife have developed snapshot learning to enhance the MDT's approach on preventing hypothermia and will be rolled out in January 2024.

MIS Year 5 specific data

Number of admissions to NNU that would have met TC admission criteria but were admitted to NNU due to staffing or capacity	Number of babies that were admitted to NNU because of their need for nasogastric tube feeding but would have been cared for on TC if NGT feeding was supported there	Number of babies that remained on NNU because of their need for nasogastric tube feeding but would have been cared for on TC if NGT feeding was supported there
0	3	3



------ GMEC mean
_____ WWL mean

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

7.1 Mortality overview

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	**Total**
	Q4 22-23			Q1 23-24			Q2 23-24			Q3 23-24			
Total births	**224**	**170**	**194**	**214**	**215**	**213**	**183**	**234**	**205**	**211**	**221**	**197**	**2481**
Total Stillbirths ≥ 24	**2**	**0**	**2**	**2**	**0**	**1**	**0**	**2**	**2**	**1**	**1**	**0**	**13**
MTOP/Lethal Anomalies ≥ 24	1	0	1	0	0	1	0	0	0	0	1	0	(4)
Late fetal loss 22 – 23+6	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Total Neonatal Deaths (0 days–28 days)	**1**	**1**	**0**	**1**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**6**
Early neonatal deaths (0-7 days)	1	1	0	1	0	0	0	1	1	0	0	1	(6)
Maternal Deaths	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

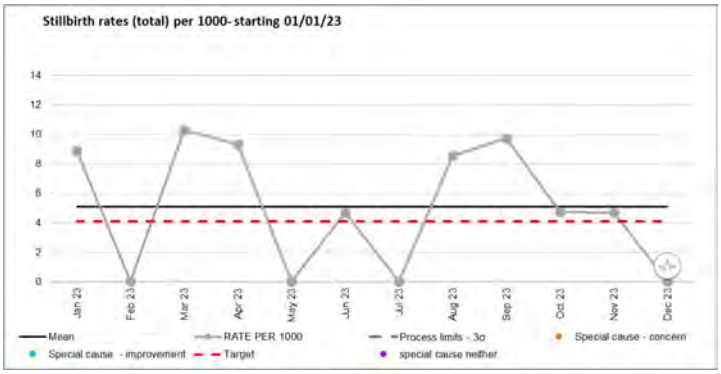
The NHS Long Term plan has set a target of reducing stillbirths and neonatal deaths by 50% by 2025. That would require England and Wales to reduce its stillbirth rate to 2.6 stillbirths per 1,000 births and the neonatal death rate to 1.5 neonatal deaths per 1,000 births.
In 2023 – the rate of stillbirths at WWL was 5.2:1000 births
The rate of neonatal deaths was 2.4:1000 births

7.2 Stillbirths
There were 2 stillbirths in Q3, 1 singleton and 1 medical termination of pregnancy (MTOP).

Stillbirths and late fetal losses from 22 weeks gestation are subject to a 72-hour review and full PMRT review.

1. 39+1 weeks gestation – shared antenatal care between WWL and Preston. Glucose tolerance test (GTT) was required however, mother declined/cancelled and did not attend for arranged GTT tests at WWL. Now confirmed that mother also declined GTT at Preston. Immediate learning identified – processes can be strengthened in regard to women who decline/cancel/DNA the GTT test to ensure that the Diabetes Specialist Midwife has oversight and appropriate counselling has taken place at the earliest opportunity AND review of guidance required re BG monitoring after 34 weeks rather than GTT. Attended at 39+1 days for elective caesarean section, on arrival no fetal heart rate detected. Accepted investigations for external placental histology, and cytogenetics. However, declined postmortem. Full PMRT review ongoing.

2. 35+6 weeks gestation - medical termination of pregnancy for multiple abnormalities identified at a late gestation. Counselled regarding options as poor prognosis at birth. Opted for feticide at fetal medicine unit, followed by MTOP at WWL. Accepted investigations for postmortem, placental histology, and cytogenetics. No identified learning at time of report, reported to MBRRACE. No immediate learning identified. Not eligible for PMRT.

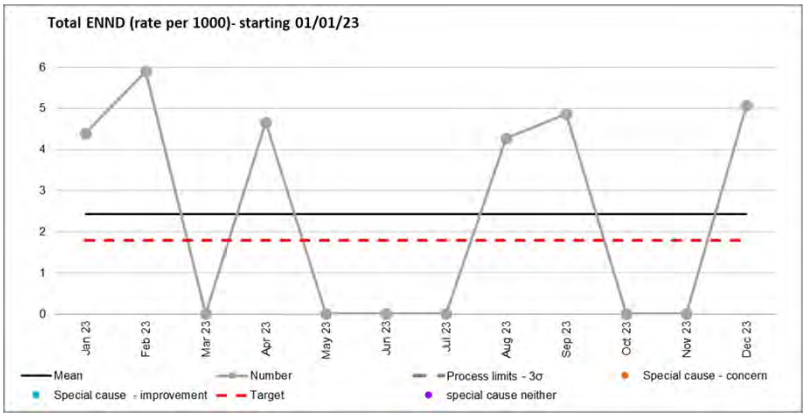


7.3 Neonatal Deaths
There was 1 neonatal death in Q3**.**

1. 20+5, Inevitable late miscarriage, baby born with signs of life. No immediate learning. Not eligible for PMRT (reported for information only)

In addition, there was 1 neonatal death that received antenatal care at WWL but was transferred to a tertiary unit and died. Following a routine growth scan at 32 weeks gestation, anomaly was identified with enlarged fetal stomach, further investigations revealed a genetic condition (epidermis bulosa).

All neonatal deaths are subject to 72hr review. Neonatal deaths above 22 weeks gestation are subject to PMRT. All neonatal deaths are referred to the coroner irrespective of gestation.



7.4 Mortality and social deprivation
Both women who had an antenatal stillbirth lived in lower deciles within the borough (decile 1 & decile 2)
1 of the 2 women was also under the care of the Fern Team – non-English speaking (asylum seeker).

The 1 woman who had a neonatal death resided in decile 9 (not an area of low social deprivation)

7.5 Mortality and ethnicity
1 mother who had a stillbirth was from a white ethnic background and 1 was of Asian background.
The 1 mother who had a neonatal death was of Asian background.

7.6 Themes identified
100% of the stillbirth cases were from the lowest deprivation areas (decile 1 & 2)
66% of mortality was of mothers from Asian background
Diabetes screening after 34 weeks is not in line with GMEC. Under review.

7.7 Actions
Process reviewed for the DNA policy for women who recurrently miss GTT appointments. Diabetic Specialist Midwife (DSM) to be made aware of women who DNA and followed up appropriately.
Review guideline with view to offer BG monitoring after 34 weeks rather than GTT.
Continue to monitor outcomes from the Fern team (commenced work in April-August 2023) to offer tailored enhanced support for families residing within decile 1 and non-English speaking women regardless of decile.

7.8 PMRT finalised cases in Q3
There are four cases under PMRT review during Q3, no cases closed at time of reporting - no timescales breached.

No exceptions

8. Saving Babies Lives (SBL)

Element		Compliancy/ Improvement Plan
Element 1- reducing smoking in pregnancy		Compliant. CO @ booking 96% for Q3. Co @ 36 weeks 96%. Smoking cessation midwife and Saving Babies Lives Lead addressing data input and collation from antenatal staff and delivery suite staff, some ongoing issues due to Euroking system. Quit date data needs improvement. Regular teaching sessions of CO monitors are undertaken. Audit regularly undertaken.
Element 2- risk assessment and surveillance for fetal growth restriction		Audit completed and compliant within SBL parameters. Most babies at risk of FGR and SGA are detected within antenatal period. WWL is in the top 10 in the country for detection rates.
Element 3- Raising awareness of reduced fetal movements.		Audit shows Dawes Redman CTG 85% within SBL parameters. Next working day scan is 61% which does not meet parameter of 80% minimum. New facility in progress of being implemented within triage department. Awaiting delivery of scan bed prior to commencement of service, all other processes are in place.
Element 4- Effective fetal monitoring during labour		All parameters for SBL are met and are above minimum targets.
Element 5- Preterm Births.		All optimisation/ SBL parameters are being met. Preterm birth lead obstetrician in place. Preterm birth midwife started in November 2023. Awaiting template of preterm birth clinic. Trends are identified in audit and highlighted issues are addressed.
Element 6 – Diabetes in Pregnancy.		One stop clinic template to be implemented within SBL parameters. HbA1C @66% measurement below minimum target at 80%. All other parameters met.
SBL training Elements 1-6.		94% doctors and midwives compliant with element modules. 6% non-compliant all contacted via e mail and face to face to address any ongoing issues with access, time allocation or learning challenges.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	80%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	89%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	80%	CNST Met

SBL Tool completed for December submission 2023. Feedback from the LMNS rated WWL evidence as offering 'Significant Reassurance' with the evidence submitted. Overall compliance with 6 elements was **80%.**

No exceptions

9. GMEC LMNS Ambition

• Reduction in still births to a rate of 3.85 per 1000 registerable births in 2023/24

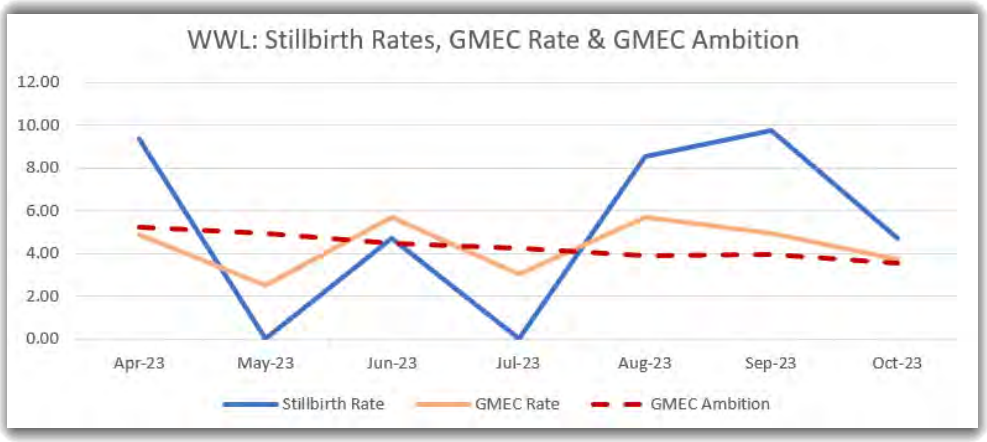
• Reduction in still births to a rate of 3.5 per 1000 registerable births in 2024/25

• Reduction of serious intrapartum brain injury to a rate of 1.0 per 1000 live births in 2023/24

• Reduction of serious intrapartum brain injury to a rate of 0.70 per 1000 live births in 2024/25

WWL will measure its progress against the GMEC LMNS ambition.

9.1 WWL and GMEC stillbirth rates against GMEC LMNS Ambition 23-24



10. Mandatory Training Compliance Midwifery

	Number attended in Q3	Percentage of staff	Rolling percent
BLS	35	23%	92%
NLS	35	23%	92%
PROMPT	48	32%	97%
From September 23 the structure of mandatory training has changed. All Midwives will be allocated 4 maternity training sessions per year, consisting of PROMPT, full day fetal physiology, maternity safety day and specialist services update. This will ensure all elements of CNST, and core competencies are covered. **No exceptions.**			

10.1 Mandatory Training Compliance Other Specialities

	PROMPT	
	Number attended in Q3	Rolling percentage
Consultant Obstetrician	4	90%
Obstetric registrar	5	100%
Anaesthetist	12	94%
MSW	14	94%
Both PROMPT and fetal physiology training is multidisciplinary with compulsory attendance from Midwives and Obstetricians. PROMPT is also compulsory for all Maternity support workers and Obstetric anaesthetists. PROMPT for all multi-professional groups was 90% by December 2023. **No exceptions**		

10.2 Mandatory Fetal Physiology Training

	Fetal Physiology	
	Number attended in Q3	Rolling %

Midwives	50	97 %
Obstetric Consultants	0	89 %
Obstetric Registrars	4	100%

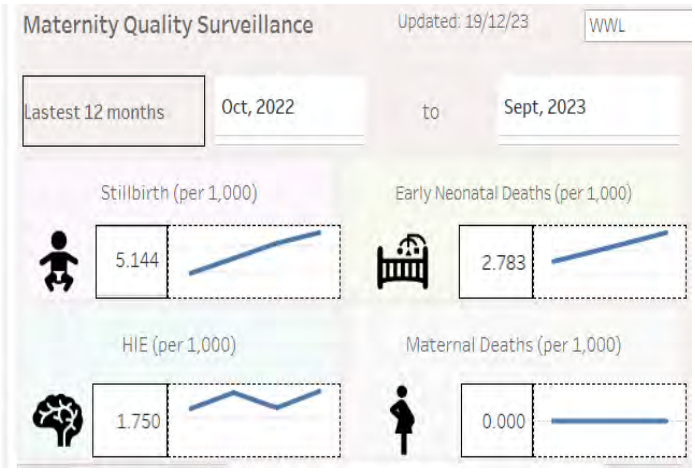
Exception 8 out of 9 eligible Consultants (excluding sickness/maternity leave) are compliant with training. Training to be scheduled at earliest opportunity. However on the cut off date for CNST compliance (7th December 2023) 90% of Consultants were compliant with fetal physiology training.

11. Workforce / Safe staffing

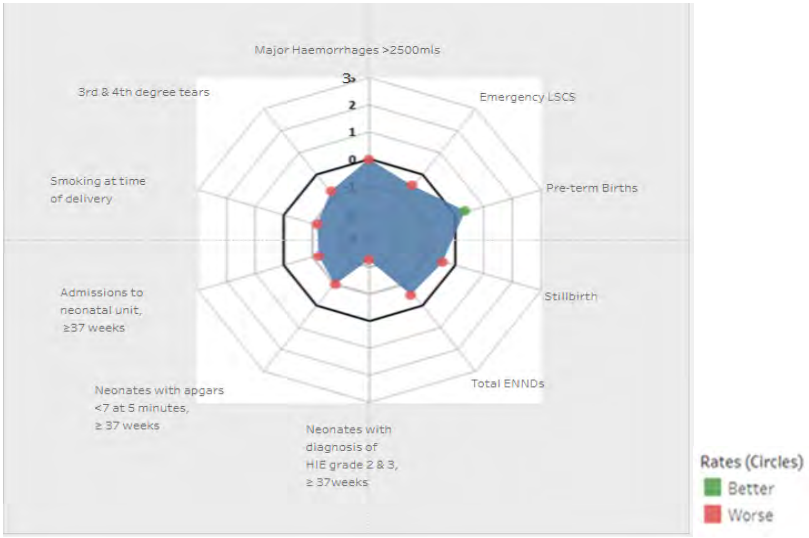
At the end of Q3 there were 5.2 WTE midwifery vacancies and 1.07 WTE MSW vacancies. There is 1 WTE Band 5 neonatal nurse vacancy and 1.73 WTE HCA vacancies.

12. Maternity Quality Surveillance Dashboard, WWL Data Source Tableaux

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



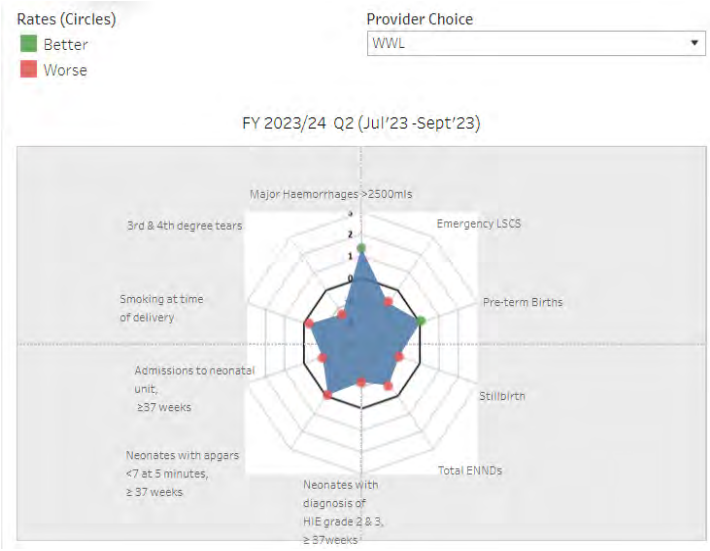
12.2 WWL data as compared to GMEC (Oct 2022 – Sep 23)



Between Oct 2022 and Sep 2023, WWL performed worse than the GMEC average for all metrics except pre-term births.

12.3 WWL Data compared to GMEC average – Q2 2023 (latest data available)

Source Tableaux



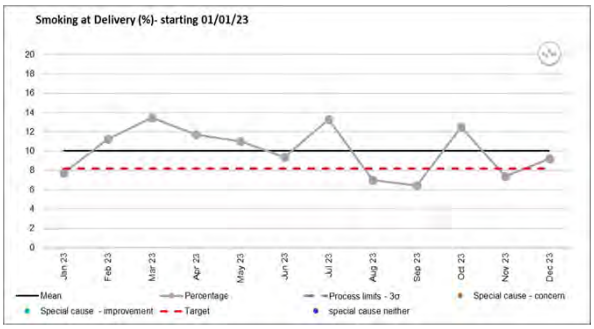
In Q2 2023, WWL has performed better than the GMEC average in rates of major haemorrhage >2.5 litres and pre-term births.

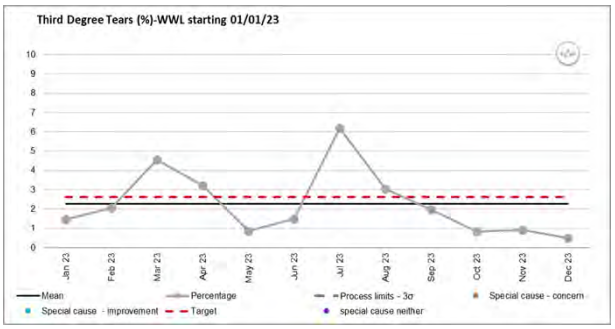
In Q2 2023 WWL has performed worse than the GMEC average in rates of smoking at the time of delivery, term admissions to NNU, stillbirth, early neonatal death, neonates with diagnosis of HIE 2 or 3 at term, 3rd and 4th degree tears, neonates with Apgars <7 at 5 at term, smoking at time of delivery and emergency Caesarean Section.

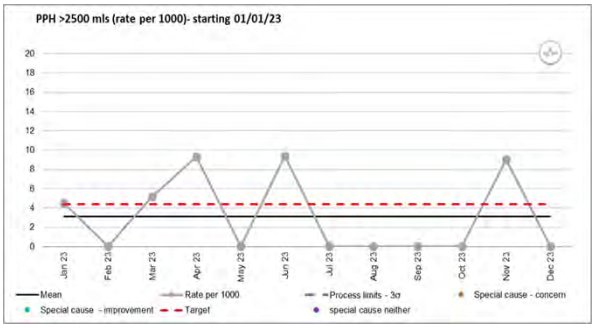
Analysis

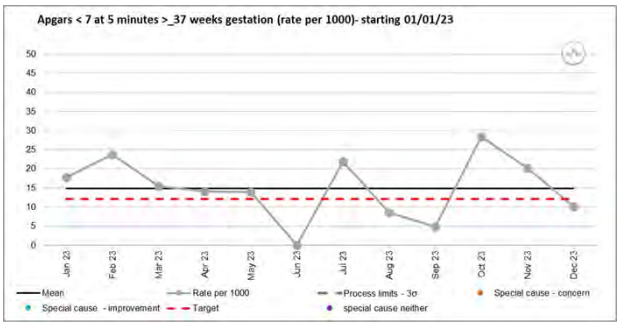
Reviews are undertaken in the Directorate in response to GMEC outlier data. In Q3 themed analyses were undertaken for Stillbirths, Early Neonatal Deaths, babies diagnosed with HIE 2 and 3, Apgars <7 @5, PPH >2500mls, 3rd and 4th degree tears and emergency Caesarean Section (see separate report) in response to the data.

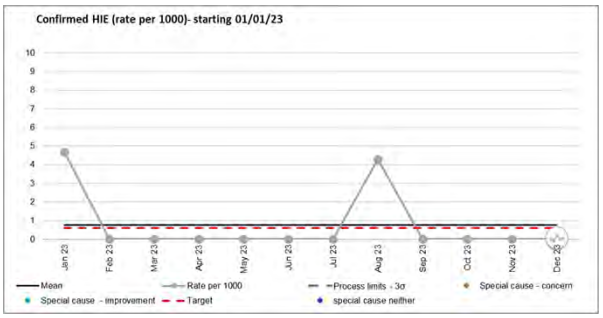
Looking at data over a period of time downward trends have been noted in several metrics at WWL which provides assurance of continuous improvement. Indeed, looking across 2023 WWL performed better than GMEC average for % age of 3rd and 4th degree tears, rate per 1000 births of PPH >2500mls. QI work continues in all areas and themes and trends monitored.

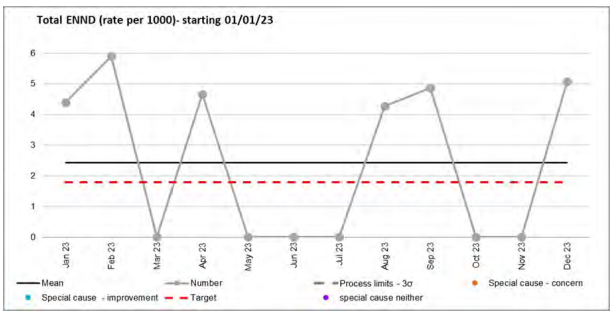


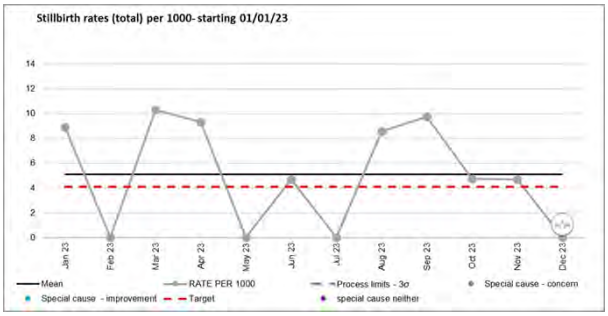


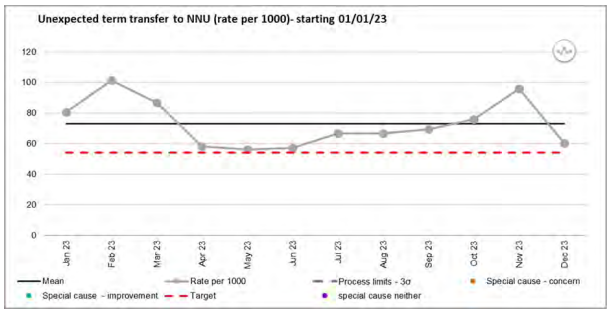












Summary

The report has not identified any new areas of concern. There is ongoing work to improve outcomes in areas that have already been identified. MIS Year 5 Safety Actions are complete and ready for Trust Board approval with 2 action plans in place. SBL targets have been met with the LMNS describing 'significant assurance.' A refreshed focus on ATAIN has begun as the new Quality and Safety Midwife commences in post. The LMNS has set its ambition for 23-24 and 24-25 in relation to stillbirth and serious brain injury and WWL will monitor its progress against the ambition.

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)	Midwives = 17 (99 % rolling complaince) Consultant = 0 (88 % rolling complaince) Registrars = 2 (100% rolling complaince)	Midwives = 9 (97.5% rolling complaince) Consultant = 0 (90% 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%	Midwives 15 attended (10%) Rolling % 87% MSW 4 attended (11%) rolling 87% Obstetric Consultants 2 attended (20%) rolling % 80% Obstetric registrars 3 attended (20%) rolling % 90% Anaesthetists 3 attended (16%) rolling % 72%	Midwives 15 attended (10%) Rolling % 96% MSW 3 attended (8%) rolling 94% Obstetric Consultants 1 attended (10%) rolling % 90% Obstetric registrars 0 attended (0%) rolling % 100% (1 now on LTS) Anaesthetists 7 attended (37%) rolling % 94%
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)	60	60	60	60	60	60	60	60	60	60	60	60
1:1 care in labour	99%	99%	100%	100%	100%	100%	100%	100%	100%	99.30%	100%	100%
Maternity Red Flags reported (>3)	4	1	4	1	0	2	5	3	4	12	15	3
Diverts: Number of occasions unit unable to accept admissions(>1)	0	0	0	0	0	1	2	0	0	0	0	1
Supernumeray Shift Co-ordinator	100%	100%	98%	100%	100%	100%	100%	100%	98.33%	98.39%	100%	100%
The number of incidents logged graded as moderate or above (>5)	2	2	2	1	2	0	1	2	2	0	3	1
All cases eligible for referral to HSIB.	1	0	1	0	0	0	1	1	1	1	1	0
Number of Datix submitted when shift co-ordinator not supernumerary*	0	0	0	0	0	0	0	0	1	0	0	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.	**Feedback from Patient** I couldn't fault my aftercare whatsoever, and I'd love a way to contact Abbie who looked after me in the delivery suite because she was an absolute angel, and she continued to check on me and my son on her shifts following which really meant a lot.	**Feedback from Patient** My birth experience was everything I could have wanted I felt like a local celebrity when I went to theatre for my caesarean section. On Christmas Day, just after midnight staff came around with hot chocolate and marshmallows and its how the little things make all the difference And thank you for the lovely present I received
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.	**No Formal walkabout took place**	**No Formal walkabout took place**
Healthcare Safety Investigation Branch (HSIB)/NHS Resolution (NHSR)/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0	0	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0

Progress in achievement of CNST 10	Work ongoing with Year 4 All standards remain on Track	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	Progress with standards OnTrack	Progress with standards OnTrack
Number of StEIS Reportable Incidents**	1	1	2	0	0	1	3	1	0	1	3	0
Number of Stillbirths	2	0	2	1	0	0	0	2	2	1	1	0
Number of Early Neonatal Deaths ***	1	1	0	1	0	0	0	1	1	0	0	1
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0

* acuity app from November 2023 ** date reported to StEIS *** before 7 days

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	30 January 2024
Chair:	Rhona Bradley

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

ALERT
▪ The Committee received the cash report and a request to support an application for external support for quarter one 2024/25. ▪ The Committee noted that WWL has undertaken its own internal planning exercise but that, with no planning guidance yet received, the plan will be amended in due course and in line with the same. ▪ The urgent and emergency care position was noted to be pressured and that Committee heard that the Trust are now operating at operational pressures escalation level (OPEL) 4, having triggered this on a number of occasions.
ASSURE
▪ The Committee received updates on the three-year plan for financial sustainability and the grip and control processes, noting positive progress being acknowledged at Integrated Care Board (ICB) level. ▪ The cost savings (CIP) month nine report was received and the Committee noted the current position. ▪ It was noted that WWL's executive team are progressing a due diligence exercise to accompany the work with Newton Europe, following review of the diagnostic element of this report.
ADVISE
▪ The Committee reviewed a deep dive report on Community Services, which was well received. ▪ The Committee received a proposal for additional multi-story car parking at the Wigan site and agreed to underwrite the required funds (£142k) for the project to progress to its next stage. A full business case will be presented at the March Committee and then the April Board meeting for the whole investment. ▪ No changes to the board assurance framework scores were considered to be required at this meeting. ▪ The Trust's proposed national cost collection process was reviewed and approved.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks associated with the multi-story car park both in terms of financing and meeting the needs of patients and staff to park safely and close to the site, were noted. Legal and reputational implications were addressed through the report and assurance taken around the current position in both regards.

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	13th December 2023
Chair:	Francine Thorpe

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

ALERT

- A report was received from the Lost to Follow Up Working Group that outlined:
  - The outcome of an initial scoping exercise highlighting the specialities most impacted
  - Terms of Reference and membership
  - An improvement plan along with timescales.

  It was acknowledged that the processes contributing to this issue are multifactoral and will require detailed work to resolve. The Committee asked for regular updates to be provided and asked that this issue be considered as part of objective setting for 2023/24.
- The bi-annual mortality report identified that although improvements have been made in the Advancing Quality metrics around sepsis; this remains a contributing factors to mortality in some cases. The committee will continue to receive regular updates on progress against these metrics.
- This report also highlighted the number of expected deaths is increasing as is the number of patients admitted from care homes who subsequently die; due to the nature of our population. This pattern is set to continue over the next few years. It was agreed that this report would be helpful to inform future service planning across the locality. There was also an increase in the number of patients that die within the A&E department during 2022. This can adversely impact famility experience, however the risk is being managed by the team as far as possible.
- A report was received from the Deteriorating Patients Group that highlihgted a concern with renal cover provided by Salford, discussions are ongoing to resolve this issue and an update will be provided for the next meeting.

ASSURE

- The bi-annual mortality report provided assurance that systematic issues highlighted in the previous report had been resolved and not recurred.
- The Infection Prevention and Control (IPC) report provided assurance on:
  - Positve performance in relation to MRSA and Clostridium Difficile Toxin
  - Increased number of IPC audits acorss the Trust including community services that demonstrated high levels of compliance

- The Aspire Accreditation Report provided assurance that good progress is being made to achieve the Trust objective for 2023/24. (CO6)
- A report from the Patient Engagement and Experience Group provided assurance that:
  - 79% of complaints are being reponded to within the agreed timeframe and we are on tracjectory to achieve the 85% target by the end of Q4 (CO7)
  - In house patient surveys in September indicated 100% patients felt involved in their care
- A report from the Patient Safety Group confirmed that our policy and plan to implement the Patient Safety Incident Response Framework (PSIRF) had been approved by the Integated Care Board. The committee noted that there will be a change in reporting incidents going forwards which will include a broader focus on themes and trends and include more information on lower level incidents.
- The Q2 report for Clinical Audit and Effectiveness Group highliighted the following:
  - 81 audits completed and presented with 76% showing full or significant assurance and re-audits showing an improvement
  - Widespread programme of audit covering all divsions across the Trust
- The Estates and Facilities Deep Dive provided information on
  - The highest scoring risks included in on their risk register along with mitigating actions being taken
  - The most frequently occurring categories of incidents

  Significant correlation was noted in the issues highlighted with information received in the Infection Prevention and Control report

ADVISE

- The IPC report outlined issues in relation to microbiology staffing and difficulties in terms of decant areas to undertake deep cleaning programmes. The risks relating to these are being mitigated as far as possible.
- The Aspire Accrediation Report indicated significant improvement in a number of areas including safety measures, patient experience metrics and some documentation. However a number of areas of focus were highlighted that will be progressed through the ward leaders forum.
- The Harm Free Care Report noted a downward trend for 2 consecutive quarters in acts and omissions of care delivery comparing 2023/24 to 2022/23. However category 3 and 4 pressure ulcers were report in quarter 2 therefore the Trust has not met the corporate objective of zero for 2023/24. (CO4)
- A report from the Deteriorating Patients Group highlighted improvements in compliance with calaculation of National Early Warning Scores (NEWS 2) and recording observations including use of the Glasgow Coma Scale (GCS).
- 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 Estates and Facilities divisional rsks were discussed and mitigating actions outlined

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	10th January 2024
Chair:	Francine Thorpe

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

ALERT

- A report was received in relation to our performance against the measures included on the Greater Manchester and Eastern Cheshire (GMEC) Perinatal Quality Surveillance Dashborad that outlined:
  - Deteriorating performance in a number of metrics from Quarter 3 2022 to Quarter 3 2023
  - WWL is performing worse than other GM providers on 9 out of the 10 metrics
  - A comprehensive analysis into each of the 10 metrics was included in the report including actions being taken where issues were identified
  - The report has been submitted to the GM Maternity Netwok for an objective review; feedback will be shared with the committee once it has been received.
- The medicine divisional deep dive alerted the Committee to:
  - Significant capacity, flow and staffing pressures particularly over the festive period and as a result of recent industrial action
  - Negative impact on continuity of care and increased risk of patient harm as a result
  - Increase in mixed sex accommodation breaches
  - Negative impact on staff morale

ASSURE

- The medicine division deep dive highlighted:
  - Regular audit of a range of patient safety and experience metrics
  - Targeted work to improve safety and experience of patients being cared for on the A&E corridor
  - Triangulation of themes from incidents and complaints
  - Alignment of patient safety and patient experience priorities to identified themes
  - Improvement in complaint response times
  - Good progress with the Aspire accreditation programme
- A presentation was received from the specialist services division in relation to changes made to breast clinics that outlined:
  - Increased ‘one stop’ capacity improving patient experience

- Targeted work to involve communities that have low levels of engagment with screening programmes to address health inequalities
- Improved compliance with 28-day Faster Diagnosis Standard
- Improved staff experience

- The quarter 2 safe staffing report highlighted:
  - Reduction in vacancies within maternity services
  - The introduction of a Maternity Acuity App to provide greater visibility of risks relating to patient safety and aid decision making in terms of staff deployment
  - A reduction in temporary spend with no associated impact on quality and safety indicators
  - Assurance that robust processes are in place to triangulate patient safety information with nursing and midwifery staffing data
- Feedback from the Patient Safety Group provided assurance that good progress is being made to implement the patient safety incident response framework (PSIRF).

ADVISE

- Ongoing relationships with the CQC have been maintained and a report was received advising a number of key changes that will impact future inspections. Dialogue with CQC relationship managers over the past two quarters has focused on:
  - The Trust's approach to supporting individuals with a learning disability to access services. Work is progressing in this area to map our progress against national standards.
  - The safety of staff to raise concerns
- The AAA report from the Deteriorating Patient Group highlighted that they had oversight of audits relating to the use of paediatric early warning scores as well as work involving adults.
- The Medcial Director confirmed that there is sufficient oversight and organisational involvement in the Lost to Follow Up Working Group. It is therefore not necessary for it to be incorporated into our organsiational objectives for 2024/25. The committee will continue to retain oversight of progress.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the board assurance framework were reviewed and no changes were made
- The medicine divisional risks were discussed and mitigating actions highlighted for those scoring 15 and above

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Research Committee
Date of meeting:	5 December 2023
Chair:	Clare Austin

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

ALERT
▪ WWL's service level agreement with the Christie Hospital (around research trials) is not yet in place although the team are hopeful that it will be by the end of the financial year 2023/24. ▪ Difficulties in reaching partners across the system were noted. Although organisations are facing pressures of their own, this creates a risk around lack of broader engagement particularly in projects involving community partners. ▪ The medicine divisional presentation showed that time for research is still an issue for staff.
ASSURE
▪ The National Institute for Health and Care Research's (NIHR's) research capability funding requirement (to enable WWL to meet University Hospital status) is now met. ▪ The Committee heard a research story which illustrated the importance of putting patients first in research and making sure that proper patient engagement is carried out. The piece also showed that patients are responding well to WWL's engagement initiatives, with around 80 people now members of WWL's Research Patient and Public Involvement Group. ▪ The Committee took assurance from the information provided to set out WWL' process for managing it intellectual property and heard that a test case has been taken through this to strengthen the assurance around this. ▪ The research assurance framework provided assurance on progress against the year's objectives.
ADVISE
▪ The research team held an event in partnership with the NIHR's Greater Manchester clinical research network, at Robin Park – this was an enormous success and was attended by the Mayor of Wigan. ▪ The Committee agreed to arrange a session where it could further consider the research corporate objectives. The aim is to develop a broader set of targets to reflect more than simply the aim of achieving university hospital status. ▪ The medicine divisional presentation provided assurance that the division is striving to undertake research in spite of capacity issues. Executive members will assist the Division's Clinical Director to gain support from its triumvirates in this regard.

▪ The Committee received minutes from the Institutional Review Group and the Research Action Group. ▪ The potential for a type of Trust wide research celebration was discussed and will be considered further by the research team.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ No significant risks were noted.

Title of report:	Board Assurance Framework (BAF)
Presented to:	Board of Directors
On:	7 February 2024
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 sixteen key strategic risks is presented here for approval by the Board. One new people risk, Internationally Educated Nurses, has been added to the BAF since the last Board meeting in December 2023. No risks have been de-escalated from the BAF and the risk scores for the fifteen existing risks remain the same.

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 three people risks within this report.

Wider implications

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

Recommendation(s)

The Board of Directors 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 10 January 2024. No patient focussed risks have been added or removed from the BAF since the last Board meeting in December 2023 and the risk scores for the five existing risks remain the same.

2.3 **People:** Three people focussed BAF risk were presented at the People Committee on 6 February 2024. One new people risk, Internationally Educated Nurses, has been added to the BAF since the last Board meeting in December 2023. No risks have been de-escalated from the BAF and the risk scores for the two existing risks remain the same.

2.4 **Performance:** The five performance focussed BAF risks were reviewed and updated for presentation at the Finance and Performance Committee meeting on 30 January 2024. No finance and performance risks have been added or removed from the BAF since the December 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 December 2023 and the risk scores for the four existing risks remain the same.

3. New Risks Recommended for Inclusion in the BAF

3.1 PR 7 - Internationally Educated Nurses, People Risk.

4. Risks Accepted and De-escalated from the BAF

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

5. Review Date

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

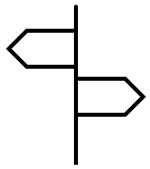
2023/24

The content of this report was last reviewed as follows:

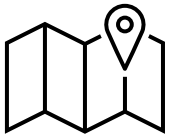
Board of Directors	December 2023
Quality and Safety Committee:	January 2024
Finance and Performance Committee:	January 2024
People Committee:	February 2024
Executive Team:	February 2024

> **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

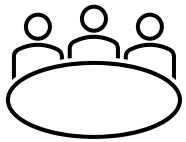


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

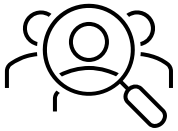


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

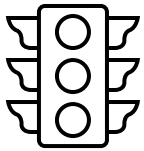
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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

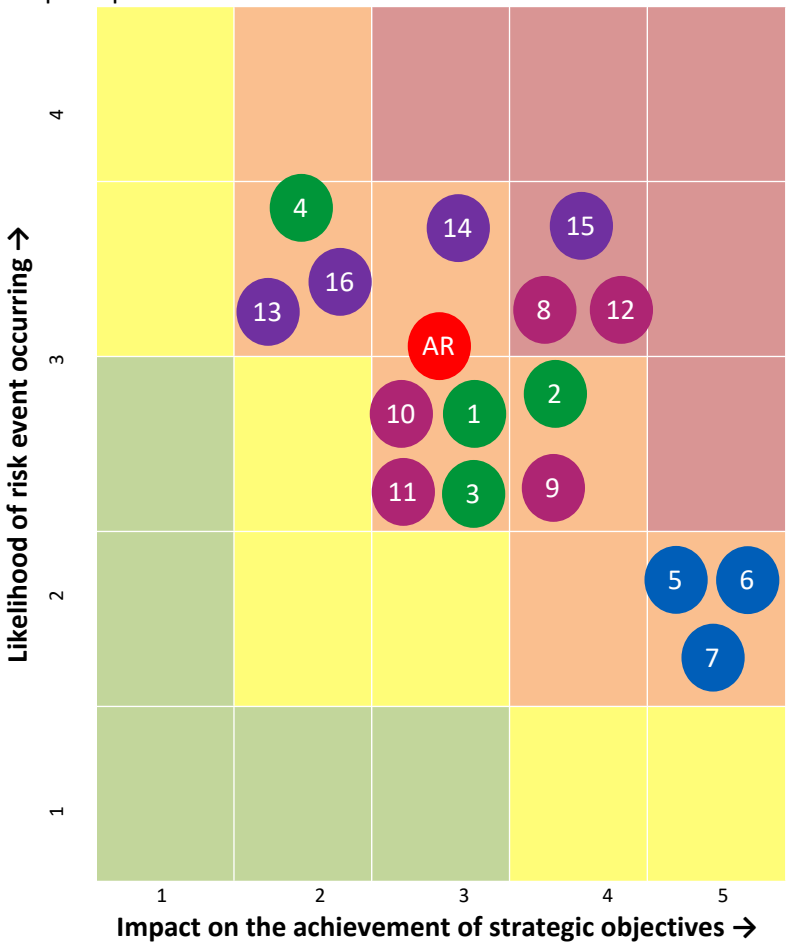
We will…
- Improve the health and wellbeing of the population we serve
- Develop effective partnerships within the new statutory environment
- Make progress towards becoming a Net Zero healthcare provider
- To increase research capacity and capability at WWL and in collaboration with EHU plan to make 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 16 strategic principal risks based on their current scores:



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

Patients

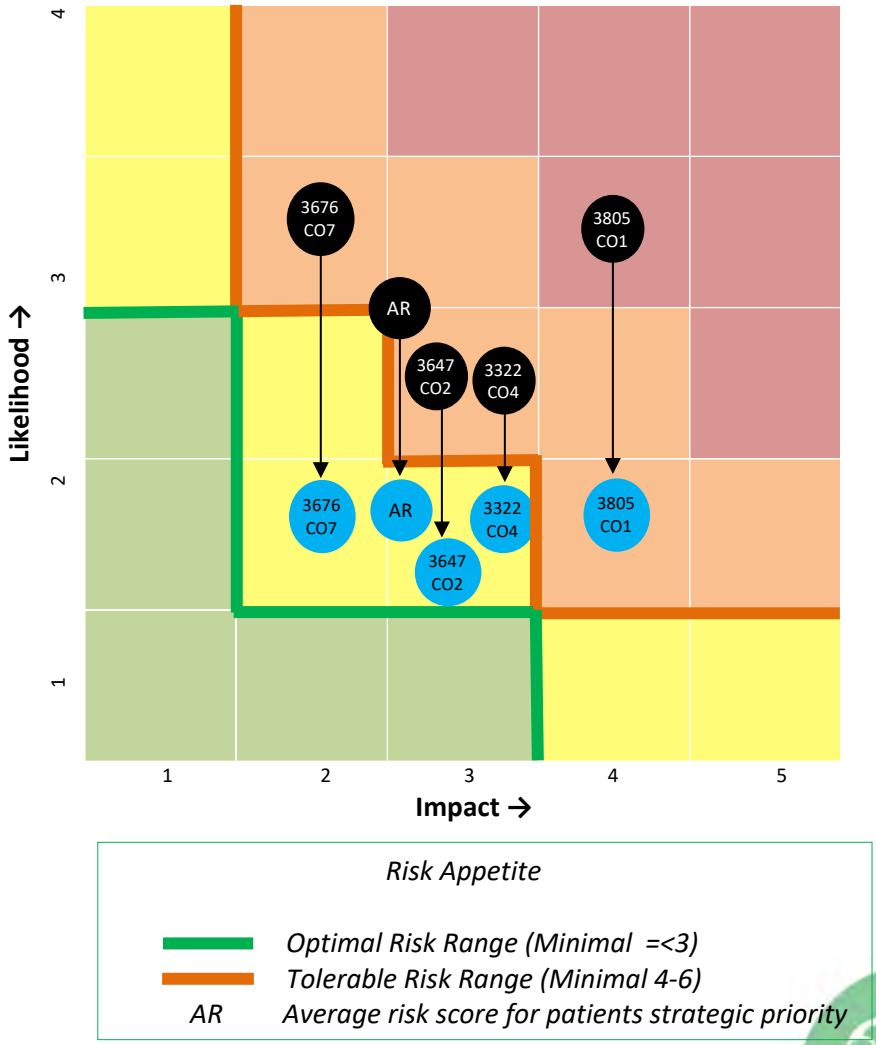
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

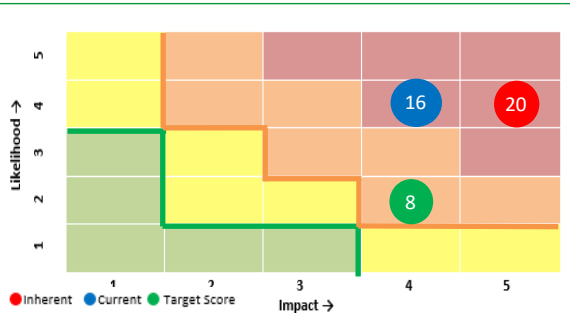
Monitoring: Quality and Safety Committee

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

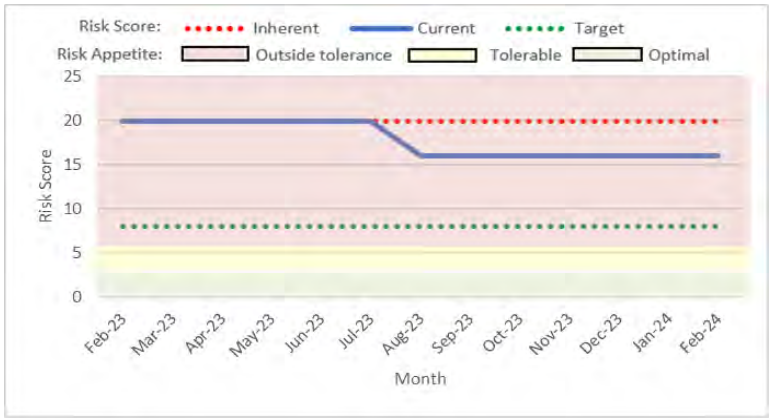
Ref.	Purpose of the objective	Scope and focus of objective
CO1	To improve the safety and quality of clinical services	To improve the compliance of Sepsis-6 care bundle as per Advancing Quality Audit, with aim to reduce mortality from sepsis.
CO2	To ensure patients and their families receive personalised 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 – *Objective Achieved.*
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:

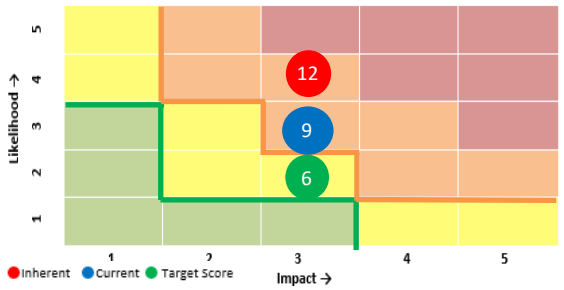


Corporate Objective: **CO1** To improve the safety and quality of clinical services					**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 1: Sepsis Recognition, Screening and Management**				
	Risk Statement:	There is a risk of the under diagnosing of patients with Sepsis, due 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	**10.01.24**			**Risk treatment**	Treat	

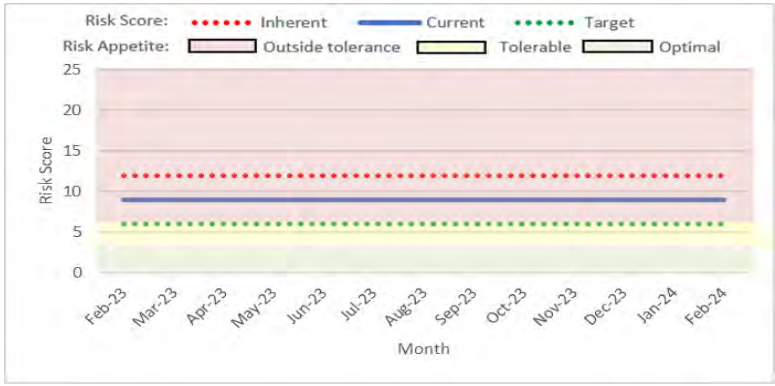
Risk Score Timeline



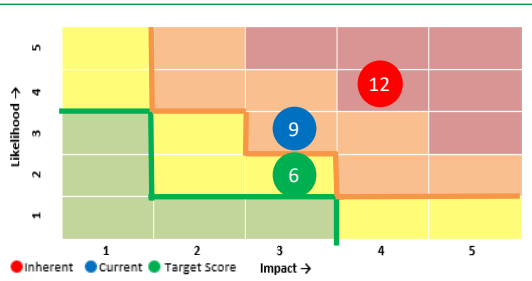
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3805**	• Sepsis Nurse = High Visibility, Ward walk rounds. Recommenced by current Sepsis Lead Nurse. • Link Nursing in all wards and 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) • Community SOP for Paediatrics is now live.	• 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. • Adult SOP remains under review by the community teams.	**2nd Line:** • Quality & Safety Committee January 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	August 2023 Completed July 2023 Completed February 2024 Sepsis Lead March 2023 Completed June 2023 Completed March 2024 Sepsis Lead October 2023 Completed

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	**10.01.24**		**Risk treatment**	Treat	

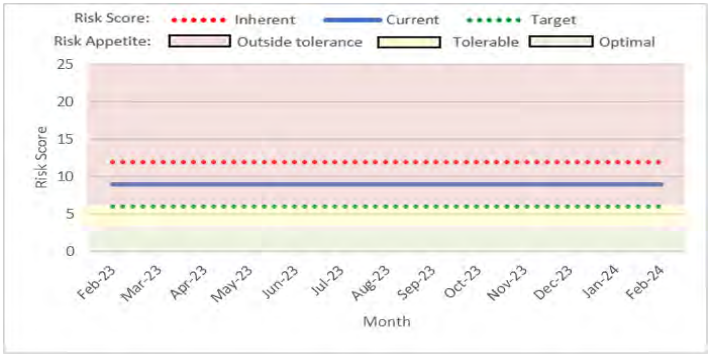
Risk Score Timeline



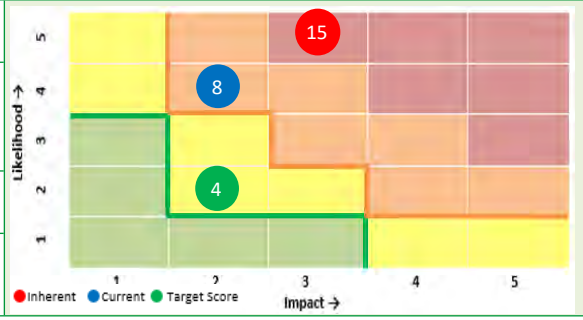
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3647**	• Monthly audit on preferred place of death undertaken on any deaths that occurred whilst patients are under the DN service. • 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 EPaCCS 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**		**Strategic Threat**	Threat- Datix ID 3322	
Date of last review	**10.01.24**		**Risk treatment**	Treat	

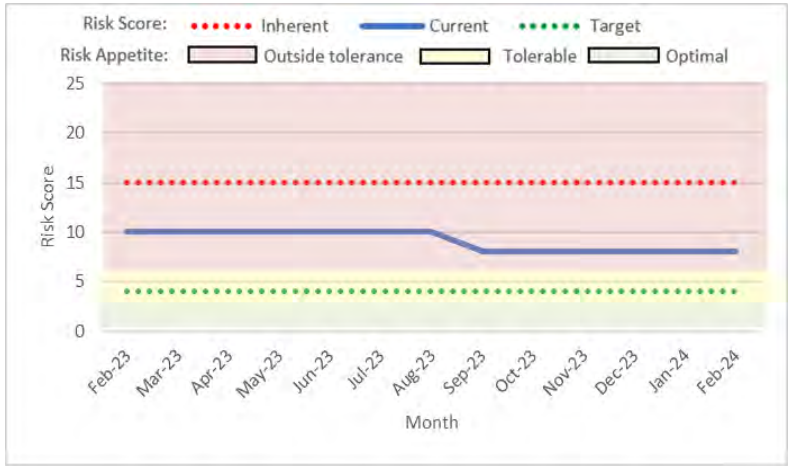
Risk Score Timeline



Existing controls	Gaps in existing controls	Assurances	Gaps	Risk Treatment	Due Date
• 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 across divisions. • First contact data now captured. • All ward leaders and matrons trained in PU verification. • Tissue viability team at full establishment and the team working differently. Corporate risk 3323 closed.	• Staff being able to be released to undergo training. • Junior workforce. • Increased scrutiny in use of bank and agency staff. • Escalated areas continue beyond winter 2022/2023 and into 2023/24. • 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. • Equipment issues. • Beds owned by individual Divisions. • Lack of consistency in Ward leaders being afforded Supernumerary status. • Lack of registered nurse oversight. Registered Nurse to patient staffing ratio's not always aligned to level of care needed. • Inconsistency in agreed staff ratios 1;8 in times of escalation reduced. • 2023/24 Q2 internal audit provides limited assurance that all clinical areas are closing the loop on action plans following PURP. • Downward trend noted in Q2 in acts and omissions in care delivery in relation to the prevention & deterioration in skin damage.	**2nd Line:** Quality & Safety Committee January 2024	No gaps currently identified	• Continue the roll out of human factor training. • Implement governance changes in managing the low-level harm panels to align to the Patient Safety Incident Response Framework (PSIRF framework). • Implement the utilisation of the revised Datix PU reporting form. • Further work and interrogation of data to be undertaken regarding relationship between end of life skin changes and pressure damage. • Explore a system wide response to pressure ulcer development utilising 'on first contact" data. • Implementation of the Repose Wedges, registered as Quality Champion Project for evaluation in 20023/24 Q3 • Roll of out the revised MASD pathway to acute and community services. • Commence differential diagnosis training as part of the verification training to enhance the verification process. • Review the Purpose T training package to prepare for implementation in the Trust as an alternative to using the waterlow risk assessment tool. • Total bed management project progressing. • Steering group to monitor through audit programme implementation of PURP action plans. • Implementation of system wide PU prevention policy – exploring a system wide response and utilisation via the care consortium utilising "on first contact data". • Review national pressure damage recommendations due for release in Q3 to inform place based systems and practice.	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	**10.01.24**			**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: **Datix ID 3676**	• Complaints SOP in place with defined roles, processes and timescales. • How to respond to a complaint training is being delivered. • Training time has been reduced from 6.5 to 4 hours. • Patient relations team provide support and guidance. • There has been a 56% reduction in complaints reported to the Patient Relations and PALS team regarding lost property, from 66 in 2023 compared to 29 in 2022.	• There are currently no backlogs. • Requirement to source venues to run further training courses. • As at Nov 2023, 73% of complaints were responded to within our agreed time frame. • Since the introduction of the boxes, the Patient Relations and PALS team do not record complaints that are solely about lost property -patients/relatives to go straight to Legal.	**2nd Line:** • Quality & Safety Committee January 2024	•No gaps currently identified.	1. Further training for staff to be arranged.	March 2024 CN

People

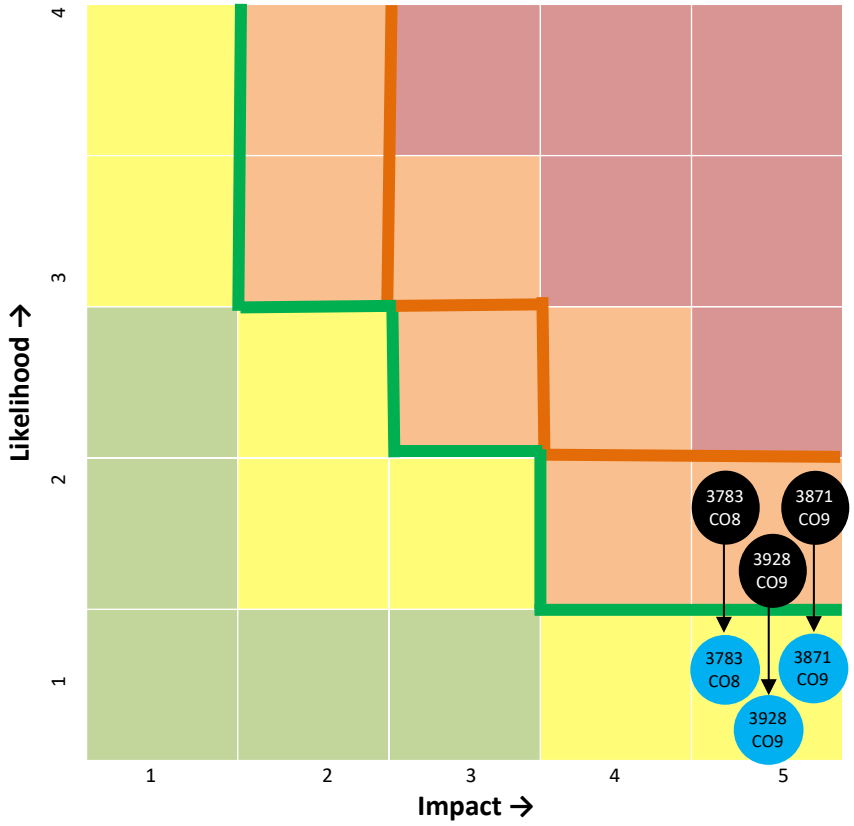
To ensure wellbeing and motivation at work and to minimise workplace stress.

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:

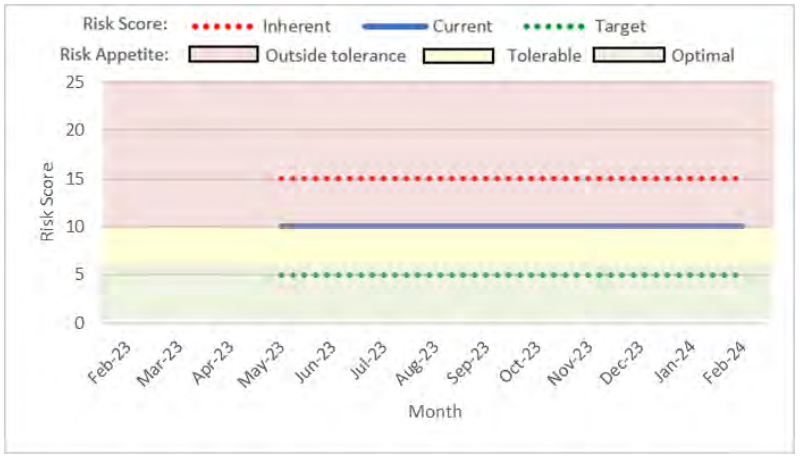


Risk Appetite

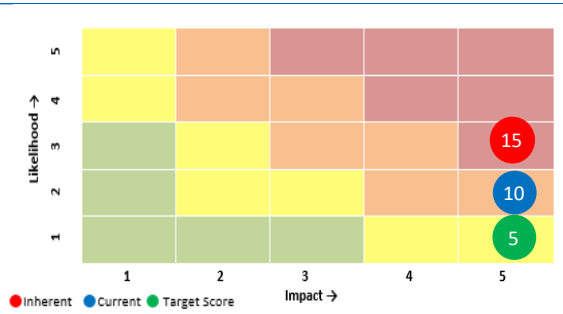
Optimal Risk Range (Cautious = <6)
Tolerable Risk Range (Cautious = 8-10)

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**	Datix ID 3572, 3229, 3227	
Date of last review	**06.02.24**		**Risk treatment**	Treat / Tolerate	

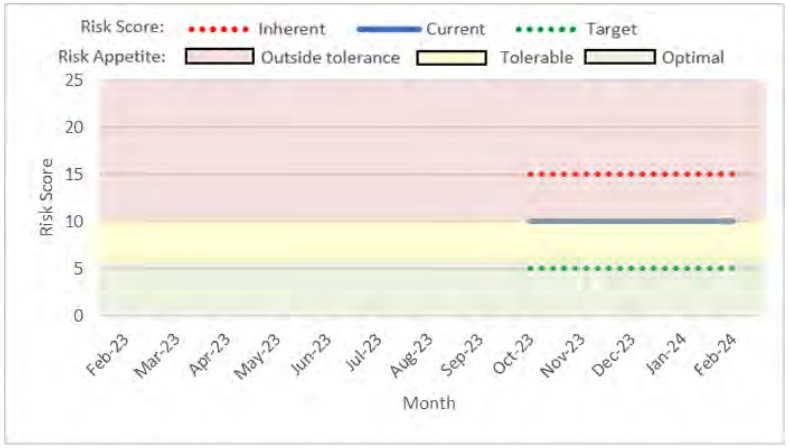
Risk Score Timeline



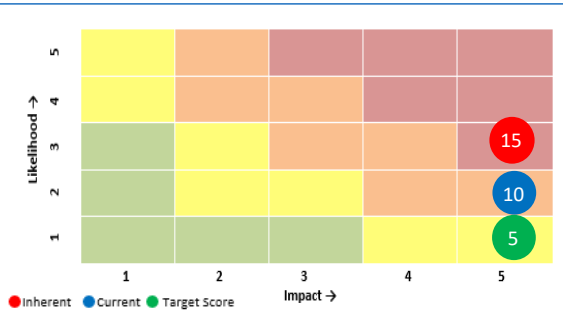
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3783** Linked risks to corporate risk register: **ID 3572** Industrial action **ID 3229** Staff absence wellbeing **ID 3227** Maintaining 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. March 2023 - CPO 2. March 2023 – D/CPO & AD for SE & W 3. March 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	**06.02.24**		**Risk treatment**	Treat / Tolerate

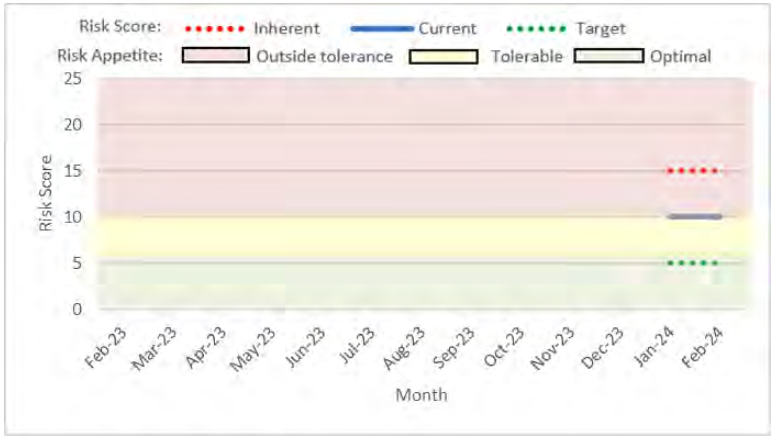
Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix 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. March 2024 (CPO) 3. March 2024 (EDI Lead) 4. March 2024 (EDI Lead) 5. March 2024 (CPO) 6. March 2024 (CPO, EDI Lead)

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 7 : Internationally Educated Nurses**			
	Risk Statement:	There is a risk that we will not retain this valued workforce. Feedback received highlights that colleagues who have been educated internationally have a negative work experience. The Trust has taken significant steps to fill ongoing qualified nursing gaps through the recruitment of over 450 internationally educated nurses.			
Lead Committee	**People**		**Risk Appetite**	Cautious	
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.	
Date risk opened	**31.01.24**		**Linked risks**	-	
Date of last review	**06.02.24**		**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: **Datix ID 3928**	• Pastoral Support post within the Nursing Professional Practice Team. • Mechanisms in place to enable feedback.	• No qualified IEN support available and pastoral support currently funded until March 2025. • Lack of recruitment strategy to fully embed IEN within existing nursing vacancies.	• Feedback shared with Board colleagues ensuring full understanding of experience of IEN. • Interim Chief Nurse recently recruited has experience of successfully supporting the IEN workforce. • Enhanced EDI Support being arranged for Ward Leaders, Matrons and other senior nursing colleagues. • New IEN Improvement Group to be established.	• Actions are very early in implementation and it is difficult to measure and see success at this stage.	1. Request funding to support Senior IEN to work within Professional Practice Team. 2. Establish Chief Nurse led IEN Improvement Group, reporting into newly established EDI Steering Group. 3. Increase visibility of senior leaders to IEN workforce. 4. Establish full action plan with improvement actions required.	1. February 2024 (CPO/CFO) 2. February 2024 (CN) 3. February 2024 (CN) 4. March 2024 (CN/CPO)

Performance

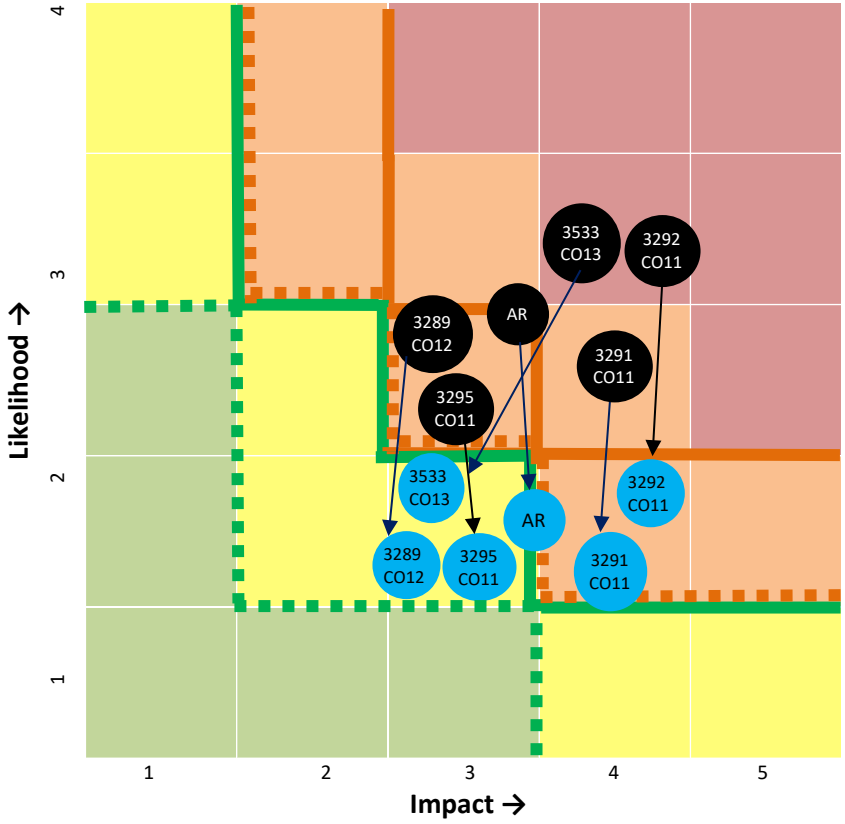
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

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

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

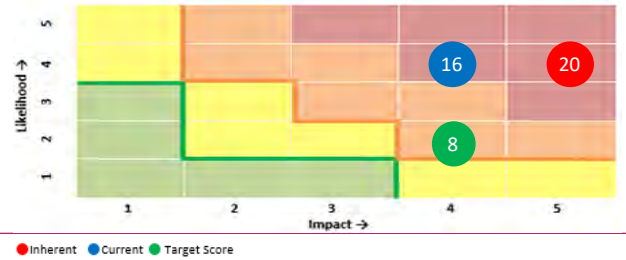


Risk Appetite

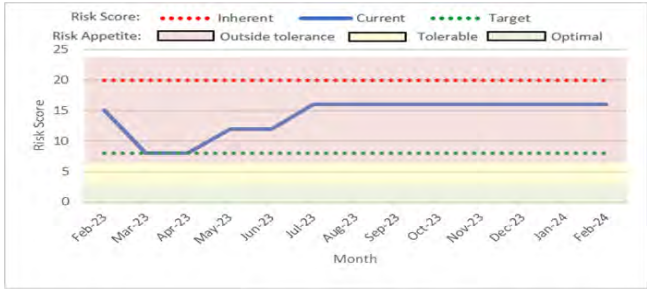
Optimal Risk Range (Financial Duties: Minimal ≤ 3)
(Performance: Cautious ≤ 6)

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 8: 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 opened	**19.10.21**		**Threat**	Datix ID 3292	
Date of last review	**30.01.24**		**Risk treatment**	Treat	

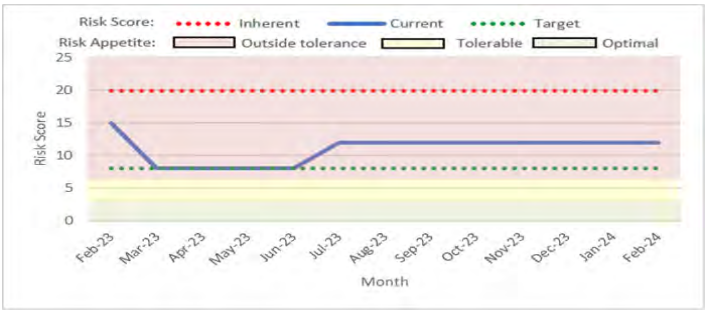
Risk Score Timeline



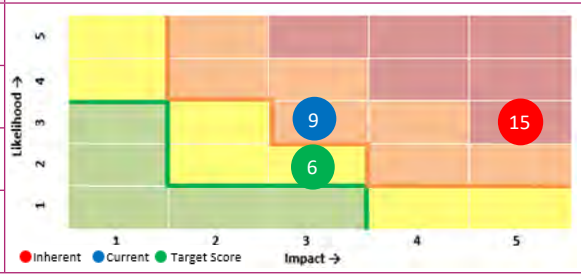
Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
• Final plan signed off by Board and submitted to NHSEI – 4th May 23. • Work is ongoing with NHSE GM ICB and locality to manage the £11.9m funding gap from the withdrawal of locality support. 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 and Q3. • 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. • GMICB agreed revised forecast with NHSE of £180m deficit (Ext). • WWL agreed forecast £10.2m excluding impact of industrial action in Dec and Jan. • WWL appointed 2 Improvement Directors (1 with finance portfolio and 1 with operational portfolio) to end of financial year initially	• 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 in Dec and Jan. • No medium to long term resource confirmation or financial planning. • Limited guidance on ERF clawback arrangements (GM and Lancs).	**1st Line:** Monthly RAPID meetings for applicable divisions. **2nd Line:** Finance & Performance Committee Jan 24.	• 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 Q4 2. GM System PMO established to support delivery of I&E position (Ext).	Mar 24/ 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 9: 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 opened	**19.10.21**		**Threat:**	**Datix ID 3291**	
Date of last review	**30.01.24**		**Risk treatment**	Treat	

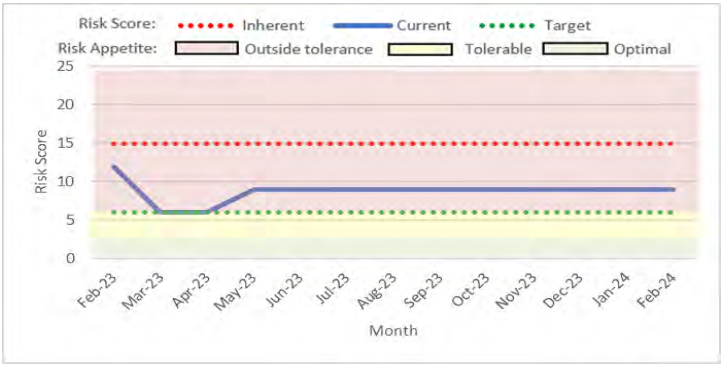
Risk Score Timeline



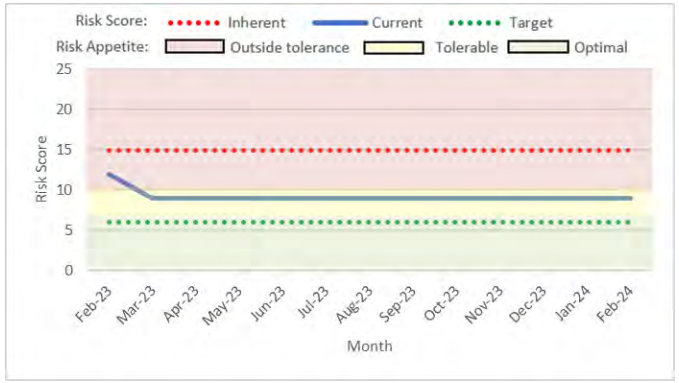
Opportunity / Threat Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• Robust CIP divisional delivery approach and governance. • Work is ongoing to identify a bridge for the locality funding included in CIP. • Monitored via Divisional Assurance 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 or Q4. • 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). • System savings group being established across Wigan locality, to be chaired by Deputy Place Based Lead • CIP fully identified in year	• Limited mechanisms to facilitate delivery of system wide savings. • GM system efficiency requirement with no plan. • GM Cash Management Strategy not yet developed (Ext).	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee Jan 2024	• 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 (Ext). 3. Cash management strategy developed.	Throughout 2023/24 CFO/DCEO Throughout 2023/24 CFO/DCEO Q4 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 10: 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	**30.01.24**		**Risk treatment**	Treat		

Risk Score Timeline



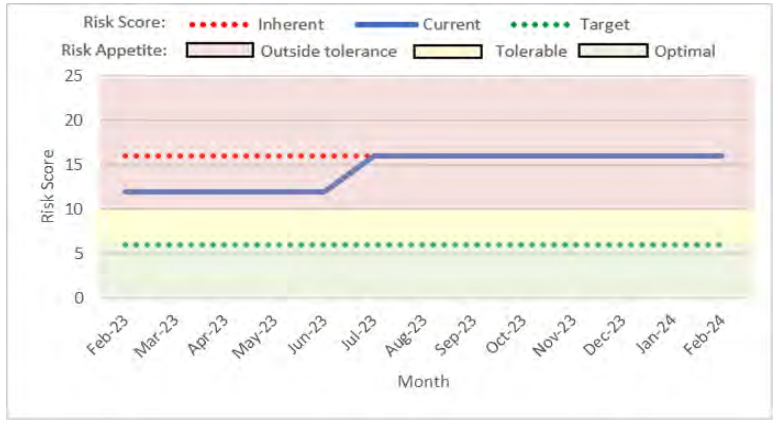
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3295**	• Lobbying via Greater Manchester for additional capital into the national process. (Ext). • Capital Priorities agreed by Executive 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 complete 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 (ext) • A balanced plan has been agreed for 2023/24 for GM.	• 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. Capital allocation remain fluid across the NW as capital spend is finalised against plans.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - Jan 2024	• 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.	Throughout 2023 CFO Q4 2023/24 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 11: Elective services**			Risk Score Timeline	
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to industrial action, demand management schemes not resulting in a reduction in demand and insufficient diagnostic capacity to deliver elective waiting times, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.				
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious		
Lead Director	**DCE**		**Risk category**	Performance Targets		
Date risk opened	**19.10.21**		**Linked risks**	Datix ID 3572, 3718		
Date of last review	**30.01.24**		**Risk treatment**	Treat		

Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: Datix ID 3289 Linked risks on corporate risk register: **3572** Industrial action **3718** Elective Recovery	• No further adjustment of Elective Recovery Fund target for December 2023 or January 2024. NHSE 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. • On track to eliminate waits over 65 weeks except for Gynaecology patients. • Residual risk for waits has been mitigated down to 145 from 1000 declared a couple of months ago. Bi weekly meetings with ICB. • 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 low complexity plus orthopaedic 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. • 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 – Jan 2024	•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 DCE March 2024 DCE March 2024 DCE

Corporate Objective: CO13 Improve the responsiveness of urgent and emergency care				**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 12: Urgent and Emergency Care**			
	Risk Statement:	There is a risk to urgent and emergency care delivery as we are consistently operating above 92% occupancy levels, due to insufficient capacity and ongoing industrial action, resulting in lack of capacity, longer waits, delayed ambulances, no right to reside patients, reduced patient flow and more scrutiny through NHS England.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious	
Lead Director	**DCE**		**Risk category**	Performance Targets	
Date risk opened	**05.09.22**		**Linked risks**	3423	
Date of last review	**30.01.24**		**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: **Datix 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 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. Diagnostic complete. Validating assumptions made and analysis of what can be saved and how this is funded. • A&E performance improvement in December, but this has deteriorated from Boxing Day into January 2024. • Flagged to the system that WWL bed base per population is considerably higher than the rest of GM. • Delay in ambulance handovers within 60 minutes has increased due insufficient capacity. • No right to reside patients has increased in January due to patients waiting for care homes and the reclassification of the 24 Jean Heyes beds as general and acute beds until 31st March 24 at the request of GM. • Hospital Discharge and Flow Programme led by DCE. • The urgent and emergency care transformation board supports system wide change. • Incident response team in place to manage industrial action risk. • Full capacity protocol.	• Insufficient capacity with over 100% occupancy rate. • Corridor care • 12 hour waits are currently increasing. • Number of no right to reside patients. • Work required further upstream regarding higher acuity of patients in borough.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – Jan 2024	•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 DCE

Partnerships

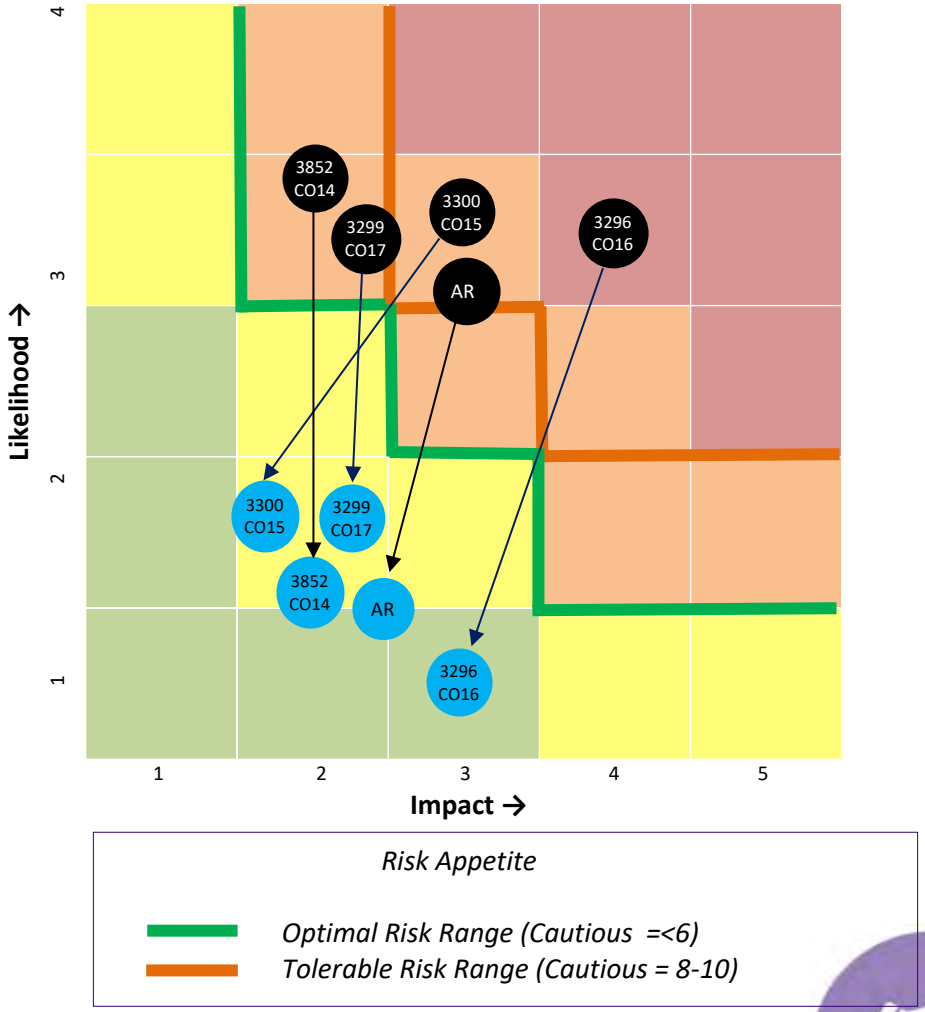
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

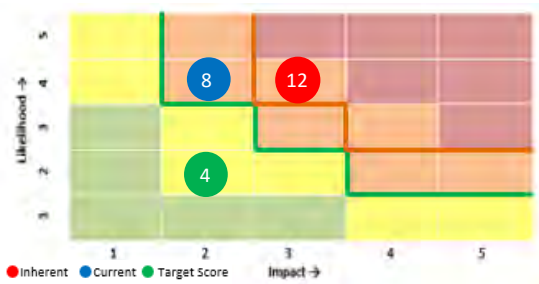
Monitoring: Board of Directors

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

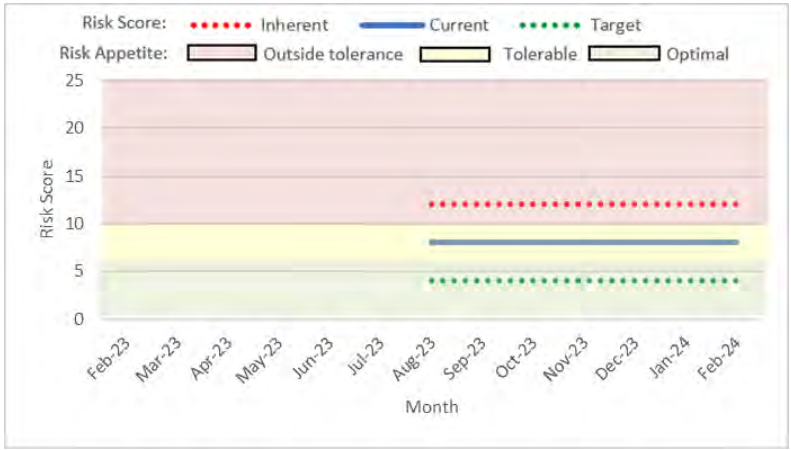
Ref.	Purpose of the objective	Scope and focus of objective
CO14	To improve the health and wellbeing of the population we serve	✓ As an Anchor institution we will work with partners to improve the health of the whole population we serve, supporting development of a thriving local economy and reducing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

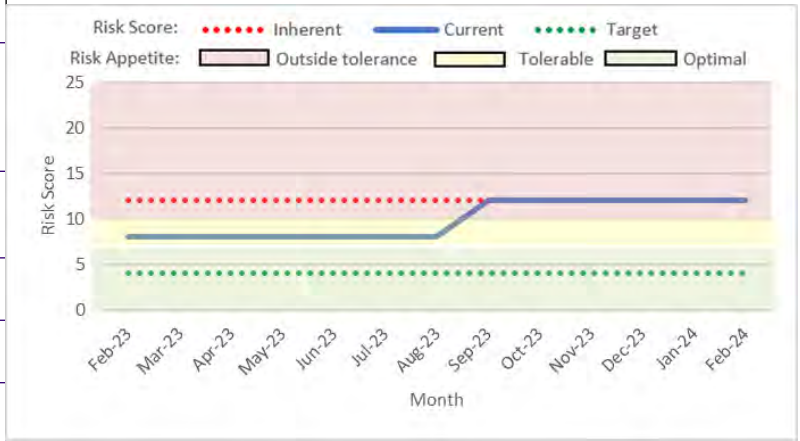
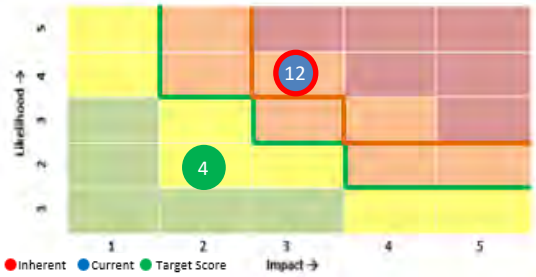


Corporate Objective: **CO14** To improve the health and wellbeing of the population we serve					**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 13: Supporting widening access to employment for local residents**				
	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	**19.01.24**		**Risk treatment**	Treat		

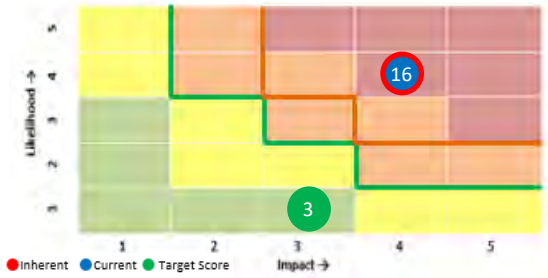
Risk Score Timeline



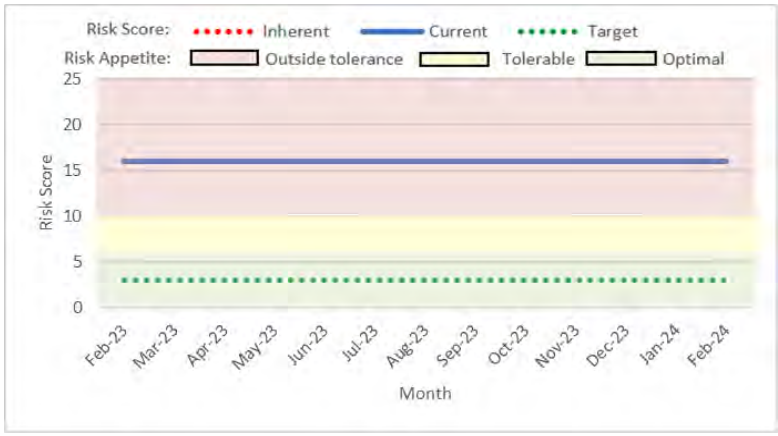
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3852**	• Progress reviewed through Anchor Institution Steering Group.	•Recurrent funding to support ongoing development and delivery 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 14: 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	**19.01.24**		**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: **Datix 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

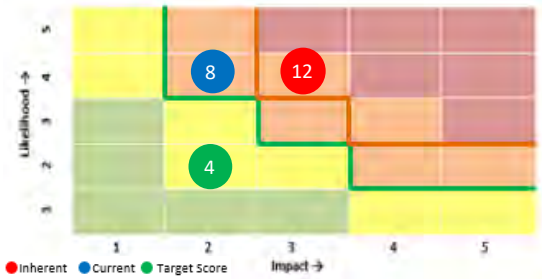
Corporate Objective: C16 Progress towards becoming a Net Zero healthcare provider					**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 15: Estate Strategy - net carbon zero requirements**				
	Risk Statement:	There is a risk that the Trust will not meet its net zero commitments and Climate Change will have an impact on the Trust delivering services, that cannot be mitigated.				
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious		
Lead Director	**DSP**		**Risk category**	Sustainability /Net Zero		
Date risk opened	**19.10.21**		**Linked risks**	-		
Date of last review	**19.01.24**		**Risk treatment**	Treat		

Risk Score Timeline

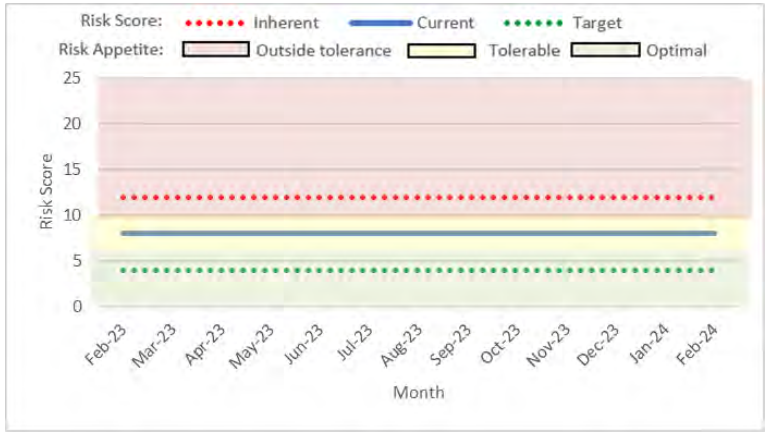


Strategic Opportunity /Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3296**	• Sustainability Manager in post. • Band 7 Energy Manager approved. • Climate Change Adaptation Plan is in development. • Heat 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 16: 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	**19.01.24**		**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: **Datix 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

Title of report:	Delegation of authority to approve year-end documents
Presented to:	Board of Directors
On:	7 February 2024
Presented by:	N/A – consent agenda
Prepared by:	Paul Howard
Contact details:	T: 07867 462561 | E: paul.howard@wwl.nhs.uk

Executive summary

Each year, the foundation trust is required to prepare an annual report and accounts and to lay these before Parliament. As externally-set timescales normally preclude approval at a regular board meeting, we have generally dealt with this by convening an additional year-end board meeting. Often this meeting takes place immediately following a meeting of the Audit Committee, which is charged with scrutinising the documents on behalf of the board and recommending their approval. Approval of our Quality Account also usually takes place at this additional meeting.

Our external auditors have suggested that the board considers delegating authority to the Audit Committee to approve the annual report and accounts. This would simplify the year-end process from their perspective and would mean it is easier to reconvene a meeting if there are unavoidable delays in being able to conclude the audit. This approach is already in use across a number of the auditor's clients and is considered to be effective.

Board members will recall that draft versions of the annual report and accounts are circulated to the full board for comment and this would continue, despite the amended approval approach. Directors would therefore retain the ability to influence the content and to raise queries on the content.

The board is therefore recommended to delegate authority to approve the annual report and accounts for 2023/24 to the Audit Committee as a pilot, with a view to making this a permanent arrangement if there are no unexpected difficulties. Permanent delegation would be subject to a further resolution of the board at a later point in time.

Similar delegation is sought in respect of approving the Quality Account. The board is recommended to delegate authority to approve the Quality Account 20232/24 to the Quality and Safety Committee, again as a pilot, with a view to making this a permanent arrangement via a later board resolution if there are no unexpected difficulties.

Link to strategy

There is no direct link to the organisation's strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications associated with this report.

Legal implications

There are no legal implications to highlight.

People implications

There are no people implications arising from this report.

Wider implications

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

Recommendation(s)

The Board is recommended to:

1. Delegate authority to approve the annual report and accounts for 2023/24 to the Audit Committee.

2. Delegate authority to approve the Quality Account for 2023/24 to the Quality and Safety Committee.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Risk Appetite 2024/25 Review
Presented to:	Board of Directors
On:	06 February 2024
Presented / Prepared by:	Head of Risk Director of Corporate Affairs
Contact details:	E: john.harrop@wwl.nhs.uk

Executive summary

This paper proposes our risk appetite statement for 2024/25 and recommends that we continue with the same risk appetite matrix approach which was approved by the Board in 2023. A new risk category has been added for hospital demand, capacity and patient flow to define our risk appetite position for this risk category and support further work in this area.

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial & Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

The Board of Directors are asked to approve the trust's risk appetite statement for 2024/25.

1. Background

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

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

1.3 The MIAA Risk Management Assignment Report 2020/21 identified control design issues with the risk strategy, processes and the risk appetite statement. In 2021/22, the risk strategy, processes and risk appetite statement were reviewed and updated by the RMG, ETM and the Board. A risk appetite matrix was devised, rather than a series of statements, and this was approved by the Board in June 2022 and February 2023. The Trust achieved High Assurance in the MIAA Risk Management - Core Controls Review Assignment Report, October 2023. The report highlighted that Governance processes are clearly defined and the Trust has a Risk Appetite statement in place. It is recommended that we continue with the same risk appetite matrix approach in 2024/25.

2. Definitions

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

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

3. Risk Appetite

3.1 Our proposed risk appetite position for 2024/25 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

Risk category and link to principal objective	Threat		Opportunity	
	Optimal	Tolerable	Optimal	Tolerable
Financial Duties	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Performance Targets	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Hospital Demand, Capacity and Flow	≤ 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

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

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

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

Least risk		← →		Most risk
Averse	Minimal	Cautious	Open	Eager

4.0 Recommendations for risk appetite scoring

4.1 The Board are asked to approve the trust's risk appetite statement for 2024/25.

4.2 It is recommended that we:

- Continue with the same risk appetite matrix approach which was devised and approved by the Board in February 2023.

Appendix 1: Risk Appetite Statements 2024/25

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

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

People

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

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

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

Performance

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

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

Risk Appetite Risk Category	Adverse	Minimal	Cautious Threat	Open Opportunity	Eager
Performance Targets	We will avoid anything that may impact on performance targets unless essential. Defensive approach to operational delivery – aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority.	Our preference is for risk avoidance. However, if necessary, we will take decisions on performance targets where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Innovations largely avoided unless essential. Decision making authority held by senior management.	We are prepared to accept the possibility of a short-term impact on performance targets with potential for longer term rewards. Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators.	We will pursue innovation wherever appropriate, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	We seek to lead the way and will prioritize new innovations, even in emerging fields. Desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control.

Risk Appetite Risk Category	**Adverse**	**Minimal**	**Cautious** Threat	**Open** Opportunity	**Eager**
Hospital Demand, Capacity and Patient Flow	We will avoid actions associated with risk. Our risk appetite increases when OPEL level 4 and/or a critical incident is declared and we will follow the actions within the Hospital Full Protocol and Incident Response Plan to discharge patients when it is safe to do so.	We are willing to consider low risk actions which support delivery of our patient flow and discharge priorities and objectives. Our risk appetite increases when OPEL level 4 and/or a critical incident is declared and we will follow the actions within the Hospital Full Protocol and Incident Response Plan to discharge patients when it is safe to do so.	We are willing to consider actions where benefits outweigh risks. We ensure that people are discharged via pathways where they receive the care and support, they need to recover. Multi-disciplinary discharge teams work together when discharging people to manage risk carefully with the individual, and their unpaid carer, representative or advocate, as there can be negative consequences from decisions that are either too risk averse, or do not sufficiently identify the level of risk.	We are receptive to taking difficult decisions to safely discharge patients when benefits outweigh risks. Where there is an opportunity to discharge a medically optimised person, multi-disciplinary discharge teams work with the individual, and their unpaid carer, representative or advocate to safely discharge the person as soon as possible via the most appropriate pathway working towards home first when it is safe to do so.	We are ready to take difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements support informed risk taking.

Risk Appetite Risk Category	Adverse	Minimal	Cautious Threat	Open Opportunity	Eager
Sustainability / Net Zero	We generally avoid net zero developments.	Net zero is a minor consideration in our decision making.	We look for opportunities to reduce our carbon footprint, but we prefer to use methodology which is tried and tested and there is a strong expectation that improvements will be demonstrable in the short term	We actively prioritise reducing or carbon footprint and are willing to be a front runner in new or novel approaches, where there is a strong underpinning evidence base that would predict successful delivery in the medium term	Reducing our carbon footprint is our primary consideration and we are willing to innovate or collaborate where there is no current established evidence base and take a longer term view of achieving sustainability benefits
Technology	We generally avoid systems / technology developments.	We are prepared to take only essential systems / technology developments to protect current operations.	We will consider the adoption of established / mature systems and technology improvements. Agile principles are considered.	We will consider systems / technology developments to enable improved delivery. Agile principles may be followed.	We view new technologies as a key enabler of operational delivery. Agile principles are embraced.

Partnerships

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

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

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

Appendix 2: Risk Appetite Statement 2024/25

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

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

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

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Safeguarding Annual Report 2022-2023
Presented to:	Board of Directors
On:	7th February 2024
Presented by:	Chief Nurse
Prepared by:	Assistant Director of Safeguarding
Contact details:	T: 01942 778300 E: carlene.baines@wwl.nhs.uk

Executive summary

The Safeguarding Annual Report provides an opportunity to reflect on the breadth and quality of safeguarding activity across Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust (WWLTH) during the period April 2022 to March 2023. Noting themes and trends, risks and mitigations through a 'Think Family' lens it aims to provide the necessary assurance in relation to the discharge of associated statutory responsibilities. The report consider previous achievements against identified priorities set in 2021/22 whilst identifying new focus areas for the year ahead.

A journey of improvement and innovation has continued throughout 2022/23 despite internal and external influences associated with increased complexity and demand against a backdrop of reduced resources and capacity. WWLTH has fully embraced the notion of safeguarding being 'everyone's responsibility' with the profile and reputation of the Think Family safeguarding service continuing to grow both internally and externally. The Think Family Safeguarding Service has maintained delivery of day-to-day business whilst remaining motivated on the continuous improvement and quality agenda, A WWL Think Family Safeguarding Mission and Vision has been developed alongside the launch of the WWL Safeguarding Strategy.

The Trust has not only maintained compliance with GM Contractual Safeguarding Standards but has further improved on this with an additional number of metric now considered to be GREEN; only 5 standards remain at partial compliance with a clear action plan for implementation in 2023/24 to obtain full compliance grading.

The WWLTH Think Family Safeguarding Service has clear priorities for the year ahead underpinned by the 'WWL Way 4wards'. Ongoing developments to the Trust Wide Safeguarding Training offer remain a key focus as does the alignment of internal workstreams with those of Wigan Safeguarding Partnership.

The Trust remains committed to safeguarding and promoting the welfare of all our patients, staff and communities which is reflected in the safeguarding leadership and commitment demonstrated at all levels.

Link to strategy

Risks associated with this report and proposed mitigations

No risks associated with this report.

Financial implications

WWLTH have a statutory obligation to safeguard adults and children; not adhering to statutory requirements could have financial implications due to potential negligence complaints and detrimental media interest.

Legal implications

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust has a statutory responsibility for ensuring that the services provided by the organisation have safe and effective systems in place which safeguard adults, children, and young people at risk of abuse, neglect, and exploitation. Safeguarding adults and children is also integral to complying with legislation, regulations and delivering cost effective care.

People implications

Safeguarding adults and children focuses on the safety and well-being of all patients but provides additional measures for those least able to protect themselves from harm or abuse. Safeguarding practice is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS.

Wider implications

Monitoring of safeguarding activity within WWLTH, in line with Wigan Safeguarding Adult Board (WSAB), Wigan Safeguarding Children Partnership (WSCP) and NHS Greater Manchester Integrated Care System Wigan (NHS GM Wigan) reporting requirements enables analysis of safeguarding themes and trends against set objectives. Delivery against agreed action plans as a result of this analysis will assist in developing a competent, confident workforce able to proactively deliver holistic health care to achieve improved outcomes for adults, children and families who need additional support.

Recommendation

Safeguarding Effectiveness Group (SEG) and subsequent committees, such as Quality and Safety Committee alongside the Board of Directors to whom this Annual Report will be presented are asked to receive the content and consider the principles outlined within the key priority and safeguarding objectives section. Further detail and oversight of safeguarding activity, inclusive of the performance of the Think Family Safeguarding Service to demonstrate assurance, will be provided via various internal and external forums with the main approving body of any associated papers, policy, service delivery plans and wider partnership activity remaining as the Safeguarding Effectiveness Group.

Safeguarding Annual Report 2022-2023

Contents

Foreword

Welcome to the second Safeguarding Annual Report for Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust (WWL) following the establishment and continued development of the Think Family Safeguarding Service. This 2022-2023 overview will outline not only the achievements of the service but those of the Trust as a whole to demonstrate maintained and improved delivery of safeguarding activity. This report will provide assurance of compliance against statutory obligations and regulatory requirements to offer confidence to the Trust Board and the Wigan Borough Partnership. Outlining challenges faced and key priorities for 2023/24 aims to generate a certainty for patients and the public that WWL remains ambitious and confident in ensuring continued improvement and performance around the safeguarding agenda.

The Think Family Safeguarding Service Objectives, as articulated within the Trust's Safeguarding Strategy for 2023-2025, are aligned with WWL Corporate Objectives and assist in demonstrating measurable impact against the **4Ps** of **Patients**, **People**, **Performance** and **Partnerships** achieved through a commitment to continue to ***Improve***, ***Integrate*** and ***Innovate***. This approach has seen improvements in safeguarding across the Trust with the importance of such activity recognised and acknowledged at all levels and across all Divisions.

Safeguarding is complex with an evidenced increasing demand to protect those in need and at most risk in the continued aftermath of the global Covid 19 pandemic, austerity and cuts to public sector services. Our Trust values of ***4ward thinking***, ***Working Collaboratively***, being ***Accountable*** and ***Respectful*** whilst ***Demonstrating Compassion*** provide a platform to assist in tackling these challenges head on by overcoming any barriers ***'the WWL Way'***.

The Think Family Safeguarding Service has a clear vision which is mirrored across the Organisation ensuring that safeguarding is embedded in everything we do and displays commitment to making a positive difference to people's lives be they patients, staff, visitors or the community at large.

It is our mission to continue to build on the successes of the Think Family Safeguarding Service by maintaining a focus on prevention and protection that considers holistically and with empathy those we seek to safeguard, hearing their voice and advocating to achieve positive health outcomes.

Reflecting Back

A number of key priorities were identified for the Trust within the 2021/22 Annual Report and is therefore prudent to review these in terms of achievements during 2022/23.

Key Priority	Achievements
Development of WWLTH Think Family Safeguarding Strategy and associated Think Family Safeguarding Workplan linked to WWL Way 4wards and Trust Corporate objectives incorporating WSAB/WSCP priorities	The WWL Safeguarding Strategy 2023-2025 has been produced and approved. This fully embeds the Trust principles aligning Safeguarding Objectives to those of the Trust the delivery of which are underpinned by a Think Family Safeguarding Workplan
Completion of internal review of WWL Think Family Safeguarding Service with any proposed restructure/business case founded on contribution and collaboration of all team members following facilitation of Service Away Day	Review and relaunch of Think Family Safeguarding Service. Successful Away Days to ensure shared purpose and ethos resulting in the development of Safeguarding Mission and Vision. Additional external investment into service to improve resource into Children in Care Team and Children First Partnership Hub
Think Family Safeguarding Training Strategy and associated Training Needs Analysis implemented to support ongoing developments ensuring WWLTH effectively maintains compliance against mandated Safeguarding Training targets whilst establishing a confident and competent workforce able to safeguard children and adults at risk	Safeguarding Training Proposal paper approved and shared with Education Committee. Ongoing work with Learning and Development Team to utilise new WWL Learning Hub to effectively map and capture training compliance. Consultation with Practice Education Team and Senior Leaders to seek agreement on merger of training packages to reflect 'Think Family' approach
Develop improved Safeguarding Supervision offer across WWLTH ensuring all staff have personal resilience and professional motivation to support safeguarding issues	All Think Family Service practitioners trained in restorative supervision. Revised supervision offer launched with extended opportunities for access across the Trust
Monitor and review Mental Capacity Act/Deprivation of Liberty Safeguard compliance against Quality Standards to support development of robust Trust wide Liberty Protection Safeguards Implementation Action Plan	Liberty Protection Safeguards now halted at national level however workstreams commenced are being utilised to ensure continuous improvement in relation to DoLS compliance and adherence to MCA principles via audit work at all levels
Review data collection and safeguarding notification processes implementing necessary changes utilising Business Intelligence support to improve data integrity and influence future service developments	Whilst service level review has been completed there has not been the necessary resource or infrastructure provided across the Trust to make the required changes. Some transformation work commenced but additional investment by IMT is required

1 Introduction

1.1. This second annual report since the founding of the Think Family Safeguarding Service showcases the continued improvement journey of safeguarding across the Trust with a clear leadership and vision that is shared and embraced. The profile of safeguarding and the accepting of a 'Think Family' approach has increased exponentially and has seen advances in practice and process that continue to ensure those at risk are protected.

1.2. A joint children and adult approach continues in line with the Trust's shared safeguarding agendas and principals. Additionally, July 2022 saw the WWL Children in Care Team moving from Community Division into the Think Family Safeguarding Service to promote a wider, corporate approach to ensuring the needs of Children in Care and Care Experienced Adults are acknowledged and prioritised across the whole Organisation.

1.3. This report will provide assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with services. A summary of safeguarding activity in relation to Safeguarding Adults and Children during 2022/23 (April 2022 to March 2023) is provided and details an overview of data performance relating to acute and community services inclusive of maternity provision. A Children in Care Annual Report 2022/23 detailing an overview of activity in regard to statutory workstreams, and commissioned service delivery is provided as a further separate report.

1.4. WWL has a diverse and experienced Safeguarding Service with specialisms that provide additional support to patients and staff affected by Domestic Abuse; the activity of the WWL HIDSVAs (Health Independent Domestic and Sexual Violence Advocates) is contained within alongside an overview of WWL input into Wigan Safeguarding Children multi-agency 'Front Door', the Children First Partnership Hub (CFPH), and Wigan Complex Safeguarding Team who support those at risk of exploitation or experience contextual safeguarding.

1.5. The 2022/23 Safeguarding Annual Report will provide the Trust Board with an overview of the local, regional, and national context of safeguarding, safeguarding practice within the Trust including progress and developments whilst giving assurance that the Trust is meeting its statutory obligations. Key priorities for the year ahead will be detailed to cement the drive and commitment of the Organisation and the Think Family Safeguarding Service moving forwards.

1.6. A significant focus of the Trust as a teaching hospital is learning, improvement and innovation. A summary of mandatory Safeguarding Training compliance as reported at year end is contained with an overview of activity by the Think Family Safeguarding Service to ensure lessons learned are embedded via a flexible and responsive approach to safeguarding education.

1.7. Safeguarding includes the early identification and/or prevention of harm, all forms of exploitation, and abuse by adherence to national guidelines and legislative frameworks. The promotion of independence and wellbeing whilst maintaining dignity and advocating choice is paramount therefore the communication of a clear safeguarding vision and mission is necessary to promote the importance of safeguarding to all.

2 Governance Arrangements for Safeguarding

2.1. The Trust discharges part of its responsibility for Board-level assurance, scrutiny, and challenge of safeguarding practice within the Trust, in line with the statutory requirements of *Section 11 Children Act (2004), Working Together to Safeguard Children (2018), the Mental Capacity Act (2005)* and the *Care Act (2014)*. In addition to the requirements of the *Children Act (2004)*, WWL as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the *Health and Social Care Act (2008).*

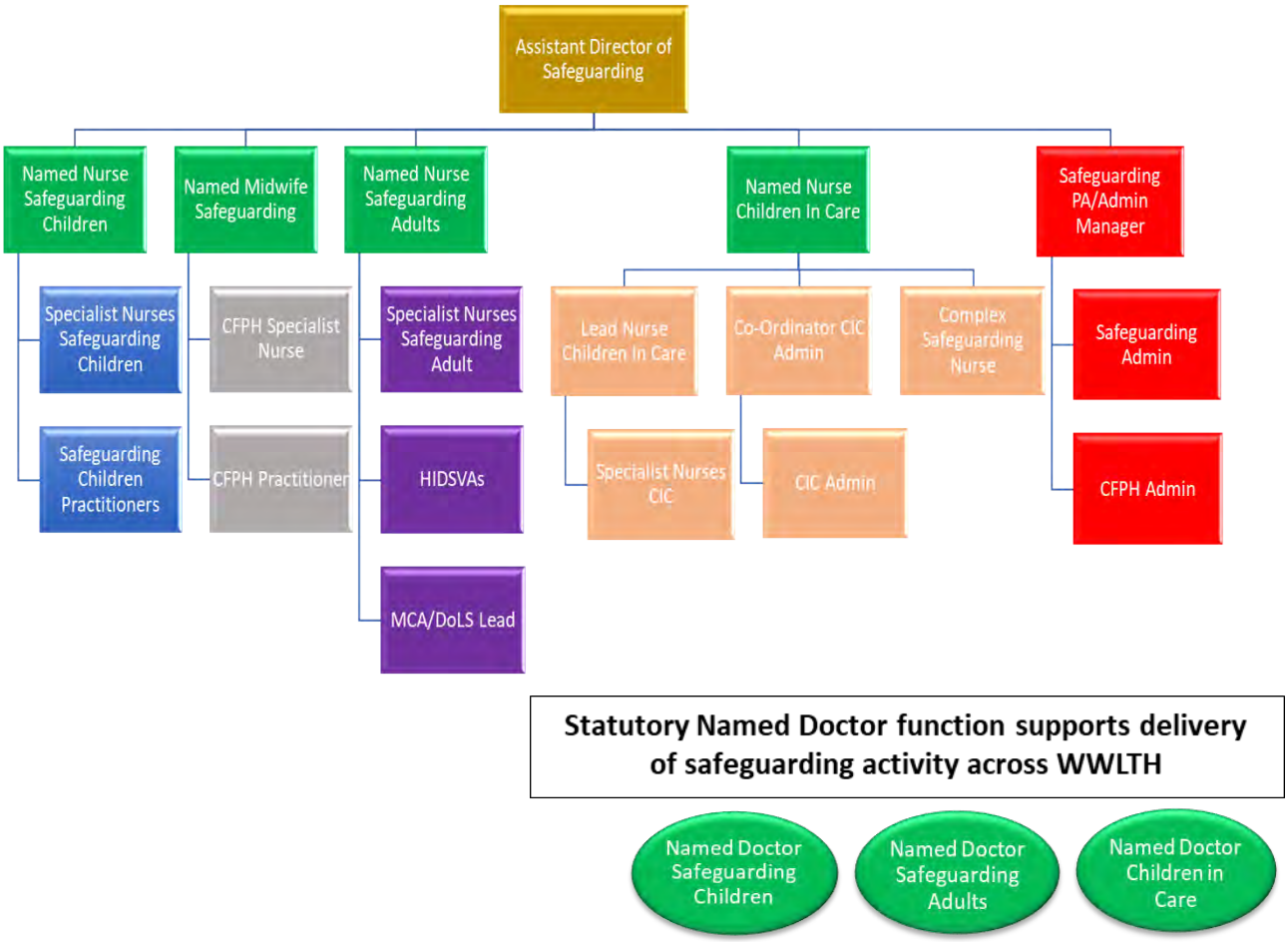
2.2. WWL is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements. The safeguarding roles, duties, and responsibilities of all organisations in the National Health Service (NHS) including WWL, are laid out in the *NHS England 'Accountability and Assurance Framework'* updated in July 2022. The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding; these have been fulfilled throughout 2022/23 with full interim cover provided during any recruitment episodes.

2.3 The Chief Nurse has executive responsibility for safeguarding and represents WWL on both Wigan Safeguarding Adult Board (WSAB) and Wigan Safeguarding Children Partnership (WSCP) Executive Groups. The Deputy Chief Nurse is portfolio holder for safeguarding and is the direct line manager for the Assistant Director of Safeguarding who is responsible and accountable for the activity of the Think Family Safeguarding Service.

2.4 The Trust has in place the statutory roles of Named Nurses for Safeguarding Adults, Safeguarding Children, Children in Care each specific to their speciality alongside a Named Midwife Safeguarding as required as a Maternity Services provider. The Named Professionals provide the organisation with operational advice, support and input influenced by strategic vision and awareness. Alongside a number of specialist safeguarding practitioners, they are committed to supporting the workforce in understanding safeguarding, embedding it into everyday business to improve outcomes. The Think Family Safeguarding Service is supported by a skilled and committed Administration Team comprising of Safeguarding PA/Office Manager, Safeguarding Co-ordinator & Data Administrator, Safeguarding Children in Care Co-ordinator plus Safeguarding and CiC Administrators. The Trust additionally fulfils the roles of Named Doctor for Safeguarding Adults, Named Doctor for Safeguarding Children and Named Doctor Children in Care.

2.5 Safeguarding governance arrangements include the WWL Safeguarding Effectiveness Group (SEG) chaired by the Chief Nurse. SEG has membership comprising, but not limited to, Non-Executive Director with lead for Safeguarding, Divisional Directors of Nursing and Designated Professionals representing NHS Greater Manchester Integrated Care Board Wigan (NHS GM Wigan). The purpose of SEG is to provide assurance in regard to safeguarding arrangements, compliance and activity, to approve reports for internal and external dissemination whilst assessing and monitoring risk in relation to organisational safeguarding duties. SEG feeds directly upwards to Trust Board via the Executive Quality and Safety Committee with lateral input into internal Divisional Quality and Effectiveness Groups. Assurance is provided to NHS GM Wigan via the Quality and Safeguarding Relationships Group which further reports at both a Wigan Borough Partnership and NHS Greater Manchester ICB level.

Think Family Safeguarding Service Structure



Full Think Family Safeguarding Service Establishment

1 WTE Assistant Director of Safeguarding
4 x WTE Named Nurses/Midwife
13 x WTE Think Family Safeguarding Specialist Nurses
2 x WTE Think Family Safeguarding Practitioners
2 x WTE HIDSVAs
1 x 0.8 WTE MCA/DoLS Lead
2 x WTE Children First Partnership Hub (CFPH) Nurses
1 x WTE Complex Safeguarding Nurse
1 x WTE Lead Nurse Children in Care (CiC)
6.8 x WTE Specialist Children in Care Nurses
6.3 x WTE Administrators (Safeguarding/CiC/CFPH)

3 Safeguarding Activity

3.1. Throughout 2022-23, the Think Family Safeguarding Service has continued to utilise capture of Safeguarding Notifications to the Safeguarding Adult and Children Teams via the mandatory prompt for safeguarding concerns within the HIS system to identify and quantify activity within acute services. Whilst this provides an overview of safeguarding activity within the Acute areas of the Trust this data does not detail outcomes, learning identified or positive case studies that can evidence these aspects and therefore provide higher level assurance.

3.2. Transformation work has commenced internally with both SystmOne Team and the Innovation Team to develop a system and dashboard that is able to articulate the breadth safeguarding activity by all Divisions and services plus the interventions completed to safeguard individuals. Whilst anecdotally the Think Family Safeguarding Service can analyse and consider safeguarding presentations as common themes and trends there remains an inability to look wider at responses to such and ultimately evidence robustly the longer-term impact of practitioners, staff and interventions on supporting individuals to stay safe and protected.

3.3. HIS notifications to the Think Family Safeguarding Service in 2022-23 regarding children have increased from the previous year (**n=2440↑13%**). In contrast the overall HIS notifications for adults have decreased (**n=5540↓10%**), however the data does also highlight a reduction in the number of inappropriate notifications/referrals to **n=861**, a **32%** decrease from the previous year. This data does not include notification of safeguarding events occurring within community services utilising SystmOne.

3.4. Throughout the year there has been an increased presence and visibility of the Safeguarding Children Team in Paediatric areas; this has supported in raising the profile of safeguarding, upskilling staff via supervision and bitesize training resulting in frontline practitioners responding in a timely and appropriate manner to safeguarding concerns. Likewise, the visibility of the Safeguarding Adult Team in clinical areas, utilisation of the duty system for a prompt response to safeguarding queries from the Emergency Village and implementation of “How to...” guides have been effective in reducing inappropriate HIS notifications but also the ability to support staff quickly and efficiently.

3.5. The Think Family Safeguarding Service focus on increased training and supervision to develop and upskill the workforce will undoubtedly result in a further reduction of HIS notifications with safeguarding activity being managed appropriately and timely at the point of patient/practitioner contact in a move away from ‘remote’, often delayed specialist safeguarding practitioner review and intervention.

3.6. To be expected, as the main entry points for WWL, both Paediatric Emergency Care Centre (PECC) and the Emergency Department (ED) remain the highest notifier of safeguarding concerns to the Think Family Safeguarding Service; with PECC completing **68%** of all notifications (**n=1659**) for children and ED completing **94%** (**n=5207**) for adults. This provides assurance of early recognition and response to concerns of abuse and neglect on presentation at WWL.

3.7. Throughout 2022-23 there have been periods of significant pressure across the Trust in terms of presentation and capacity within ED, acute bed capacity, staff resource with periods of Critical Incident, despite this, recognition and response to safeguarding concerns has consistently remained high.

3.8. WWL Safeguarding data highlights a similar pattern to last year with the main concerns for those children notified to the Think Family Safeguarding Service relating to Mental Health issues with a total of **n=950** notifications; of these **n=469** related to children and **n=187** for concerns regarding mental health issues in parents/carers.

3.9. This is reflective of National trends with the impact of increasing mental health needs post-Covid being witnessed and felt across both acute and community children's services. Before the COVID-19 pandemic, rates of mental illness in England had been slowly and steadily rising, however national data highlights COVID-19 has accelerated this trend. The British Medical Association reported Mental Health services in England received a record **4.6 million referrals** during 2022 (up **22%** from 2019) and it is acknowledged there are concerns that demand for mental health services is outstripping the resources currently afforded to them.

3.10. The *Mental Health of Children and Young People in England (2022)* report, published by *NHS Digital*, identifies rates of probable mental disorder increased from around **1 in 8** young people aged 7-16 years to more than **1 in 6.** For those aged 17-19 years, rates increased from **1 in 10** to **1 in 4**. For children and young people, the latest evidence suggests that rates of mental illness may be growing at a faster rate than those amongst adults.

3.11. Notifications for adults presenting with mental health concerns have remained static from last year at **n=1228**. Of note, as the year has progressed, is an increase of **58%** in the number of parents/carers presenting with mental health concerns.

3.12. The 'Think Family' approach across the Organisation as can be seen in the data above has progressed with recognition of the impact of parental/carer mental health issues on children and the wider family readily being identified by WWL practitioners. In addition, collaborative work with Greater Manchester Mental Health Foundation Trust (GMMH) as the main provider of mental health services in the borough has helped to improve the response to these presentations. Facilitation of joint meetings between safeguarding and mental health practitioners at all levels throughout the year has supported in the development of joint policy and process creating a shared understanding to effectively manage incidents of a safeguarding nature whereby both physical and mental health are a presenting concern.

3.13. The highest levels of activity overall for the WWL Safeguarding Children Team are around referrals to mental health services and Children's Social Care (CSC) thereby providing assurance in terms of the response to mental health and safeguarding concerns.

3.14. There has been continued high levels of inpatient activity on Rainbow Ward for children with eating disorders; these are invariably long stay admissions requiring *Section 85 (Children Act 1989)* notifications to the Local Authority. The medical, clinical, social and emotional complexity of these children mean that a robust package of care with clear multi-agency support plan is required. Often there is a requirement to detain children with eating disorders under the *Mental Health Act*; this presents further challenge for Paediatric staff however support and intervention by the Think Family Safeguarding Service is readily available and initiated.

3.15. Childhood obesity and safeguarding concerns is an emerging trend this year. Childhood obesity is a key public health concern which has an impact on morbidity, mortality and child development with health risks increasing with duration and severity of the obesity. Obesity is the most common nutritional disorder affecting children across the

UK and is much more common in families living in poverty. The management of obesity is complex and challenging, and professionals working with obese children should be mindful of the possible role of abuse or neglect in contributing to obesity.

3.16. The end of the year has seen a number of children who are clinically obese and within the safeguarding arena. The Safeguarding Children Team are working with Paediatric Services, 0-19 Service and multi-agency partners to explore and address this growing need and consider system challenges that may present in addressing these needs.

3.17. Response to identification of safeguarding concerns is crucial in protecting individuals from further harm and in ensuring improved outcomes. There has been continued extensive input throughout the year, led and supported by WWL Safeguarding Adult Practitioners and Named nurse in relation to the Harm Free Care agenda with activity relating to Pressure Ulcers, Unsafe Discharge and Falls being a focus of improved data collection and analysis.

3.18. The Named Nurse Safeguarding Adults has maintained work internally to ensure concise review, should harm have been caused by WWLTH, whilst alerting to safeguarding concerns arising from the care and provision offered to individuals by other agencies.

3.19. Domestic Abuse is one of the ten categories of abuse as legislated by the *Care Act 2014*. Throughout the year, there has been an increase of **3%** in the number of victims of Domestic Abuse identified by WWLTH practitioners (**n=1148**).

3.20. Improvements have been made to the referral process for Domestic abuse concerns when additional specialist support is required. In November 2022 a new online referral system was introduced for Domestic Abuse referrals to WWL HIDSVAs; this generates an automated notification to the Think Family Safeguarding Service thereby improving timeliness to response and additional support required assisting with more accurate data collection. This system ensures a single process of referral across the Trust accounting for staff and services that do not utilise the HIS system as had been previously identified as a risk in terms of administering effective support to domestic abuse irrelevant of which WWL service patients present to.

3.21. Referrals to the HISDVA services continue to be predominantly relating to female victims (**n=986**) an increase from **n=935** in 21/22. A total of **n=162** victims identified as male. There are no emerging patterns in the age of victims, with the most prevalent age group being aged between twenty and thirty-nine years of age, equating to half of all referrals to the service. There has been a significant increase in the referrals regarding staff, with a total of **n=62**, an increase of **17%** requesting support from the WWL HIDSVA Team in 22/23.

3.22. The capture of Maternity Safeguarding activity has previously been presented at the point of booking via the Special Circumstance Referral Forms (SCRF). 2022/23 SCRF data (**n=544**) indicates SCRF collection has been relatively static compared to **n=515** in the previous year. However, it must be acknowledged this data only provides recognition of concern rather the assurance in relation to evidence of appropriate responses by front line practitioners.

3.23. Throughout 2022/23 work was undertaken by the Named Midwife Safeguarding to ensure a process of data capture that robustly demonstrates the *Threshold of Safeguarding* presentation for women accessing Midwifery Services alongside service interventions to safeguard women, children and unborns. Inevitably the change in data collection presents some challenge when considering comparison to previous years. Additionally further work is ongoing by the Named Midwife Safeguarding to capture themes and trends which will in turn influence wider midwifery service developments, training and policy.

3.24. Throughout 20023/23 the Think Family Safeguarding Service have embedded the Wigan Safeguarding Partnership priorities within all safeguarding activity with the child's

Lived Experience being a focus throughout maternity safeguarding training. It is therefore important to consider individuals in the context of family and the cumulative effect of harm. Pregnancy information is now shared with the WWL Children in Care team for any woman or father of the unborn who is recognised as a child in care or care experienced adult under twenty-five years of age to support with care planning and preventative interventions.

3.25. A breakdown of all safeguarding related activity highlights the numbers of unborn babies subject to new Child Protection (**n=67**) or Child in Need Plans (**n=98**). Associated activity in relation to attendance at Initial and Review Child Protection Conference is captured with the Maternity Service providing input to ensure an effective multi-agency plan to safeguard unborn children. Additionally, requests made to the Midwifery Service for Court Reports are collated with the Named Midwife Safeguarding and wider Think Family Safeguarding Service supporting on the completion and quality assurance of such. There were **n=45** requests were made to midwifery services for 2022/23 relating to Court Report activity.

3.26. A total of **102** Police referrals were received in relation to unborn babies considered to be at risk of harm. Pregnant women discussed at MARAC meetings (Multi Agency Risk Assessment Conference) due to risk of Domestic Abuse was **n=41**. Police referrals is a continuing trend not always relating to high risk from Domestic Abuse and is indicative of the additional complexities in relation to maternity safeguarding presentations and supportive of findings linked to increased presentation of mental health and alcohol/substance misuse concerns. A total of **n=21** Female Genital Mutilation cases were noted over the year compared to **n=16** the previous 2021/22 year. However limited detail is available in terms of type and presentation to service. Future reporting will hopefully generate a deep dive into this area to provide additional assurance related to the muti-faceted response to this practice.

3.27. Significant progress has been made during the year in understanding the Child Death processes across the Organisation in conjunction with the relevant Divisions and how this aligns to the *Child Death Statutory Guidance (2018)* in line with the *Children and Social Work Act 2017*. An action plan was developed to outline the work required with a number of actions now completed. The beginning of the year saw the successful appointment of the Designated Doctor for Child Death, who will lead in coordinating responses and health input to the child death review process. Work has included ongoing involvement with several Child Deaths and supporting parents and WWL staff in conjunction with the Bereavement Team and Chaplaincy.

3.28. A theme throughout the year has been a notable increase in the number of escalations across the team, activity across the team demonstrates this increase and this has been highlighted by the Local Authority Safeguarding Unit Team as a positive in terms of WWLTH and their focus on children in recognition of delay and drift.

3.29. There are escalations of cases across both acute and community services, with community cases predominantly around neglect; evidence of neglect and drift and delay in cases with little change for children suffering abuse and neglect. The themes around acute escalations are mainly around discharge and placement suitability, drift and delay resulting in inappropriate length of stay and safeguarding concerns alongside underlying mental health concerns. Similarly, from an adult perspective escalations arise from concerns regarding responses for those self-neglecting and from an unsafe discharge perspective.

3.30. The Wigan Safeguarding Children Partnership (WSCP) and Wigan Safeguarding Adult Board (WSAB) Resolution Policy is consistently utilised effectively by WWL at all levels including involvement from the Named Nurses where escalation cannot be resolved at practitioner and first line manager level. Training has been provided around “Escalation”

and the increase in escalations provides some assurance around the effectiveness of this training delivered throughout the year.

3.31. Challenges have continued around the retrieval of Community Safeguarding activity with differing methods of data collection used to capture notification of safeguarding events. However, there is a high level of activity for the both the Safeguarding Adult and Safeguarding Children Team in relation to advice, training, and supervision. It is acknowledged that due to the nature of caseloads and provision of longer-term interventions community practitioners are highly skilled in the management of complex cases.

3.32. Positive case examples throughout the year provide assurance around a strong focus on children and their lived experience and highlight significant practitioner input and impact in response to identified need. Furthermore, the number of Rapid Review/Root Cause Analysis/After Action Reviews completed with 0-19 services in response to learning identified through incidents has reduced throughout the year.

3.33. The Think Family Safeguarding Team continue to review current safeguarding data collection and processes with the aim of providing greater assurance around outcomes and lived experience for children and adults. Work is ongoing, both internally and with multi-agency partners to capture and provide a data set across agencies that produces a robust and holistic picture of safeguarding adults and children across the Borough.

4 Training, Supervision and Support

4.1. Throughout 2022-2023 an area of priority has been a visual presence from the Safeguarding Service across areas of the Organisation to support collaborative work across Divisions and with frontline practitioners. There has been a strong focus on visibility and training across PECC, Rainbow, Neonates and Midwifery, alongside, District nursing services and ED with all acute wards now have a linked Safeguarding Nurse.

4.2. The Think Family Safeguarding Service has focussed on training, advice, and supervision afforded to all WWL staff to support development and ensure early identification of safeguarding initiating responses to concerns of abuse and neglect. This approach also provides the opportunity to identify areas of service development.

4.3. At times, this very proactive, hands-on approach by safeguarding practitioners has posed significant challenge due to reduced staffing numbers across all teams within the Safeguarding Service and staffing demands within the Divisions. It has been well evidenced that access and availability of safeguarding support improves response and confidence in managing safeguarding concerns which importantly results in improved patient experience. Whilst the 'formal' programme of contact and visibility has been hindered at times, the Safeguarding Service has responded to urgent and emerging incidents readily and as required.

4.4. The safeguarding needs of children and adults within the Wigan Borough are becoming more complex and more apparent. Safeguarding Supervision is key for all community and acute services staff during these very challenging and demanding times to support practitioners with the increasing number of difficult cases. This year saw an increase of **28%** (**n=219**) in the number of *1:1* supervision sessions facilitated by the Safeguarding Children Team and an increase of an impressive **530%** (**n=208**) in the number of practitioners accessing group supervision sessions.

4.5. The restorative aspect of supervision supports practitioners with the emotional challenge of addressing safeguarding needs whilst retaining a focus on the lived experience and needs of the child/adult. Safeguarding Supervision is delivered in a mandated but also flexible format. The Safeguarding Adult Team have focussed on developing links with the Community Division and been successful in establishing relationships and supporting with complex cases throughout 2022-23.

4.6. A positive pattern and upward trajectory of the data throughout the year has resulted in all levels of Safeguarding Adults and Children Training now being fully compliant as per NHS GM Contractual Standards. Additional face to face Level 3 Safeguarding Children sessions were facilitated throughout the year to support staff in accessing and achieving compliance.

4.7. In addition, the Safeguarding Service have developed and delivered bitesize training sessions to support development of practitioner knowledge in line with the emerging themes of Child Safeguarding Practice Reviews (CSPRs), Safeguarding Adult Reviews (SARs), Brief Learning Reviews (BLRs), and internal learning from IPIRs (Immediate Post Incident Review).

4.8. The identified subject areas this year have been *Escalation Policy, Trauma Informed Care, Strategy Meetings, Professional Curiosity*, *Lived Experience/Voice of the Child* and *self-*

neglect. A total of **n=40** bitesize session has been delivered with **n=371** staff attending. Current workstreams are focussed on tailoring existing training sessions into a Think Family context in order to support increased skills, knowledge and competence of all staff regardless of adult, maternity or paediatric specialism.

4.9. A review of the supervision offer to Midwives, including revision of the current policy and mapping of requirements across the workforce, has been undertaken. From early 2023, there has been a rolling programme of safeguarding supervision provided by the WWL Think Family Safeguarding Service at both acute and community venues. Further monitoring and review of the supervision offer has been provided by the Named Midwife Safeguarding with ongoing current innovations to increase supervision attendance, whilst reducing time away of practitioners within the clinical setting. A 'stop & tea' method will be rolled out across 2023/24 and presented for oversight at monthly SEG.

4.10. Additionally, the WWL Think Family Safeguarding Service have been increasing visibility and presence across acute Maternity Wards and Community Midwifery Clinics to promote reactive supervision and advice regarding safeguarding concerns ensuring practitioners are supported in their safeguarding duties.

4.11. A Safeguarding Training package has been developed and delivered for both the Cavendish and Clinical Induction programme ensuring all new employees to WWL have an introduction to Safeguarding Adults and Children. This has been successful in not only ensuring practitioners are aware of their safeguarding obligations but provides an opportunity to raise the profile of the service and safeguarding in general.

4.12. In response to a local Child Safeguarding Practice Review *'Child Elliott'* followed by an examination of complaints/incidents relating to patient care when restrictive interventions have been deemed necessary to maintain safety and clinical care, the Think Family Safeguarding Service have developed and implemented improvements in the application of least restrictive practice.

4.13. A 'Least Restrictive' Core Group was established with the development of an overarching action plan to facilitate the shift required; training of staff in the principles of least restrictive practice inclusive of practical skills such as clinical holding was identified as key to embedding the approach consistently and effectively, and a roll out of CPI training is scheduled for front line practitioners for 2023/24.

4.14. Work is ongoing jointly with the Think Family Safeguarding Service and Practice Education Team to enhance and improve the model of safeguarding training delivery to offer flexibility and promote engagement. The bitesize sessions in future will contribute to mandatory training hours, this will support improved compliance and enable staff to access training relevant to identified learning needs

5 Contributing to Multi-Agency Safeguarding

5.1. The Think Family Safeguarding Service contributes widely to the partnership via Wigan Safeguarding Adult Board (WSAB) and Wigan Safeguarding Children Partnership (WSCP) subgroups and workstreams. Additionally full participation by WWL representatives occurs via the Domestic Abuse Strategic Oversight Board and Community Safety Partnership.

5.2. WSCP revised their governance structure during the year resulting in a change to the subgroups. There are now three main overarching subgroups: the Safeguarding Performance subgroup and Learning and Improvement subgroup, alongside the Wider Safeguarding Forum. WWL Think Family Safeguarding Service are represented at all subgroups and contribute to WSCP workstream with relevant senior leaders in attendance at WSCP Executive Board.

5.3. WSAB subgroup structure remains unchanged with Organisational Safeguarding, Learning and Quality and Self-neglect. The Named Nurse Safeguarding Adult is from 2023 the co-chair of the Organisational Safeguarding sub group and is an active member of the other sub groups and forums.

5.4. The WSCP adopted practice priorities including *Voice of the Child*, *Professional Curiosity, Critical Thinking and Challenge, Impact and Analysis* and *SMART Action Planning*. These priorities are embedded within WWL Safeguarding Children Team training plan and reflect the learning identified within IPIRs.

5.5. Collaborative work alongside the WSAB has ensured the use of MOSAIC (Local Authority Safeguarding Case Recording System) is now fully embedded in practice within the Safeguarding Adult Team. This has been key in 2022/23 in ensuring safeguarding oversight, quicker feedback to WWL staff to enable safe discharge, additional support for community health services to improve and inform care planning whilst reducing inappropriate/ duplicate referrals to the Local Authority.

5.6. The Safeguarding Children Team play a key role in delivery of WSCP multi-agency training, delivering training on *Graded Care Profile 2*, *Level 3 Safeguarding Children training*, *Safe Sleep training, Professional Curiosity* and *SMART Action Planning* which is accessible by all multi-agency partners with professionals from a variety of disciplines in attendance.

5.7. Partnership workstreams associated with the Safeguarding Adult agenda via Brief Learning Reviews (BLR) and Serious Adult Review (SAR) have increased significantly over 2022/23 with **2** SARs completed and **1** SAR commenced in addition to **2** BLRs completed and **5** BLRs commenced. 7 minute Briefings readily shared across WWL Learning and improvement (wigansafeguardingadults.org).

5.8. There are similar levels of activity in regard to BLRs and Child Safeguarding Practice Reviews (CSPRs). The number of ongoing CSPRs has reduced throughout the year due to completion of legacy reviews with a positive NHS GM Wigan ICB validation visit to acknowledge that learning from such has been embedded across WWL. Validation visits for the CSPRs are undertaken by the NHS GM Wigan Designated Nurse Safeguarding Children to review the WWL evidence for the legacy Serious Case Reviews and recently published Child Safeguarding Practice Review. Positive feedback was received against progress and onward innovation to embed lessons learned. The Named Nurse Safeguarding Children attends

WSCP Case Review subgroup and meets with the Partnership monthly to update ongoing actions.

5.9. The Think Family Safeguarding Service are also supporting considerable activity resulting from internal IPIR/StEIS activity/DATIX that often requires a parallel process of either BLR or notification/alert to the Local Authority where it is deemed that harm has been caused as a result of Neglect or Acts of Omission.

5.10. Work was ongoing in 2022/23 in relation to **12** Local CSPRs, **4** of which were legacy Serious Case Reviews, whereby the completion of final report was hindered by the Covid Pandemic. At the end of 2022-23 action plans were completed for **9** CSPRs with validation visits completed, work was ongoing on **3** CSPRs.

5.11. All reviews, both adults and children, generate Action Plans which are key to supporting single and Multi-Agency learning with WWL Think Family Safeguarding Service, via the leadership of the Named Professionals vital in driving this agenda.

5.12. Learning opportunities within the Safeguarding Children agenda and implementation of practice changes across a number of WWL services with underpinning themes relate to *'Voice of the Child and Lived Experience', 'Transition', 'Professional Curiosity and Escalation', 'Trauma Informed Practice', 'Working with families where engagement is problematic or resistant', 'Information Sharing and Communication'* and *'Use of Evidenced Based Tools'*. From a Safeguarding Adult perspective, the biggest challenge and theme within safeguarding reviews are *lack of collaborative working, self-neglect*, and *Mental Capacity.*

5.13. A Multi-Agency Risk Assessment Conference (MARAC) involves the sharing of information relating to the highest risk domestic abuse cases with representation inclusive of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from statutory and voluntary sectors. The primary focus of the MARAC is to safeguard the adult victim however actions to safeguard children and manage the behaviour of the perpetrator will also be considered.

5.14. WWL's contribution to MARAC is co-ordinated by the Think Family Safeguarding Service and throughout 2022/23 a total of **1418** MARAC cases were heard within meetings, a slight reduction from 2021/2022. MARAC meetings per week have reduced to three from five enabling cases to be fully reviewed to ensure criteria is met and action plans are robust, with the aim to reduce repeat MARAC cases.

5.15. The Think Family Safeguarding Service continues to host co-located 'Health' roles via the employment of a Complex Safeguarding Nurse based at Wigan Police Station within the Complex Safeguarding Team, and Specialist Nurses Safeguarding Children based within the Children First Partnership Hub. Whilst these post holders have a specific remit in terms of the multi-agency approach to exploitation of children and the 'Front Door' to Safeguarding, practice is embedded widely in terms of the 'Think Family' approach embraced by the whole safeguarding service.

5.16. Children's First Partnership Hub (CFPH) is based at Wigan Life Centre and is the 'front door' for all safeguarding children referrals to Social Care. From May 2023 the line management of WWL health posts within CFPH was transferred to the Named Midwife Safeguarding.

5.17. 2022/23 has seen an increase in complexity and demand associated with safeguarding children, indicated by recent high profile National Children Safeguarding Practice Reviews (CSPRs) National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk) and Local Child Safeguarding reviews Local Child Safeguarding Practice reviews (wiganlscb.com). Subsequently further investment from NHS GM Wigan has been secured to increase specialist safeguarding nursing provision within CFPH to x2 WTE with additional administrative support.

5.18. As is well versed when considering 'what works well' in relation to safeguarding it is often the practice of informal communications and development of mutually supportive professional relationships. Therefore, periods of high demand require a flexible and supportive response from the wider Safeguarding Children Team to ensure essential activity is maintained with multi-agency teams.

5.19. The role of the WWL Health Practitioners within the Children First Partnership Hub is to undertake immediate health information sharing and attend Initial Strategy Meetings. 2022/23 activity in relation to attendance at Strategy Meetings (**n=691**), sharing of Health Information (**n=884**) and Health screenings (**n=3545**) sheds light on the volume of activity related to the partnership and the vital role of WWL Health Practitioners in supporting multi-agency assessments and interventions to safeguard children and families.

5.20. The pre-birth protocol meeting was established as a multi-agency partnership meeting to ensure assessments and plans for unborn babies are progressing in a timely and effective manner, with robust and proportionate arrangements agreed for the birth to avoid delays and/or unsafe discharge from the maternity unit. The meetings provide a collaborative approach to pre-birth assessment and support involvement of the Adoption Team and the Court Progression Officer in an appropriate manner. The pre-birth protocol continues to be monitored with safeguarding input and oversight by the Named Midwife Safeguarding.

5.21. Community Safety Partnership Domestic Abuse Strategy 2021 – 2024 aims at being '*aspirational and that Wigan as a Borough deem domestic abuse as being unacceptable in all its forms, and where we want people in our community to be able to live safely and have happy lives free from abuse'*. WWL as a major health provider within the Borough advocates and works as a key partner agency in fulfilling this strategy. The Named Nurse Safeguarding Adults is a key member of the Domestic Abuse early intervention subgroup reviewing MARAC systems, GMP developments and support for Domestic Abuse victims alongside and the newly established MATAC programme for perpetrators. This is further supported by the Assistant Director for Safeguarding as core member of the Domestic Abuse Strategic Oversight Board.

5.22. The Safeguarding Children Team have participated in all WSCP multi-agency audits throughout the year, these have explored *Neglect, children subject to repeat child protection plans, sexual abuse, domestic abuse* and *step up/step down*. Action plans are developed from learning points identified feeding into WSCP Audit action plan meetings to review multi-agency actions and provide assurance across partners.

5.23. The Named Nurse Safeguarding Children has contributed to an ongoing workstream with CSC and Police Partners reviewing and developing the Strategy Meeting process. Improvements have been made, evidenced by assurance activity, with regards to timeliness for Strategy Meetings, thresholds being met and clear evidence of excellent multi-agency information sharing and decision making. This supports in providing the right support at the right time for those children at risk of harm.

5.24. The role of the WWL Health Practitioner within the Children First Partnership Hub is to undertake the immediate health information sharing, following refinement of process and collaborative work with 0-19 Team regarding attendance at Strategy Meetings, there has been a **4%** reduction in strategy meetings completed by the CFPH Specialist Practitioner ensuring most appropriate attendance at such meetings.

5.25. A piece of development work has been completed by the Named Doctor and Named Nurse Safeguarding Children alongside CSC regarding Child Protection Medicals and Section 47 enquiries. This has been successfully implemented with the provision of Interim medical

reports to assist legal processes in a timely manner and supporting a multi-agency approach to safeguarding children at risk of significant harm.

5.26. The process around Child Deaths is overseen by the Named Nurse Safeguarding Children supported by the Safeguarding Children Team who are responsible for contributing to the *Child Death Overview Panel (CDOP)* processes. Sadly **24** Child Deaths were reported during 2022/23; **7** of which of which were unexpected with all of those following the Joint Agency Review process as outlined by the Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk).

5.27. A significant piece of work has been undertaken by the Named Nurse Safeguarding Children in conjunction with Divisions to provide insight into the Child Death processes across the Organisation and how this aligns to the *Child Death Statutory Guidance (2018)* in line with the *Children and Social Work Act 2017*. This has included ongoing involvement with several Child Deaths with regards to supporting parents in conjunction with the Bereavement Team.

5.28. Review of governance processes to ensure consistency and adherence to statutory guidance, and of workstreams, continues to ensure all correct information is collated and submitted for the Child Death Overview Panel. A robust action plan has been drafted to support internal Child Death processes and to confirm the Trust is compliant with statutory expectations in relation to practices introduced to ensure effective and responsive support to families following the loss of a child. There is a requirement to establish a new workstream of Key Worker for Child Death, again as outlined in Statutory Guidance, with the Think family Safeguarding Service implementing this via utilisation of existing resources and collaboration with wider Teams.

5.29. The numbers of children subject to Child Protection Plan (CPP) across the Borough has decreased from the previous year with an **11%** reduction (**n=461**). There has been a focus on those children subject to CPP for longer than twelve months with multi-agency review of action plans to ensure they are SMART and do not to contribute to drift and delay.

5.30. The categories for CPP identify the majority of plans are around emotional abuse, locally a significant number of children are exposed to Domestic abuse, and therefore victims of domestic abuse, will contribute to a larger cohort within this category. Neglect is the second largest category of CPP; a number of escalations from WWL Community Division are regarding chronic neglect.

5.31. The Safeguarding Children Team process legal requests, support practitioners in providing a quality, evidence-based report, and complete redaction of records. The process for requesting and completion of legal requests differs across acute and community services, legal requests for acute practitioners/services are managed via the Legal Team. This has been recognised as a risk and submitted on to the risk register with an action plan to address.

5.32. The internal work around the Pressure Ulcer and Harm Free Care agenda is significant from a partnership perspective. Any areas whereby the Trust is considered to have caused harm requires robust investigation and is considered via Strategy Meetings in line with *Section 42* Safeguarding Adult processes. The Named Nurse Safeguarding Adult takes a lead in this work and is able to provide advice and assurance linked to Adult Social Care referral pathways upon identification of a pressure ulcer.

5.33. The introduction of the Pressure Ulcer Policy, Standard Operating Procedure and Decision Tree reflects the commitment to ensure proportionate safeguarding responses alongside robust review of each incident to consider learning opportunities. This improvement work has been shared across the partnership with Adult Social Care, NHS GM

Wigan and WSAB colleagues excited by the proactive and solution focused approaches being driven by WWL.

5.34. The embedding of the policy alongside the safeguarding decision tool will be key in assisting practitioners to take accountability for making appropriate referrals to the Local Authority following a multi-agency discussion via the WWL Pressure Ulcer Panel, removing a blanket approach to referrals, and providing a more person focused approach to identifying harm has seen positive results. Embedding such practice has been embraced by the Think Family Safeguarding Service and supported significantly by the Chief and Deputy Chief Nurse.

5.35. Internal process to consider STEIS reportable harm following Concise Investigation with ongoing input and support from a safeguarding perspective to ensure accuracy and objective consideration of concerns has been a key workstream for the Safeguarding Service throughout 2022/23.

5.36. The Safeguarding Adult Team attended a high number of Strategy Meetings in relation to pressure ulcers during 2021/22 but this has significantly reduced in 2022/23 as a result of the aforementioned innovations allowing both WWL and the Local Authority to support those more complex patients requiring a robust multi agency approach.

5.37. The Safeguarding Adult Team link extensively with the Local Authority Quality and Performance Officers (QPO) in relation to adults in care home settings. The team is involved in the safeguarding of adults requiring residential or nursing care at point of contact with WWL services should safeguarding issues arise; this may be associated with acquired pressure ulcers, falls, medication errors or disclosures of abuse.

5.38. This activity has been further enhanced in 2022/23 with the Named Nurse Safeguarding Adults attending the Care Home and Supported Living Providers Forums to share expertise and knowledge of cross-cutting safeguarding themes.

6 Achievements and Assurance

6.1. Key priorities set within the previous Annual Report (2021/22) outlined a number of objectives for the Think Family Safeguarding Service. Whilst focus on these has remained it is inevitable that additional or adapted workstreams have been developed as influenced by the political climate, social contexts, and local agendas.

6.2. The service has ensured prioritisation of statutory obligations therefore maintaining a clear focus via SEG on the multi-faceted nature of safeguarding. Reporting to internal and external groups, committees and boards has much improved providing assurance and reassurance to executives, governors, and key stakeholders in regard to performance.

6.3. A full Safeguarding Service Away Day was completed in quarter 2, with a follow up in quarter 4. There was a focus on developing a shared mission and vision for the service and review of service delivery with the development of the overarching Think Family Safeguarding Workplan. The service was able to cement the Think Family Safeguarding Vision and Mission Statement whilst enabling refocus on priority areas such as training, supervision and audit to further influence advancements in safeguarding practice for the whole Organisation.

6.4. Throughout the year the Think Family Safeguarding Service has had input and oversight into Datix and IPIRs where there are concerns around safeguarding; learning themes reflect those identified with safeguarding reviews locally and nationally in terms of *escalation, voice of the child/making safeguarding personal, critical thinking and challenge* and *trauma informed practice*.

6.5. Learning themes have been addressed by workstreams, with ongoing assurance activity planned to evidence the impact of work completed. Ongoing work around safeguarding governance processes has been facilitated throughout the last year to ensure the effective management of the StEIS process and the interface with the Local Authority reporting of incidents; to maintain transparency from a WWLTH perspective, the PSIRF reporting system will be a further change to managing and addressing risk/reporting incidents, and DATIX is currently being utilised more frequently as a safeguarding notification tool for advice and support determined by internal investigations.

6.6. NHS GM Wigan Designated Nurses undertook Safeguarding Validation Visits in Quarter 2 and Quarter 3 of 2022/23 to consider compliance against agreed GM Safeguarding Contractual Standards. A collaborative and supportive approach was taken and ensured transparent and honest dialogue in determining agreed assurance levels against a number of specific metrics. The final report was approved via NHS GM Wigan ICB Quality and Safety Group in January 2023.

6.7. Across sixty-three standards relating to safeguarding adult, children and children in care activity the Trust was rated GREEN in **58** with only **5** standards rated AMBER and deemed to evidence only Partial Compliance. This was a further improvement on the previous year with **6** additional standards now considered GREEN.

6.8. There is a clear action plan to support improvements and developments which is monitoring via SEG to ensure progress is made facilitating any additional intervention to overcome barriers to achieving full compliance against any standard.

6.9. There are **2** standards solely related to Children that are rated AMBER; both regarding the Child Death Review Process with the WWL Child Death Action Plan in place to support in achieving full compliance with regards to the standards and *the Child Death Statutory Guidance (2018)*; this is shared with SEG for oversight and monitoring.

6.10. The remaining **3** AMBER standards relate to policy in the main to ensure Organisational Safeguarding via robust Human Resource process or linked to wider practice such as Least Restrictive. As discussed earlier within this report a significant Trust Wide piece of work has been undertaken in relation to Least Restrictive Practice and it is therefore anticipated that this standard will move to GREEN in 2023/24.

6.11. The 'Think Family' approach to safeguarding has become further mainstreamed across the Trust. This has been achieved in part by safeguarding practitioners being visible in clinical areas plus a duty system bolstered and refined to provide responsive and reactive internal support and guidance whilst responding to queries from external partners and agencies. Members of the service have worked positively and enthusiastically to embed this ethos reviewing internal processes and acting on staff and service user feedback.

6.12. Participation in a range of internal and multi-agency audits, shared and ratified via SEG, resulted in the implementation of policy and procedure whereby impact to improve outcomes alongside a willingness to share good practice and data to further support WWL and partnership developments can be seen. Collaboration with all has been embraced and a confident safeguarding workforce has been established.

6.13. WWL fully complies with the *Mental Capacity Act 2005* and *Deprivation of Liberty* (DoLS) legislation. Patients subject to DoLS are discussed in partnership with Local Authority colleagues and key areas for consideration include the level of enhanced nursing care applied, use of covert medications and use of sedations. Patients requiring Level 4 enhanced care (1:1) call for additional consideration and oversight by the MCA/DoLS Lead and Safeguarding Adult Practitioner in conjunction with ward staff regarding this level of restriction. Clear explanations are given as to what this means under the *MCA (2005)* which compliance against is audited regularly to ensure reduction in restrictions are applied at the earliest opportunity.

6.14. 1845 DoLS have been submitted to the Local Authority for the year 2022/23 with 90+% evidencing a recorded Mental Capacity Assessment (MCA). The MCA/DoLS Lead for WWLTH, an integral team member within the Think Family Safeguarding Service, provides oversight on all DoLS supporting staff to rescind the application when it is no longer applicable.

6.15. Future development of the Think Family Safeguarding agenda remains a priority; the service is keen to work in a different way to ensure staff are supported and patients are protected. Complex cases are increasing which continue to impact on workload whilst there remains specific and commissioned work, either via SEG or the partnership, that place demands on time and resource.

Next Steps – Looking Forward to 2023/24

As outlined within the Safeguarding Strategy 2023-2025 and underpinned by a comprehensive operational workplan there is a clear direction set in terms of what the Trust wants to achieve in the coming year.

Safeguarding Objectives are outlined against the 4Ps as broad overarching statements. Utilising these objectives as a guide assists in refining in simple terms safeguarding priorities in 2023/24.

It is the interlinking of the Safeguarding Strategy and Workplan that enables the provision of just one key priority being identified for the next year.

Key Priority for 2023/24
Develop a data system and dashboard that is able to articulate the breadth of safeguarding activity and intervention by all Divisions and Services across the Trust *The aim is that data reporting will begin to clearly convey the levels of complexity and demand at an individual, service and divisional level but more importantly will start to evidence impact of the organisation in terms of improving health outcomes for those whom it seeks to safeguard based on the success of interventions resulting from increase knowledge, skill and competence of WWL Staff at all levels.*

Safeguarding Objectives 2023-2025

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

- ***We will build on our successes creating a pathway of development***
- ***We will learn from what hasn't worked well striving to do better***
- ***We will act with integrity and compassion to advance improvements, integration and innovation***

Conclusion

It is hopefully clear from this report that the safeguarding offer across the Trust continues to be strengthened with progression via a journey of quality improvement and innovation. The wealth of activity driven by the Think Family Safeguarding Service is difficult to convey within the limitations of this document however the commitment and desire to ensure patients, staff and the people of Wigan are safe and protected when in contact with WWL services permeates at all levels across the Organisation with a reach far beyond that of the Think Family Safeguarding Practitioners.

The commitment to improve safeguarding provision via effective care delivery can be seen in not only the successes identified within this report but when acknowledging the challenges faced, sparking enthusiasm to overcome these and make positive changes. From policies to process, supervision to training, education to advice and recognition and response, every single strand of safeguarding activity, provision and intervention is considered in the context of those who need additional support and protection. Internal forums such as SEG ensure robust monitoring and oversight of safeguarding issues and advancements whilst groups such as Safeguarding Champions bring the passion for influencing safeguarding to crucial frontline practitioners by capturing the lived experience of patients through the advocacy role operated by WWL staff.

WWL are key players across the Wigan Borough Partnership, often leading on development and improvement work that can be adapted and embedded within external services and agencies. It is acknowledged that achievements in safeguarding is only possible with the commitment and drive of all WWL staff and with this significant improvements in safeguarding compliance and assurance can be evidenced. Safeguarding will continue to be at the core of every contact, intervention and communication as a golden thread that helps to weave a supportive web to hold safe and secure those in need of protection.

Whilst there are many positives to be taken from this report it is important that assurance does not slip to reassurance; continued critical analysis and application of what works well alongside learning from reviews is necessary to facilitate transition from a reactive model of safeguarding to one that is truly preventative. The year ahead will be a springboard off the platform of achievements in 2022/23 to launch the WWL safeguarding offer to the next level in terms of assurance, quality and improvement.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Children in Care Annual Report 2022- 2023
Presented to:	Board of Directors
On:	7th February 2024
Presented by:	Chief Nurse
Prepared by:	Assistant Director of Safeguarding & Named Nurse Children in Care
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Executive summary

The purpose of this report is to provide an overview and an opportunity to reflect on the breadth and quality of activity delivered by Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust (WWLTH), inclusive of the Specialist Children in Care Team, during the period April 2022 to March 2023 as assurance that the Trust continues to meet statutory responsibilities in respect of Children in Care (CiC). The report seeks to acknowledge past achievements whilst identifying key priorities for the year ahead. There have been capacity and demand issues across the 12-month period; despite this the WWLTH Children in Care Team has not only delivered on day-to-day business but has striven to innovate, progress and improve via targeted workstreams and individual development.

Nationally numbers of Children in Care are rising; at year end March 2023 the number of Children in Care to local authorities in England rose to **83,840** up **2%** from 2022 in a continuing trend. Locally, the number of Children in Care to Wigan increased from **614** children in 2022 to **679** children by March 2023. Wigan has a higher than national average number of Children in Care with increasing numbers of Unaccompanied Asylum-Seeking Children (UASC), again as reflected in national trends.

Alongside increasing numbers of Children in Care, increasingly complex issues from a health and social perspective are also evident. Despite the challenges faced Wigan children in care achieve better than national average health outcomes as highlighted within the annual SSDA903 Government data return.

The Children in Care Team remains committed to meeting the health needs of the Children in Care and Care Leavers population of Wigan Borough and continues to work collaboratively with the Local Authority, Corporate Parents, and key partners to improve outcomes for our children and adults with care experience.

Link to strategy

☒ Patients ☒ Performance
☒ People ☒ Partnerships

Risks associated with this report and proposed mitigations

Throughout the reporting period and despite the increased funding into the WWL Children in Care Service delays and difficulties in recruitment to nursing posts saw reduced capacity in staffing and resource. This risk was articulated and managed via the Corporate Risk Management Group with full transparency of the challenges to commissioners within NHS GM Wigan. Despite these issues the CiC Team maintained full compliance with statutory obligations and care provision ensuring adherence to standards outlined within national and local frameworks. In 2023, recruitment to ensure near full establishment in addition to robust mitigation factors has seen the removal of the service from the risk register.

Financial implications

WWLTH have a statutory obligation and Corporate Parenting responsibility for Children in Care; not adhering to these requirements could have financial implications due to potential negligence complaints and detrimental media interest.

Legal implications

The Corporate Parenting responsibilities of Local Authorities include having a duty under *Section 22(3)(a) of the Children Act 1989* to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional, and mental health and acting on any early signs of health issues and must arrange for them to have a health assessment as required by *The Care Planning, Placement and Case Review (England) Regulations 2010.* An extension of these corporate parenting responsibilities is via commissioning of health services by Integrated Care Boards and thus further to health provider organisations.

People implications

The Children in Care Team focuses on the safety and improving the well-being of our children and young people. The pre-care experience continues to have a significant impact on the future lives of our children and young people and they remain susceptible to further abuse and exploitation. Safeguarding practice is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS.

Wider implications

Monitoring of Children in Care activity within WWLTH, in line with the Wigan Safeguarding Children Partnership (WSCP), Wigan Borough Clinical Commissioning Group (WCCG) reporting requirements (now NHS GM Wigan) and Wigan Corporate Parenting Strategy enables analysis of Children in Care themes and trends against set objectives. One of the themes identified is transition and transfer of care in and out of borough.

Recommendation(s)

Safeguarding Effectiveness Group (SEG) and subsequent committees, such as Quality and Safety Committee, to whom this Annual Report will be presented are asked to receive the content and consider the principles outlined within the key priorities for 2023-2024 section.

This report is to be received as additional assurance by NHS GM Wigan via Integrated Quality and Safety Group (IQSG) in regard to discharge of statutory responsibilities with a request to continue to support the WWLTH CiC Team via review of service specification and facilitation of relationships with key partners to ensure the health needs of Children in Care continue to be met.

Children in Care Annual Report 2022-2023

Contents

1 Introduction

1.1. The purpose of this report is to provide an overview of the Children in Care Service and a retrospective view of the work completed from 1st April 2022 to 31st March 2023 to ensure Wrightington, Wigan and Leigh Teaching Hospitals NHS Trust (WWL) meets its statutory responsibilities in respect of Children in Care.

1.2. Children in Care (CiC) are referred to in legal terms as 'Looked After Children'. In England and Wales, the term 'Looked After Children' is defined in law under the Children Act 1989.

1.3. A child is 'Looked After' by a Local Authority if they are in their care, or they are provided with accommodation for more than 24 hours by the Local Authority. Looked After Children 'Children in Care' fall into four main groups:

- Children who are accommodated under voluntary agreement with their parents.
- Children who are the subject of a care order or interim care order.
- Children who are the subject of emergency orders for their protection.
- Children who are compulsorily accommodated; this includes children remanded to the Local Authority or subject to a criminal justice supervision order with a residence requirement.

1.4. The term 'Looked After Children' includes unaccompanied asylum-seeking children (UASC), children in friends and family placements, and those children where the agency has authority to place the child for adoption. It does not include those children who have been permanently adopted or who are subject to a special guardianship or residency order.

1.5. Our children in Wigan have requested that we refer to them as Children in Care or 'Our Children' and therefore this will be the name used in this report going forward where appropriate.

1.6. Children in Care share many of the same health issues as their peers however these are often more significant and complex and are more likely to be unmet. Many Children in Care continue to experience significant health inequalities once they have entered the care system. Meeting the health needs of these children and young people requires a clear focus on access to services. This approach can be assisted by commissioning effective services, delivery through provider organisations and ensuring availability of individual practitioners to provide and co-ordinated care.

1.7. The content of this report, subject to approval, will be shared with NHS Greater Manchester Integrated Care Wigan (NHS GM Wigan) via the Safeguarding and Relationship Group and Wigan Corporate Parenting Board. The report focuses on key drivers of work including the local and national context, commissioning arrangements for Children in Care and work with other statutory partners.

1.8. The NHS has a major role in ensuring the timely and effective delivery of health services for Children in Care (Department of Education, 2015) therefore this report includes information about service performance and sets out the objectives and priorities for the coming year.

1.9. As was the case in 2021-2022 the total number of children in care has risen nationally, with local increases also noted. The number of Children in Care to Local Authorities in England rose to **83,840**, **up 2%** continuing the rise seen in recent years National SSDA903 Data Return 2023.

1.10. Both the numbers of children entering the care system and those exiting have increased, at **33,000** children and **31,680** children respectively. The number of children leaving the system nationally due to adoption also decreased by **2%** to **2,960** in total.

1.11. Many of the changes within the data release can be explained by the large increase in unaccompanied asylum-seeking children (UASC) this year. UASC have increased by **29%,** following the **37%** increase seen last year. Wigan has mirrored this increase in UASC, referred to locally as Separated Children.

1.12 The general characteristics of the national CiC cohort remain largely unchanged with males accounting for **57%** of children, females account for **43%.** Over a third of children in the care system are older with a significant proportion of these aged between ten and fifteen years.

1.13. Wigan CiC cohort is in the main very reflective of the national picture in terms of gender and age range however is less diverse with predominantly minimal ethnic variation from White British.

2 Statutory Frameworks, Legislation and Guidance

There are several pieces of legislation and guidance which inform responsibilities and requirements regarding working with Children in Care. The key documents are summarised below:

Legislation for All	Legislation and Statutory Guidance Specific to children
• The Crime and Disorder Act 1998 • Female Genital Mutilation Act 2003 • Mental Capacity Act 2005 • Convention on the Rights of persons with Disabilities 2006 • Mental Health Act 2007 • Children and families Act 2014 • Modern Slavery Act 2014 • Modern Slavery Act 2015 • Serious Crime Act 2015	• Promoting the Health of Looked After Children Statutory Guidance (2015) • United Nations Convention on the Rights of the Child 1989 • Children Act 1989 and 2004 • Children and Social Work Act 2017 • Leaving Care Act (2000) • Working Together to Safeguard Children Statutory Guidance (2018) • Looked After Children: Knowledge skills and competencies of health care staff (2015) • The Care Planning, Placement and Case Review (England) Regulations (2010)
Frameworks and Guidance	
• Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019) • Special educational needs and disability code of practice: 0-25 years (Department of Education and Department of Health, 2015) • Who Pays? Determining responsibility for payments to providers (NHS England, 2015). • NICE Guideline PH28: Looked After Children and Young People (2010, updated 2015) • NICE Quality Standard QS31: Looked After Children and young people (2013) • Future in Mind: Promoting, protecting, and improving our children and young people's mental health and wellbeing (2015). • Who Pays? Determining responsibility for payments to providers (2013) • National Tariff Payment System (2019) • Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (2013) • Guide to the Children's Homes Regulations, including the Quality Standards (2015)	

2.1. The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to CiC inclusive of the provision of a Named Nurse Children in Care and Named Doctor for Children in Care; these have been fulfilled throughout 2022/23.

2.2 The Chief Nurse has executive responsibility for safeguarding; be that adults at risk, children, or Children in Care (CiC) and also represents WWL on both Wigan Safeguarding Adult Board (WSAB) and Wigan Safeguarding Children Partnership (WSCP) Executive Groups of which oversight of CiC are a standard feature. In July 2022 Specialist Children in Care Team transferred from Community Division to join the Think Family Safeguarding Service to ensure a corporate approach to support this cohort of children with full management responsibility not sitting with the Assistant Director of Safeguarding.

2.3. Named Nurse Children in Care, directly line managed by the Assistant Director of Safeguarding, provides the Organisation with operational advice, support and input influenced by strategic vision and awareness.

2.4. A team of specialist Children in Care Nurses and administrators within the specialist commissioned team assist in fulfilling the role and duties required to deliver against statutory obligations for CiC with direct clinical input being a main feature of day-to-day health intervention.

2.5. The WWLTHT safeguarding governance arrangements include the Safeguarding Effectiveness Group (SEG) chaired by the Chief Nurse. SEG receives both monthly and quarterly reports in regard to Children in Care

3 Reflecting Back

The strategic priorities identified through discussion with all our key stakeholders with a drive to ***Improve***, ***Integrate*** and ***Innovate*** and have formed the basis in delivering last year's priorities and ambitions.

Key Priority	Achievements
The CIC Service had benefitted from additional financial outlay in 2022 however the application and impact of this is yet to be fulfilled and therefore it remains a key focus of the organisation and key individuals; a number of audits will be facilitated to demonstrate the outcome of such investment	A Position Statement regarding service priority, based on level of risk and clinical need, was agreed at July 2022 Safeguarding Effectiveness Group and the service included on the Risk Register. A review of caseloads was undertaken to identify any detriment to patient care and the RAG rating tool utilised for ongoing care. The recruitment process has now been completed, and the service removed from the Risk Register in August 2023
Analysis of the health needs of the CiC cohort was an area for further review and development; there was a priority to better understand the changing complexities of this group of children which in turn would further influence service developments and improvements	Profiling was completed and is presented in the patient section of the report and includes profile of Separated Children (UASC) and children identified with or being assessed for neurodiversity, and children with an Educational Health Care Plan (EHCP)
The CiC Service model is focused on 'school-age children' only. Whilst there were no concerns in relation to the quality of health provision delivered by the Health Visiting Teams within 0-19s services there is an unnecessary transition and conflicting care delivery arrangement for children. The CiC Team, supported internally by WWL Senior Leads and Commissioners, will seek to incorporate the 0–4-year-old caseload by ensuring specialist CiC Nursing provision and intervention for all CiC regardless of age	This priority has not been able to progress as anticipated largely due to the challenges with capacity and recruitment within the specialist CiC Team. There will be continued focus and co-working with 0-19s practitioners and service leads to ensure the Public Health Universal model is complimented by the specialist CiC Team for this cohort of children with clearly defined service specifications, pathways and transition criteria agreed. This will be a priority again for 2023/24
A key priority workstream was to consider health outcomes for our Children in Care; in addition to measurement of activity and intervention, the service needed to evidence the impact of the service in terms of health enhancing and promoting behaviours	The team have made some progress in this workstream but there is still work ongoing that is embedded within the team's work plan. An electronic version of feedback questionnaires utilised by the team needs to be explored further. The team have demonstrated the outcomes from service delivery via case studies which are presented via monthly SEG meetings. The team have also been successful in a bid for optimisation of SystmOne to develop data collection in order to further evidence outcomes
Review and revision of IHA and pre-adoption medical pathways is required to improve adherence to statutory and legislative timescales. Co-production with the Local Authority is necessary to yield enhancements in the experience of children, carers, and families	Progress has been made in compliance with the statutory timescale as a result of the joint escalation pathway between the service and the Wigan Local Authority.
Implementation of mandatory CiC training across the organisation in line with the Intercollegiate Document Looked after Children: roles and competencies of healthcare staff (December 2020). An additional programme of partnership training, inclusive of Foster Carers and care placement staff, has been rolled out with specific emphasis on improving health outcomes for CiC	A training session has also been developed and included within the mandatory training for staff working within paediatric departments with a focus on discharge planning and understanding the health needs of CiC

4 Children in Care Service Activity

4.1. Nationally Children in Care numbers are increasing. The number of Children in Care in England and Wales has increased every year since 2010. In 2022/23 the numbers of Children in Care in Wigan increased from **614** to **679**, an increase of **11%**. Throughout the reporting period **242** children started to be 'looked after' by Wigan Local Authority with **180** children ceasing to require state care.

4.2. The WWL CiC Team is responsible for the care of not only Wigan CiC, regardless of placement which can include transfer to another Local Authority area and/or Integrated Care Board (ICB) but also for those CiC placed into the borough by other Local Authorities, identified as CiCOLAs (Children in Care of Other Local Authorities).

4.3. The WWLTH Children in Care Nursing Team use a RAG rating tool (*see Appendix 1)* to rate the complexity and associated need for health intervention. The number of children who require additional support and intervention supplementary to statutory health assessments account for approximately half of the children on the CiC nurse caseloads. This has resulted in a significant increase in demand across every area of health activity related to Children in Care including the number of Initial Health Assessments (IHA), Review Health Assessments (RHA) and Adoption Medicals.

4.4. Children in Care share many of the same health issues as their peers however these are often more significant and complex and are more likely to be unmet. Many children in care continue to experience significant health inequalities once they have entered the care system. The increase in the complexity of the health needs for Children in Care locally is thought to be due to children being taken into the care of the local authority later and the impact of this on children's physical and mental health.

4.5. The mental health of children and young people has been further compounded by the impact of the Covid 19 Pandemic. Nationally and locally, we have seen an increase in the number of children presenting in extreme emotional distress and mental health conditions such as eating disorders. We also know that Children in Care are representative at a higher level in our more targeted services such as Targeted Youth Support Service (TYSS), Complex Safeguarding Team and Special Educational needs and /or disability (SEND) with often co-dependant issues related to health presentations.

4.6. Meeting the health needs of these children and young people requires a clear focus on access to services. The model of service delivery via the Children in Care Team assists this focus by ensuring availability of individual, named practitioners to provide and coordinate care within an assertive outreach model.

Number of Children in Care known to CiC Team – year end March 2023

Cohort descriptor	End March 2023
Number of Wigan Children in Borough (in)	**479**
Number of Wigan Children out of Borough (OOB)	**200**
Number of Children placed in Wigan from other Local Authorities (CiCOLA)	**192**
Number of Children on WWL Health Visitor caseload	**133**
Number of children on WWL CIC nurse caseload	**557**

**Note – Some CiC placed OOB will retain WWL Practitioner, likewise some CiCOLA will not require WWL practitioner intervention as care remains with host LA/ICB*

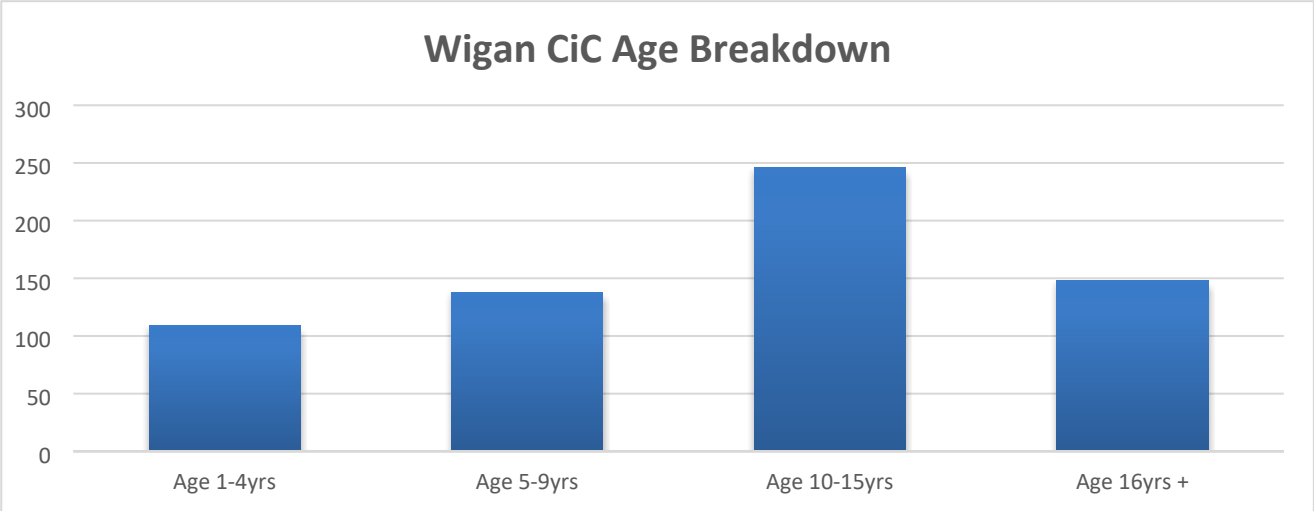
4.7. The numbers evidence a plateau of CiC numbers at year end however comparison of CiC numbers since 2018/19 demonstrates an increase in children placed in the care of the local authority comparable with national figures. At year end the total number of CiC to Wigan Local Authority was **679** with around **36%** at any one time placed outside of the Wigan boundary (*ref: SSDA903 Data return 2023)* whereby alternative health provision maybe provided but oversight by the WWLTH Named Nurse CiC and wider CiC Team must be coordinated and maintained. Of the CiC placed outside of wigan Borough **51** children were placed at a distance of twenty miles or more; this in itself can create additional challenges in terms of continuation and transfer of health provision.

4.8. The CiC Team were also responsible for the provision of statutory care and health interventions to **192** CiC placed in the area by other Local Authorities (CiCOLAs) however this figure throughout the year has been as high as **250** CiCOLA (*ref: SSDA903 Data return 2023*)

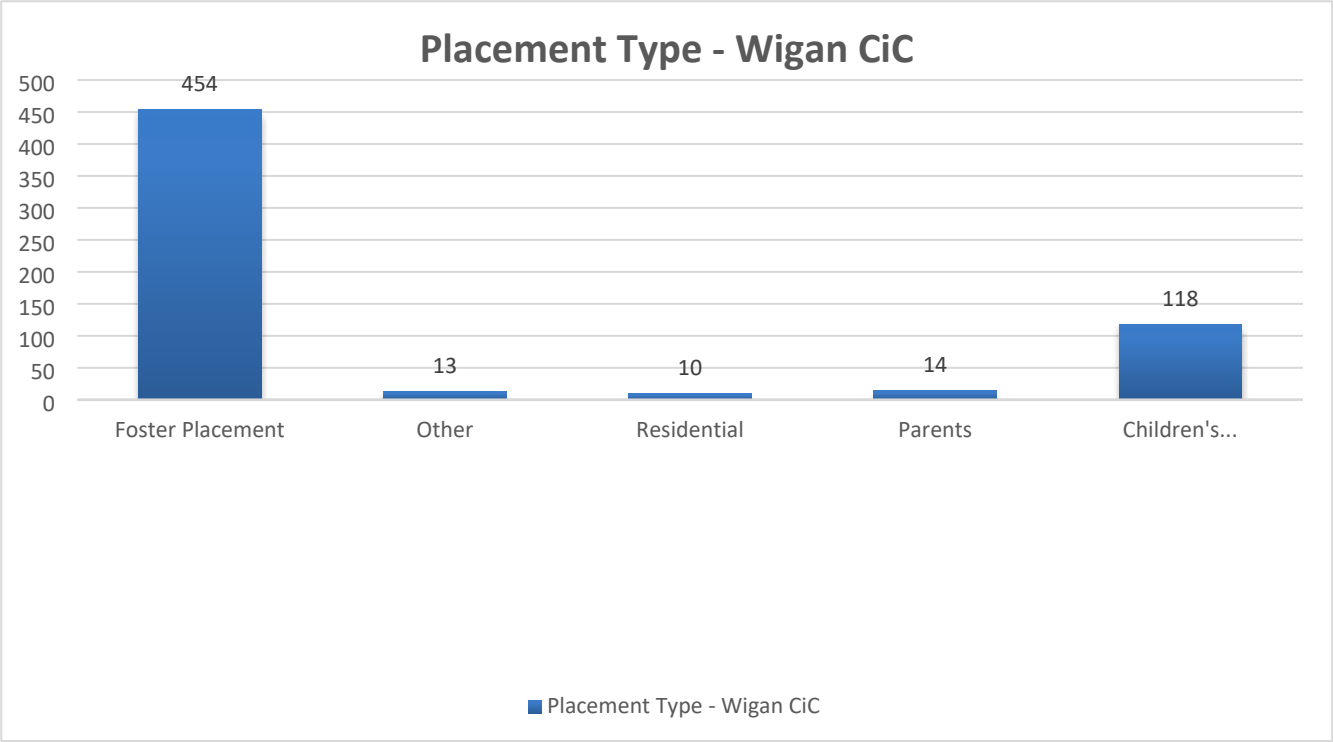
4.9. The complexity of each child and associated need for health intervention following health assessment by Specialist CiC Nurses for children aged four to eighteen years, at year end, can be broken down as follows:

- **84** Children rated **RED**
- **287** Children rated **AMBER**
- **186** Children rated **GREEN**

4.10. It can be seen from this that the current number of children who require supplementary support and intervention in addition to statutory health assessments (those rated as red or amber) account for **66%** of the caseload of the CiC team. The CiC team work closely with the Complex Safeguarding Specialist Nurse to ensure continuity of assessment and care for young people and reduction in duplication of provision. As of July 2022, the line management of the Complex Safeguarding Nurse has transferred to the Named Nurse CiC due to the cross-over in cohort and working practices in relation to CiC and those young people who at risk of or experiencing child exploitation.



4.11. Placement type and stability understandably impacts on the quality of care experienced by children within the care system, in turn this can increase or decrease associated risks linked to health outcomes. It is acknowledged that CiC who remain at home with parents, and some children placed in Residential Settings, may be subject to ongoing or increased levels of abuse and neglect. Whilst numbers in each of these cohorts are significantly lower than those in fostering placements, as is nationally reflected and one of the overarching aims of the recent Care Review, there is anecdotal evidence to suggest these children require and therefore benefit from specialist and more frequent support interventions. This is again an area of review and monitoring by the CiC team and one which can generate increased demands on resource.



4.12. The CIC service has seen a large increase in Separated Children (UASC) over the last twelve months. It is anticipated that this will continue to grow as the national requirements have changed. Wigan Local Authority are now expected to accept up to **1%**, having previously allocated **0.07%** of their entire child population, this equates to approximately **69** children. Wigan Local Authority recorded **40** Separated Children **(6%)** at year end via the SSDA903 return however up to **50** as Separated Children were recorded throughout the year up from **12** children in 2021/22.

4.13. All **50** separated young people were male. **29** of these children were placed out of the Wigan Borough with a further **14** Separated Children placed in Wigan from other Local Authorities. The increase in this cohort of young people identified difficulties in access to interpreters which further impacted on statutory timescales for assessment. At the time of writing the report access to interpreters has improved. The most requested languages are Pashto, Polish, Surami, Arabic, Amharic and there are generally no problems with interpreters for these languages at the current time.

4.14. The CiC Team have also completed caseload profiling of children with an Education Health Care Plan (EHCP); there are **129** Wigan children with an EHCP in place. Records were reviewed to identify if an EHCP plan and annual update were available on the young person record. There were a number of records without an annual update to the EHCP, this was discussed with the Virtual School Head, who acknowledged issues and agreed to escalate to SEND service Lead within the Local Authority. A further review of CIC caseloads was undertaken to identify children that are neurodiverse.

Children In Care identified with or undergoing assessment for neurodiversity

Cohort	Number
Number of children undergoing assessment	**61**
Number of children with diagnosis of ADHD	**181**
Number of children with ASD	**19**
Number of children with ASD and ADHD	**16**

4.15. This cohort of children represents **49%** of the CIC Specialist nurse caseload. These children and their carers require and therefore benefit from specialist and more frequent support interventions which can generate increased demands on resource.

4.16. The team have continued to involve our Children in Care and Care Experienced Young People (Care

Leavers) via consultation and feedback to and ensure that their voices are central to our improvement journey. This is critical in helping us understand the improvements that we need to make and give us the ability to empower people to make positive choices about their health and care. In order to continue to capture the voice and lived experience of Children in Care, a redesign of the questionnaires to an electronic version is planned. Supporting patients to take responsibility for their own health needs and access the most appropriate service when required.

4.17. The team have continued to focus on improving the health literacy of Young People. As Young People prepare to leave care it is important to know where to access health information and use information when making decisions about health. Health literacy can encourage positive lifestyle change and empower young people to effectively manage health conditions. The team continues to provide each Young Person with a copy of a Health Passport before their eighteenth birthday. The team continues to improve, innovate, and involve Young People in this process and have planned consultation work to redesign the Health Passport.

5 CiC Staffing, Supervision and Wider Organisational Support

5.1. Extra investment into the CiC Service in 2022 has seen the recruitment of additional nurses and administrative staff; however, this additional resource has then been impacted by maternity leave, sickness, and retention of staff.

5.2. Throughout the financial year the CiC service continued to manage care delivery despite the sustained capacity and demand challenges. The nursing team have maintained a flexible and responsive approach to ensuring statutory health assessment completion and provision of health interventions by utilising caseload management via the RAG rating process and close working with key partners to ensure effective prioritisation.

5.3. Staffing issues associated with sickness, recruitment difficulties due to knowledge and skills required, and maternity leave in the CiC team impacted on performance data due to the backlog created. This was raised and discussed both internally with senior leads and externally with Head of Service in the Local Authority and Designated Nurse colleagues within NHS GM Wigan.

5.4. Administration provision for Initial Health Assessment (IHA) clinic management was transferred from within WWLTH Community Paediatrics Service to the CiC Team administrators. This has resulted in a clear oversight of the Statutory timescale adherence and management of weekly escalations to the Local Authority.

5.5. All Specialist CiC Nurses receive three-monthly safeguarding supervision facilitated by the Specialist Safeguarding Children Nurses within the Think Family Safeguarding Service. Additional supervision was also available via the Named Nurse for CIC and the Lead nurse CIC due to the increase in CiC complex cases with an offer of face to face reactive and responsive supervision, advise, support and guidance.

5.6. Safeguarding Supervision is considered in an adapted Signs of Safety context referred to as 'Signs of Success' for CiC to allow a strength-based approach; consideration of what works well, what practitioners are worried about and what needs to happen is fundamental to eliciting change for children whilst effectively managing risk. Supervision and escalation are intrinsically linked with adaptations to supervision templates and recordings reflecting discussions whereby drift and delay in multi-agency intervention and care plans may result in lack of protection and increased incidence of harm.

5.7. The planned optimisation of SystmOne will improve data collection processes allowing clinicians more time to focus on clinical intervention and to further evidence outcomes. It will also allow practitioners access to the right information at the right time.

5.8. The ability of health care staff to recognise and respond to safeguarding concerns for CiC and Care

Experienced Adults is influenced heavily by the provision of high quality, up to date, relevant training. The Trust has a statutory and contractual requirement to demonstrate how it will educate and train its staff on the safeguarding agenda. The Think Family Safeguarding Service, now inclusive of the Named Nurse CiC, supported by Learning and Development Colleagues lead on developing and coordinating a comprehensive training offer to ensure all staff achieve the appropriate level of skill, knowledge, and competence commensurate to their roles.

5.9. Further developments to raise awareness of CiC and Care Experienced Adults have been developed within Bitesize Training sessions regarding the impact of Trauma and Adverse Childhood Experiences. There is an additional need to ensure all relevant Trust Policy and Standard Operating Procedures are reviewed with a view to adherence from an 'acute' perspective of pathways and process involving CiC.

5.10. Child Safeguarding Practice Reviews (CSPRs) have involved Children in Care with a number of Serious Adult Reviews (SARs) relating to those with prior care experience. These reviews have traditionally been overseen and inputted from a WWL perspective by the Named Nurses for Safeguarding Children and Adults however it is seen as crucial to improve learning across the Organisation that future training and workforce developments required as a result of such reviews are influenced by the knowledge and experiences of the Named Nurse Children in Care. The move of the CiC Team to the Think Family Safeguarding Service in July 2022 is a positive in ensuring wider organisational awareness of the health needs of Children in Care and Care Experienced Adults is a priority.

5.11. The team have continued to raise awareness of CiC and Care Experienced Adults across the Trust via a number of appeals via the WWL Communication Team with the full support of the Executive Team. There was a Christmas Appeal and an Easter Appeal for donations with an overwhelming response from the WWL family.

6 Corporate Parenting

When a child comes into care, the Local Authority becomes the '*Lead Corporate Parent*'. The term 'corporate parent' means the collective responsibility of the council, elected members, employees, and partner agencies, for providing the best possible care and safeguarding for the children who are in the care of the Local Authority.

6.1. WWL have a duty to provide the best possible care and safeguarding for the children who are looked after by us. As Corporate Parent we want to see our children flourish with good health, to be safe and happy, to do well at school and enjoy good relationships with their peers. To make the most of leisure opportunities, hobbies, and interests, and to grow towards adulthood equipped to lead independent lives and make their way as adults in higher education, in good careers and jobs, and to be financially secure.

6.2. The Named Nurse CiC attends Corporate Parenting Operational Group and sits on the appropriate subgroups to progress workstreams which include the Safeguarding Children Partnership and Health and Wellbeing subgroups plus Signs of Success subgroup (modified from Signs of Safety specifically for Children in Care). This group has priorities across areas including participation and engagement, aspiration and opportunity, independence, placement permanence and stability. The Assistant Director of Safeguarding, supported by the Named Nurse CiC, represents WWL at a strategic level via attendance a Wigan Corporate Parenting Board.

6.3. The Named Nurse CIC and WWL Talent for Care Apprentice Co-Ordinator have progressed the WWL offer of upcoming programmes and apprenticeships for Care Leavers. There is a planned Introduction day for 17th August 2023; the programme is two weeks online with Princes Trust and then 8 weeks on placement 3 days a week in positions of ward helper or administration roles. Pastoral support is provided by the WWL team and there is also support in applying for jobs and interviews. There is also a guaranteed interview agreed by WWL Head of Human Resources. Referrals to the programme are made directly to The Princes Trust. The success of this programme will be monitored and reported in future Annual and Quarterly reports.

7 Contribution to further Multi-agency Forums and Activity

7.1. Work has continued regarding Children in Care with SEND, with particular focus on Education and Health Care Plans (EHCP) alongside increasing emphasis on the provision of mental health support for CiC with the Named Nurse CiC attending the therapeutic mapping meetings to support this work. Profiling of the caseloads has ensured that the EHCP is incorporated within the annual statutory Review Health Assessment.

7.2. It is recognised that there is an increasing need, particularly following the pandemic, to support the mental health of children in our care. There has been a secured agreement for a mental health practitioner (employed by Greater Manchester Mental Health NHS Foundation Trust) to attend the Care Leavers Hub to offer support, alongside practitioners from the WWL CiC Team.

7.3. Mental health challenges remain a significant issue due to increased waiting lists for specialist mental health support. As part of the therapeutic mapping meetings a business plan was formulated to commission a bespoke emotional and mental health wellbeing offer for Children in Care.

7.4. Wider multi-agency work completed via the Corporate Parenting Board and Operational Group supports placement stability for the children in our care. In addition to these groups the Named Nurse CiC attends Placement Stability and Permanence Panels to provide an expert view into the process. The commencement of these supportive discussions and planning meetings is reported to

have improved several placements which has had a positive effect on the lives of the children being considered.

7.5. Additional to the strategic and operation commitment to partnership working is the day-to-day activity carried out by the specialist and Named Nurse CiC associated with individual children. There is an increasing requirement for attendance at not only statutory 'Children Looked After' reviews to inform and influence holistic care planning but additional Strategy Meetings, Care Planning Meetings and Professional Meetings. There is a direct correlation between the increasing number and complexities of CiC and the demand and capacity on the team to participate in this activity.

7.6. The depleted and under resourced CiC Team have worked tirelessly to ensure effective contribution to children's meetings to influence good care planning, management of risk and consideration of health needs when requiring placement change.

7.7. The CiC Team further support development of the wider workforce by contributing to multi-agency training for Foster Carers and working closely with placement providers of Residential Care and Supported Accommodation to improve health outcomes utilising referral and signposting to services. This is a key area for further development in 2023/24 with a plan to increase the offer of Drop-ins at residential homes. The Named Nurse also attends a newly developed working group with residential placements within the borough to develop and strengthen relationships.

7.8. The team have continued to improve and innovate whilst exercising their corporate parenting responsibilities in progressing work experience opportunities and employment within WWL for our Care Experienced Young People. This project is in its early stages, and we will continue to work with Our Talent for Care Team and the Local Authorities Aspiring Futures team to progress these opportunities.

8 Transition

8.1. The CiC Team and WWL as a whole continue to place our children and young people at the centre of service redesign, recognising their expertise in their experience of care and ensuring they have an influential voice. We will learn from the experience of our children in care to redesign our pathways to meet their needs and expectations. In practice, this will mean seamless single pathways instead of a series of interactions with health and care professionals in different parts of the system.

8.2. The CiC Specialist Nurses will utilise *Every Contact Counts*. Preparing to leave care is a significant time and it is important to know where to access health information and use information when making decisions about health. By promoting their health literacy, it can encourage positive lifestyle change and empower them to effectively manage health conditions. Each young person will receive a copy of a Health Passport before their eighteenth birthday and a copy of their final health plan. The CiC Specialist Nurse will inform the GP of any health needs and they will be entitled to free health prescriptions until the age of twenty-five years.

9 Pre – Adoption Activity

9.1. Most of the pre-adoption support is offered to children who are held on the WWL Health Visiting caseload due to the age at which most children are placed for adoption. Children subject to pre-adoption processes on the caseload of CiC Team are assessed and rated as 'Amber or Red' based on level of need with consideration of the new placement; families are offered a monthly or three-monthly contact to provide any ongoing advice and support around parenting or any unmet health needs and/or investigations.

9.2. The allocated Specialist CiC Nurse is responsible for attendance at care planning meetings and CLA reviews and close liaison with the previous health care professional to ensure referrals are made into Wigan services if the child has been transferred from another Local Authority. If the child is already under the care of services in the originating area, then the allocated CiC nurse will ensure a transfer is made swiftly as opposed to discharge and new referral which causes lengthy, unnecessary delays.

10 Service Specification Children in Care Health Team

10.1. The CiC Team is commissioned by NHS GM Wigan under an agreed service specification that is outstanding review and update for 2023/24. The service is measured against a number of locally defined outcomes which are in the main reflective of national performance indicators reportable by the Local Authority. These indicators (SSDA903) provide performance data that is required by central government from Children's Social Care departments.

10.2. Performance of the service is determined via agreed Key Performance Indicators (KPIs) and scrutiny of the adherence to the agreed standards for Children in Care. The current KPI schedule is collated quarterly and presented to the Safeguarding and Relationships Group (formally IQSG) following approval at SEG. Additional reporting monthly is provided internally to WWL to ensure robust oversight and response to emerging challenges that may impact KPI returns.

10.3. Whilst activity in relation to Initial Health Assessment (IHA) timeliness is not included within the national SSDA903 reporting, there remains a requirement for the service to support and therefore highlight the completion of such. A significant part of the CiC Team's service delivery is associated with IHA completion with subsequent health intervention and care provision often deriving from early identification of health need upon children's entry into the care system.

10.4. The Safeguarding and Relationships Group is a subgroup of the NHS GM Wigan Clinical Governance Committee. The Group reviews and monitors compliance against statutory safeguarding responsibilities using the 'NHS Provider Safeguarding Audit Tool' included in the contract. Sixty-seven Key lines of Enquiry (Standards) are reviewed by the Designated Nurses alongside the WWLTH Think Family Safeguarding Service and eleven of these standards are specific to Children in Care. Of these eleven standards, all **eleven** standards were rated as **GREEN** and therefore fully compliant, a repeat of the compliance in 2021/22.

11 Initial Health Assessment (IHA) Performance

11.1. Initial Health Assessments (IHA) are required to be completed within twenty working days of a child entering care. All Initial Health Assessments are completed by a qualified doctor which is a requirement set out in Statutory Guidance. The IHA should result in a health plan, which is available in time for the first statutory review by the Independent Reviewing Officer (IRO).

11.2. To succeed with the twenty working day target, there is a reliance on the establishment of effective partnership working and excellent communication pathways. Children's social care and commissioned health services must work proactively together to facilitate timely assessments. Timely notification from the Local Authority to advise of 'care' status is essential however notification is just one step within the IHA pathway to be completed if compliance with statutory timescales is to be achieved. Streamlined provision that considers available resource, robust communication and a shared understanding of practitioner/organisational responsibilities is also required. Concerns remain that this process is not being fully utilised, contributing to the delay in assessment experienced by some children.

11.3. The ongoing delay in receipt of statutory paperwork from Children's Social Care in Wigan has been escalated via NHS GM Wigan to Social Care management with training provided by the Named Nurse CiC to educate new Social Workers and those new to Wigan regarding the process and forms for completion. Reoccurring instances remain escalated to the named social worker by the CiC Administration Team and to Social Care management by Named Nurse CiC as they arise. Despite these agreed escalation process and individual case discussions there remains significant delay for some children receiving IHA within statutory timescales.

11.4. Additional oversight and responsibility for CiC placed outside of Wigan and those placed by other

Local Authorities is required by the WWLTH CiC Team however there are many factors at play in achieving 100% compliance with the timescale threshold as set within national guidance. For Wigan CiC placed out of area there is reliance on other health teams to facilitate the assessment process; for the CiCOLA cohort it is often the case that significantly delayed notification of new into care status means completion of entire pathway within twenty working days is unachievable from the outset.

11.5. There continues to be robust monitoring and analysis of IHA compliance by the CiC Team, of which it is recommended is featured as part of regularly reporting to Wigan Corporate Parenting Board to further elicit response and reaction to performance challenges and barriers to improvement.

11.6. Detailed analysis of the entire pathway, incorporating audit of the child's journey is to be completed in the coming year, this will map performance across all parts of the IHA pathway against an adapted NHS England IHA exemplar pathway.

11.7. Overall, in 2022/23 out of **218** CiC requiring IHA, inclusive of those placed outside of Wigan and CiCOLAs, **60** children **(28%)** were seen within twenty working days. This is an area for improvement in terms of compliance however more robust analysis of the data and pathway in full is required to understand specific challenges and therefore influence changes in practice and/or process.

12 Review Health Assessment (RHA) Performance

12.1. Review Health Assessments (RHA) are a statutory requirement for all CiC and are required to be completed every six months for children under the age of 5 years and annually for children over this age. The RHA is a holistic assessment including emotional wellbeing and physical health. The recommendations and health plan from all RHAs are shared with the child's social worker (SW) and Independent Reviewing Officer (IRO).

12.2. Health Visitors within the Local Authority commissioned 0-19 Service complete the assessments for children under five years, whilst the Specialist CiC Team complete assessments for school age children and young people up to age eighteen years. There are agreed pathways and commissioning arrangements that identify the lead service for Wigan CiC placed out of area and CiCOLAs.

12.3. There have been well muted national challenges in terms of health responsibility for children who are placed outside of their host authority; from a Wigan CiC Team perspective this can often mean maintaining caseload responsibility for CiC placed at distance or delivering a service to CiCOLAs whereby a reflective arrangement is often not reciprocated. The CiC Team continue to work closely with service leads, local and national Named and Designated professionals to ensure all CiC, regardless of origin or placement, receive timely assessment of health needs.

12.4. All RHAs for children assessed as 'Red or Amber' were prioritised for completion within timescale during this reporting period however similar to IHA processes there is a reliance on effective cross-boundary working but also sufficient in-house resource to meet demands of the cohort.

13 Registration with GP Performance

13.1. The CiC team have a KPI of **100% GP registration** for the children on caseload and this is reviewed at IHA and at each RHA to ensure support can be provided should carers be struggling to register children. At the end of Q4 2021/22, **100%** of children receiving assessment from or coordinated by WWLTH CiC Team were registered with a GP.

14 Dental Checks for Children in Care

14.1. The CiC team have a KPI of **100% registration with dentist** for the children on caseload and **100% attendance for yearly dental check-up**. All CiC are encouraged to register with a local dentist of their choice and advice relating to oral hygiene is provided by health practitioners when completing statutory health assessments. Practitioners must record the dental practice and dates of appointments attended with this information assisting the Local Authority in confirming compliance with routine dental checks as part of the SSDA903 return.

14.2. It is recognised that Children in Care may have difficulty in accessing dental health services in their

local area due to capacity issues in dental practices. In order to support Children in Care who are unable to register at a dental practice by the usual method the Named Nurse CiC is a referrer for the *Referral Pathway for Looked after Children to General Dental Practices in Greater Manchester for Routine Care* which ensures access for all. All children on CiC caseloads will be issued with a letter to present at dental practices requesting prioritisation, should this not be successful referral to the scheme will be facilitated.

14.3. There have not been any referrals made to GM pathway due to inability to access local dental provision within Wigan. Unfortunately, this picture is not replicated for our Care Experienced Young People. They are not eligible for referral on the *Referral Pathway for Looked after Children to General Dental Practices in Greater Manchester for Routine Care* and there is no provision for priority registration. Care Experience has now become a Protected Characteristic and further discussions need to be held with GM ICB to focus on addressing this issue.

15 Immunisation Status of Children in Care

15.1. The CiC team have a KPI of **100% compliance with routine childhood immunisation schedule** for the children on caseload. Specialist CiC nurses are responsible for encouragement of this public health offer and for assessment of the need for alternative ways of working to support carers to access immunisation programmes. There was a slight reduction in immunisation compliance which echoes Greater Manchester statistics and is indicative of a reduction in consent for school age immunisation schedules across all areas.

15.2. The CiC team have several specialist nurses who are able to offer immunisation in the home environment. In order to facilitate this the Named Nurse CiC is collaborating with the Immunisation Lead in 0-19 service to support the management of this cohort of CiC who benefit from a more flexible approach to routine provisions.

16 Overview of SSDA903 Indicators for Wigan Children in Care

16.1. The number of children who have been in care for a period of twelve months or more, is identified as the qualifying cohort for the SSDA903 return to Central Government. A cohort of **481** Wigan children was identified as being 'Looked After' for a period of more than one year and therefore eligible for reporting within the SSDA903 return.

16.2. Children who have remained in care for a period of more than one year should experience an improved quality of life, not least of all evidenced improvements in holistic health. The SSDA903 return provides crucial data to both the Local Authority and Integrated Care Board in understanding the needs of this cohort to enable the commissioning of health services which are able to focus on improving outcomes.

16.3. SSDA903 data tables are published yearly and provide an overview of national, regional, and local performance against a wide range on indicators inclusive of those specially designed to demonstrate health outcomes.

16.4. Data in relation to completion of RHA, Development Checks, Immunisation status, Dental Checks, Substance Misuse concerns and Strengths and Difficulties Questionnaires (SDQs) are all captured. The SDQ is a short behavioural screening questionnaire whose primary purpose is to give social workers and health professionals information about a child's wellbeing. A score of 0 to 13 is considered normal, 14 to 16 is borderline, and 17 to 40 is a cause for concern. The following table shows performance against all these metrics for Wigan CiC alongside the reported national averages.

SSDA903 Return Data for Wigan CiC 2022/2023

National Performance Indictor	Wigan Borough	National Average
% of Children in Care who have had a health assessment in the last 12 months	**96%↓ (CiC Team report 98%)**	**89%↔**
% of Children in Care who are up to date with immunisations	**87%↑ (CiC Team report 94%)**	**82%↓**
% of Children in Care who have had an annual dental check in the last 12 months	**84%↑ (CiC Team report 92%)**	**76%↑**
% of Children in Care with an up-to-date developmental assessment (under 5's)	**100%↔**	**88%↓**
% of Children in Care aged 5-16 years with SDQ score reported (completed by CIC nurse)	**75%↓ (CiC Team report 93%)**	**75% ↓**
% of Children in Care identified as having substance misuse concerns	**2%↓ (CiC Team report 6%)**	**3%↔**

*NB Data reported in the 2021/22 Annual Report differs from that shown in the SSDA903 data online as per issues below

16.5. As can been seen in the above table there are continued challenges with transfer of data from health systems to Local Authority systems. Despite significant inputting being completed by the CiC Team onto Local Authority records there remains a data lag and conflicting inputting resulting in a lower submission to Government than is evidenced within CiC health records.

16.6. Significant challenges were faced by the CiC Team in ensuring effective SSDA903 reporting due to reduced capacity but also challenges accessing the Local Authority system, The 903 cohort was also not simple to define, and the delay of information being received by out of area health teams for Wigan CiC placed at distance further compromises the final submission.

16.7. Regardless the centrally reported data against the indicators in relation to health and developmental outcomes remains higher than the national average. Where there is a downward trend in performance noted this is reflective of the national trends seen across the country. Wigan CiC Service has a longstanding and proud history of supporting the Local Authority in achieving positive SSDA903 returns, and it is anticipated that in 2022/23 these figures will again continue in an upward trend back to pre-pandemic levels. This will be further supported by increased nursing and administrative resource that can facilitate assertive outreach to engage children in health enhancing activities alongside robust overview and analysis of timescales and outcomes.

16.8. In terms of substance misuse, the number of CiC in Wigan with identified substance misuse concerns by the specialist nursing team has decreased on previous year but is still double that of the national average however the data reported by the Local Authority shows a lower than national average rate

16.9. Caution however must be exercised in understanding the context behind this data; it may well be the case that CiC in Wigan, or the child population of the borough in general, has experienced an increase in use of illicit substances but it must also be considered that the 'screening' of concerns occurs during completion of RHA or during a health intervention. As Wigan offer a specialist CiC Nursing Service that performs well against requirements for RHA completion but also sees children at frequent and increasing intervals based on need and risk, it could be considered that the figures for Wigan reflect a positive in terms of recognition and response as opposed to increasing drug use within the CiC cohort.

16.10. In terms of SDQ data, the data reports on Wigan children living within Wigan that had an SDQ completed by the CIC team. It does not incorporate SDQ for Wigan children placed out of borough (completed by social worker), the final cumulative data is awaited from Wigan Local Authority.

17 Achievements and Challenges

17.1. The reporting year has seen an increased demand in terms of complexity, transiency of the population, availability of supportive services and provision alongside challenges with staffing capacity and resource across all areas.

17.2. Opportunities to continue to innovate and utilise in relation to changes in practice were embraced alongside a steadfast determination to implement interventions that would support CiC in the aftermath of such.

17.3. The 903 Statutory Data return (SSDA903) identified **96%** of Wigan Children (**98%** as per CiC Team data) had their statutory health assessments completed within the year regardless of placement but for those Wigan CiC remaining in borough and therefore accessing WWLTH services **100%** had their statutory health assessment completed.

17.4. The CiC Team continued the health drop-in for Care Leavers. This is delivered jointly with Spectrum Healthcare and allows care leavers the opportunity to attend the Care Leavers Hub for health advice. There is open invite to the Drop-In sessions at the Care Leavers Hub, where young people can seek out health advice and support. Care leavers also have access to the Children in Care Specialist Nursing Team for health advice and support, up to the age twenty-five.

Case Study example of Specialist CiC Nurse Intervention

Setting the Scene	To maintain confidentiality, in line with NMC guidelines and adhere to data protection guidance, the young person referred to in this case study will be named 'Simon'. Simon is 17 years old and became accommodated under Section 20 by Wigan Local Authority. He has been exposed to many Adverse Childhood Experiences throughout his childhood, having witnessed domestic abuse, maternal alcohol misuse and he had made disclosures about neglect. This resulted in a breakdown of family relationships and Simon reporting that he would rather be taken into care than live with family members.
Overview and actions	Simon lives in a semi-independent placement in the Wigan area. He is provided with 15 hours support from a keyworker who helps him with his pathway to independence. The aim is for Simon to leave care at eighteen with the necessary skills to enable him to live independently. Simon attended A&E in April 2022 with abdominal pain; he did not wait to be seen. He attended alone but informed staff that he had a Social Worker as he was a young person in care which triggered the WWL Safeguarding Children Team via A&E HIS Notification, to inform the CIC team of his attendance. His CIC nurse visited his placement to check on his welfare, however he had gone out and staff were unsure when he would return. They were unsure of the full details of his abdominal pain as he wasn't very open with staff and avoided discussions about his health. Trauma informed practice is grounded in the understanding that trauma exposure can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional, or spiritual well-being. A key aspect of the CiC nurse role is to build relationships with children and young people and hope that having safe, compassionate, empathetic, and trusting relationships can buffer the impact of trauma.
What was the outcome	Over several months his CIC nurse visited his placement in an attempt to build a relationship with Simon. After several visits he eventually asked for a chat, in a location of his choice. He said that he was worried about his health, but he felt overwhelmed by medical jargon. He had been suffering with intermittent abdominal pain for approximately nine months. He had also made several GP appointments then cancelled at short notice as he was anxious. The CIC nurse was able to complete a holistic review of Simon's health and supported him to arrange a GP appointment. She also supported him to attend the appointment, which then resulted in a referral to a specialist medical team for further investigations. Simon was supported to access health services that he had previously avoided due to fear. The building of trust was integral to accessing support. Simon was seen by his CIC nurse in an environment he was comfortable in, and he received the reassurance that he required. Simon was also supported to understand medical jargon and improve his health literacy.

18 Key Priorities for 2023/2024

The four Ps – Patients, People, Performance and Partnerships encapsulate the areas on which we want to focus our development and improvement. The four Ps will form the focus of our annual objectives which will be reviewed annually and include measurable goals to keep us on track to deliver our ambitions. Key to delivering these ambitions are the strategic priorities that have been identified through discussion with all our key stakeholders: **Improve, Integrate and Innovate.**

Key Priorities
➢ The CIC Service has benefitted from additional financial outlay in 2022 which in turn has increased resource and capacity however the application and impact of this is yet to be fulfilled and therefore it remains a key focus of the organisation and key individuals – Review and reorganisation of caseloads is to be implemented in 2023/24 to ensure resilience should future challenges with capacity arise. The service will move from a 'Locality' model of delivery to a geographical team split that considers the newly defined Wigan Borough Service Delivery Footprints (SDFs). Audits will be utilised to reflect the success of the changes
➢ The CiC Service model remains focused on 'school-age children' only however it remains an ambition to ensure an equitable offer of specialist provision regardless of age for all CiC with a move to make the service 0-18yrs. Additionally there will be a review of the Wigan Adolescent Offer by the partnership as a whole; this will involve consideration of the current Complex Specialist Nurse post and the offer to Young Offenders. Joint working with WWL Community Division will be a priority to ensure the best possible, cost-effective service offer for children who require targeted and specialist health input
➢ A key priority workstream remains evidencing outcomes; in addition to measurement of activity and intervention the service needs to further integrate the 'So What?' to provide next level assurance whilst evidencing the impact of the service in terms of health enhancing and promoting behaviours. Optimisation of functionality of SystmOne is underway to assist with collation of this data alongside the development of electronic feedback questionnaires – this will be applied and analysed in 2023/24 as a significant priority
➢ There is a training need for the service regarding Separated Children (UASC). This cohort of young people have a specific set of health needs, an increase in knowledge will assist the team in developing pathways and ensuring a trauma informed response from services. The service will continue to contribute to the Therapeutic Mapping meetings and will assist in the oversight, monitoring and tracking of the outcomes from the introduction of the commissioned psychological service (The Meadows).
➢ The service plan to complete consultation work to enable a redesign of the Care Leavers passport but in addition to this review the entire offer for young Crae Experienced Adults (Care Leavers aged 18-25yrs) in line with the Borough's Corporate Parenting Promise.
➢ To maintain the achievement of 'GREEN' rating against all eleven CiC standards within the 2022-2023 Audit Tool to measure NHS Provider compliance with the legislation and statutory guidance in relation to Safeguarding Children, Young People and Adults at Risk and Looked After Children reviewed by NHS GM Wigan on an annual basis.

19 Conclusion

The Children in Care Team has experienced several challenges throughout the year particularly in regard to staffing, capacity and demand which has negatively impacted service delivery. All posts have now been recruited to and awaiting commencement to post. This is creating a culture of improvement and innovation with a boosting of morale and desire to make things better for this cohort of children.

Whilst a business case has been approved and a review of team structure has taken place there is a period of growth and implementation required to ensure the positive impact of such investment, not only for the organisation but the partnership and more importantly the cohort of children as a whole**.**

The data and narrative provided within this report presents a summary of activity across the CiC service, and WWLTH in its entirety, throughout 2022/23 culminating in a picture that demonstrates acceptable levels of assurance in regard to the discharge of statutory duties.

The CiC Team is focussed on promoting the best possible outcomes for Children in Care and Care Experienced Adults considering the value of impact and outcomes from a patient centred perspective by analysing the 'So What?' of every possible contact.

The CiC Team, the wider Think Family Safeguarding Service and WWLTH remain committed to meeting the health needs of the Children in Care population of Wigan Borough and will continue to work collaboratively with NHS GM Wigan, the Local Authority, Corporate Parents, and key partners to continuously improve systems and quality of care.

APPENDIX 1

Children in Care Caseload RAG Rating Tool

Red = visit/contact 1 monthly dependent on need	Tick that apply
1. Resident in children's home **WITH** safeguarding concern/ unmet health needs	
2. Poor attendance at school or NEET **WITH** safeguarding concerns/ criminality etc	
3. Unstable placement/ frequent moves	
4. Medical condition not managed or not under control	
5. Escalating emotional and behavioural issues e.g., anger, self-harm, anxiety, low mood	
6. CSE risk, Missing from home	
7. Criminality, missing from home	
8. Frequently missing from home	
9. Living at home with parents with safeguarding concern/ unmet health needs	
10. Concern re, safety and risk substance misuse, sexual health concerns	
11. Other- please state	
Amber = visit/contact 3 monthly dependent on need	
1. Average attendance at school	
2. Unsettled or change in placement	
3. Medical condition that is managed but needs oversight	
4. Low level emotional behavioural (accessing CAMHS/counselling)	
5. Missing from home episodes	
6. New move to pre adoptive placement	
7. Neurodevelopmental disorder / investigations	
8. Outstanding immunisations	
9. Resident in children's home but no safeguarding concerns	
10. Other – please state	
Green = visit/ contact 6 monthly dependent on need	
1. Settled in college/school	
2. Settled in placement for over 6 months	
3. No medical condition	
4. Minimal limited emotional behavioural difficulties	
5. Other - please state.	

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Maternity and Neonatal Dashboard Report
Presented to:	Board of Directors
On:	7.February 2024
Presented by:	N/A – consent agenda
Prepared by:	Gemma Weinberg Digital Midwife / Simon Needham Neonatal Unit Leader for Cathy Stanford Divisional Director of Midwifery 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 of Directors are asked to note the November 2023 dashboard and overview of indicators as outlined below.

Maternity and Neonatal Dashboard December 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.

December 2023 Exception report - Maternity
Summary

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

- There were three midwifery red flags reported. It should be noted here that the method of collecting red flag reports has changed from last 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 December 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 December, but the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

Steis reportable Incidents

There were no Steis incidents reported in December. The unit was placed on divert on one occasion due to issues with medical staffing – this has been reported to Steis in January.

Green

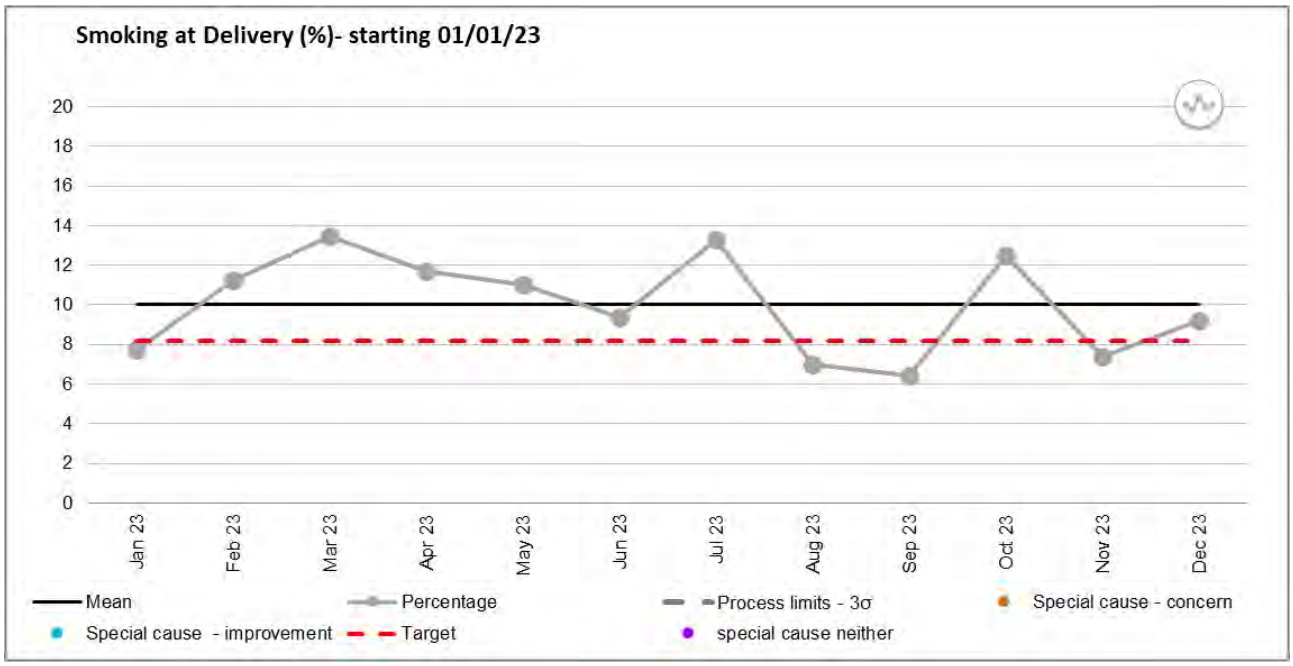
Women booked by 12+6 weeks This has remained consistently green for more than 12 months. We are performing better than most trusts in GM for this metric.

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

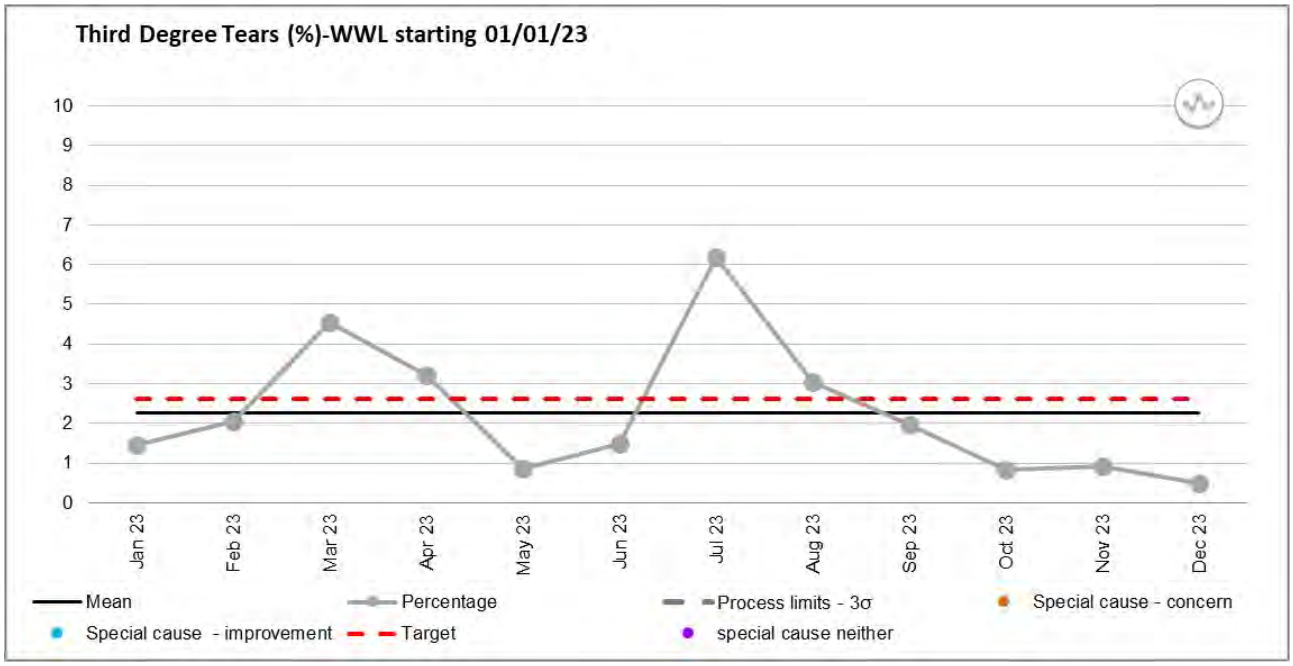
The number of mothers who have opted to breastfeed – This saw a significant drop in July, but figures have improved in the subsequent months. Work continues to improve this metric.

Supernumerary Shift coordinator – This remained at 100% in December.

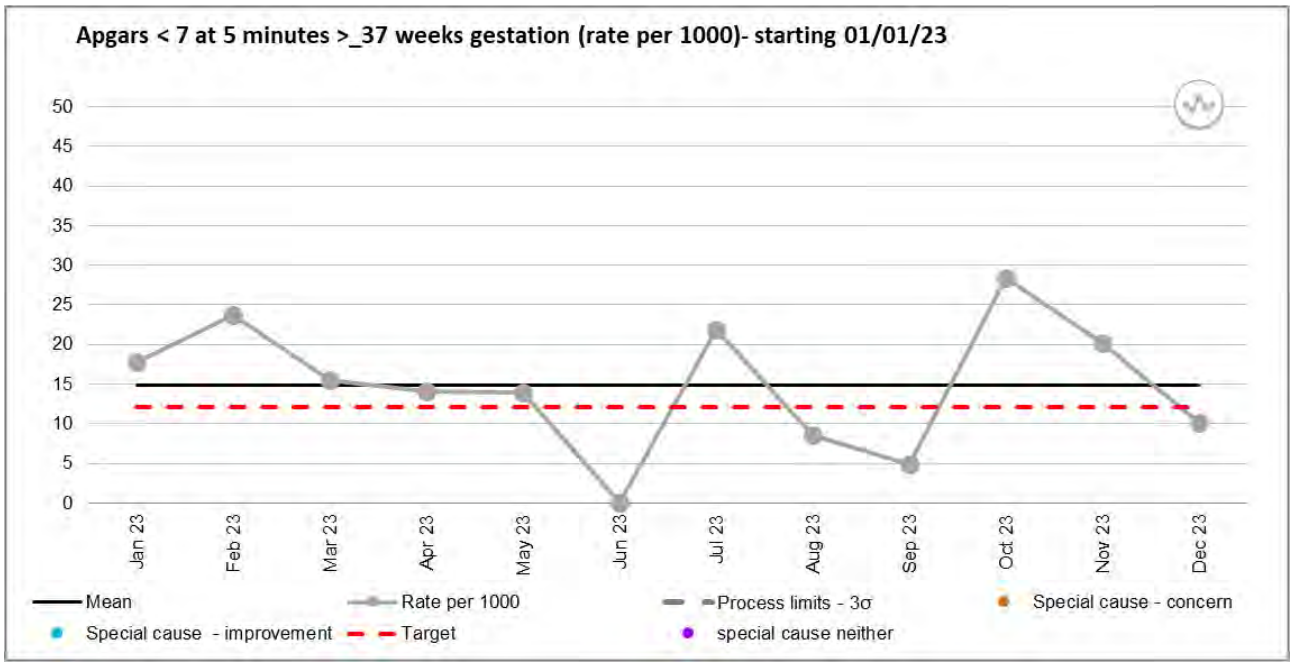
Smoking at the time of Delivery (SATOD). This saw a significant drop in the August and September figures. October saw a spike in the figure, but this has seen a drastic decrease in November. December shows another slight uptick. Work continues to promote and encourage smoking cessation throughout pregnancy. The below SPC chart shows our SATOD rates in comparison to GM. It can be seen that in August, September and October 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 figure for December equates to one woman who had a 3rd degree tear. The below SPC chart shows how we compare to the rest of GM for this metric (red line).



All infants with Apgar's less than 7. This saw a spike in October with a slight drop in November. December sees this metric returning to green levels. All cases are fully investigated. The below SPC chart shows how our figures compare to the GM average (red line).



Amber

Bookings. October and November saw these returning to green levels. However, December sees a further drop to amber levels. A similar pattern can be seen last December.

PN Length of stay – this saw a spike in October but has dropped back into amber levels in November and December.

Number of registerable births. The metric had remained at green levels for the past four months. December sees a slight dip into amber levels.

Women readmitted within 28 days of Delivery. There were 2 maternal readmissions recorded in December. One was for a UTI and one was for leg pain (?DVT).

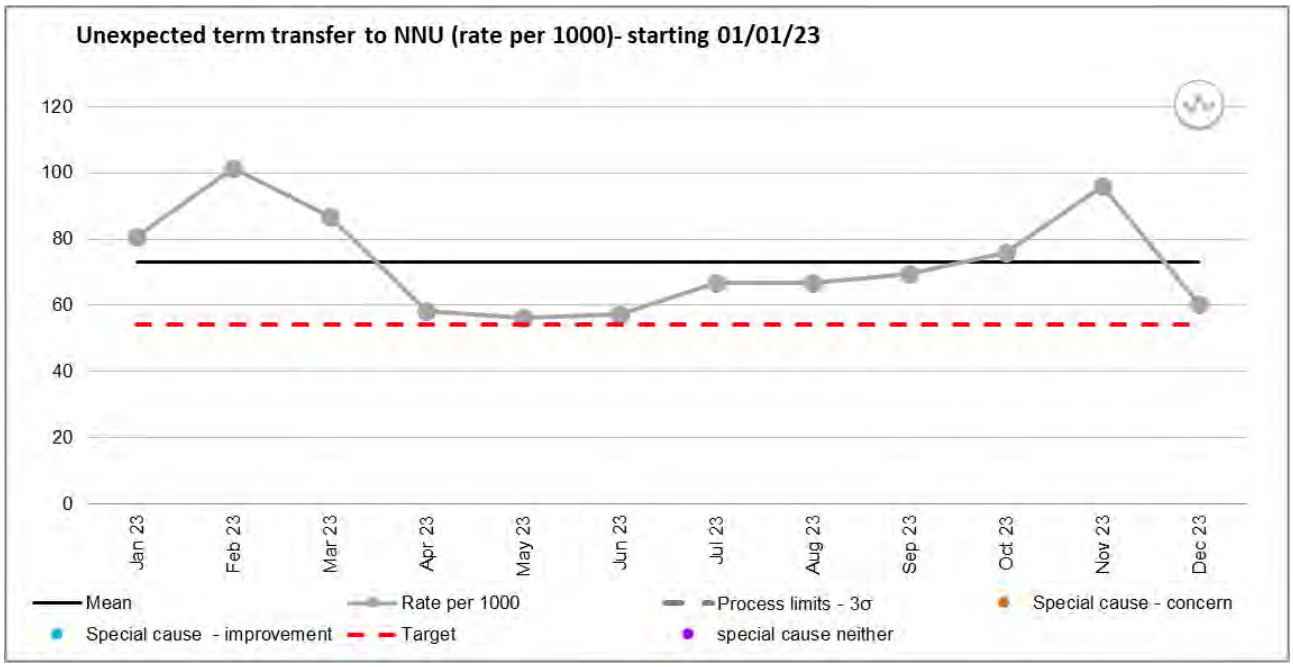
Skin to skin contact – This metric saw a rise in September, but the months following have seen the metric return to amber levels. Work continues to improve this metric.

Red

Re-admissions of babies within 30 days These figures have been at normal levels since August, but December sees a spike. Most cases were due to jaundice (62%). All cases were managed appropriately and there were no omissions in care. In view of the increased number, a deep dive into these admissions has been completed and there were no issues noted or common themes found.

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

Term admissions to NNU. This figure remains red and had been relatively static for several months. There had been a rise in the figure in November. December sees a slight decrease in this figure despite it remaining red. The metric in December is at its lowest level since June. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate and to try to improve the figures in this metric. The below is an SPC chart showing our rates in comparison to the GM average (red line).



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 for 2023. This will provide more oversight in a quicker timeframe for metrics if they are a concern.

December 2023 Exception report – Neonatal

Summary

The December 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 90% of shifts in December and above the national average.
- The unit was above the BAPM recommendation for majority of shifts in December.
- The unit was open throughout December.
- There were no complaints received in December.

Steis reportable Incidents

There were no Steis incidents in December 2023.

Green

% of Shifts to BAPM – This metric remains 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 fifteen consecutive months.

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

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

Amber

There was one amber metric in December.

% of Babies Receiving Delayed Cord Clamping – this metric has improved throughout the year. However, the medic in charge of the delivery will determine if it is safe to continue the procedure.

Red

Term admissions to NNU. This figure remains red. The figure over the last few months had improved to an average of 6 to 7% from previous months at the start of the year. There was a spike this month. However, consistent with the increase of admission to the NNU. 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. From 7th December 2023 we will be fully compliant with BAPM Transitional Care guidance. The main change

is to incorporate tube feeding in the Transitional care setting. This should have an impact in reducing term admissions to the NNU.

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 Hospital 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**	**221**	**197**
	Number of Bookings (*one month retrospective*)	**≥ 240**	**≤ 200**	**2022 Bookings**	**254**	**258**	**215**	**260**	**247**	**249**	**201**	**241**	**237**	**216**	**233**	**220**	**240**	**240**	**205**
	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%	46.61%	41.12%
	% 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%	0.45%	1.02%
	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%	9.50%	10.66%
	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%	41.63%	48.22%
	% 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%	24.89%	34.01%
	% 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%	16.74%	14.21%
	% 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%	16.66%	4.76%
	% 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%	7.22%	15.78%
	Number of Successful VBAC Deliveries			Births/month	6	5	4	3	1	7	3	3	6	5	5	3	5	7	1
	% 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%	9.78%	9.47%
	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%**	**42.53%**	**45.18%**
	% 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%	0.45%	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%	4.98%	4.57%
	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**	**1.6**	**1.7**
	Number of In-Utero Transfers In from Other Units				1	1	1	2	0	0	4	5	5	4	3	1	4	4	4
	Number of In-Utero Transfers Out to Other Units				0	0	0	1	0	0	1	3	6	0	0	0	1	1	0
	%of Women Smoking at Booking			2022 Bookings = 17%	12.20%	14.30%	11.62%	11.15%	11.74%	10.44%	9.45%	11.60%	8.86%	12.50%	14.10%	8.18%	7.91%	9.16%	7.80%
	% 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%**	**7.40%**	**9.18%**

	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%**	**76.36%**	**74.49%**
	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%**	**56.36%**	**56.63%**
	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%**	**92.92%**	**91.71%**
Workforce	**Prospective Consultant Hours on Delivery Suite**	**60 hours**	**< 60 hours**	**Nat Standard**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**
	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**	**1.28**	**1.0128**
	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%**	**100.00%**	**100.00%**
	Percentage of Shifts Where Shift Co-Ordinator Able to Remain Supernumerary	**100%**	**< 100%**	**Nat Standard**	**100.00%**	**98.30%**	**98.30%**	**100.00%**	**100.00%**	**98.20%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**98.33%**	**98.39%**	**100.00%**	**100.00%**
	Diverts: Number of Occasions Unit Unable to Accept Admissions				1	1	0	0	0	0	0	0	1	2	0	0	0	0	1
	Diverts: Number of Women During Period Affected by Unit Closure				0	0	0	0	0	0	0	0	2	0	0	0	0	0	1
	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%**	**11.54%**	**11.63%**
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%**	**0.93%**	**0.51%**
	% 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%	4.85%	11.11%
	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%	62.96%	86.67%
	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%	40.45%	42.86%
	PPH 1500 – 2500mls 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%	3.20%	4.08%
	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%	0.91%	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	1	
	Number of Women Requiring Level 3 Critical Care			Births/month	0	0	0	0	0	0	0	0	0	0	0		0	0	1
	Maternal Deaths			Nat rate per 1000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Women Re-Admitted Within 28 Days of Delivery	**≤ 1**	**> 4**	**16 in 2022**	**4**	**3**	**3**	**2**	**0**	**2**	**2**	**2**	**0**	**4**	**0**	**1**	**3**	**0**	**2**
	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	0	1
ality	Stillbirths**			Nat rate 3.5 per 1000 births	0	1	1	2	0	1	2	0	0	0	2	2	1	1	0
	Early Neonatal Deaths (*before 7 days*)			Nat rate per 1000 births	3	0	0	1	1	0	1	0	0	0	1	1	0	0	1
	Number of Babies Born Under 37 Weeks				20	13	17	23	12	18	10	18	21	17	22	18	11	22	14
	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**	**4**	**2**
	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	0	0

Neonatal Morbidity & Mort	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%	0.90%	0.51%
	Singleton Babies Born < 30 Weeks Gestation			Births/month	1	0	0	1	1	2	1	0	2	0	1	1	0	0	1
	% Whose Mother Received $MgSO_4$	100%	90%	Rolling % of eligible babies	0.00%	N/A	N/A	0.00%	0.00%	50.00%	100.00%	N/A	50.00%	N/A	100.00%	100.00%	N/A	N/A	100.00%
	Singleton Babies Born < 34 Weeks Gestation			Births/month	7	2	5	2	2	4	4	4	3	4	1	1	0	0	1
	% Whose Mother Received Full Course of Steroids (*1 week prior to delivery*)	100%	90%	Rolling% of eligible babies	100.00%	0.00%	83.33%	50.00%	50.00%	100.00%	25.00%	100.00%	66.67%	25.00%	100.00%	66.67%	N/A	N/A	100.00%
	Mothers Who Did Not Receive Full Course and Omissions in Care Noted	**0**	**> 1**	**Eligible Mothers**	**N/A**	**0**	**0**	**0**	**0**	**N/A**	**0**	**0**	**0**	**0**	**0**	**0**	**N/A**	**0**	**N/A**
	% of Babies Who Had Defered Cord Clamping				84%	84%	81%	82%	82%	82%	85%	84%	92%	84%	81%	87%	88%	86%	87%
	% of Babies Born < 37 Weeks Whose Mother Recieved IV Antibiotics				35%	31%	12%	22%	0%	44%	50%	50%	14%	35%	35%	33%	0	18%	14%
	Unexpected Term Admissions to NNU (*as % of births > 37 weeks gestation*)	**3.50%**	**> 4.5%**	**Births > 37 weeks/month**	**3.81%**	**8.45%**	**8.16%**	**8.08%**	**10.13%**	**8.67%**	**5.82%**	**5.64%**	**5.73%**	**6.67%**	**6.67%**	**6.95%**	**7.58%**	**9.60%**	**6.04%**
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**	**16**	**21**
	Number of Incidents Reported				66	51	59	78	50	84	74	94	86	95	77	74	72	92	42
	Number of Concise Investigations				2	1	0	0	0	0	0	0	0	0	0	0	0	2	0
	Number of StEIS Reported Incidents				2	0	0	1	1	2	0	0	1	3	1	0	1	3	0
	Number of Midwifery Red Flags Reported				5	1	5	5	1	4	1	0	2	5	3	4	7	15	3
	Number of Complaints				0	1	0	1	1	2	2	4	2	0	1	0	2	3	2
	Number of Letters of Claim Received				0	0	1	0	0	0	0	0	0	0	0	1	0	0	0

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	GOSWH Quarterly Report, April-June 2023
Presented to:	Board of Directors
On:	07 February 2024
Item purpose:	Information
Presented by:	N/A – consent agenda
Prepared by:	Abigail Callender-Iddon, Guardian of Safe Working
Contact details:	Abigail.callender-iddon@wwl.nhs.uk

Considerations against the Trust's Vision and Values: The safety of patients is a paramount concern for the Trust. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of doctors and dentists in training are designed to ensure that this risk is effectively mitigated, and that this mitigation is assured.

Recommendations: Present report at LNC, People's Committee, JDF, TMEC
Share report with departmental leads

Executive Summary

For the period April-June 2023 (Quarter 1), there have been:

- 60 Exception reports submitted by 16 doctors.
- 56 hours and 10 minutes of overtime claimed.
- Most exception reports were made by Foundation Year 1 doctors.
- General Medicine and Obstetrics and Gynaecology had the most Exception reports.
- Main reasons for exception reporting for overtime included workload and staffing shortages.
- 1 reported immediate safety concern and 1 immediate safety concern identified by the guardian of safe working.
- No fines levied

Report of the Guardian of Safe Working Period April 2023 to June 2023

1. Introduction

This is the first Quarterly report for the financial year 2023/2024, based on a national template, by the Guardian of Safe Working. THE GOSW's primary responsibility is to act as the champion of safe working hours for doctors and dentists in training and to provide assurance to the Trust that they are safely rostered and that their working hours are compliant with the 2016 Terms and Conditions of Service. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. It also highlights missed training opportunities.

2. High Level Data for the Period April- June 2023

Total number of established training posts: 210

Total number of doctors/dentists in training on 2016 TCS: 193

Total number of Full-time doctors/dentists in training: 162

Total number of Less than Full-Time doctors/dentists in training: 31

Total number of locally employed junior doctors: 59

Amount of time available for the Guardian to do the role per week: 4 hours

Administrative support provided to the Guardian per week: 3 hours

Amount of job planned time for Educational Supervisors: 0.25 PA

3. Exception Reports- Quarter 1 (April-June 2023)

Total number of Exception Reports for the period: 60
Breach Type:

- Hours/Overtime- 53
- Educational- 5
- Service Support- 2

Number of doctors that engaged with Exception Reporting: 16 doctors (8%) generated 60 exception reports.

Number reported as an Immediate Safety Concern: 1
Total number of work schedule reviews: 1

3.1 Exception Reporting by Specialty

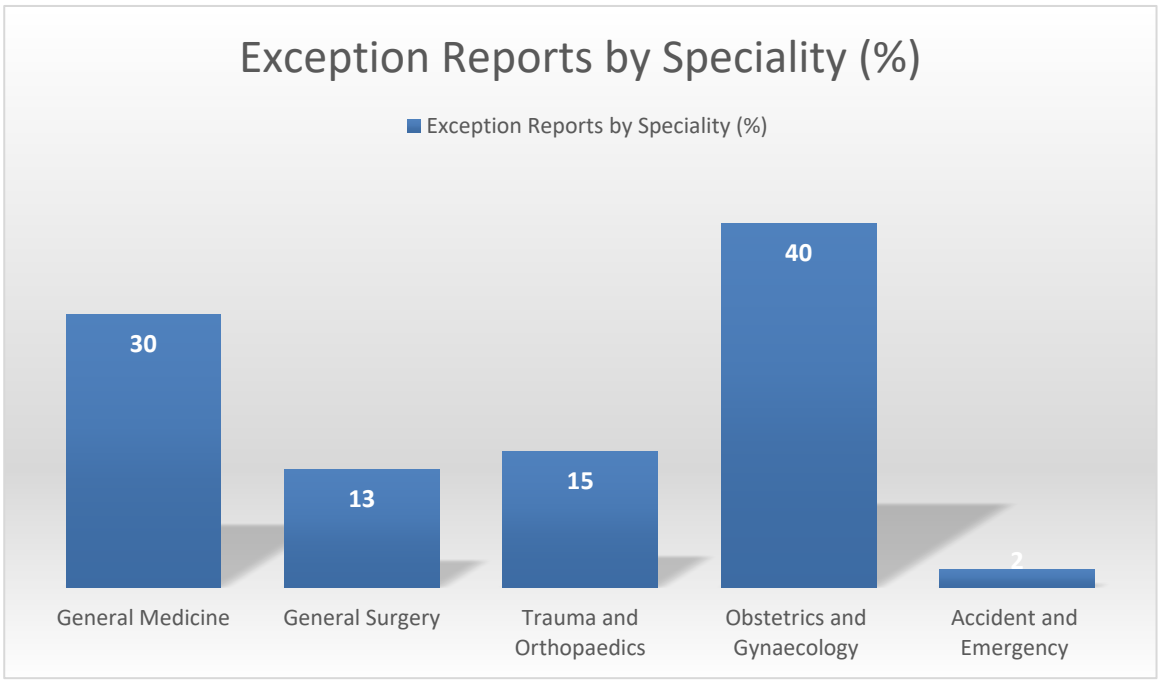
General Medicine- 30% (18)

General Surgery- 13% (8)

Trauma and Orthopaedics- 15% (9)

Obstetrics and Gynaecology- 40% (24)

Accident and Emergency- 2% (1)



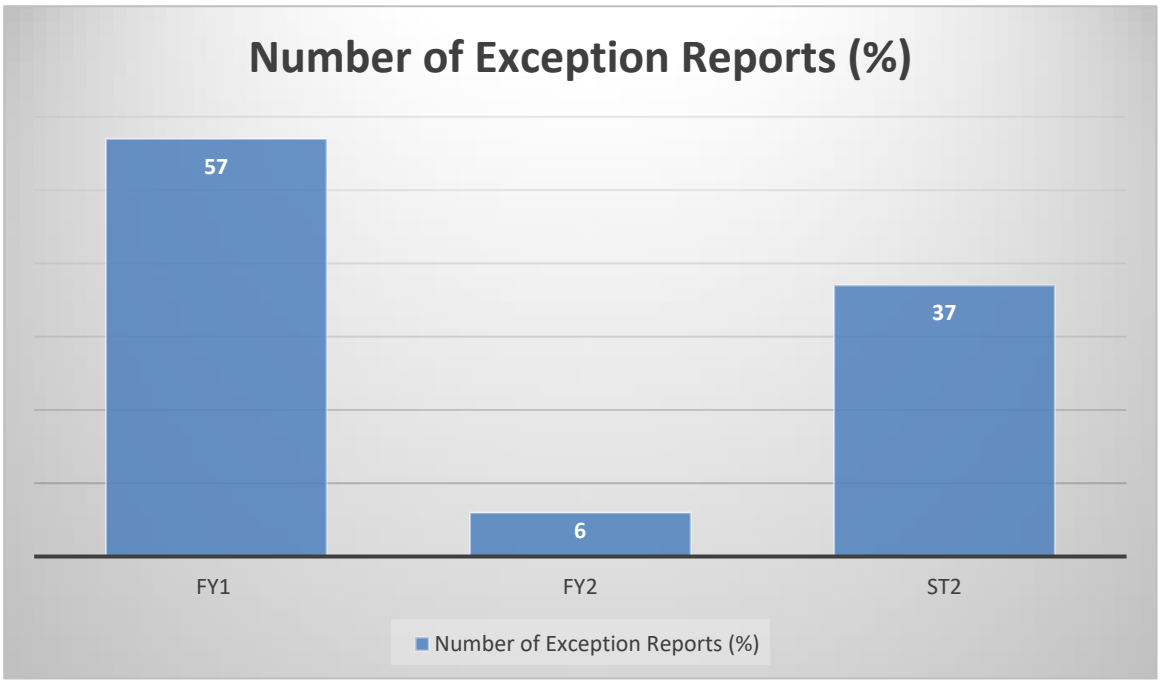
Obstetrics and gynaecology had the largest number of exception reports for the period with the reasons for these exception reports relating to workload in the gynaecology assessment unit, having to come in 1 hour early to help prepare for theatre lists and long theatre lists.

3.2 Exception Reports by Doctor's Grade

Foundation Year 1- 57% (34)

Foundation Year 2- 6% (4)

Specialist Trainee 2- 37% (22)



3.3 Work Schedule Reviews

One work schedule review took place in Trauma and Orthopaedic surgery between April to June 2023 for the FY 1 doctors who were scheduled to work on a Tuesday afternoon until 4 PM however were required to attend FY1 teaching between 2PM- 5PM, thus finishing work 1 hour later than the rostered working time.

3.4 Exception Report Outcomes

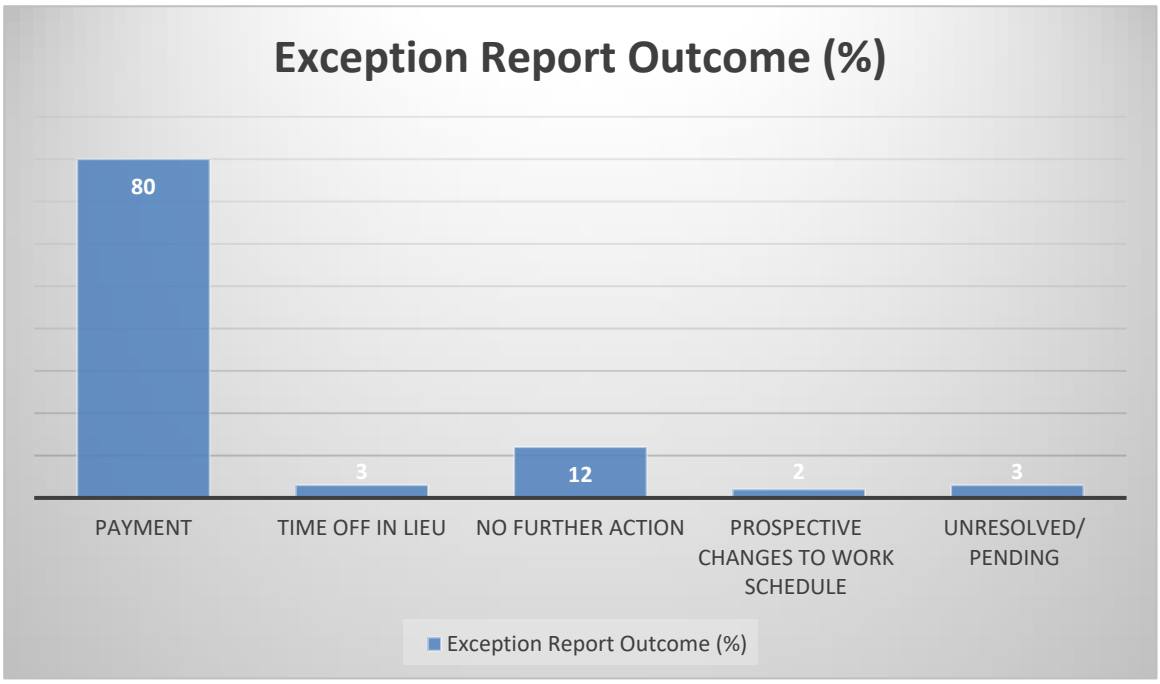
Payment- 80% (48)

Time off in Lieu- 3% (2)

No further Action- 12% (7)

Prospective Changes to Work Schedule- 2% (1)

Pending/Unresolved- 3% (2)



Total number of overtime hours claimed:

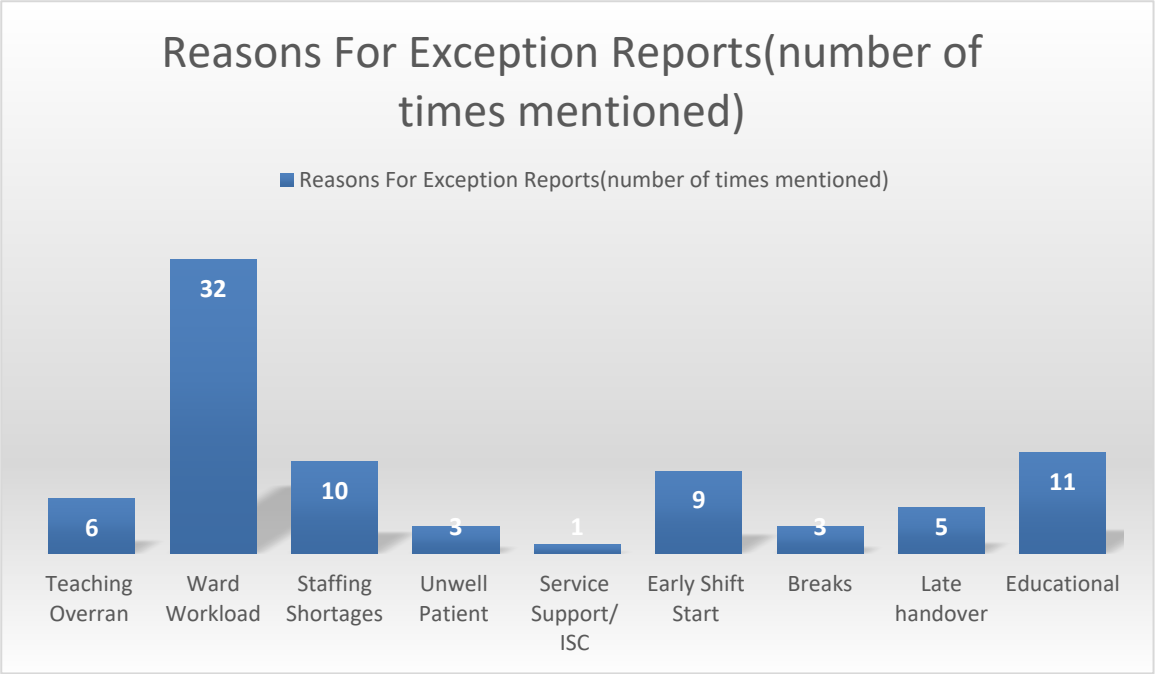
- Extra normal hours: 54 hours 45 minutes
- Extra premium hours: 1 hour 25 minutes

On average doctors were working an extra 16 minutes per week.

3.5 Reasons for Exception Reports in this period

Please note that one exception report might have included more than one reason.

- Teaching Overran- 6
- Ward Workload- 32
- Staffing shortages- 10
- Unwell patient- 3
- Service support/ Immediate Safety Concern- 1
- Early Shift Start- 9 (asked to come in early to help prepare for theatre lists)
- Breaks 3
- Late handover- 5
- Unable to attend teaching/ Late for teaching (Educational)- 11



3.6 Immediate Safety Concern

One exception report was highlighted as an Immediate Safety Concern for this period. This occurred in the General Medicine department. The locum registrar cancelled the scheduled night shift which meant that the Foundation Year 2 doctor did a shift in which he reported feeling unsupported and overworked.

There was one further exception report that was not highlighted as an immediate safety concern but on reflection, should have been. The doctor reported that due to staffing shortages (no SHO), she had to act up above her grade (FY1) and felt unsupported and overworked.

3.7 Breaches that attract Financial Penalty

Fines are levied when working hours breach one or more of the following situations:

i. The 48 hours average working week.
ii. Maximum 72 hours worked within any consecutive period of 168 hours.
iii. Minimum of 11 hours continuous rest between rostered shifts.
iv. Where meal breaks are missed on more than 25% of occasions.
v. The minimum non-residential on call overnight continuous rest of 5 hours between 22.00 – 07.00 hours.
vi. The minimum 8 hours total rest per 24 hours non-resident on call shift
vii. The maximum 13 hours shift length
viii. The minimum 11 hours rest between resident shifts

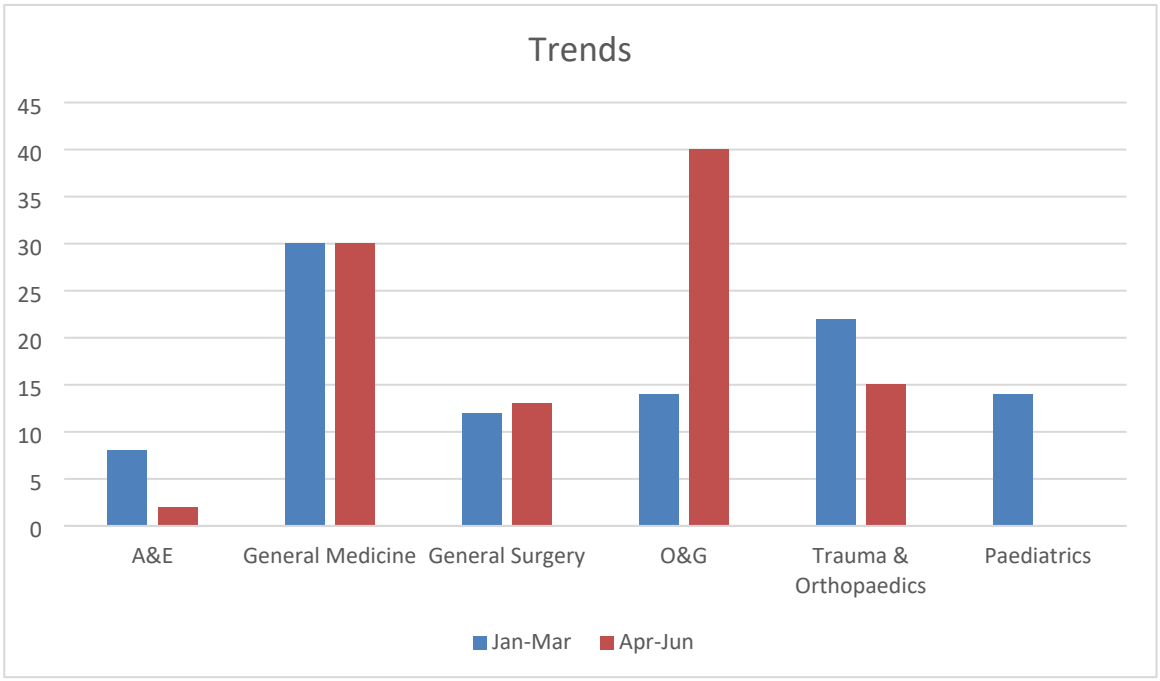
3.7.1

A proportion of the fine, apart from fines for breaks where payment is 100%, is paid to the Guardian of Safe Working, as specified in the 2016 Terms & Conditions of Service (TCS) (see penalty rates and fines below). The TCS also specifies that the JDF is the body

that decides how accrued monies are spent within the framework identified within the TCS.

	Total Value of Penalty	Hourly Penalty Rate Paid to the Doctor
Additional hours worked attract a basic rate	X 4 the basic hourly rates	X 1.5 of the basic hourly locum rate
Additional hours worked attract an enhanced (night) rate	X 4 the enhanced hourly rate	X 1.5 of the enhanced hourly locum rate

3.8 Comparison of Quarter 1 (April- June 2023) with Quarter 4 (January-March 2023)



3.9 Speciality Specific Trends: Comparison of Jan-Mar 2023 and Apr-Jun 2023

Accident and Emergency

1 Exception Report- Educational; late for teaching by a few minutes. Downward trend.

General Medicine

18 Exception Reports- Unwell patient, chasing jobs, FY1 teaching 1 hour, Staffing shortages, last minute cancellation of locum. The same percentage as previous quarter.

1 FY1 doctor had to cover for SHO during twilight shift and said, 'it may entail acting above level.'

Scheduled teaching should be in the rota.

General Surgery

8 Exception Reports- Unable to take breaks, ward pressures, late handover, emergency in theatre, patients missed by day team, staffing shortages, workload, unwell patient.

Slight increase in percentage in comparison to previous quarter.

Trauma and Orthopaedics

9 Exception Reports- Ward pressures, 1 minute late for grand round, unwell patient, chasing results and investigations.

Decrease in percentage of reports in comparison to previous quarter.
Majority regarding FY1 teaching not scheduled into rota (1 hour).

Obstetrics and Gynaecology

24 Exception Reports- Being asked to come in 1 hour early to start theatre list, high workload, staffing shortages, Unable to attend teaching, working in A&E corridor, Busy gynaecology assessment unit.

Significant increase in percentage of exception reports. Several reports about a 1 hour early start to prepare for theatre list.

Paediatrics

No Exception Reports

3.10 Recommendations

Work schedule reviews of the Trauma and Orthopaedics FY1 rota and the Obstetrics and Gynaecology ST2 rota.

18 Exception Reports

GOWSH Quarterly Report

April to June 2023

Highlights

- 60 Exception reports submitted by 16 doctors.
- 56 hours and 10 minutes of overtime claimed.
- Most exception reports were made by Foundation Year 1 doctors.
- General Medicine and Obstetrics and Gynaecology had the most Exception reports.
- Main reasons for exception reporting for overtime included workload and staffing shortages.
- 1 reported immediate safety concern and 1 immediate safety concern identified by the guardian of safe working.
- No fines levied

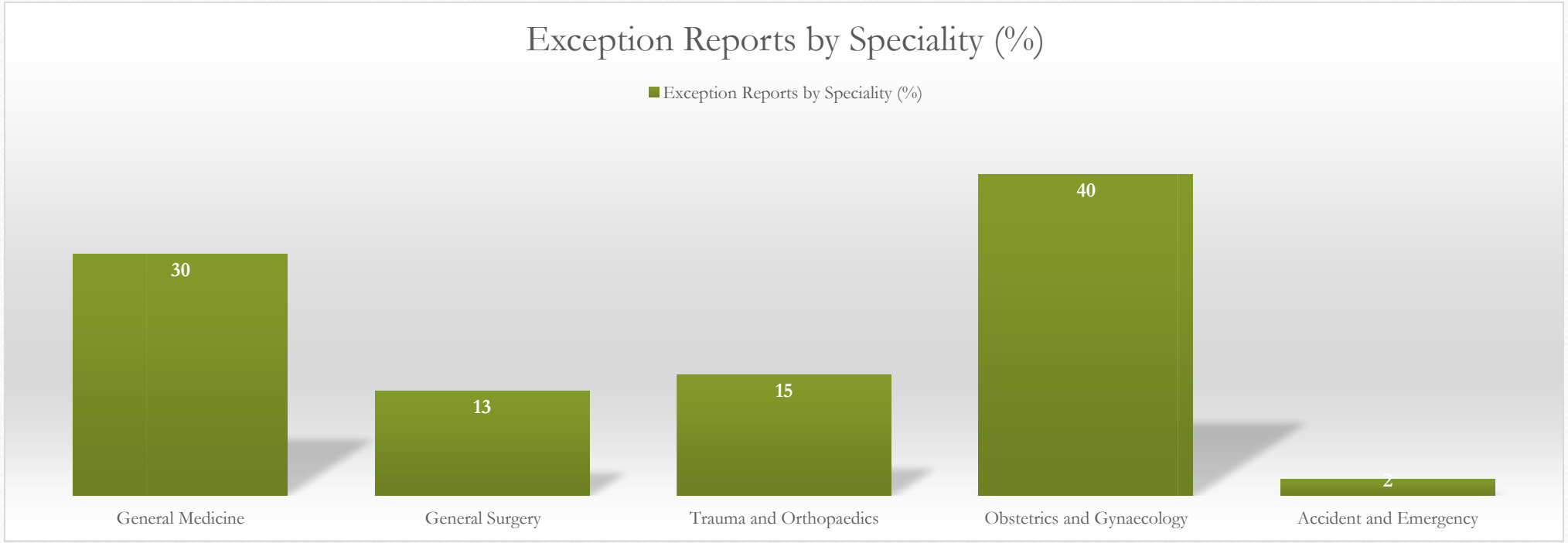
High Level Data: April – June 2023

- Total number of established training posts: 210
- Total number of doctors/dentists in training on 2016 TCS: 193
- Total number of Full-time doctors/dentists in training: 162
- Total number of Less than Full-Time doctors/dentists in training: 31
- Total number of locally employed junior doctors: 59

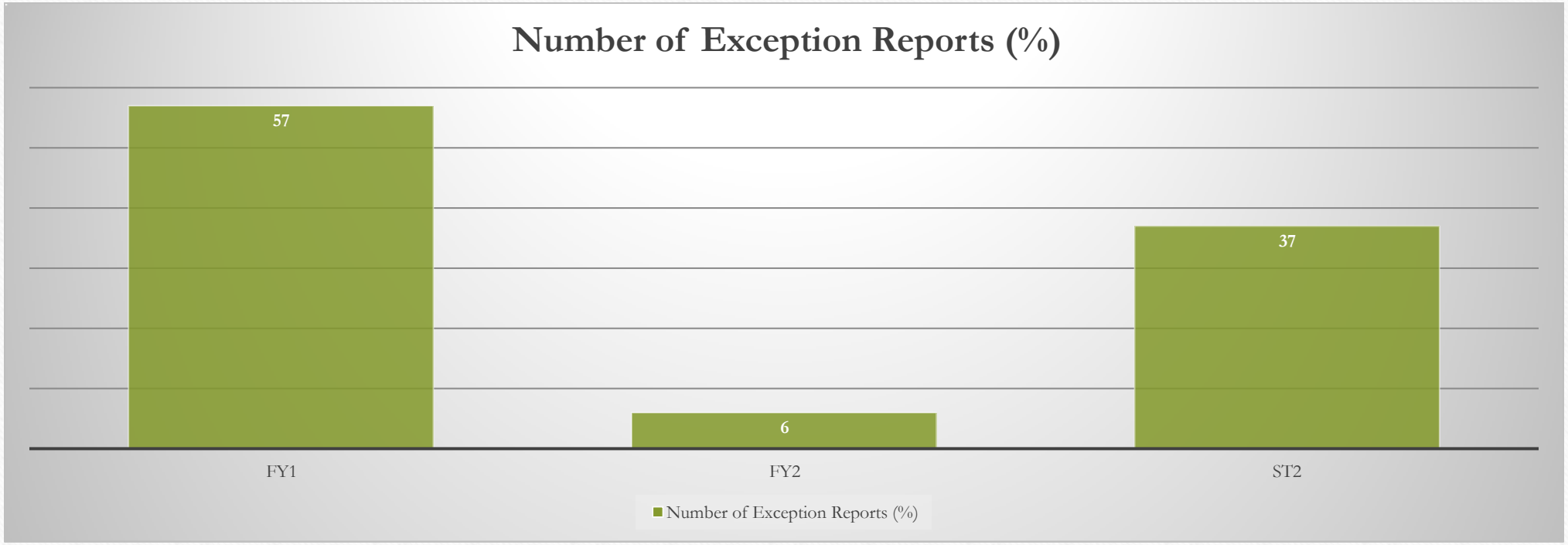
Exception Reports April- June 2023

- Total number of Exception Reports for the period: 60
- Breach Type:
  - Hours/Overtime- 53
  - Educational- 5
  - Service Support- 2
- Number of doctors that engaged with Exception Reporting: 16 doctors (8%) generated 60 exception reports.
- Number reported as an Immediate Safety Concern: 1
- Total number of work schedule reviews: 1

Exception Reports by Speciality



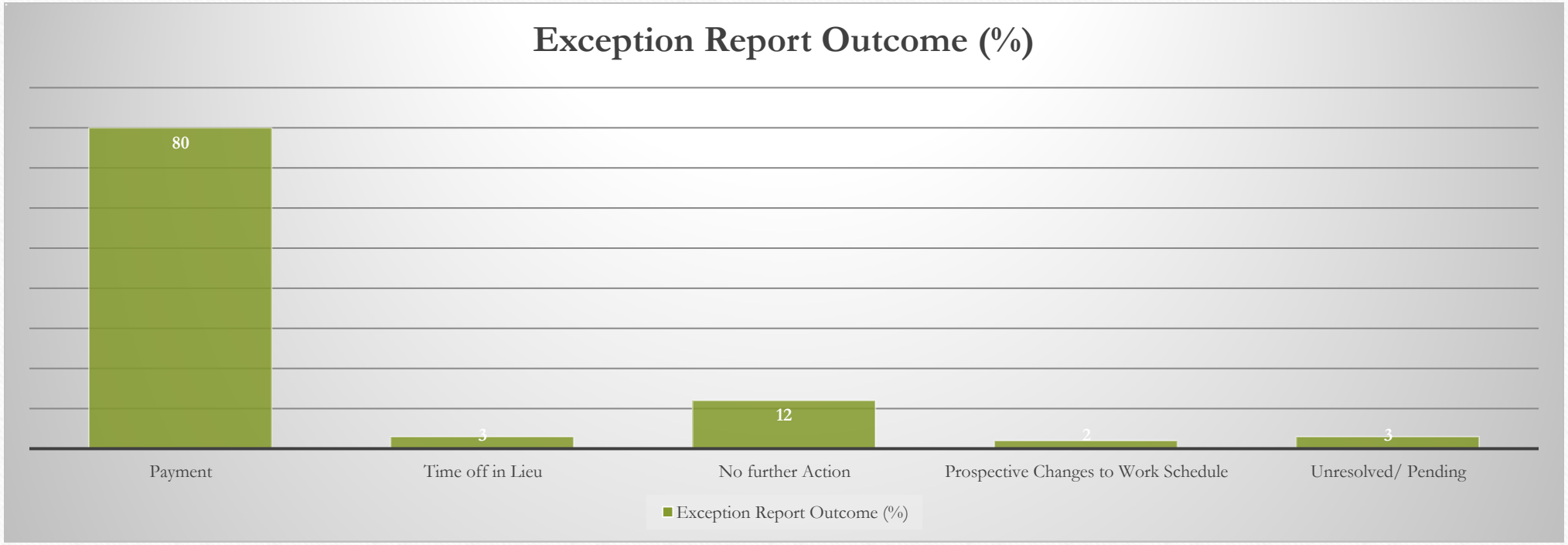
Exception Reports by Doctor's Grade



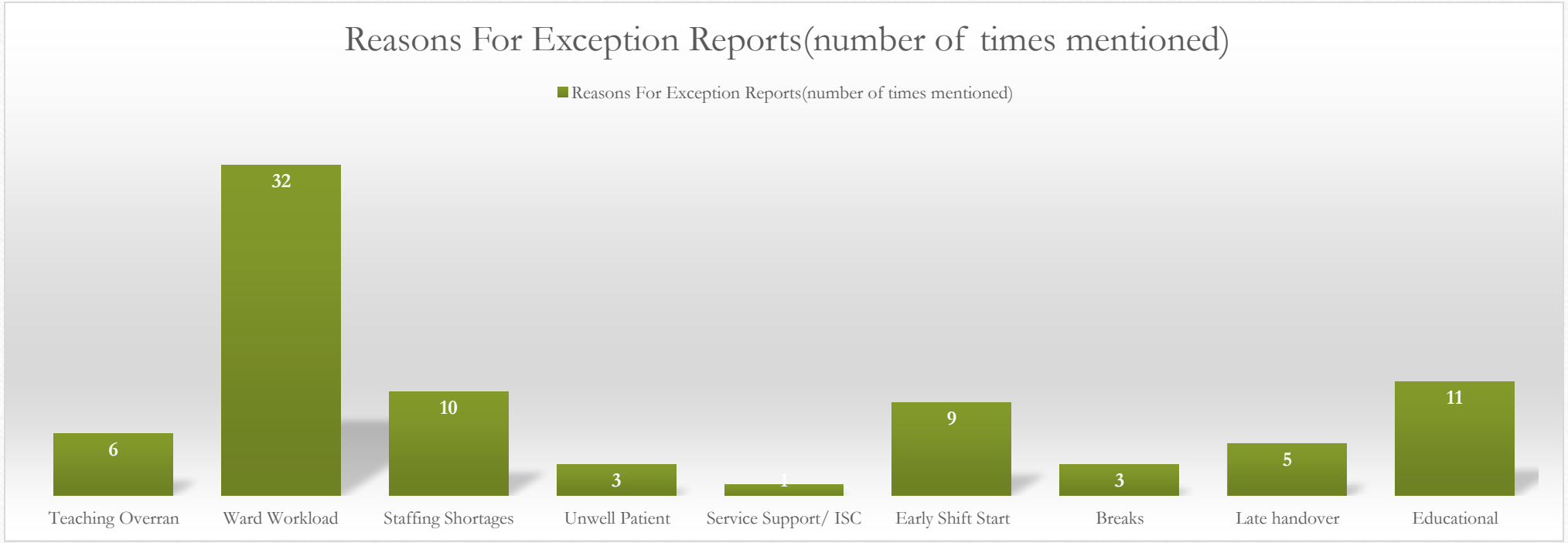
Work Schedule Reviews

- One work schedule review took place in Trauma and Orthopaedic surgery between April to June 2023 for the FY 1 doctors who were scheduled to work on a Tuesday afternoon until 4 PM however were required to attend FY1 teaching between 2PM- 5PM, thus finishing work 1 hour later than the rostered working time.

Exception Report Outcomes



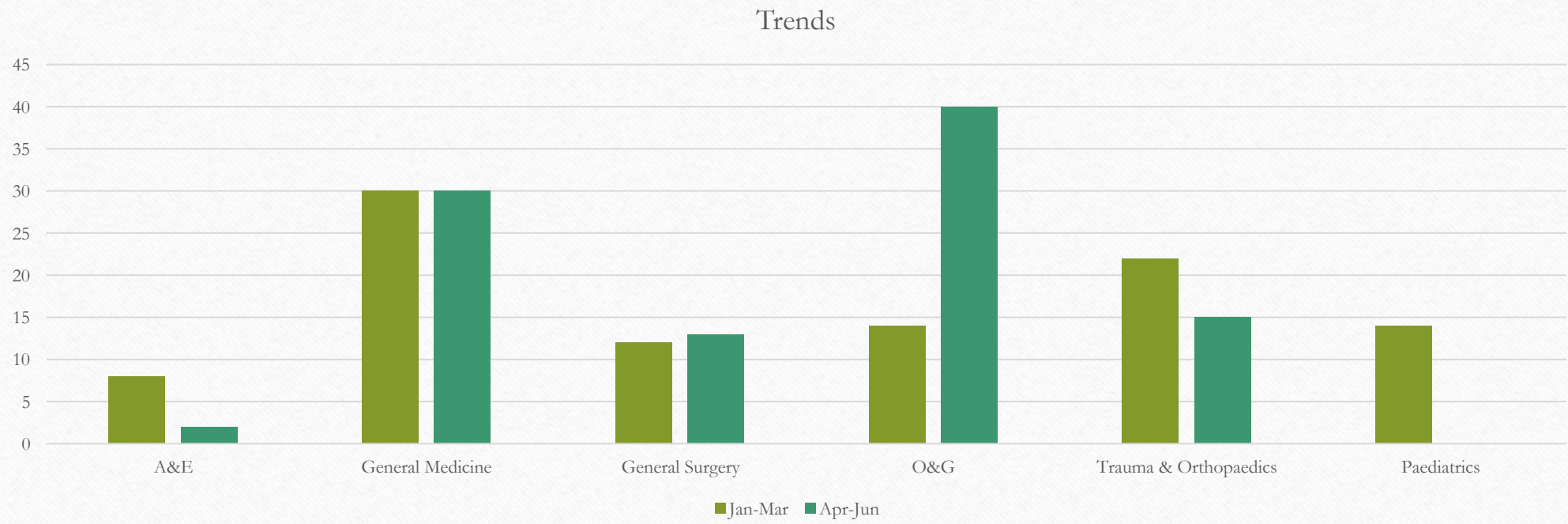
Reasons for Exception Reports



Immediate Safety Concerns

- 2 identified
- Unexpected staffing shortages: doctors having to act above their grade
- Reported feeling overworked and unsupported

Comparison of Quarter 1 (April- June 2023) with Quarter 4 (January-March 2023)



NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	GOSWH Quarterly Report July-Sept 2023, Quarter 2
Presented to:	LNC, People's Committee, JDF, TMEC. Share report with Departmental Leads.
Date of paper:	1st January 2024
Item purpose:	Information
Presented by:	Abigail Callender-Iddon, Guardian of Safe Working Hours
Prepared by:	Abigail Callender-Iddon, Guardian of Safe Working Hours
Contact details:	T: (01942822626) E: Abigail.callender-iddon@wwl.nhs.uk

Executive summary

For the period July- September 2023 (Quarter 2), there have been:

- 61 exception reports submitted by 16 doctors.
- 45 hours and 55 minutes of overtime claimed.
- 59% submitted by FY2 doctors and 28% submitted by FY1 doctors.
- General Medicine (38%) and Trauma and Orthopaedics (41%) had the most exception reports.
- The main reasons for exception reported for overtime included staffing shortages and difficulty logging into trauma database resulting in lengthy trauma meetings post night shifts.
- 2 Immediate Safety Concerns: no medical registrar cover; FY1 holding 2 bleeps on night shift.
- No fines were levied.

Link to strategy and corporate objectives

The safety of patients is a paramount concern for the Trust. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of doctors and dentists in training are designed to ensure that this risk is effectively mitigated, and that this mitigation is assured.

Financial implications

Fines are levied against the Trust when working hours breach specific conditions outlined in the 2016 Terms and Conditions of Service.

Legal implications

Exception Reports were introduced in the 2016 Junior Doctors' contract. The GOSWH monitors the working hours of junior doctors through exception reports. Exception reports could be submitted by trainees whose working hours or patterns deviate from their work schedules. Where exceptions form a pattern, steps should be taken to prevent recurrences. The GOSWH oversees the safety of junior doctors working and provides assurance in the system of exception reporting and rest monitoring.

People implications
Junior doctors are a vital part of the Trust's workforce. It is important that they are sufficiently rested as it impacts safe and quality patient care and junior doctor well-being. Doctors in training require educational opportunities that enable them to learn and progress.

Wider implications
Junior doctor burnout is associated with increased levels of staff sickness, staff attrition and dissatisfaction with the working environment.

Recommendation(s)
The GOSWH Quarterly and Annual Reports will be presented to LNC, JDF, TMEC and People's Committee. It will also be shared with the departmental leads who will consider the implications for their department and staff.

1. Introduction

This is the second Quarterly report for the financial year 2023/2024, based on a national template, by the Guardian of Safe Working. THE GOSW's primary responsibility is to act as the champion of safe working hours for doctors and dentists in training and to provide assurance to the Trust that they are safely rostered and that their working hours are compliant with the 2016 Terms and Conditions of Service. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. It also highlights missed training opportunities.

2. High Level Data for the Period July- Sept 2023

Total number of established training posts: 210
Total number of doctors/dentists in training on 2016 TCS: 193
Total number of Full-time doctors/dentists in training: 162
Total number of Less than Full-Time doctors/dentists in training: 31
Total number of locally employed junior doctors: 59
Amount of time available for the Guardian to do the role per week: 4 hours
Administrative support provided to the Guardian per week: 3 hours
Amount of job planned time for Educational Supervisors: 0.25 PA

3. Exception Reports- Quarter 2 (July-Sept 2023)

Total number of Exception Reports for the period: 61
Breach Type:

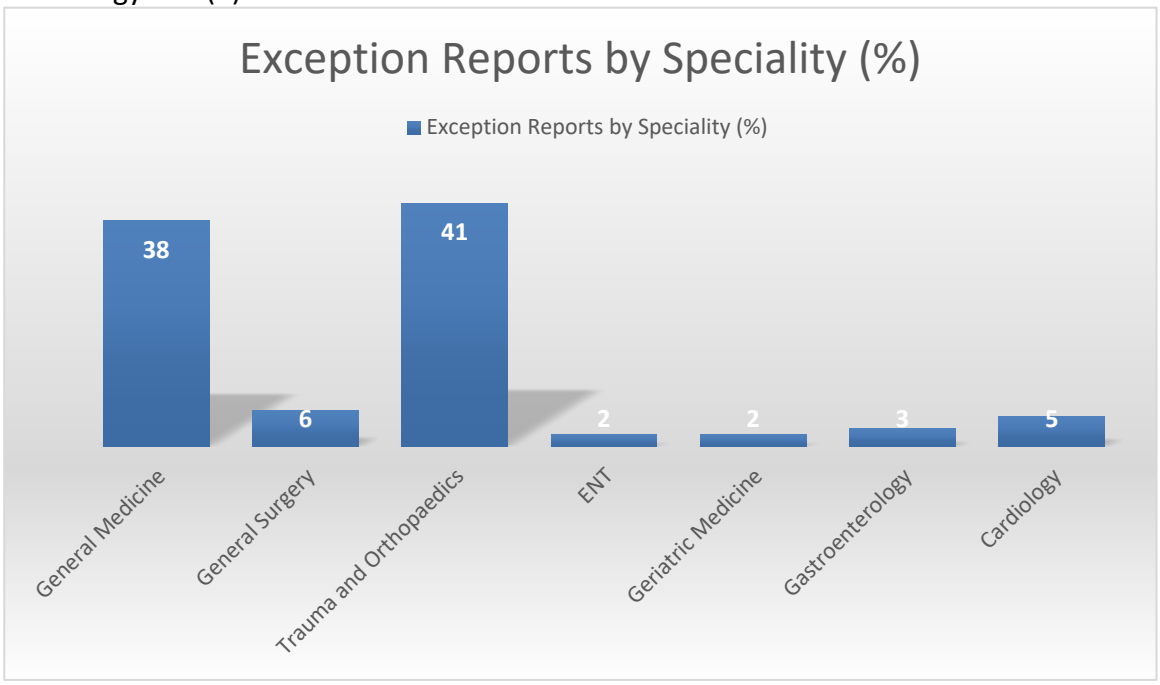
- Hours/Overtime- 46
- Educational- 6
- Service Support- 3

- Pattern-5
- Rest- 1

Number of doctors that engaged with Exception Reporting: 16 doctors (8%) generated 61 exception reports.
Number reported as an Immediate Safety Concern: 2
Total number of work schedule reviews: 0

3.1 Exception Reporting by Specialty

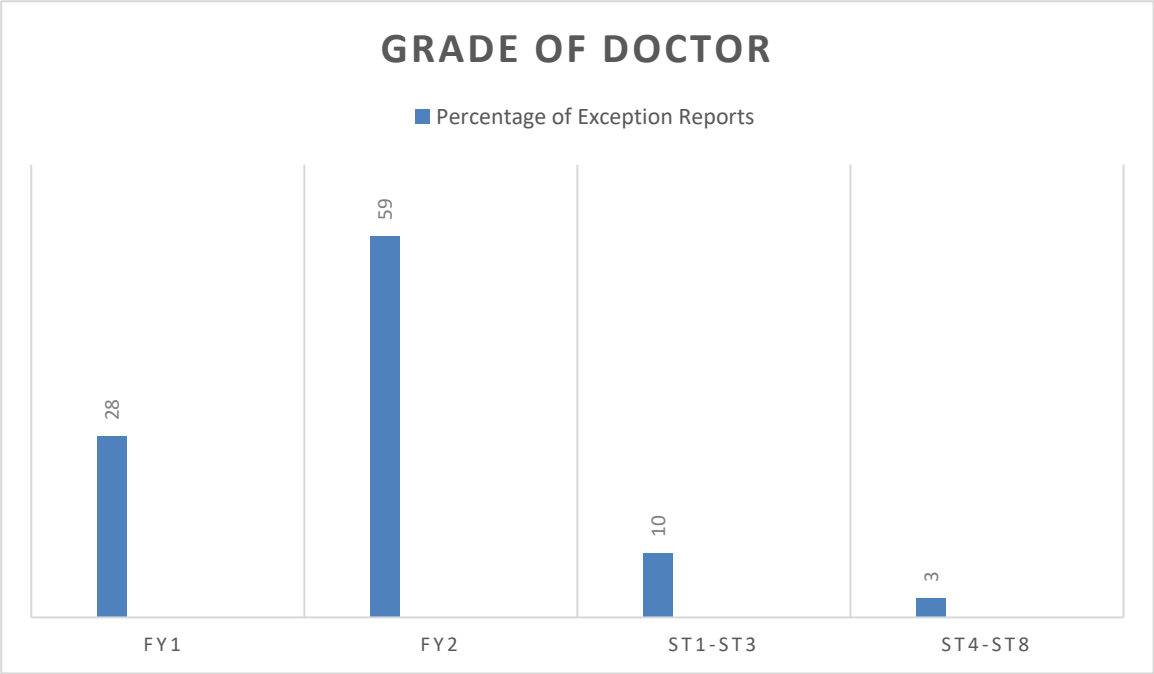
General Medicine- 38% (23)
General Surgery- 6% (4)
Trauma and Orthopaedics- 41% (25)
ENT- 2% (1)
Gastroenterology- 3% (2)
Geriatric Medicine- 2% (1)
Cardiology- 8% (5)



Trauma and Orthopaedics had the largest number of exception reports for the period with the reasons for these exception reports relating to workload, sickness, delayed handover, length of trauma meeting post nights and lack of access to the trauma handover database.

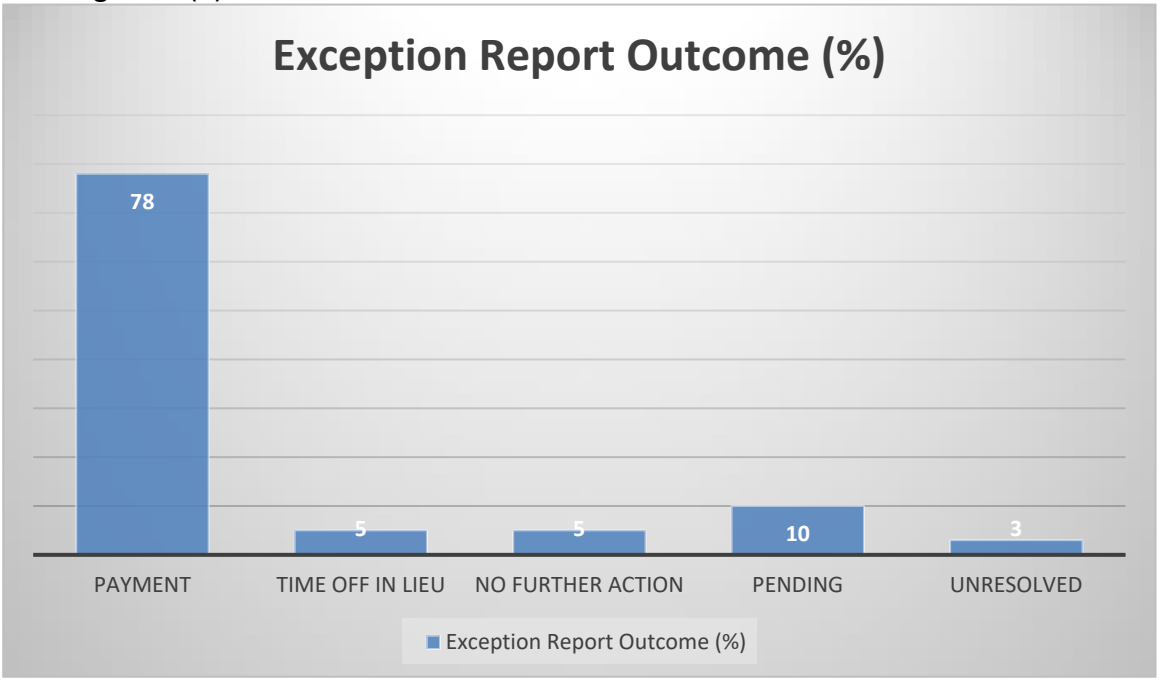
3.2 Exception Reports by Doctor's Grade

Foundation Year 1- 28% (17)
Foundation Year 2- 59% (36)
Specialist Trainee 1- ST3- 10% (6)
ST 4-ST8- 3% (2)



3.3 Exception Report Outcomes

Payment- 78% (48)
Time off in Lieu- 5% (3)
No further Action- 5% (3)
Unresolved- 2% (1)- Service support
Pending- 10% (6)- Educational



Total number of overtime hours claimed:

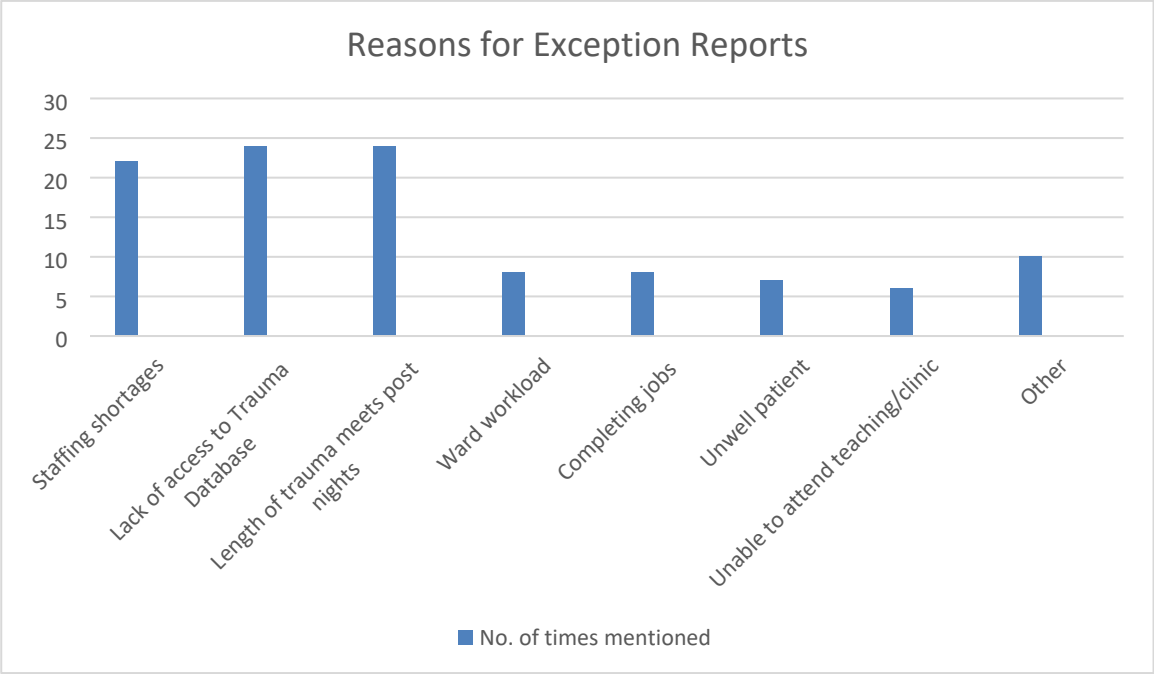
- Extra normal hours: 36 hours 10 minutes
- Extra premium hours: 9 hour 45 minutes
- Total 45 hours 55 minutes

On average doctors were working an extra 13 minutes per week.

3.4 Reasons for Exception Reports in this period

Please note that one exception report might have included more than one reason.

- Completing Ward Jobs- 8
- Industrial Action- 1
- Staffing shortages- 22
- Ward Workload- 8
- Unwell patient- 7
- Immediate Safety Concern- 2
- Unable to attend teaching/clinic/training- 6
- Missed Breaks- 2
- Complications in Theatre-1
- Mandatory Training- 1
- No locum cover- 1
- Holding 2 bleeps- 1
- Documentation-1
- Staff sickness- 1
- Lack of access to trauma handover database- 24
- Lengthy trauma meet post nights- 24



3.5 Immediate Safety Concern

Two exception reports were highlighted as Immediate Safety Concerns for the period July-September 2023. Both were in General Medicine department. One was highlighted as there was no medical registrar. The consultant carried the medical registrar bleep.
The other exception report was highlighted as there was no ward SHO overnight. The FY1 had to step up holding both the FY1 and the ward cover SHO bleeps.

3.6 Breaches that attract Financial Penalty

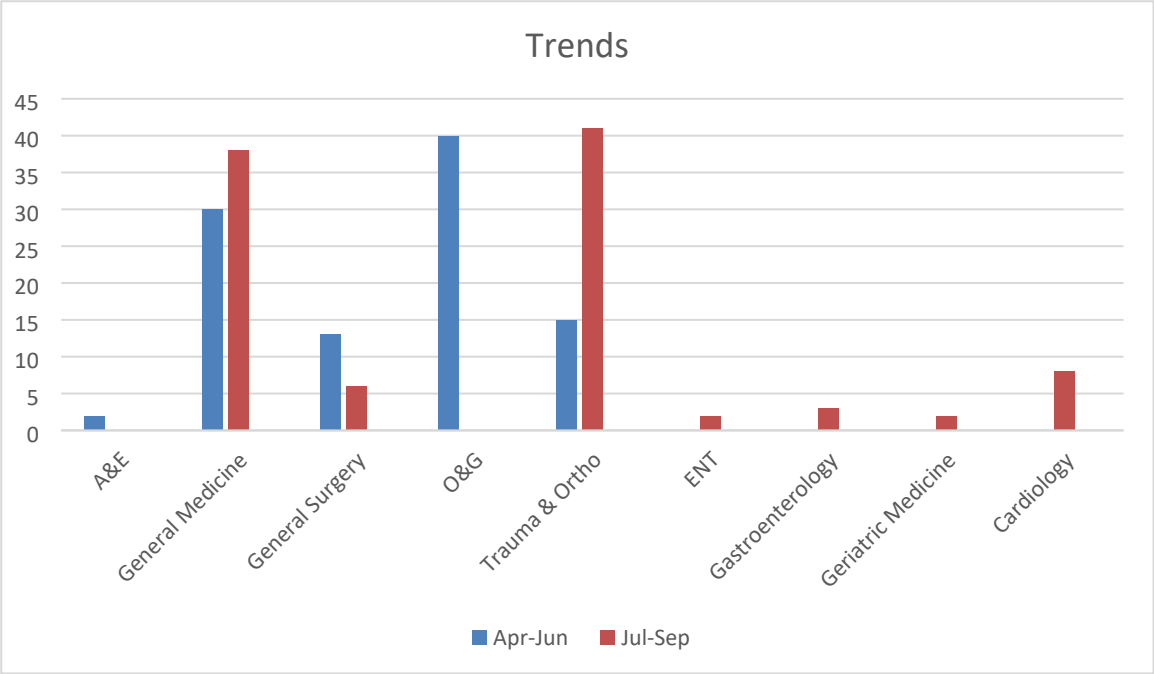
Fines are levied when working hours breach one or more of the following situations:

i. The 48 hours average working week.
ii. Maximum 72 hours worked within any consecutive period of 168 hours.
iii. Minimum of 11 hours continuous rest between rostered shifts.
iv. Where meal breaks are missed on more than 25% of occasions.
v. The minimum non-residential on call overnight continuous rest of 5 hours between 22.00 – 07.00 hours.
vi. The minimum 8 hours total rest per 24 hours non-resident on call shift
vii. The maximum 13 hours shift length
viii. The minimum 11 hours rest between resident shifts

3.6.1
A proportion of the fine, apart from fines for breaks where payment is 100%, is paid to the Guardian of Safe Working, as specified in the 2016 Terms & Conditions of Service (TCS) (see penalty rates and fines below). The TCS also specifies that the JDF is the body that decides how accrued monies are spent within the framework identified within the TCS.

	Total Value of Penalty	**Hourly Penalty Rate Paid to the Doctor**
Additional hours worked attract a basic rate	X 4 the basic hourly rates	X 1.5 of the basic hourly locum rate
Additional hours worked attract an enhanced (night) rate	X 4 the enhanced hourly rate	X 1.5 of the enhanced hourly locum rate

3.7 Comparison of Quarter 1 (April- June 2023) with Quarter 2 (July-Sept 2023)



3.8 Speciality Specific Trends: Comparison of Jan-Mar 2023 and Apr-Jun 2023

Accident and Emergency
0 Exception Reports- 1 Previously. Downward trend.
General Medicine
23 Exception Reports-18 Previously. Upward trend. Reasons: Completing jobs, staffing shortages, ward workload, unwell patient, documentation, immediate safety concern, missed breaks, late for teaching, unable to attend clinic, FY1 holding SHO bleep.
General Surgery
4 Exception Reports- 8 Previously. Downward trend. Reasons: Staffing shortages, missed teaching, unwell patient, complications in surgery, mandatory training (assessment of competency of blood cultures), Completing jobs.
Slight increase in percentage in comparison to previous quarter.
Trauma and Orthopaedics
25 Exception Reports- 9 Previously. Significant upward trend. Reasons: Sickness, workload, delayed handover, length of trauma meeting post nights, lack of user access to trauma handover database.
Obstetrics and Gynaecology
0 Exception Reports- 24 Previously. Significant downward trend.
ENT
1 Exception Report- 0 Previously. Upward trend. Reasons: Missed protected teaching to complete ward jobs, unwell patient.
Gastroenterology
2 Exception Reports- 0 Previously. Upward trend. Reasons: Staffing shortage, unwell patient.
Geriatric Medicine
1 Exception Report- 0 Previously. Upward trend. Reasons: Unwell patient.
Cardiology
5 Exception Reports- 0 Previously. Moderately significant upward trend. Reasons: Ward workload, unable to attend clinics.

3.9 Recommendations

- Trauma and Orthopaedics to address access to trauma handover database at induction.
- Trauma and Orthopaedics to address the length of trauma meets post nights.
- General medicine to avoid FY1 acting up and holding 2 bleeps (especially during the night shifts).

GOWSH Quarterly Report

July to September 2023

Highlights

- 61 exception reports submitted by 16 doctors.
- 45 hours and 55 minutes of overtime claimed.
- 59% submitted by FY2 doctors and 28% submitted by FY1 doctors.
- General Medicine (38%) and Trauma and Orthopaedics (41%) had the most exception reports.
- The main reasons for exception reported for overtime included staffing shortages and difficulty logging into trauma database resulting in lengthy trauma meetings post night shifts.
- 2 Immediate Safety Concerns: no medical registrar cover; FY1 holding 2 bleeps on night shift.
- No fines were levied.

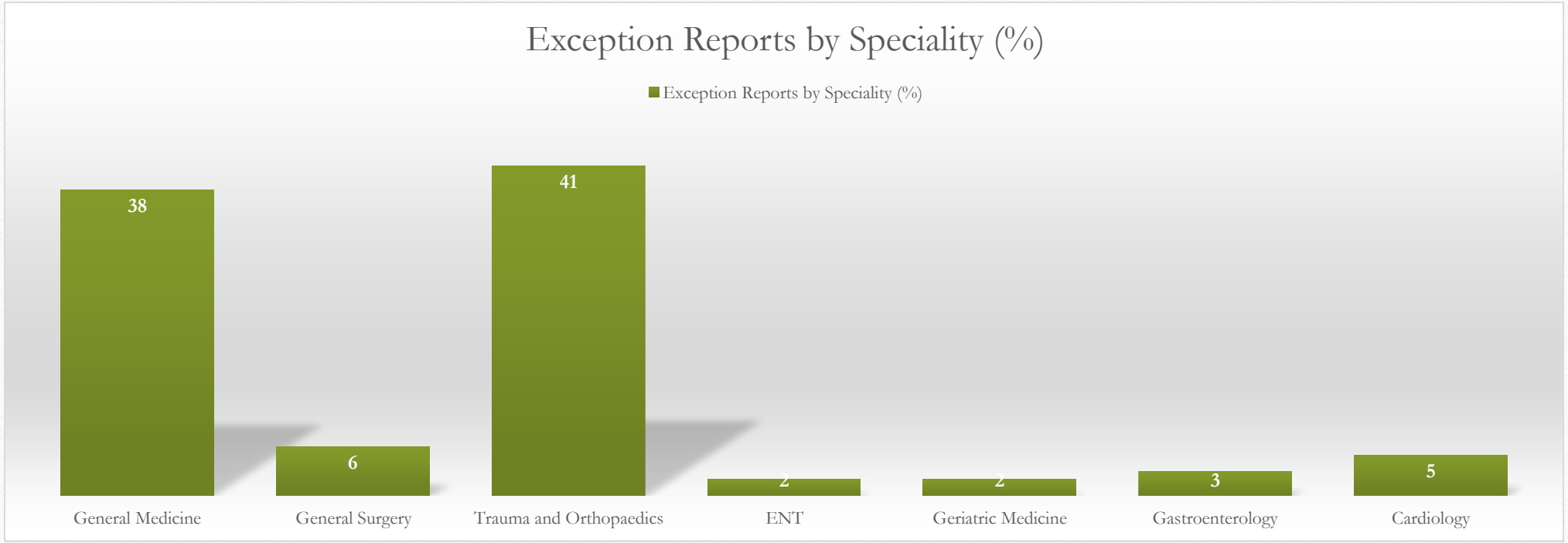
High Level Data: July – Sept 2023

- Total number of established training posts: 210
- Total number of doctors/dentists in training on 2016 TCS: 193
- Total number of Full-time doctors/dentists in training: 162
- Total number of Less than Full-Time doctors/dentists in training: 31
- Total number of locally employed junior doctors: 59

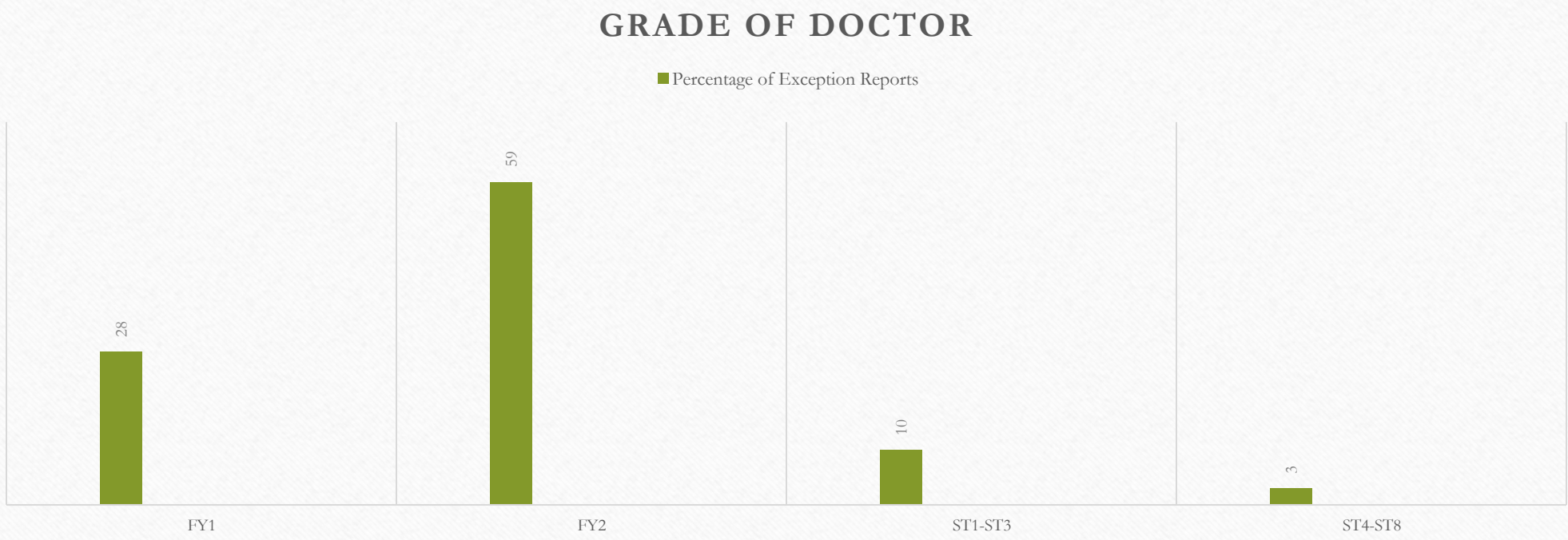
Exception Reports July-Sept 2023

- Total number of Exception Reports for the period: 61
- Breach Type:
  - Hours/Overtime- 47
  - Educational- 6
  - Service Support- 3
  - Pattern- 5
- Number of doctors that engaged with Exception Reporting: 16 doctors (8%) generated 61 exception reports.
- Number reported as an Immediate Safety Concern: 1
- Total number of work schedule reviews: 1

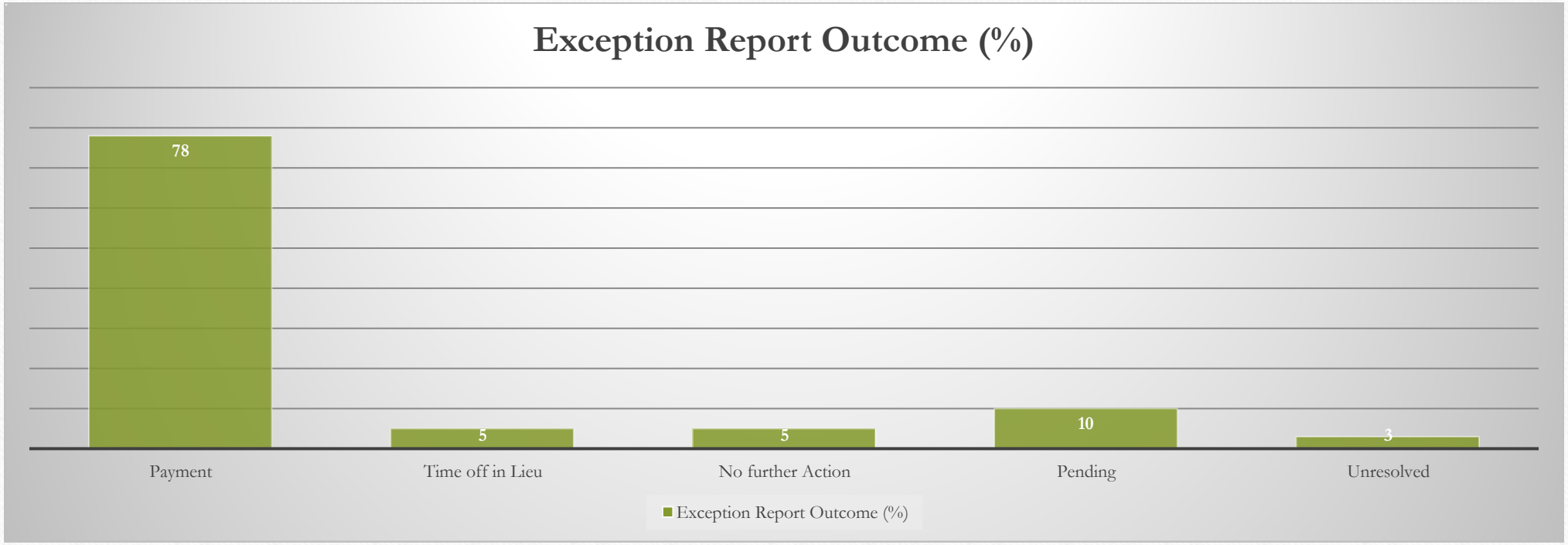
Exception Reports by Speciality



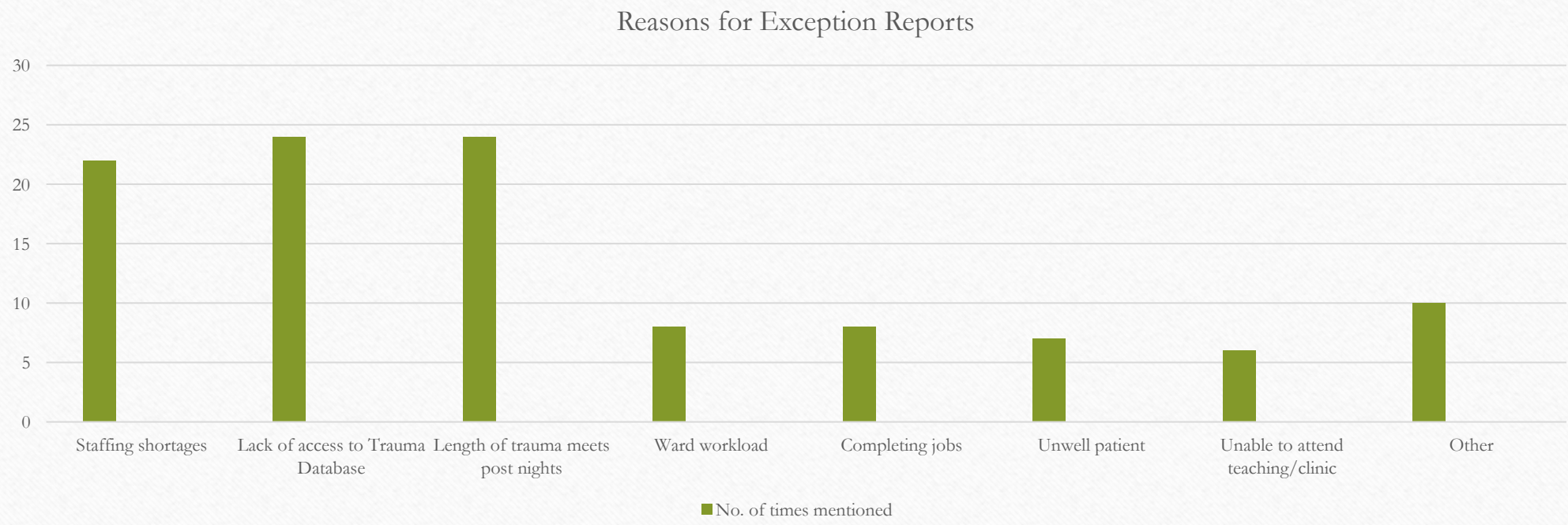
Exception Reports by Doctor's Grade



Exception Report Outcomes



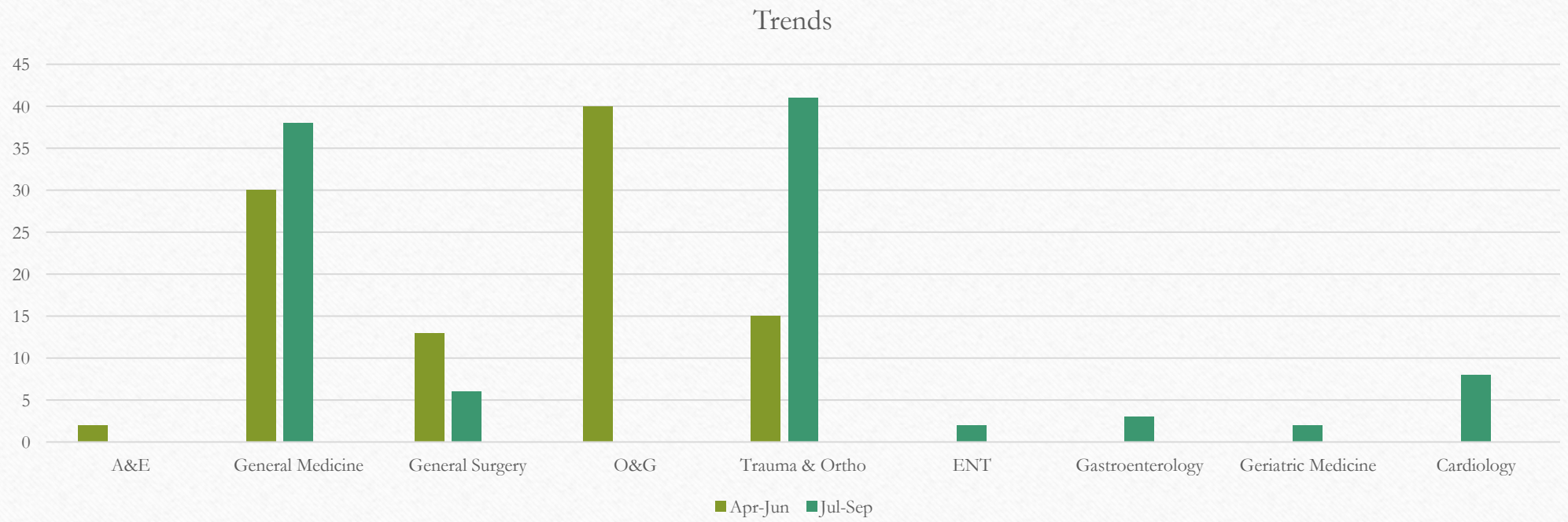
Reasons for Exception Reports



Immediate Safety Concerns

- 2 identified
- Both in General Medicine
- Unexpected staffing shortages: doctors having to act above their grade. No ward SHO. FY1 held both bleeps overnight.
- No medical registrar. Consultant held bleep.

Comparison of Quarter 1 (April- June 2023) with Quarter 2 (July-September 2023)



Recommendations

- Trauma and Orthopaedics to address access to trauma handover database at induction.
- Trauma and Orthopaedics to address the length of trauma meets post nights.
- General medicine to avoid FY1 acting up and holding 2 bleeps (especially during the night shifts).

WWL Freedom to Speak Up Report

Reference period, 1st September 2023 to 5th January 2024

Presented for discussion by, Tracy Boustead (FTSU Guardian) on Thursday 11th January 2024.

Service Development Headlines:

The events that surround the terrible crimes of Lucy Letby are an important reminder of the importance of continuous investment for a 'speak up safely' culture, at WWL.

Three key organisation actions taken include the:

1. The Guardian Service Limited, 8 Devonshire Square, London EC2M 4PL contract for service, ceased on 31st August 2023.
2. Interim FTSU (non-ringfenced) Director level appointment, with effect from 1st September 2023.
3. Transition to Greater Manchester Freedom to Speak Up provision, early 2024.

Service Feedback:

"Thank you for all the help and support. I'm really glad that I could talk to you. I won't hesitate to contact you if any worries or concerns."

"Thank you, going via the normal HR route wouldn't have been possible without putting a target on my back."

"I am now comfortable and happy with the colleagues and workplace. Thank you it was really great to speak with you during the times of struggle."

"We all agreed that just putting our thoughts down on paper has been really helpful and your guidance has also been invaluable so thank you for that. I truly mean that personally, you have been a fantastic support."

"The service is great. It provides is a safe space to raises concerns without being judged, also having someone impartial to facilitate the matter means there is no bias."

Rolled up Service Insights:

A total of twelve (12) Freedom to Speak-up cases have been opened, since the 1st of September 2023. Six (7) of these have been named with five (5) cases remaining anonymous.

Nine (9) of the cases related to Staff Experience. One (1) case related to Patient Safety. One (1) case deemed not to be appropriate for the service. One (1) case related to Policy Development.

Five (5) cases resolved same day, seven (7) cases within five (5) working days, four (4) cases between twenty (20) and thirty (30) working days.

Currently there is (1) case open/live. This case to be discussed with Chief People Officer on 11th January 2024. This case expected to close same day.

Of the nine (9) Staff Experience cases, six (6) related to HR policy, procedure, and practice. Three (3) related to rude, unkind behaviours from a peer (1) or a leader (2). Of the three (3) relating to such behaviour, two (2) have been resolved informally. To note, one (1) of the two (2) that have been resolved, the local managers signposted our colleague to the FTSU service, it is understood that these managers did not feel empowered to resolve.

The Patient Safety case was a collective concern related to leadership style, behaviours, and governance. This concern was originally raised to a senior leader who reinforced that the FTSU service was the best place route to resolution. This case resolved informally after a 30-day period of support from the service.

Recommendations:

1. Leader and management training for FTSU and People Management fundamentals.
2. Promotion of the FTSU service.
3. Increased FTSU resource.

N.B. All recommendations supported by Mark Jones (Chair) Claire Austin (Non-Executive) Mary Fleming (Chief Executive Officer) Juliette Tait (Chief People Officer) on Tuesday, 19th December 2023. Recommendation 3 actioned by commissioning the new Greater Manchester NHS provision.

Next Steps:

- New service live: 15th January 2024
- People Committee: 6th February 2024

Appendix 1:

January 2024 Handover data

FTSU Contacts	**January 2024**
No of cases carried forward from December 2023.	2
No of new cases in January 2024.	1
No of closed cases in January 2024.	2
No of ongoing cases as at 5th January 2024.	1
Directorate	**New Cases**
Specialist Services	1

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Statutory, mandatory and recommended posts
Presented to:	Board of Directors
On:	7 February 2024
Presented by:	Not applicable – consent agenda
Prepared by:	Paul Howard
Contact details:	T: 07867 462561 | E: paul.howard@wwl.nhs.uk

Executive summary

There are a number of posts set out in legislation that a foundation trust is required to have. Additionally, there are a number of posts that are required by regulators or which have been recommended as a result of inquiries, investigations or as best practice.

A table summarising the various requirements and the respective post holders is attached to this report as appendix 1. This has been reviewed during January 2024 and is presented by the executive team to provide assurance of compliance.

Link to strategy

There is no direct link to the organisation's strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications associated with this report.

Legal implications

The content of this report covers legal requirements for foundation trusts and serves to provide assurance that all statutory requirements have been satisfied.

People implications

There are no people implications arising from this report.

Wider implications

This report is intended to ensure that the organisation complies with best practice in corporate governance.

Recommendation(s)

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

Appendix 1

Post	Description	Required by	Post holder
STATUTORY POSTS			
Accounting Officer	The Chief Executive must be designated as the Accounting Officer	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Mary Fleming, Chief Executive
Director of Infection Prevention and Control	An individual with overall responsibility for infection prevention and control and accountable to the registered provider in NHS provider organisations.	Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance	Kevin Parker-Evans, Chief Nurse
Responsible Officer for Revalidation	A medical practitioner, at the time of appointment and for the preceding 5 years, who must remain a medical practitioner during the course of their appointment. Duties set out in the regulations	The Medical Profession (Responsible Officers) Regulations 2010	Sanjay Arya, Medical Director
Executive lead for safeguarding	A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements	Section 11, Children Act 2004 and Working Together to Safeguard Children 2015 (mandatory guidance)	Kevin Parker-Evans, Chief Nurse
Authorised Officer in relation to removing person causing nuisance or disturbance	Any English NHS staff member authorised to exercise powers which are conferred or an authorised officer in respect of English NHS premises	Section 120, Criminal Justice and Immigration Act 2008	Ian Bradley, Interim Security and Car Parks Manager
Accountable Emergency Officer	Board-level director responsible for EPRR with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements and to provide assurance to the Board.	Section 252A National Health Service Act 2006	Claire Wannell, Chief Operating Officer
Accountable officer for controlled drugs	A fit, proper and suitably experienced person who satisfies the requirements as to seniority, reporting arrangements and activities	Section 8 The Controlled Drugs (Supervision of Management and Use) Regulations 2013	Mike Parks, Director of Pharmacy

Post	Description	Required by	Post holder
Chair	There must be a Chair of the organisation	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Mark Jones, Chair
Chief Executive	There must be a Chief Executive of the organisation	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Mary Fleming, Chief Executive
Designated Individual	Duty to secure that suitable people and suitable practices are used in the course of carrying out the licensed activity and that the conditions of the licence are complied with.	Human Tissue Act 2004	Kathleen Robinson, Mortuary Manager
Data Protection Officer	To inform and advise on legal obligations, on the carrying out of data protection impact assessments, to act as the point of contact for the ICO and to monitor compliance with personal data policies.	Section 69 Data Protection Act 2018; General Data Protection Regulation	Natalie Baxter, Data Protection Officer (under an agreement with Blackpool Teaching Hospitals NHS FT)
Chief Finance Officer	There must be a finance director on the board	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Tabitha Gardner, Chief Finance Officer
Registered medical practitioner or dentist as a director	One of the executive directors must be a registered medical practitioner or dentist	Schedule 7, paragraph 16(2) to the National Health Service Act 2006	Sanjay Arya, Medical Director
Registered nurse or registered midwife as a director	One of the executive directors must be a registered nurse or midwife	Schedule 7, paragraph 16(2) to the National Health Service Act 2006	Kevin Parker-Evans, Chief Nurse
Nominated individual	Responsible for supervising the management of the carrying on of CQC regulated activities.	Regulation 6, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Kevin Parker-Evans, Chief Nurse
Named doctor for safeguarding children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions.	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Vineeta Joshi, Paediatric Consultant
Designated doctor for child death	To take a lead in coordinating responses and health input into child death review processes across the locality.	Child Death Review: Statutory and Operational Guidance (England), October 2018	Vineeta Joshi, Paediatric Consultant

Post	Description	Required by	Post holder
Named lead for adult safeguarding	To support other professionals in their agencies to recognise the needs of adults. This should be explicitly defined in job descriptions. (At WWL this is split between a named nurse and a named doctor to reflect arrangements for safeguarding children and looked after children.)	The Care Act 2014	Dr Muhammad Akram, ED Consultant Paula Johnson, Named Nurse for Safeguarding Adults
Named nurse for safeguarding children	To support all activities necessary to ensure the organisation meets its responsibilities to safeguard/protect children and young people. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018; Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework; Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff	Sarah Rhodes, Named Nurse for Safeguarding Children
Named midwife for safeguarding	To support other professionals in their agencies to recognise the safeguarding needs of pregnant women and the unborn/newborn child. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018; Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework	Kerry Ryan, Named Midwife for Safeguarding
Responsible Person	To ensure the correct processing of blood or blood components, including storage and distribution and providing information as required	Blood Safety and Quality Regulations 2005	Jim Wesson, PAWS
Medical Physics Expert (Nuclear medicine/unsealed radioactive sources and Radon monitoring)	An individual with the knowledge, training and experience to act or give advice on matters relating to radiation physics applied to exposure of unsealed radioactive sources. This includes providing advice on disposal and secure storage of radioactive material.	Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and Ionising Radiation Regulations 2017 Administration of Radioactive Substances Advisory Committee (ARSAC) and Environment Agency	Tony Hughes, Medical Physics Expert

Post	Description	Required by	Post holder
Medical Physics Expert (Laser Safety)	An individual with the knowledge, training and experience to act or give advice on matters relating to laser physics (non-ionising radiation) applied to exposure	Control of Artificial Optical Radiation (AOR) Regulations 2010 British Standards Institute: BS EN 60825-1: 2014 Safety of Laser Products	Colin Swift, Medical Physics Expert
Radiation Protection Advisor (Ionising Radiation)	An individual with the knowledge, training and experience to act or give advice on matters relating to radiation physics applied to exposure to ionising radiation	Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and Ionising Radiation Regulations 2017	Lorna Sweetman, Radiation Protection Advisor
Radiation protection supervisor	To secure compliance with the regulations in respect of work carried out in areas made subject to local rules.	Part 3, Section 14 Ionising Radiation Regulations 2017 and Health and Safety Executive Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)	Lee Unsworth (lead RPS, with specific RPSs for different modalities)
MANDATORY POSTS			
Caldicott Guardian	A senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly	Health Service Circular HSC 1999/012	Sanjay Arya, Medical Director
Guardian of Safe Working Hours	To oversee work schedule review process and to address concerns relating to hours worked and access to training opportunities	2016 terms and conditions of service for doctors and dentists in training	Abigail Callender-Iddon, Consultant Paediatrician
Accredited Security Management Specialist	Focal point for the local delivery of professional security management work carried out to a high standard within a national framework	Direction to NHS bodies on Security Management Measures 2004	Ian Bradley, Interim Security and Car Parks Manager

Post	Description	Required by	Post holder
Accredited Local Counter-Fraud Specialist	To manage fraud, bribery and corruption risks across the organisation and ensure the Trust is compliant with the NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013), relating to Fraud, Bribery and Corruption.	NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013) 2021	Collette Ryan, Fraud Specialist Manager
Senior Information Risk Owner	Executive director or member of the senior management board with overall responsibility for an organisation's information risk policy, accountable and responsible for information risk across the organisation.	David Nicholson letter dated 20 May 2008 (Gateway reference 9912)/Data Security and Protection Toolkit	Richard Mundon, Director of Strategy and Planning
Senior Independent Director	To provide a sounding board for the Chair and to serve as an intermediary for other directors when necessary. Should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or secretary has failed to resolve or for which such contact is inappropriate.	Provision B.2.11 of the Code of Governance for NHS Provider Trusts	Rhona Bradley, NED
Mental Capacity Act Lead	Responsible for providing support and advice to clinicians in individual cases, and supervision for staff in areas where these issues may be particularly prevalent and/or complex.	Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework	Jean Ramsdale, Mental Capacity Act Lead
Named Doctor for Looked After Children	To advocate and ensure that looked after children's issues are reflected in policies and service delivery across the organisation.	Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework; RCN Looked after Children: roles and competencies of healthcare staff	Dr Felvira Godinho, Named Doctor for Looked After Children

Post	Description	Required by	Post holder
Named nurse for looked after children	A registered nurse with additional knowledge, skills and experience that has a particular role with looked after children and is the lead professional for these children	Looked After Children: Knowledge, Skills and Competences of Health Care Staff (Intercollegiate Role Framework March 2015); Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework	Alison Jones, Named Nurse for Children in Care
Company Secretary	The secretary of the foundation trust or any other person appointed to perform the duties of secretary	Foundation Trust Constitution	Paul Howard, Director of Corporate Affairs
Resuscitation Officer	Responsible for coordinating the teaching and training of staff in resuscitation. One WTE per 750 members of clinical staff is recommended.	Resuscitation Council (UK) Quality Standards for cardiopulmonary practice and training	Matt Sawers and Darren Forster, Rebecca Smith (from March 2024). This does not meet the recommended ratio but the lead executive is aware and comfortable.
Medication error lead	A board-level director to have the responsibility to oversee medication error incident reporting and learning	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Sanjay Arya, Medical Director
UK Visa and Immigration Authorising Officer	Senior and competent person responsible for the actions of staff and representatives who use the Sponsorship Management System	UK Visas and Immigration	Juliette Tait, Chief People Officer
Health inequalities lead	Named executive board member responsible for tackling inequalities	Bullet C4(4), letter from Simon Stevens and Amanda Pritchard dated 31 July 2020 (“Phase 3 letter”)	Sanjay Arya, Medical Director
Patient Safety Specialist	The key patient safety experts in health care organisations – they are ‘captains of the team’ and provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations.	Clause 33.9 of the NHS Standard Contract	Carrie McManus, Head of Patient Safety

Post	Description	Required by	Post holder
RECOMMENDED POSTS			
Learning from Deaths Champion	To ensure that processes are robust, focus on learning and can withstand external scrutiny, that quality improvement becomes and remains the purpose of the exercise and that the information published is a fair and accurate reflection of achievements and challenges	National guidance on learning from deaths (National Quality Board, March 2017)	Martin Farrier, Director of Digital Medicine
NED Lead for Freedom to Speak Up	A nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board	Freedom to Speak Up Review 2015	Clare Austin, NED
NED maternity board safety champion	To ensure unfettered communication from 'floor to board'	Safer Maternity Care 2016, and Ockenden Review 2020	Mary Moore, NED
Designated board member for Maintaining High Professional Standards (MHPS)	Representations may be made to the designated Board member in regard to exclusion, or investigation of a case if these are not provided for by the NHS body's grievance procedures. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights.	Maintaining High Professional Standards in the Modern NHS (2003)	Francine Thorpe, NED
Wellbeing Guardian	To look at the organisation's activities from a health and wellbeing perspective and act as a critical friend, while being clear that the primary responsibility for our people's health and safety lies with Chief Executives or other accountable officers.	NHS People Plan	Ian Haythornthwaite, NED

Post	Description	Required by	Post holder
MRI responsible person	A person with day-to-day responsibility for safety in the MRI centre	MHRA guidance	Barry Burgess, Cross-Sectional Imaging Manager
Freedom to Speak Up Guardian	A person appointed by the organisation's Chief Executive to act in a genuinely independent capacity	Freedom to Speak Up Review, Feb 2015	NHS Greater Manchester
Freedom to Speak Up Executive Lead	At least one nominated executive director to receive and handle concerns	Freedom to Speak Up Review, Feb 2015	Juliette Tait, Chief People Officer
Medication Safety Officer	A person notified to the Central Alerting System to support local medication error reporting and learning and to act as the main contact for NHS England and MHRA.	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Kim Ferguson, Clinical Pharmacist
Board-level lead for Net Zero	Board-level lead	Delivering a Greener NHS, 2021	Richard Mundon, Director of Strategy and Planning