Board of Directors - Public Meetings

Wed 02 October 2024, 14:30 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

14. Declarations of Interest

Information *Mark Jones*

Verbal item

14.1. Register of directors' interests

14.1 Private Board - Directors DoIs - Sep 2024.pdf (2 pages)

15. Minutes of the previous meeting

Approval *Mark Jones*

15. Minutes_Board of Directors - Public Meeting_070824.pdf (7 pages)

16. Action Log

Discussion *Mark Jones*

16. Public Board Action Log - Aug 2024.pdf (1 pages)

17. Research Story

Information *Video*

18. Chair's report

Information *Mark Jones*

19. Chief Executive's report

Information *Mary Fleming*

19. CEO Board Report Oct 2024_Final.pdf (6 pages)

20. Committee chairs' reports

Information *Non Executive Directors*

20.1. Quality and Safety

Information *Francine Thorpe*

20.1. AAAQSsept24.pdf (2 pages)

20.2. Finance and Performance

Information *Julie Gill*

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

20.3. Audit Committee

Information *Ian Haythornthwaite*

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

20.4. People Committee

Information *Lynne Lobley*

20.4. AAA People - Aug 2024.pdf (2 pages)

20.5. Research

Information *Clare Austin*

20.5. AAA - Research - Sep 2024.pdf (2 pages)

21. Integrated performance report

Information *Sanjay Arya/ Sarah Brennan/ Kevin Parker-Evans/ Juliette Tait*

21. Board of Directors M5 2425 IPR.pdf (4 pages)
21a. M5 2425 Integrated Performance Report.pdf (19 pages)

22. Maternity reports

Kevin Parker-Evans

Reports to follow

23. Partnerships report

Information *Richard Mundon*

23. Trust Board - Partnerships Report October 2024 FINAL.pdf (5 pages)

24. Finance report

Information *Tabitha Gardner*

24. Board Cover Sheet - Trust Finance Report August 2024.pdf (2 pages)
24a. Trust Finance Report 24-25 August Month 5 Board.pdf (16 pages)

25. Complaints annual report

Information *Kevin Parker-Evans*

25.PRD annual report June 2024 new format.pdf (21 pages)

26. Board Assurance Framework

Information *Paul Howard*

26.BAF Report Board October 2024.pdf (29 pages)

27. Freedom to Speak Up Guardian's report

Information *Selina Morgan*

27. FTSU Quarterly report for Board 17.09.24 v0.3.pdf (6 pages)

28. Reflections on equality, diversity and inclusion

Discussion *Mark Jones*

Consent Agenda

29. Risk Management Framework

Ratification

29.Board FS Risk Management Framework.pdf (2 pages)
29a. Risk Management Framework for Board Ratification.pdf (16 pages)

30. Revalidation report

30.Appraisal Revalidation Annual Submission_Trust Board.pdf (27 pages)

31. Guardian of Safe Working Hours

Information

31.GOSWH WWL Annual Report 2023-2024.pdf (9 pages)
31a. GOSWH Quarter 1 April to June 2024.pdf (9 pages)

32. EPRR core standards

32. EPRR Statement of Compliance 2024-2025 - WWL.pdf (1 pages)
32a. 240816 NHS Core Standards for EPRR 2024 WWL Self Assesment v1.pdf (5 pages)
32. 241002 - Report on NHS EPRR Core Standards 2024.pdf (4 pages)

33. Date, time and venue of the next meeting

Information

04 December 2024, 1:15pm, Trust Headquarters Boardroom.

Agenda item: 14.1

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Directors' declarations of interest
Presented to:	Board of Directors
On:	2 October 2024
Purpose:	Information
Prepared by:	Deputy Company Secretary E: nina.guymer@wwl.nhs.uk

NON-EXECUTIVE DIRECTORS	
Name	**Declared interests**
AUSTIN, Claire	Employed by Edge Hill University as Pro-Vice-Chancellor and Dean, Faculty of Health and Social Care and medicine.. Son works for Azets Audit Services Limited as a Trainee Auditor..
BRADLEY, Rhona	Trustee, Addiction Dependency Solutions charity Governor, Learning Training Employment (LTE) Group Non-Executive Director, Home Group Housing Association Spouse is The Rt Hon Lord Bradley of Withington
GILL, Julie	Employed by Cheshire Constabulary as Assistant Chief Officer
HAYTHORNTHWAITE, Ian	Chair, Countess of Chester NHS FT
HOLDEN, Simon	Chairman of Governors, Pear Tree Academy School Director, Simon Holden Associates Limited
JONES, Mark	Nil declaration
LOBLEY, Lynne	Nil declaration
MOORE, Mary	Director and shareholder, Scenario Health Ltd (CRN: 13066776) Non-Executive Director, Stockport NHS Foundation Trust
THORPE, Francine	Independent Chair, Salford Safeguarding Adults Board

EXECUTIVE DIRECTORS	
Name	**Declared interests**
ARYA, Sanjay	Clinical private practice, Beaumont Hospital and WWL. Undergraduate Clinical Lead in Cardiology, Edge Hill University. Contracted to act as Principle Investigator for Triage Heart Failure Study Medtronic Company (in association with Manchester Foundation Trust). Honorary position on the Advisory Panel at Bolton University Medical School. Director and Chair of the Hospital Doctors' Forum, British International Doctors' Association (CRN: 01396082) Director, Highbank Grange (Bolton) Residents Association Limited (CRN: 04300183) Spouse is General Practitioner in Bolton
BRENNAN, Sarah	Nil declaration
TAIT, Juliette	Nil declaration
FLEMING, Mary	Nil declaration
GARDNER, Tabitha	Governor, Aspiring Learners Academy Trust Spouse is director of Manchester University NHS FT
HOWARD, Paul	Director and shareholder, PDH Advisory Limited (CRN: 09800579) Independent Person for Bolton Council Tutor and examiner for the Chartered Governance Institute UK and Ireland Spouse works for North West Ambulance Service NHS Trust and is shareholder of PDH Advisory Limited (CRN: 09800579)
MILLER, Anne-Marie	Spouse is director of Railway Children charity and Railway Children Trading Company Limited Spouse acted as a Fundraising Consultant for WWL on one project in 2023/24
MUNDON, Richard	Nil declaration
PARKER-EVANS, Kevin	Spouse is Head of Safeguarding and Designated Adult safeguarding nurse for NHS Greater Manchester (Stockport Locality)

Board of Directors - Public Meeting

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Attendees

Board members

Mark Jones (Chair), Abdul Ashish (Deputy Medical Director), Rhona Bradley (Non-Executive Director), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Ian Haythornthwaite (Non-Executive Director), Paul Howard (Director of Corporate Affairs), Nigel Kee (Interim Chief Operating Officer), 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), Kevin Parker-Evans (Chief Nurse), Juliette Tait (Chief People Officer), Francine Thorpe (Non-Executive Director)

Absent: Sanjay Arya (Medical Director), Simon Holden (Non-Executive Director)

Meeting minutes

122. Declarations of Interest

Information

No declarations of interest were made.

Mark Jones

123. Minutes of the previous meeting

Approval

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

Mark Jones

15. Minutes_Board of Directors - Public Meeting_050624.pdf

124. Action Log

Mark Jones

The Board reviewed the action log, noting that all actions due had been completed with updates recorded therein.

16. Public Board Action Log - Jun 2024 v1.pdf

125. Chair's report

Information

Mark Jones

The Chair begun by acknowledging the recent public disruption triggered by the tragic death of three young girls and the associated injury of several others, which had recently occurred in the nearby town of Southport. He would hand over to the Chief Executive so that she may provide a briefing on the same.

He was pleased to communicate the recent decision made by the Council of Governors to extend his term of office by a further three years and that he would be with WWL to see through the Wigan System Transformation Programme. He emphasised that this will entail support for all, reduction of health inequalities, support for staff as changes are made and the strengthening of the robustness in the organisation's financial position.

Further, he noted that tracking health inequalities is fast becoming part of the Trust's core business and advised that Board that the ICB are now providing core assessment tools, access to data sets and expert input for trusts to help with this.

He explained that he would no longer be attending the Provider Oversight Meetings with ICB colleagues and members of WWL's executive team, as the meeting is of operational nature and moving forwards, he had asked that executives ensure that they meet with non-executive director (NED) colleagues regularly to disseminate any relevant information from there and ensure that items are added to committee agendas where assurance is required in specific areas. He noted that he would still however be attending relevant system levels meetings and emphasised the need for executives and non-executives to work together to ensure substantial grip and control on this at board level.

Finally, he reminded that Board of the recent review of the Three Wishes Charity Strategy, he thanked the Chief Finance Officer and Director of Communications and Stakeholder Engagement for their work on this. He provided a breakdown of the annual plan for 2024/25 and expressed a keenness for the teams involved to take it this forwards with enthusiasm.

126. Chief Executive's report

Information

Mary Fleming

The Chief Executive asked the Board to note her regular report which had been shared in advance of the meeting, instead wishing to turn her attention to the aforementioned tragedy. She offered condolences to the families of those who had died on behalf of the WWL Board and extended its upmost thanks to all NHS colleagues, including the staff at WWL, who responded to the major incident called during the attack and also to the riots that arose in the following days. She thanked police colleagues who had responded and continued to work with local partners to maintain safety amongst communities across the country. She understood that there is a nervousness amongst staff created by the resulting civil unrest and emphasised that the Board want staff to feel supported throughout this difficult time. WWL is proud of its multicultural workforce and does not tolerate discrimination or offensive comments being made at work or via social media, per its antiracism statement. She was clear that the law applies equally to all and appropriate action will be taken against any staff taking part in illegal riots or protests. She affirmed that staff will continue to be updated with relevant information and offers of support, following initial communications around safety and wellbeing. She concluded by emphasising that WWL works as one team, is proud of its diversity and will remain true to its values. She implored colleagues to check in on one another throughout this difficult time.

Board members echoed her sentiments and were keen to ensure that the communications which had recently been shared with staff continue.

The Director of Communications and Stakeholder Engagement added that her team are working with colleagues within the GM ICB to ensure that all trusts are aligned and consistent in their messaging. She affirmed that messaging will continue for as long as support and advice is required. In response to a request from the Chair, she agreed to ensure that these communications are shared with the Council of Governors.

ACTION: A M Miller

18. APPROVED CEO Board Report July 2024.pdf

127. Committee chairs' reports

Information

Non Executive Directors

The Non Executive chairs of the Board's assurance committees presented their respective reports.

127.1. Quality and Safety Committee

Information

Francine Thorpe

The Chair asked where the Escalation and Assurance Group referenced in the report reports to.

The Chief Nurse advised that this is a newly established group which will report to the Quality and Safety Committee and be chaired by the Deputy Chief Nurse, with divisional leaders in attendance. He added that he has been asked to present this nationally as model practice, since WWL is thus far the only trust working in this way.

19.1. AAA Q&S July 2024.pdf

127.2. Finance and Performance Committee

Information

19.2. AAA F&P - July 2024.pdf

Julie Gill

127.3. Audit Committee

Information

Ian Haythornthwaite

Mr I Haythornthwaite added that the sign off of the year end items listed evidenced that the external auditors confidence that the organisation is in a good position with no significant concerns or risks to be raised to the board for 2023/24.

19.3. AAA - Audit Committee - 26 Jun 2024.pdf

127.4. People Committee

Information

Lynne Lobley

The Chair asked how those coming in to work for the Trust straight from education could support the position around the aging workforce within the community division, noting concerns around how the more senior staff will be replaced.

The Chief Nurse advised that a legacy mentor scheme is being considered, which will see senior staff who have retired work with new recruits to provide support and guidance. Rotational work will be offered for acute and community nurses as well as allied health practitioners (AHPs) moving forwards to support development and cross departmental working.

The Chief People Officer noted that succession planning will take place where there is a high volume of employees at either a very junior or senior role. She was pleased to celebrate the recent addition of four trade apprentices at WWL, it being the first in the locality to recruit to these positions.

The Chief Executive added that NHS providers have contacted herself and the Chair to ask them to feed back on any specific gaps within the workforce.

The Chief People Officer suggested that support for BAME staff to reach a more senior level would be helpful - she noted that the Deputy Medical Director is currently completing the Nye Bevan Programme and is keen to support those working in the medical profession to develop their leadership skills.

The Chief Executive recalled her attendance at a recent meeting with Prof C Austin (Vice Chancellor of Edge Hill University) which had been attended by the Mayor of Greater Manchester and saw very positive and encouraging conversations going on around how to encourage the generation now coming through University to begin a career in healthcare.

19.4. AAA People - Jun 2024.pdf

128. Maternity reports

Kevin Parker-Evans

The Chief Nurse provided a summary of the reports which had been shared prior to the meeting.

He expressed confidence in how good WWL are at providing 1:1 maternity care, referencing a lady who had recently unavoidably given birth in the hospital car park, having received the same high standard of care and with a health baby being delivered.

He highlighted that non-smoking status at birth had recently seen the lowest reported figure for a significant period, this has since increased but he has requested more detailed reporting around what is done during the nine month period to support women to stop smoking.

Mrs M Moore was pleased to see all learning from approved investigations and actions will be monitored through internal governance processes. She further noted that when there was a retained swab, staffing over night was noted as an issue but the data for staffing that night is shown as green.

The Chief Nurse advised that the maternity team have a real advantage in terms of moving staff around to help with capacity - the unit was staffed but he agreed to check that there were no significant issues that should have been reported.

He went on to noted that at a recent system level maternity meet WWL were well represented, Mrs M Moore and Mrs F Thorpe also being present.

Mrs L Lobley noted some delays in women getting to surgery for c-sections reported and asked what the reasons for this were.

The Chief Nurse noted that he has asked the Divisional Director of Midwifery and Neonates to include the reasons for these delays in the next report, noting that in some cases this is because the women were not suitable to have surgery.

Mr I Haythornthwaite noted that WWL is not always reaching its target in terms of steroids and asked what the clinical significance of the target being missed is.

The Chief Nurse advised that he will consider this moving forwards and add detail to the next report.

Lady R Bradley noted difficulty in identifying trends as the graphs fluctuate so much.

The Chief Nurse advised that this may be affected by the transition in reporting style, he clarified that moving forwards the statistical process control (SPC) charts will assist to identify upper and lower limits and provide a clearer picture of trends.

The Director of Strategy and Planning clarified that circa 18 months worth of data is required to allow for trends to be properly identified.

The Interim Chief Operating Office asked whether enough is being done to share the good practice done around smoking cessation and how women can be supported following discharge.

The Chief Nurse agreed that additional support is required from partners across the health social care to aid continued cessation.

It was noted that the papers provided had been reviewed and scrutinised by the Quality and Safety Committee in the first instance but the important of the Board being properly assured on maternoty related matters was emphasised.

128.1. Maternity Dashboards

Information

20.1b. Neonatal Dashboard - June 2024.pdf
20.1a. Maternity Dashboard - June 2024.pdf
20.1. Maternity Dashboard report June 24.pdf

128.2. Perinatal Surveillance Report

Information

20.3b. Perinatal Exception Report - June 2024.pdf
20.3.Maternity Perinatal Quality Surveillance Q1 24-25 (For Board).pdf
20.3a. Perinatal Dashboard - June 2024.pdf

128.3. Neonatal Staffing review

Approval

The Board noted that there was no additional staffing ask, staffing level being compliant but that when additional funding would be made available there will be a request to increase the establishment to meet the recommendation for quality roles in AHP positions.

20.2. NNU Staffing Paper July 2024 MIS Safety Action 4 final version.pdf

129. Integrated performance report

Information

Nigel Kee/Abdul Ashish/Juliette Tait/Kevin-Parker Evans

The Interim Chief Operating, Chief People Officer, Officer, Deputy Medical Director and Chief Nurse presented their
respective quadrants of the score card and associated narrative for June 2024.

Quality and safety

In response to a query from the Chair about the reason for the increase in complaints, the Chief Nurse explained that this is due to a multitude of factors including the completability of the complaints, staff changes in the complaints team and staff availability throughout the resolution process due to current pressures.

People

Mrs L Lobley asked how WWL are performing against rate card adherence, recalling that WWL were using the GM rate card.

The Chief People Officer noted that the GM rate card is due to be removed as one of the terms of the doctors strike agreement. She thought that WWL perform as middle of the pack but did not know for sure.

Mr I Haythornthwaite noted the current sickness rate at 140 people over a month which equates to circa 4000 days in terms of lost time and asked what is being done to address this.

The Chief People Officer advised that there are two ongoing strands of work currently. The first is systematically reviewing the details of each individual cases to see if the staff concerned can be redeployed; the second is revision of the policy for managing long terms sickness in line with NICE guidance. She noted that WWLs policy is flexible, which is positive as it is supportive for staff but does not provide enough support for managers.

Finance and performance

The Interim Chief Operating Officer acknowledged that the 'no criteria to reside' rate is high and added that a multi agency meeting would be held shortly to consider how this figure can be reduced. Following a recent visit from the national GIRFT (getting it right first time) team, the Leigh site has achieved GIRFT surgical hub accreditation.

Mrs L Lobley noted the theatre utilisation position and asked about how much of this is hampered by basic issues which may be easy to fix, such as late starts and early finishes.

The Interim Chief Operating Officer agreed that this is the case a lot of the time and advised that productivity rather than utilisation is now being given focus, as this is the key metric which links more closely with delivery of the financial and operational plans.

The Director of Strategy and Planning added that the company Foresight is being used across GM to consider theatre performance, including utilisation and benchmarking.

Mrs F Thorpe noted that WWL are just below the 77% national target and asked what mechanism is used to monitor how much longer after the 62 days patients ultimately begin treatment.

The Interim Chief Operating Officer confirm that this is monitored and that clinical harm reviews are carried out to determine whether harm is caused as a result of a delay.

The Chief Executive noted that many trusts are experiencing issues with the low level funding for capital estates maintenance and also the impact of industrial action.

The Chair emphasised the importance of the board taking assurance on when workforce plans will come to fruition in tandem with the financial position.

Mrs F Thorpe asked about how the rota gaps, which result in spend on bank and agency, are being tackled.

The Deputy Medical Director advised that a multi pronged approach is being taken, including utilising the

AHPs workforce and nurses to fill gaps where this is appropriate. The Chief Executive added that employment of several clinical fellows has been signed off, for a set period, which will allow WWL to cover some workforce gaps at a more reasonable cost

Mr I Haythornthwaite queried the link between capital spend and cash.

The Chief Finance Officer clarified that capital monies could not be used to support revenue expenditure

It was clarified that, in contrast to the £300k of funding provided by NHSE to cover the impact of industrial action during the previous year, no support would be provided during the current year.

The Chief Finance Officer noted that the current demonstrable progress provides more assurance around delivery of CIP but was clear that the messaging across the organisation must reinforce the importance of continuing to push for delivery.

Mrs L Lobley sought more assurance about work done to increase CIP to bridge the existing gap.

The Chief Finance Officer advised that there us a constant review of schemes within the divisions and the Board were also informed of some additional transformation resource which is tasked with considering the CIP programme and the work model for the team supporting this, providing fortnightly updates for the executive team.

The report was received and noted.

21a. Board of Directors IPR M3 2425.pdf
21. Board of Directors M3 2425 IPR.pdf

130. Finance report

Information

Tabitha Gardner

The Chief Finance Officer presented the report, which was recieved and noted.

22. Trust Finance Report June 2024 Board.pdf
22a. Trust Finance Report 24-25 June Month 3 Board.pdf

131. Board Assurance Framework

Information

Paul Howard

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

No queries were raised and it was noted that this evidenced how effectively the board and its committees work to provide scrutiny in key areas.

The Director of Strategy and Planning noted that the 'Partnerships' dashboard is not discussed in any other forum and wished to highlight some piece of work which strengthen WWLs partnership working. WWL are hosting the infection prevention control service which will be used by WHICH TRUSTS. Further, her reminded the board that the Wigan System Transformation Programme would be due to progress in September 2024, with local partners - he noted that the risk score for PR14 (risk to delivery of effective partnership working across GM and the locality has decreased to 9. The Board supported this change.

The Board **APPROVED** the report and confirm that it provides an accurate representation of the current significant risks to the delivery of the Trust's strategic objectives

23. BAF Report Board August 2024final.pdf

132. Reflections on equality, diversity and inclusion (ED&I)

Discussion

Mark Jones

Mrs L Lobley noted that more information is required about the ethnicity and socioeconomic status of pregnant mothers are needed to help support the narrowing of health inequalities in this area, referring back to the discussion around the maternity papers

The Chief Nurse advised that this is being captured, albeit is not included in the report as statutorily, this is not required. He agreed to include this moving forwards. The Chair of the Quality and Safety Committee noted that the committee had also discussed this and taken assurance around the current position.

The Board were pleased to see the organisation taking part in a 90 day antiracist challenge.

It was highlighted that the corporate report template has now been amended to ask colleagues to give consideration as to how their report may impact equality, diversity or inclusion at WWL. ED&I reflections are discussed at all assurance committees and moving forwards, it was suggested that related comments are included in the advise section of the associated AAA reports.

The potential for strengthening safeguarding service provision through utilisation of postcode data was highlighted.

The board were pleased to see progress in this area and an increase in ED&I related challenge.

Consent Agenda

133. Committee terms of reference

Approval

The terms of reference for the Quality and Safety, People and Finance and Performance Committee for 2024/25 were **APPROVED**.

25. ToR - People Committee 2024.pdf
25. DRAFT F&P Committee ToR 2024.pdf
25. DRAFT ToR - QS 2024 NG EH amends v1.pdf

134. Date, time and venue of the next meeting

Information

2 October 2024, 1:15pm, Trust Headquarters Boardroom.

Action log: October 2024

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
7 Aug 2024	126/24	Chief Executive's report	Ensure that communications pertaining to civil unrest are shared with the Council of Governors.	AM Miller	ASAP	Staff communications were shared with governors on 7 Aug 2024. **Action closed.**

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	02/10/2024
Item purpose:	Information
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 and corporate objectives

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.

Equality, diversity and inclusion implications

The report references our Anti-Racist Organisation Statement, Equality Diversity Inclusion Strategy and National Inclusion Week 2024.

Which other groups have reviewed this report prior to its submission to the committee/board?

N/A.

Recommendation(s)

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

Report

In August, our Urgent and Emergency Services at the Royal Albert Edward Infirmary (RAEI) received a 'Good' overall Care Quality Commission (CQC) rating, as well as 'Good' for well-led, responsive, caring and effective. I was pleased that the CQC recognised our positive safety-focussed culture, and that our staff treat people with compassion, kindness and dignity. However, the safe part of the rating has changed from 'Good' to 'Requires Improvement'. This rating was reduced due to not all staff being up to date with some elements of mandatory training at the time of inspection which took place earlier this year, as well as timeliness of the services and staff shortages. Since the CQC visit significant improvements have been made including a refurbishment of waiting room areas, providing a better and safer environment for our patients, relatives and carers. The safety of patients, visitors and our staff will continue to remain our strong focus.

I was delighted to welcome Lisa Nandy, Wigan MP and Secretary of State for Culture, Media and Sport in September, to see the latest updates on our new Endoscopy build at the RAEI site. Ms Nandy was given a tour of the current building site set to be our new four-storey development which will support the expansion and reconfiguration of the Endoscopy Unit. The new development will create facilities that meet the requirement for modern service delivery, providing quicker access to endoscopy procedures, ultimately leading to better outcomes for patients, as well as an improved environment for both patients and staff. It is due to be completed by Summer next year and construction plans have been carefully designed to ensure that current endoscopy services continue to be delivered while the work is undertaken.

Alongside the development at RAEI, we are also increasing the number of endoscopy rooms at Leigh Infirmary from three to six, supporting earlier diagnosis of conditions including bowel cancer, and other gastrointestinal diseases, with one treatment room at Leigh already accepting patients, and the two remaining rooms due to be finished this Autumn. In total, £14.5m is being invested into endoscopy services across WWL's RAEI and Leigh Infirmary sites. Being able to invest in our services is something I am really proud of, especially as we currently carry out 9,000 endoscopy procedures a year. Ms Nandy praised the innovation, creativity and passion our staff give to improve healthcare for the people of Wigan Borough, and I am extremely thankful for everyone's continuous hard work to ensure that patients will be receiving the highest possible standards of care, with improvements in privacy and dignity, increased patient choice, and more timely appointments. Leigh Infirmary also achieved Surgical Hub Accreditation, this Summer, which is brilliant news not just for Leigh Infirmary but for the Trust and community as a whole.

The Executive team and I were delighted to be part of Wigan Council's 'Progress with Unity' launch in early September, marking a new approach to deliver change within the Wigan Borough. 'Progress With Unity' is the revived corporate identity and coat of arms for Wigan Council moving forward. It was Wigan Council's motto 50 years ago and it has been refreshed for 2024 to reflect the progress since 1974 when the 14 towns came together to create the Borough of Wigan. 'Progress With Unity' has two key missions – the first is to create fair opportunities for every resident of the borough, which is something we are also passionate about here at WWL, as we see the impact health inequalities can have. The second key mission is to make all of our Wigan Borough towns and neighbourhoods flourish for those who live and work in them to make the

place we work the very best for the people who live here. WWL will play a key part in this as an anchor institute and Wigan's largest employer.

September also saw the official launch of a new Wigan locality-wide Urgent and Emergency Care Transformation programme, a strong step in our partnership work alongside Wigan Council and the Greater Manchester Integrated Care Board, as well as Newton Europe who are supporting us to implement the programme. It is a one-of-a-kind, bespoke programme which will signal how we want to work together as one team: creating a seamless health and social care system to improve outcomes for residents of the Wigan Borough. The programme will help deliver changes to models of care, processes and practices that will enable social care and hospital staff to work together to enable patients to receive care in the right place, at the right time, promoting independence as opposed to unnecessary hospital stays. Integration and collaboration will be at the heart of what we do, as we work to make community-based services, and home care more available as an alternative to our Emergency Department.

Additionally, our new Chief Operating Officer, Sarah Brennan, officially joined us at the start of September. Sarah brings with her a wealth of knowledge and experience, which she has already started to showcase, leading on and driving forward the new Urgent and Emergency Care Transformation programme working closely with our partners across the Wigan Borough.

Partnership working was also strengthened in September with a Greater Manchester (GM) Super Multi-agency Discharge Event (MaDE). The event brought together local health and care system partners, to support improved patient flow across the entire system, recognising and unblocking delays, and challenging, improving and simplifying complex discharge processes. It was great to see that despite the significant pressure across the Trust, and the wider GM system, we still managed to see improvements in a number of key metrics, as well as improved patient flow and new ways of working which can now be embedded before Winter pressures increase. The collaboration and engagement between social care, voluntary, mental health along with primary and community care was great to see and a perfect example of how it's vital we all work together to ensure the right care is delivered at the right time and in the right place.

Operationally, Winter planning is well underway as Winter is always a challenging period for Health and Social Care systems, with demand for services typically increasing, resulting in increased pressures on hospitals, community services and primary care. Our Resilience Team are leading on our seasonal preparedness plan which sets out the actions and measures being put in place to manage the anticipated increase in pressures, including supporting safe and effective patient flow, risk mitigation, concise escalation and de-escalation processes and staff health and wellbeing considerations. This will be supported by the launch of our annual flu and covid vaccination programmes which began in September, as well as wellbeing initiatives and infection control campaigns e.g. 100 Days of Hand Hygiene.

Regarding our current financial position, there has been some slippage with our deficit and cost improvement programmes. These continue to be a pressure and so our focus will remain on the delivery of recurrent savings to support our longer-term financial sustainability. Whilst the financial situation continues to be a challenge, we are confident that with everyone working together, our three-year plan can be delivered, through transformation over the longer term, improving productivity and managing costs responsibly, whilst ensuring quality and safety is maintained. We continue to work within the GM System and progress with our plans are reviewed each month as part of the GM Performance Oversight Meetings.

Improving the experience of our staff also remains a focus, and progress continues on our commitment to become an anti-racist organisation. This includes actively listening and learning from colleagues at our monthly all staff and leadership briefings to understand what being anti-racist means to them, what action for change would make the biggest difference and how we can all work together to be an anti-racist organisation. Staff and leaders' responses will help shape the improvements we are committed to make, along with input from our Staff Networks and Equality, Diversity and Inclusion Workstreams. This was further supported by National Inclusion Week in September, during which several lunch and learn sessions and masterclasses were held for colleagues and leaders to help raise awareness of Equality Diversity and Inclusion related topics, and provide the tools needed to take action as we work together to make WWL a more inclusive workplace. I appreciate we still have a way to go, and the recent tensions amongst our community showcased this, but I am extremely proud of our diverse workforce, and we will continue to make the improvements needed so that every single member of our Trust feels welcome, valued and assured that they have our full support.

Another opportunity for staff to have a voice is through the annual NHS National Staff Survey which has just launched. This is an opportunity for staff to ensure their thoughts, feelings and ideas are captured to inform necessary changes needed to make the Trust an even greater place to work and receive care.

Similarly, we also continue on our journey to be an outstanding Trust. August and September also saw the promotion of several national campaigns which support patient safety including sepsis awareness, falls prevention and celebrating the impact that research has on our delivery of safe patient services. Colleagues from across our divisions have also been recognised for their outstanding work and contributions to our patients, staff and beyond as we announced this year's Staff Thanks and Recognition Awards Finalists. We will be celebrating their achievements and announcing this year's winners later this month at a fully sponsored celebration evening.

Finally, I want to acknowledge the publication of Lord Darzi's report on the state of the National Health Service in England which was published recently. The report paints a deeply sobering picture of the current performance challenges our NHS teams are managing day-to-day across the country. It is an incredibly thorough, and at times an incredibly hard look, at the challenges facing the NHS. The findings are not a surprise, however what is new is the articulation of the sheer scale of the challenge in front of us. What the Darzi Report reinforced was the need to focus on recognising where parts of the system are getting things right, where they are working well, and how we spread best practice and scale this up right across the country. Lord Darzi shared our view that many of the answers are already out there, clearly demonstrating what the future could look like. As CEO I am committed to system working, embedding a culture of continuous improvement and inclusion, and to ensure we move forward as an NHS organisation to provide the services and care our local population need and deserve, right now and in the future.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	11th September 2024
Chair:	Francine Thorpe

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

ALERT

- The Q1 Patient Safety Incident Report highlighted continued themes in relation to incidents reported about suboptimal care of a deteriorating patiet, delayed diagnosis and treatment delays. Learning from the investigations of these incidents is taken through the relevant working groups which the committee receives regular reports from.
- The Q1 Harm Free Care Report highlighted an increase in grade 2 pressure ulcers reported within the Emergnency Department and on Aspull ward. Deep dives are being undertaken to investigate whether there are any themes. The report also outlined an issue in the reporting of Catheter Acquired Urinary Tract Infections (CAUTI), further work is being undertaken to address this. Updates on these issues will be provided in future reports.
- The Infection Prevention Control Annual Report indicated low uptake of flu and covid vaccinations amongst Trust staff in 2022/23. Members of Committee were keen to understand how this could be improved for this year and wanted the Board to actively promote this across the organisation.

ASSURE

- The Maternity Deep Dive highlighted that:
  - We are on track to meet the agreed targets in the Saving Babies Lives work programme
  - We are expecting to achieve the CNST standards for this year
  - Work is progressing to strengthen service user feedback through the Matenrity Voices Partnership
- The Q1 Harm Free Care Report confirmed that we are on trajectory to meet the target for corporate objective CO4. In addition the report confirmed a number of wards had zero pressure ulcers within the last 12 months. Discussion following presentation of the report confirmed that we are working collaborativley with care homes on this agenda.
- The Clinical Audit and Effectiveness Annual Report provided assurance that we have robust processes in place to undertake a wide range of audits at a local and national level. The report evidenced improvement actions being generated where necessary and processes in place for re-audit. The report also outlined how the organisation manages the distribution and oversight of NICE guidelines.

- A benchmarking self-assessment was received in relation to a Mersey Internal Audit (MIAA) report that compared key aspects of Quality Committees across their client base. The self-assessment RAG rated our committee as green against all recommendations with underpinning evidence. Members of the Committee agreed with the self-assessment.
- The Infection Prevention and Control Annual Report highlighted:
    - Robust approach to the management and oversight of infection outbreaks
    - Good compliance with training
    - Reduction in Clostridium Difficile and E. Coli cases compared to the previous year
    - Zero MRSA infections
    - The challenges of undertaking deep cleaning with the current levles of bed occupancy were discussed and it was highlighted how this is being combined with essential maintenance work
- A The Q1 Patient Safety Incident Report provided assurance that the new Patient Safety Incident Response Framework has been implemented and is embedded within the organisation. Evidence of how learning from investigations is being used to drive improvement and shared across the organisation was provided.

ADVISE

- The Committee's reflections on Equality Diversity and Inclusion included:
    - Positive feedback in relation to the maternity reports which highlighted monitoring of ethnicity in relation to a range of indicators. Information was also oultined in terms of targeted support to vulnerable women and those from the most deprived areas of the borough.
    - Challenge in terms of patient experience noting that the complaints annual report indicated that the majority of complaints come from people who are white british. This will be picked up through the Patient Experience Group
    - Challenge in terms of limited informationin relation to inclusion being referenced in committee reports.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the board assurance framework were reviewed; no changes were made.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	24 September 2024
Chair:	Julie Gill

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

ALERT

- The specialist services division provided the deep dive presentation – the committee noted that the division is significantly off plan and wished to see more assurance around the mitigations for delivery of the elective plan from month 6 and the cost improvement programme (CIP) target. A report will be provided at each meeting for the remainder of the financial year to maintain committee oversight of delivery of the position. The division will be asked to attend committee meetings where this is felt appropriate.
- Progress with the 65 week target for elective care was noted – this was slightly off track at the end of September 2024 but assurance provided that all remaining patients will have treatment dates for October 2024.
- The finance report notes that the best case scenario is plan delivery, with the mid-case being that there is a £17.1m deficit, versus plan of £14.2m deficit.

ASSURE

- An update was provided on progress with the multi-story care park project. This is due to come to the Board of Directors in December 2024.
- The committee noted continual close monitoring of cash. The latest NHSE guidance indicates that WWL's deficit will be cash backed and WWL will not require cash drawdown in-year.
- Delivery of the CIP plan was noted in month although year to date is behind plan by £600k.
- An update was provided and good progress noted in respect of the digital development programme.

ADVISE

- Slippage in recurrent CIP was noted and the potential impact on the financial sustainability plan. The CIP mitigation areas were noted, and a further update would be received at month 6.
- The committee received benefits realisation reports for the business cases which provided for additional emergency department senior house officers and additional senior house officer clinical fellows. These were noted but will be deferred for further consideration at the November 2024 meeting.
- Business cases for the theatre 12 fit out and enabling works as well as a 3T MRI scanner at the Wrightington site were both approved.

▪ Urgent and emergency care monitoring was discussed and it was noted that this links with discussions had at the Provider Oversight Meeting, therefore it was agreed that the data would be aligned moving forwards to ensure that this and the Quality and Safety Committee each receive the relevant information without overlap.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ The board assurance framework was noted but no changes to the scores were requested.

Committee report

Report from:	People Committee
Date of meeting:	13 August 2024
Chair:	Lynne Lobley

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

ALERT
▪ The committee received a report on Oliver McGowan training, which was supported although issues were noted with the significant impact that release for the training has in terms of headcount, resource and working hours lost over the course of the year. The committee were however pleased to see the progress that the team have made in rolling out this training. Alternative options for delivery are being explored. ▪ The committee noted through the specialist division's deep dive report that they have an aging workforce, may of whom are likely to cease employment with the trust at a similar time, thereby creating a workforce shortage. ▪ The committee noted that the Empactis absence management system will be rolled out Trust wide, although it is not fully funded. The original business case outlined savings for the Trust that the implementation should bring based on reduction in absence rates and it was agreed that a benefits realisation report will be required when more data is available, to allow us to assess the return on investment.
ASSURE
▪ The junior doctors' strike did not impact elective care and was well managed overall. ▪ There is a plan to increase placements for student nurse and to introduce a rotational working model to allow students to gain experience in more areas, this was well received. ▪ Plans to support international doctors to complete mandatory training were evidenced. ▪ The specialist services division's deep dive illustrated good engagement within the division in terms of the staff survey response rate as well as the results. ▪ The staff story was provided by an Acute Discharge Facilitator who had completed an apprenticeship with WWL and gone on to deliver a quality improvement project. The story highlighted for the committee: - How well apprentices are supported - How accessible and effective WWL's quality/continued improvement course is and how well colleagues are supported throughout this - Evidence of sustained improvement in weekend discharge numbers as a result of the project. ▪ The 'People' dashboard showed a reduction in long term sickness cases and that WWL are the lowest in respect of turnover within Greater Manchester. Resident doctor compliance for mandatory training has also increased up from 43% to 89%.

- The Guardian of Safe Working gave assurance around the reduction of exception reports, although the issue with doctors often holding too many bleeps was noted to be ongoing.
- WWL's engagement in the NHS England Equality Diversity and Inclusion (EDI) Partners Programme and the NHS England Chief Nursing Officer 90 Day Global Challenge was positively received.
-

ADVISE

- The committee took an update on the position on workforce digitisation.
- A national referendum on pay will be held for junior doctors which will give a better indication of the future position regarding industrial action.
- Content in papers was noted to be appropriately EDI focussed in relevant areas.
- The audit and risk report illustrated good progress being made in areas which had previously been highlighted as being of concern.
- The Mutually Agreed Resignation Scheme was noted to have been approved by the board and the committee noted that headcount reduction has been built in to the cost improvement programme, to be monitored by the Finance and Performance Committee, and People Committee will provide oversight of workforce transformation and planning schemes
-

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- None.

Agenda item: 20.5

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Research Committee
Date of meeting:	3 September 2024
Chair:	Clare Austin

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

ALERT
▪ The committee raised several times throughout the meeting the matter of clinicians not having time to do research (including attending research related meetings). This has been highlighted as a concern previously and a need for additional support here was identified. ▪ The number of joint clinical academic positions required to meet the requirements for university hospital status is yet to be met, however, it was noted that there were a number of upcoming positions which are hoped soon to be filled with joint appointments and evidence of an improved recruitment process which should support this increase.
ASSURE
▪ At its last meeting the committee asked for assurance around clinical research incidents (reported via Datix) – a report was provided which evidenced assurance around processes in place for managing these. ▪ The research assurance framework was reviewed, and assurance noted around the progress of work as aligned to research objectives, including done with the Wigan Health and Care Research Forum; changes in recruitment process; performance against the National Institute for Health and Care Research recruitment target and research capability funding targets. ▪ The research finance report provided assurance around the increase in income for 2024/25 so far with a positive trajectory set out for 2025/26. ▪ A positive research spotlight report was provided by the medicine division, with good progress noted.
ADVISE
▪ The committee sought further transparency around the surpluses identified through the finance report. ▪ A positive patient research story was received. ▪ The committee discussed the need for further work to be done to ensure that all WWL's research related publications and research activity are captured and recorded in the same place.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ No significant risks were noted.

Title of report:	M5 2425 Integrated Performance Report
Presented to:	Board of Directors
On:	02.10.24
Item purpose:	Information
Presented by:	Director of Strategy & Planning
Prepared by:	Principal Data Analyst, Data Analytics and Assurance
Contact details:	BIPerformanceReport.wwl.nhs.uk

Executive summary

The latest month, for M5 June 24 update of the Trust's Integrated Performance Report (IPR) is presented to the Board of Directors.

The Integrated Performance Report presents a holistic overview of the Trust's key metrics and how each are performing compared to set (national where available) targets. The IPR has been developed using NHS England's Making Data Count (MDC) methodology, which uses Statistical Process Control (SPC) Charts to clearly identify trends in performance and comparison to targets.

Following the Trust level view and holistic narrative, for each specific area: Quality & Safety, People, Performance and Finance, there is then a summary page, narrative and insight report which focuses on 4 specific metrics from each area. The detail in the report enables evaluation against key metrics to identify where the Trust is performing well and where there are opportunities for improvement.

Link to strategy and corporate objectives

2030 Strategy
Patient
Performance
People
Partnerships

Risks associated with this report and proposed mitigations

There are no risks currently associated with the report.

Financial implications

There are no financial implications currently associated with the report; key financial metrics are measured within the report.

Legal implications

None currently identified.

People implications

None currently identified with the report; key People metrics are measured within the report.

Equality, diversity and inclusion implications

None currently identified.

Which other groups have reviewed this report prior to its submission to the committee/board?

Wider Leadership Team .

Recommendation(s)

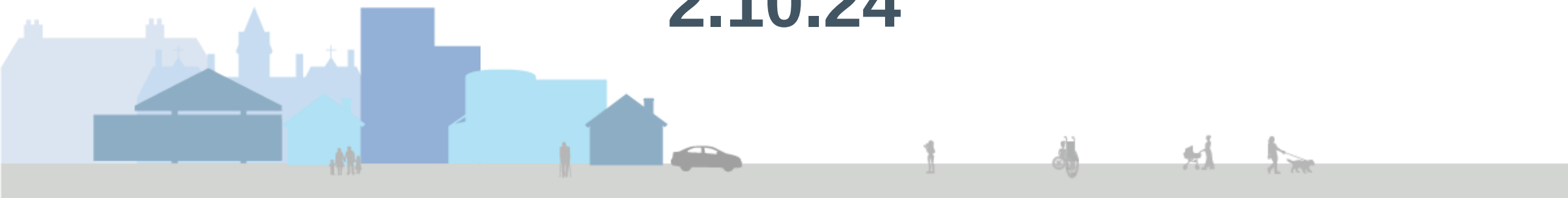
The committee is recommended to receive the report and note the content.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

M5 24/25 Integrated Performance Report

Board of Directors

2.10.24



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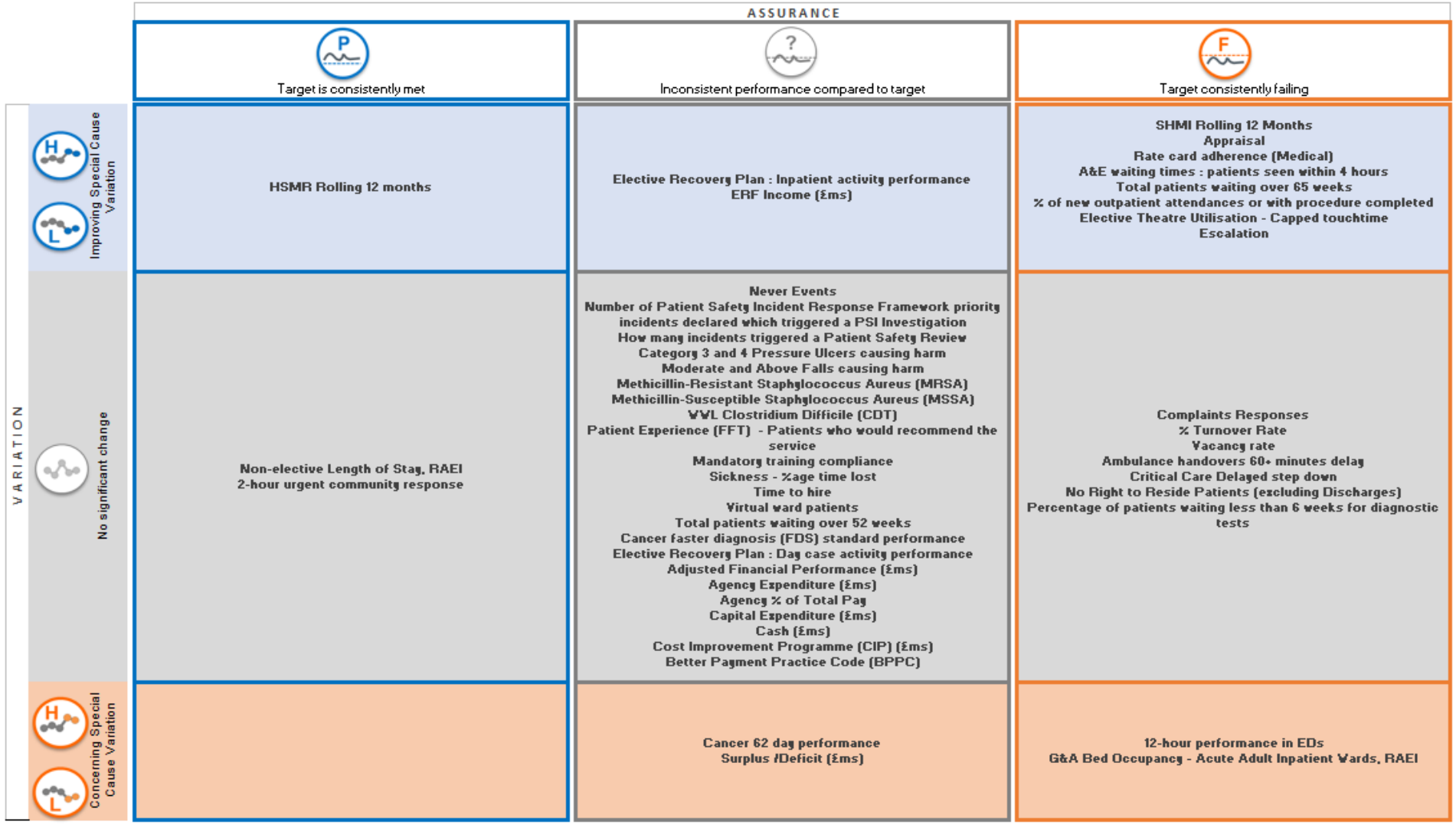
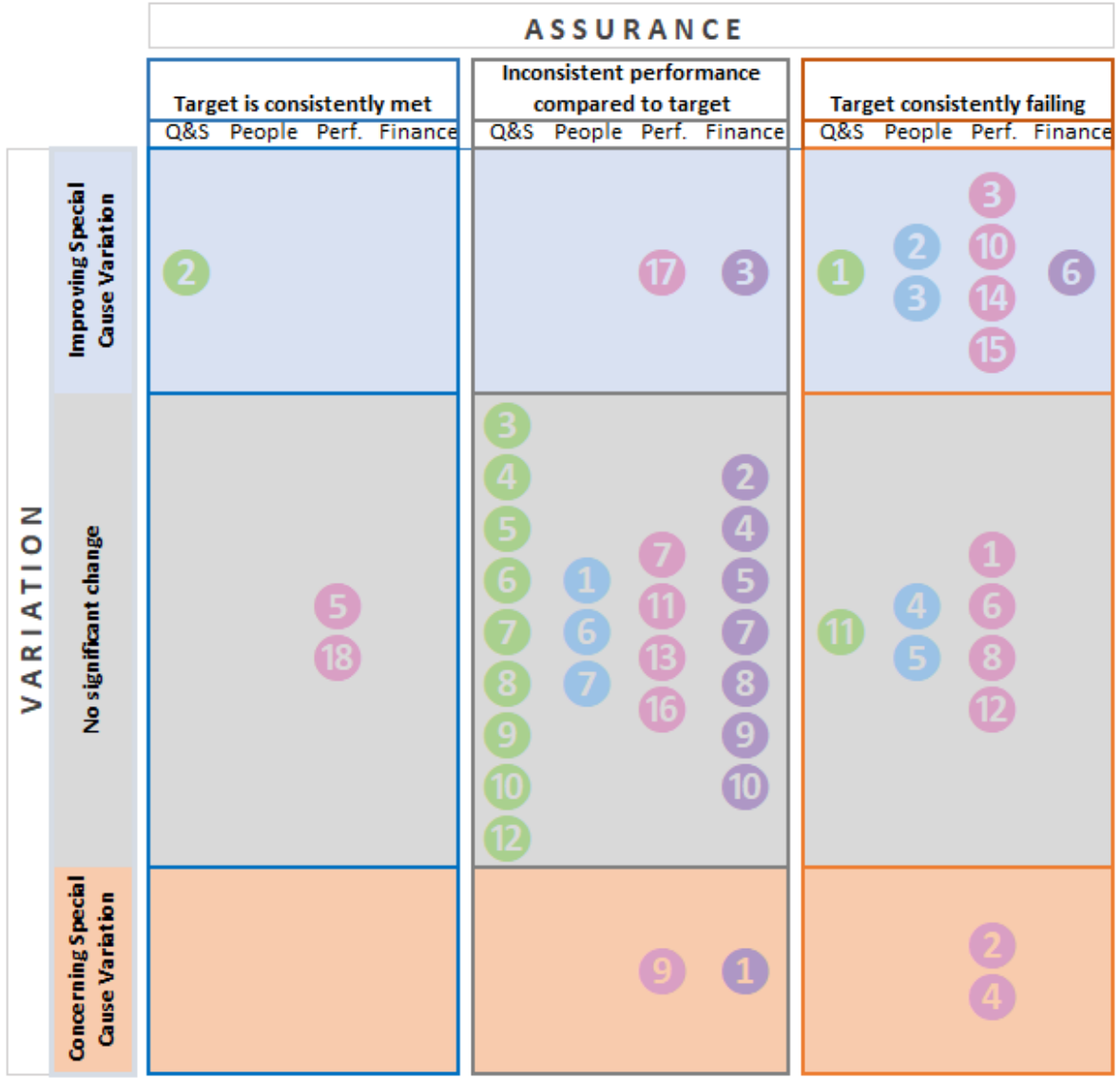
Trust Matrix : M5 August 24



Trust Matrix : M5 August 24



Quality & Safety KPIs

1. SHMI Rolling 12 Months
2. HSMR Rolling 12 months
3. Never Events
4. Number of Patient Safety Incident Response Framework priority incidents declared which triggered a Patient Safety Incident Investigation
5. How many incidents triggered a Patient Safety Review
6. Category 3 and 4 Pressure Ulcers causing harm
7. Moderate and Above Falls causing harm
8. Methicillin-Resistant Staphylococcus Aureus (MRSA)
9. Methicillin-Susceptible Staphylococcus Aureus (MSSA)
10. WWL Clostridium Difficile (CDT)
11. Complaints Responses
12. Patient Experience (FFT) - Patients who would recommend the service

People KPIs

1. Mandatory training compliance
2. Appraisal
3. Rate card adherence (Medical)
4. % Turnover Rate
5. Vacancy rate
6. Sickness - %age time lost
7. Time to hire

Performance KPIs

1. Ambulance handovers 60+ minutes delay
2. 12-hour performance in EDs
3. A&E waiting times : patients seen within 4 hours
4. G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI
5. Non-elective Length of Stay, RAEI
6. Critical Care Delayed step down
7. Virtual ward patients
8. No Criteria to Reside Patients (excluding Discharges)
9. Cancer 62 day performance
10. Total patients waiting over 65 weeks
11. Total patients waiting over 52 weeks
12. Percentage of patients waiting less than 6 weeks for diagnostic tests
13. Cancer faster diagnosis (FDS) standard performance
14. % of new outpatient attendances or with procedure completed
15. Elective Theatre Utilisation
16. Elective Recovery Plan : Day case activity performance
17. Elective Recovery Plan : Inpatient activity performance
18. 2-hour urgent community response

Finance KPIs

1. Surplus /Deficit (£ms)
2. Adjusted Financial Performance (£ms)
3. ERF Income (£ms)
4. Agency % of Total Pay
5. Agency Expenditure (£ms)
6. Escalation (£ms)
7. Capital Expenditure (£ms)
8. Cash (£ms)
9. Cost Improvement Programme (CIP) (£ms)
10. Better Payment Practice Code (BPPC)

Trust Holistic Narrative : M5 August 24

The in-hospital and out-of-hospital SHMI continues to show improvement and is now at 103.78. HSMR is 90.81 and we are performing better than equivalent GM Trusts. There was a further increase in the number of complaints received in August however our compliance improved with a focus on early resolution within Divisions to de-escalate and answer complaints in a more timely manner. With regard to our workforce, sickness absence rate was 5.2% (in-month) and represents by common cause variation with stress/anxiety/depression remaining the greatest proportion of absence. Absence management system (Empactis) continues to be rolled out. The Rate Card Adherence for month 5 shows further improvement and is now at 92.6% (against target of 80%). The results of the GMC survey of trainees has seen a positive improvement with overall satisfaction improved from 55% last year to 83%. Good progress made on mandatory training compliance for lead employer doctors moving from 25th position in the North West region to 8th out of a total 30 Trusts with a compliance rate of 89.78%, exceeding 85% target.

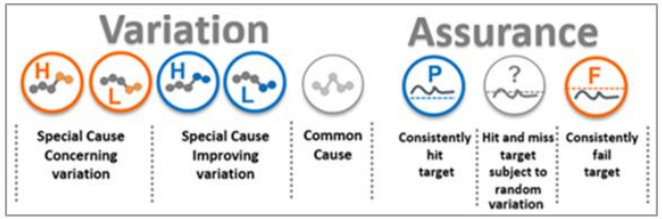
There were some noticeable UEC pressures beginning to be seen in the latter part of the month. The 4-hour national A&E standard for August 2024 marginally improved (73%) but the 75% target was not met. A revised UEC improvement plan has been developed in conjunction with the UEC Team and the implementation is being supported by the Transformation team. The ambulance handover delays continued to show improvement. The bed occupancy continues to be 100% throughout August 2024 however, despite this, the Trust has maintained the de-escalation of the AAA space with that area now being utilised as a therapy area. All specialties remain focused on having no one waiting more than 65 weeks by the end of September, although some patients have chosen to delay their treatment dates. Elective theatre utilisation remains above target, with further improvement seen at Leigh in month. Cancer services continued to exceed the 28-day faster diagnosis standard but there are some pathways that have been under pressure to maintain (or improve) this standard. Inpatient electivity activity against plan is overperforming at 122%. This positive position is being driven by surgical specialties with the Orthopaedics position still behind plan. However, orthopaedics have a recovery plan to support an improved activity and income position which is being closely monitored. Overall, the elective activity is £0.5m behind plan in month and £0.9m year to date. Agency expenditure is £1.0m in month 5 which is the highest in this financial year however August saw a continuation of sustained de-escalation in the hospital, with reported escalation costs for August of £0.4m.

Quality & Safety Overview: M5 August 24

Quality & Safety Metrics

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	SHMI Rolling 12 Months	May 24	103.78	100			109.58	107.74	111.42
2	HSMR Rolling 12 months	Jun 24	90.81	100			94.01	91.51	96.52
3	Never Events	Aug 24	0	0			0	0	2
4	Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI Investigation	Aug 24	1	4			3	0	10
5	How many incidents triggered a Patient Safety Review	Aug 24	35	33			33	0	54
6	Category 3 and 4 Pressure Ulcers causing harm	Aug 24	0	0			0	0	3
7	Moderate and Above Falls causing harm	Aug 24	4	1			2	0	5
8	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Aug 24	0	0			0	0	0
9	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Aug 24	2	0			1	0	6
10	WWL Clostridium Difficile (CDT)	Aug 24	6	5			5	0	19
11	Complaints Responses	Aug 24	70.7%	90%			63.5%	38.6%	88.5%
11	Patient Experience (FFT) - Patients who would recommend the service	Aug 24	90.7%	86.7%			87.2%	80.1%	94.3%

Summary icons key:



Quality & Safety Narrative: M5 August 24

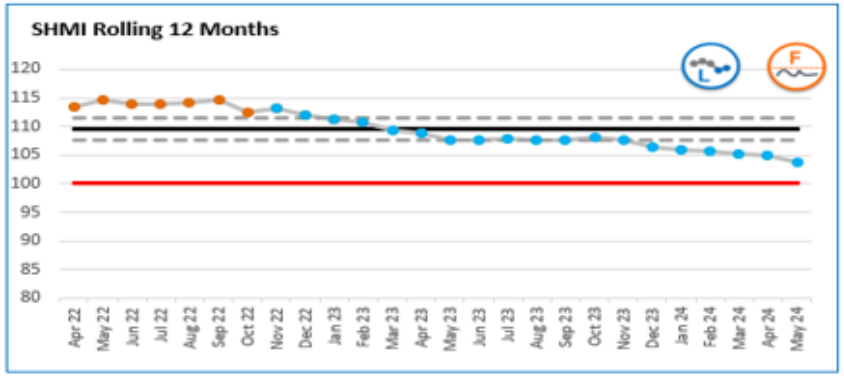
SHMI / HSMR
Our in hospital and out of hospital SHMI continues to reduce and is now at 103.78 which has lowered again from the previous month. It should be noted that the data relates to May 2024 in line with national data releases. As a comparison with GM peers, Bolton NHSFT was at 112.25 in March and Tameside & Glossop was at 100.75 despite WWL having a lower bed base than these two NHS Trusts. HSMR for WWL is 90.81 as compared to Bolton which is 110.80 and Tameside & Glossop at 110.41 therefore WWL is performing better than equivalent GM trusts with this metric

Incidents
In month 5 (August 2024), 1 incident triggered a Patient Safety Incident Investigation (PSII) as per our Patient Safety Incident Response Plan (PSIRP). This was under the suboptimal care of a deteriorating patient category and related to a patient was initially moved to the discharge lounge with plans to go home but later transferred back to an inpatient area due to emerging social issues. Upon transfer to Aspull Ward, the patient was peri-arrest, they were prescribed and administered naloxone. Concerns were raised as the patient had shown signs of opioid toxicity and their condition improved following administration. It was noted that the patient had not been prescribed or administered opioids during their admission. Additional issues included the failure to escalate the patients elevated NEWS score and incomplete SBAR documentation prior to transfer. Due to these concerns, a patient safety incident investigation (PSII) has been commissioned. This incident has also been discussed and early learning points highlighted through the Escalation Assurance Group, Chaired by the Deputy Chief Nurse. It will return to this group on the conclusion of the investigation to consider as part of the wider work being undertaken by this Group.

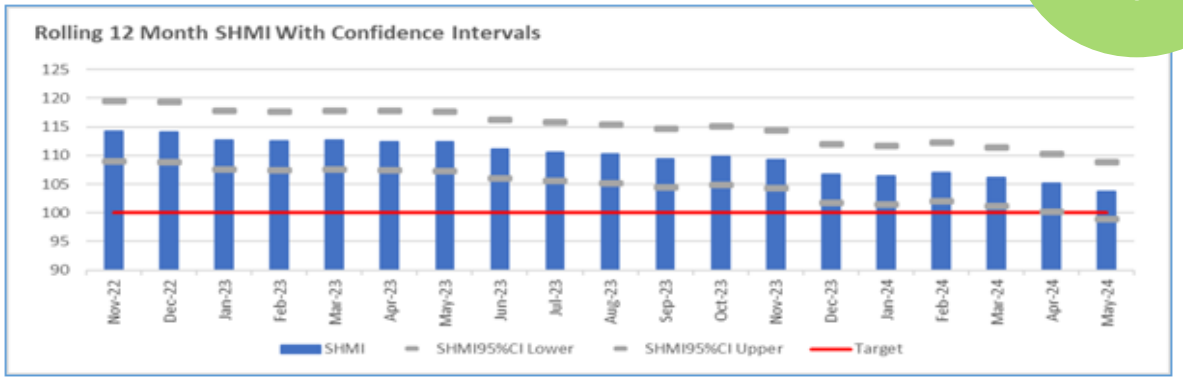
Complaints
There was another increase in the numbers of complaints received in M5. This month our compliance figures increased and there is a focus on early resolution within Division to deescalate and answer complaints speedier. Training sessions are continuing, and targeted sessions have taken place for areas with higher complaints. Current compliance is at 70.7%.

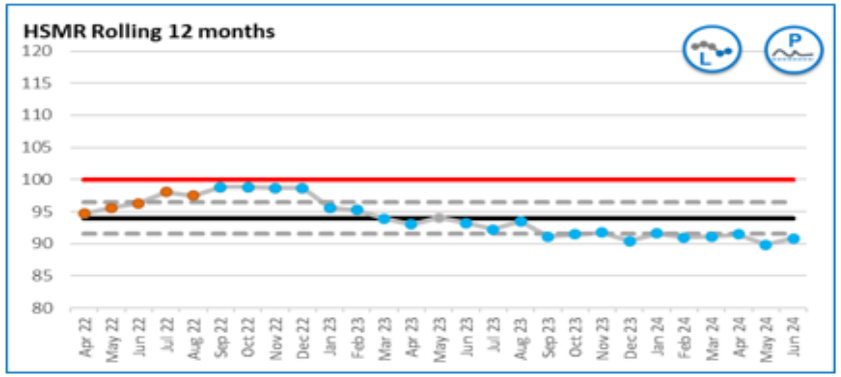
Quality & Safety Insight Report: M5 August 24

Focus : Quality & Safety

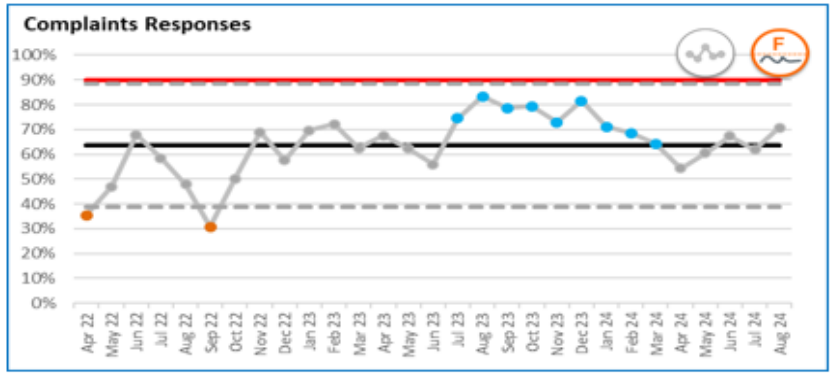


May-24
103.78
Variance Type
Special cause improving variation
Target
100
Target achievement
Metric is constantly failing the target





Jun-24
90.81
Variance Type
Special cause improving variation
Target
100
Target achievement
Metric is constantly achieving the target



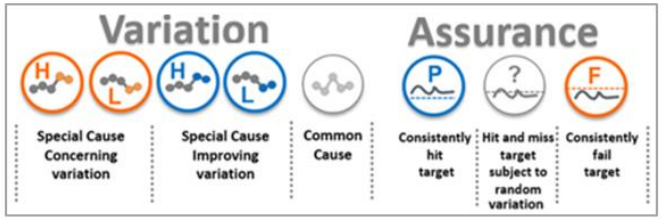
Aug-24
70.7%
Variance Type
Common cause variation
Target
90%
Target achievement
Metric is constantly failing the target

Summary:	Actions:	Assurance:
SHMI and HSMR Monthly and quarterly mortality review groups continue to review any areas of SHMI that are alerting and seek assurances that these are being managed appropriately **Complaints responses** Complaints compliance is under weekly review and monitor progress of overdue complaints	**SHMI/HSMR** Continue Sepsis improvement plans to ensure that patients are appropriately managed Work with system partners to ensure appropriate discharge placements for patients **Complaints responses** Continue to support Divisions in quality checking of complaints, as well as planning for future workshops Continue to embed improvements within Datix to use as a management and escalation tool	**SHMI/HSMR** SHMI is currently within national expected range 'funnel plot' and has been so for many months. Both SHMI and HSMR is continuing to fall and is similar to other similar sized GM Trusts **Complaints responses** Complaints performance has improved in M5 and work is continuing to ensure responses are completed in a timely fashion by managing timescales within Divisions better

Our People Overview : M5 August 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Mandatory training compliance	Aug 24	95.4%	95%		?	94.9%	94.0%	95.9%
2	Appraisal	Aug 24	82.2%	90%	H	F	79.5%	77.8%	81.2%
3	Rate card adherence (Medical)	Aug 24	92.6%	80%	H	F	54.6%	34.6%	74.5%
4	% Turnover Rate	Aug 24	8.8%	8.5%		F	8.9%	8.6%	9.2%
5	Vacancy rate	Aug 24	6.6%	5%		F	6.2%	5.1%	7.2%
6	Sickness - %age time lost	Aug 24	5.2%	5%		?	5.2%	4.6%	5.8%
7	Time to hire	Aug 24	59.4	65		?	57.8	48.0	67.7

Summary icons key:



Our People Narrative : M5 August 24

Sickness absence rate at 5.2% (in-month) and represents by common cause variation. Long term sickness cases remain at >100 staff absent from work more than 4 weeks, based on ESR data (6 weeks lapse). Stress/Anxiety/Depression remains the greatest proportion of absence. Absence system (Empactis) continues to be rolled out, the system is implemented across all non-medical teams within Specialist Services and Community – system will encourage greater engagement and provide drill down into divisional and individual trends. System will enable divisional performance and compliance with sickness monitoring and leadership engagement.

Rate Card Adherence for month 5 shows special cause improving variation of 92.6% against target of 80%. Result driven by rates for medical staff in ECC via an approved LPV, in line with GM and organisational protocols. Sustained result expected to generate change from consistently failing assurance. GMC survey results for trainees released. Feedback from 94% of group. Overall satisfaction improved from 55% last year to 83%. Additional improvements show across Out of Hours clinical supervision; Induction and Local Teaching. Challenges around workload has drop from 59% to 42% - drop has occurred across the NHS.

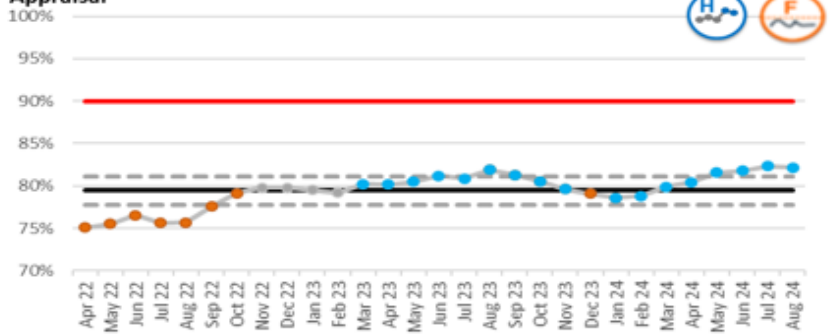
Vacancy rate at 6.6% in month. This area remains as a common cause variation as results have remained static around 6.2% since January 2023. All vacancies are subject to strict approval process. Some clinical vacancies are expected to reduce as new starters expected from Sept although will be offset due to increased vacancies within the unregistered nursing/midwifery workforce. This is in part related to the movement of staff into Trainee Nursing Associate posts and Nursing apprenticeship posts. The Trust is actively reviewing the support provided to 'New to Care' posts and aligning these posts to educational and development opportunities to support career pathways and personal and professional growth. Ongoing rolling vacancies within catering and domestic services plus decontamination services. Apprenticeship routes are being explored and will be supported when Talent for Care post commences and links to education centres can be reestablished.

Mandatory Training MIAA audit carried out recently to test processes established to measure on-going compliance with statutory & mandatory training requirements and assurances of reporting through governance structures. Audit findings indicate there are good systems of internal control designed to meet the system objectives, and controls are generally being applied consistently. Audit report to be shared once recommendations are signed off. Good progress made on mandatory training compliance for lead employer doctors. Progressed from 25th position in the North West region as of January 2024, to 8th out of a total 30 trusts with a compliance rate of 89.78%, exceeding 85% target.

Our People Insight Report : M5 August 24

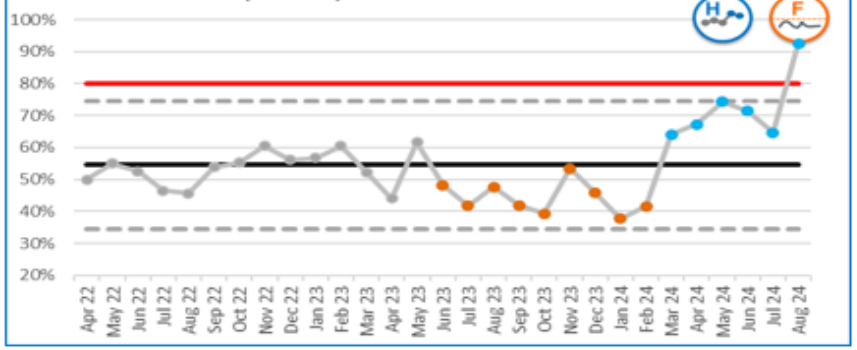
Focus : People

Appraisal



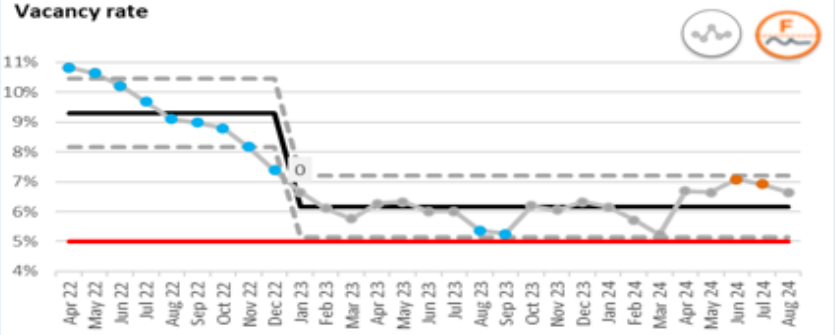
Aug-24
82.2%
Variance Type
Special cause improving variation
Target
90%
Target achievement
Metric is constantly failing the target

Rate card adherence (Medical)



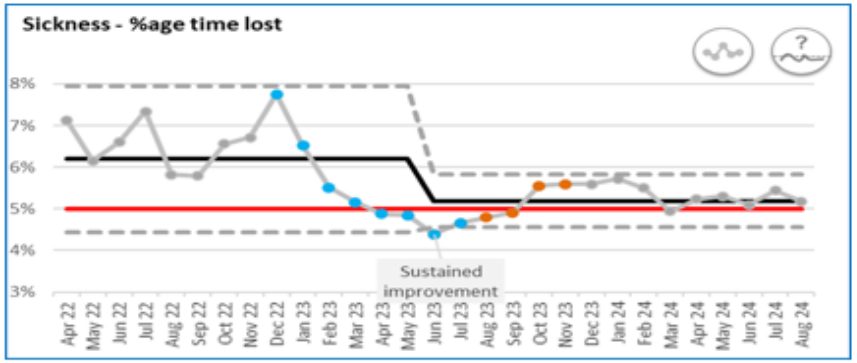
Aug-24
92.6%
Variance Type
Special cause improving variation
Target
80%
Target achievement
Metric is constantly failing the target

Vacancy rate



Aug-24
6.6%
Variance Type
Common cause variation
Target
5%
Target achievement
Metric is constantly failing the target

Sickness - %age time lost



Aug-24
5.2%
Variance Type
Common cause variation
Target
5.0%
Target achievement
Inconsistent performance compared to target

Summary:

1. National mandatory training compliance showing a slight decrease with Fire Safety L2, IPC L2, IG, Moving & Handling, Safeguarding L3 all below target. Most of these are face to face sessions, which impacts compliance rates. All are showing an uptick since last month apart from Fire Safety and Safeguarding.
2. Expected improved result in mth 5 shows special cause improving variation of 92.6% against target of 80% for Rate card adherence.
3. Mth 5 vacancy remains as common cause variation as results have remains static between process limits over 12 months . Driven in part by increased vacancies in E&F plus Ward Clerks and movement among TNAs and NAs.
4. Sickness remains as a common cause variation at 5.2% in mth 5.

Actions:

1. Detailed compliance information shared with Divisions. Discussion at Divisional Assurance Meetings. Monthly escalation report via Wider Leadership Team to be established. Compliance was likely to reduce in M5 due to large intake of medics (Lead Employer), improvement plan remains in place to continue focussed work to maintain compliance levels.
2. ECC rates now linked to approved LPV. In line with GM and operational protocols.
3. Actively reviewing the support provided to 'New to Care' posts and aligning these posts to educational and development opportunities. Apprentice routes to be explored with talent for care lead being reintroduced
4. Support to leadership is ongoing to assist with positive engagement and supportive return to work conversations. Empactis roll out continues to support improved engagement. Community and Specialist Services implemented to all non-med groups.

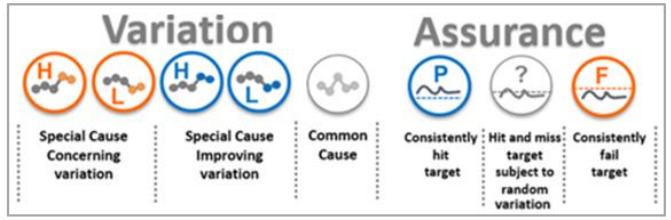
Assurance:

1. Oversight to be provided by new Wider Leadership Team Meeting. Oversight via Education Governance Groups and escalation to ETM for areas of concern.
2. Governance in place to monitor and take forward improvements. Further improvements expected as some further data cleanse to take place i.e. some errors in reporting linked to Dental.
3. Oversight via internal executive led panel around vacancy control. Newly qualified staff are due to commence in Mth 6 which should support decrease in vacancies along with actions described.
4. Oversight via monthly ER review meetings with divisional HR reps and divisional assurance meetings.

Our Performance Overview : M5 August 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Ambulance handovers 60+ minutes delay	Aug 24	98	0		F	230	41	418
2	12-hour performance in EDs	Aug 24	16.2%	10%	H	F	15.7%	12.9%	18.4%
3	A&E waiting times : patients seen within 4 hours	Aug 24	72.9%	75%	H	F	69.3%	65.9%	72.8%
4	G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI	Aug 24	100.0%	96%	H	F	99.2%	97.6%	100.8%
5	Non-elective Length of Stay, RAEI	Aug 24	4.15	4.68		P	4.06	3.47	4.65
6	Critical Care Delayed step down	Aug 24	15	0		F	17	3	30
7	Virtual Ward Occupancy	Aug 24	74.3%	80%		?	85.3%	62.0%	108.7%
8	No Right to Reside Patients (excluding Discharges)	Aug 24	125	50		F	134	116	151
9	Cancer 62 day performance	Jul 24	64.3%	70%	L	?	77.8%	67.4%	88.2%
10	Total patients waiting over 65 weeks	Aug 24	298	54	L	F	838	267	1409
11	Total patients waiting over 52 weeks	Aug 24	2218	1667		?	3529	1297	5762
12	Percentage of patients waiting less than 6 weeks for diagnostic tests	Aug 24	77.1%	95%	H	F	74.0%	66.6%	81.5%
13	Cancer faster diagnosis (FDS) standard performance	Jul 24	78.3%	77%		?	78.6%	70.8%	86.4%
14	% of new outpatient attendances or with procedure completed	Aug 24	46.8%	46%	H	F	44.1%	42.2%	46.0%
15	Elective Theatre Utilisation - Capped touchtime	Aug 24	86.1%	85%	H	F	80.1%	75.2%	84.9%
16	Elective Recovery Plan : Day case activity performance	Aug 24	94.0%	100%		?	98.7%	84.9%	112.4%
17	Elective Recovery Plan : Inpatient activity performance	Aug 24	122.0%	100%	H	?	94.9%	67.2%	122.6%
18	2-hour urgent community response	Aug 24	82.6%	70%		P	83.9%	74.1%	93.6%

Summary icons key:



Our Performance Narrative : M5 August 24

The performance against the 4-hour national standard in A&E, for August 2024, marginally improved, however the 75% target was not met. A revised UEC improvement plan has been developed in conjunction with the UEC Team. The implementation is being supported by colleagues from the Transformation Team and Newton Europe.

Although the daily average number of patients waiting over 12 hours for a bed in the A&E has varied over the month, the average performance has not fallen below the mean for 11 consecutive months. The delays are being addressed as part of the Discharge and Flow Improvement programme and reported at executive level.

The over 60-minute ambulance handover delays continue to fail the target. However, the percentage of delays has continuously fallen and was less than 5% in August. The project for improvement continues to have a focus and additional actions are being rolled out to eliminate all over 60-minute delays. This metric correlates to seasonality, with levels remaining above previous years.

The G&A bed occupancy continues to be 100% throughout August 2024 and for the 8th time over 9 months. However, the Trust has maintained the de-escalation of the AAA, with AAA now being utilised as a therapy area.

All specialties are now on target to clear 65 week waits by the end of September, with the exception of patient choice or clinically complex patients. Gynae remains a pressure area due to the number of patients seen in quick succession by Medinet requiring diagnostics, follow up and for about 15% of patients, surgery. The number of patients remaining to treat in month is impacted by mutual aid being provided to Bolton. Elective theatre utilisation remains above target, with further improvement seen at Leigh in month.

Cancer services continued to exceed the 28-day faster diagnosis standard. It is however on a downward trajectory and could fail over coming months. 62-day performance in August is a concern, performance was 64.3% against the target of 70%. Challenges achieving the target are primarily driven by Breast, Lower GI and Gynae performance due to capacity constraints in these high-volume pathways.

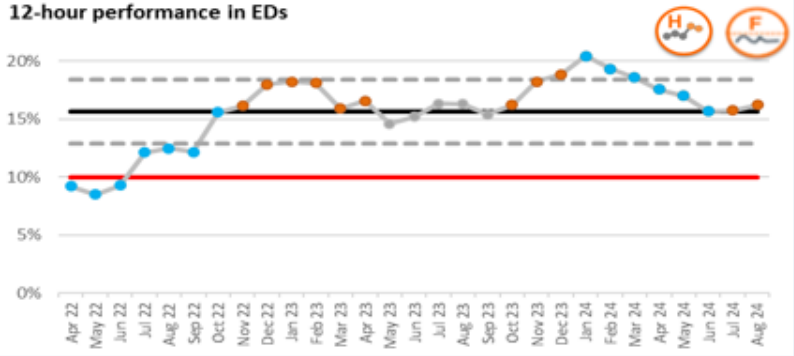
Inpatient electivity activity against plan is overperforming at 122%. This positive position is being driven by surgical specialties with the Trauma and Orthopaedics position remains behind plan. Trauma and Orthopaedics has a focused plan to support an improved activity position which is being closely monitored by the executive team.

Delayed step downs from ICU remain a concern, with a significant adverse impact on patient experience. However, delayed step downs did not result in any delayed admissions to ICU in month.

Our Performance Insight Report : M5 August 24

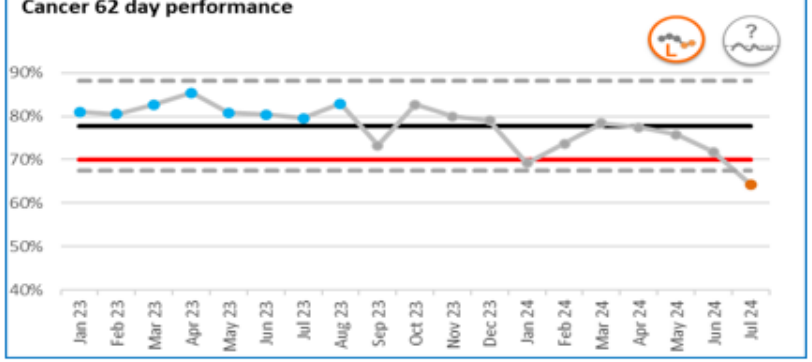
Focus : Performance

12-hour performance in EDs



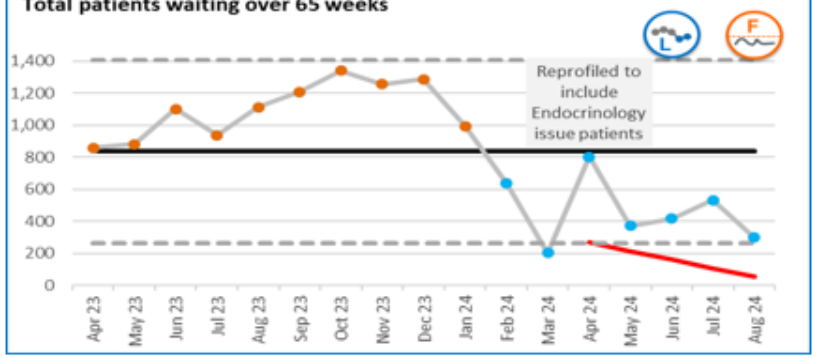
Aug-24
16.2%
Variance Type
Special cause concerning variation point
Target
10%
Target achievement
Metric is constantly failing the target

Cancer 62 day performance



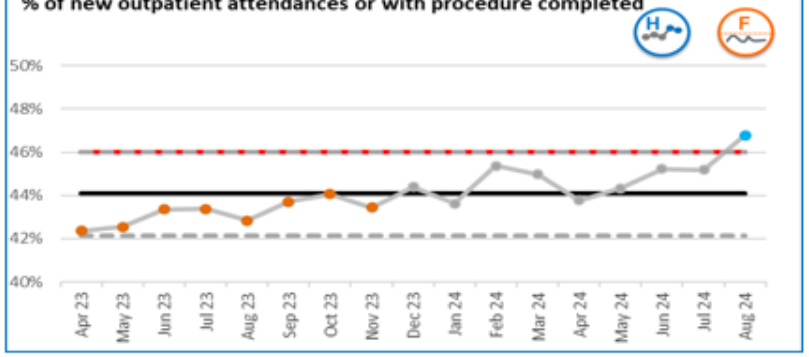
Jul-24
64.3%
Variance Type
Special cause concerning variation point
Target
70%
Target achievement
Inconsistent performance compared to target

Total patients waiting over 65 weeks



Aug-24
534
Variance Type
Improving special cause varitation
Target
108
Target achievement
Metric is constantly failing the target

% of new outpatient attendances or with procedure completed



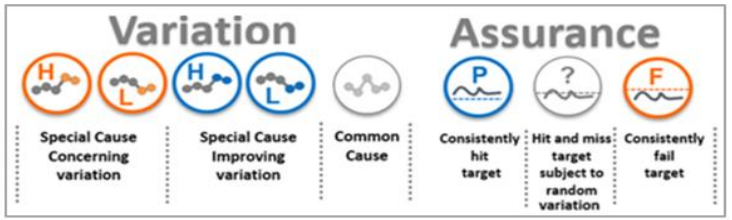
Aug-24
46.8%
Variance Type
Special cause improving variation point
Target
46%
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
1. A&E 12-hour performance in August was 16.2% which sees an improvement. 2. Some improvement in performance this month in patients waiting over 65 weeks – gynae is the primary risk however plan in place to mitigate. 3. 62-day performance is causing concern, failing the target this month. Elective inpatient activity exceeds target in month 4. Elective inpatient activity is above plan overall	1. Back to Basics, Ambulance Turnaround project and focus on daily breaches 2. Gynae is the primary risk however plan in place to mitigate with consultant connect and Medinet contract in place which goes live 17th August 3. Whilst achieving target there is work on the challenged areas in achieving the 62 day target in breast, lower GI and gynae performance. Detailed action plans and transformation of pathways is underway to drive improvements. due to capacity constraints in these high volume pathways. Recovery plan for T&O which isn't achieving plan – regular oversight and scrutiny from executive team	1. Sustained position 2. Micromanagement of waiting lists, gynae insourcing. all specialties are now on target to clear 65 week waits by the end of September, with the exception of patient choice or clinically complex patients. 3. Insourcing of Medinet is having a positive impact, resulting in a reduction of 81 65- week waiters 4. Achieving plan overall

Our Finance Performance Overview : M5 August 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Surplus /Deficit (£ms)	Aug 24	-1.38	-0.96			-1.10	-7.29	5.08
2	Adjusted Financial Performance (£ms)	Aug 24	-1.38	-0.94			-0.71	-5.32	3.90
3	ERF Income (£ms)	Aug 24	9.38	9.87			8.92	7.41	10.43
4	Agency Expenditure (£ms)	Aug 24	0.99	0.64			0.93	0.48	1.39
5	Agency % of Total Pay	Aug 24	3.1%	3.2%			2.7%	1.7%	3.6%
6	Escalation (£ms)	Aug 24	0.42	0			0.64	0.50	0.78
7	Capital Expenditure (£ms)	Aug 24	1.26	2.14			2.40	-2.20	7.00
8	Cash (£ms)	Aug 24	14.07	15.12			16.62	6.56	26.68
9	Cost Improvement Programme (CIP) (£ms)	Aug 24	2.28	2.28			2.09	0.77	3.42
10	Better Payment Practice Code (BPPC)	Aug 24	94.4%	95%			93.6%	89.6%	97.7%

Summary icons key:

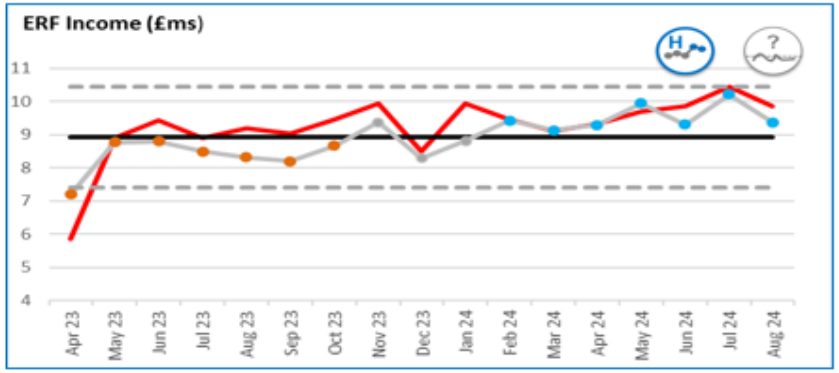


Our Finance Performance Narrative : M5 August 24

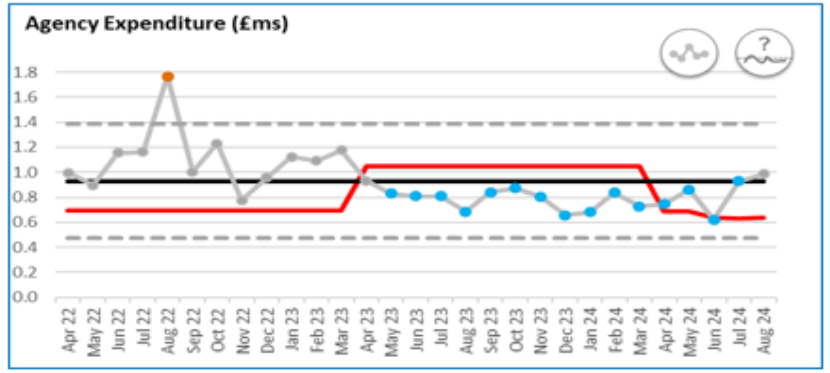
Description	Performance Target	Performance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Red	The Trust is reporting an actual deficit of £1.4m for month 5 (August) which is £0.4m adverse to plan. Year to date, the Trust is reporting an actual deficit of £7.3m which is £2.0m adverse to plan. The adverse variance needs to be recovered by the end of the financial year to achieve the 2024/25 plan.
	Adjusted financial position: Achieve the financial plan for 2024/25.	Red	
ERF Income	Achieve the elective activity plan for 2024/25.	Amber	Elective activity is £0.5m behind plan in month and £0.9m year to date. This activity shortfall needs to be recovered by the end of the financial year to achieve the 2024/25 plan. Advice & Guidance income of £0.4m YTD has been included in the non-divisional income position for diverted activity, this will reduce the YTD adverse ERF variance to £0.5m when the divisional split is confirmed.
Agency	To remain within the agency ceiling set by NHSE.	Amber	Agency expenditure is £1.0m in month 5 which is the highest in this financial year. This is marginally below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure.
Escalation	Sustained reduction in escalation spend for 2024/25.	Green	August saw a continuation of sustained de-escalation in the hospital, with reported escalation costs for August of £0.4m.
Capital expenditure	Achieve capital plan for 2024/25.	Green	Month 5 expenditure is £1.3m, which is £1.0m below plan. The CDEL plan of £9.3m is fully committed with schemes in flight. The YTD variance is due to timing of scheme expenditure. Further business cases for lease capital are seeking approval in September.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber	The Trust has a closing cash balance of £14.1m for August 2024 which is £1.0m below plan. There was a decrease of £3.1m in month due to the variance to the revenue plan and other timing differences in payment of invoices.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red	In month 5, the Trust has delivered £2.3m CIP which was on plan in month. The year-to-date adverse variance of £0.6m relates to prior month slippage. As at month 5, there is an unidentified gap of £1.1m in year and £1.7m recurrently. Work is ongoing with the Divisions to close the gap.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Amber	BPPC performance to end of August is 93.4% by volume and 95.3% by value, which is a slight improvement to previous months.

Our Finance Performance Insight Report : M5 August 24

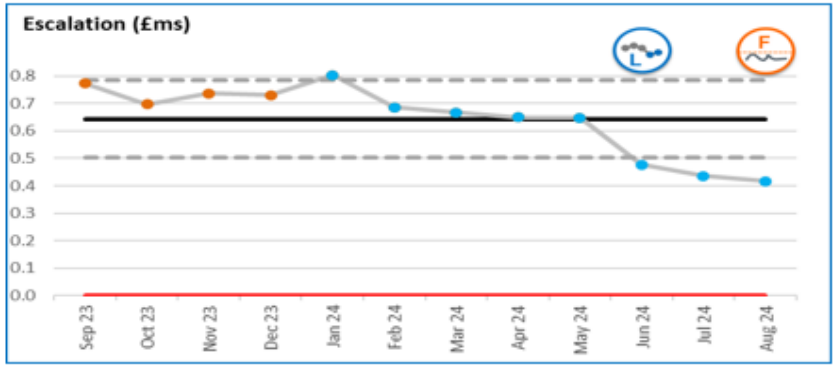
Focus : Finance



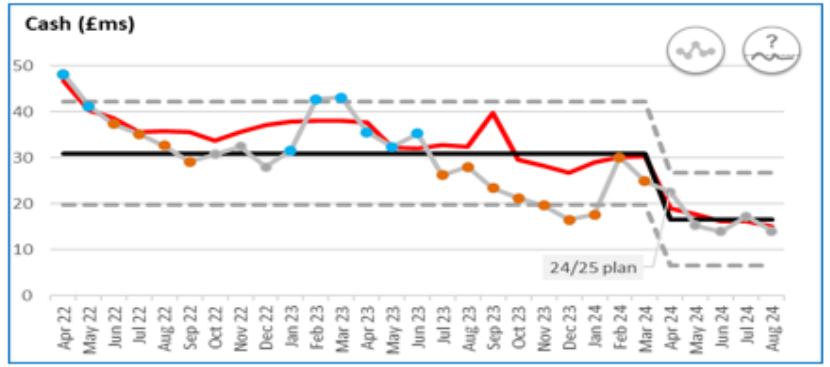
Aug-24
9.38
Variance Type
Special cause improving variation
Target
9.87
Target achievement
Inconsistent performance compared to target



Aug-24
0.99
Variance Type
Common cause variation
Target
0.64
Target achievement
Inconsistent performance compared to target



Aug-24
0.42
Variance Type
Special cause improving variation
Target
0
Target achievement
Metric is constantly failing the target



Aug-24
14.07
Variance Type
Common cause variation
Target
15.12
Target achievement
Inconsistent performance compared to target

Summary:

1. Elective activity is £0.5m behind plan in month and £0.9m year to date. This activity shortfall needs to be recovered by the end of the financial year to achieve the 2024/25 plan.
2. Agency expenditure is £1.0m in month 5 which is the highest in this financial year. This is £0.1m below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure.
3. August saw a continuation of sustained de-escalation in the hospital, with reported escalation costs for August of £0.4m.
4. The Trust has a closing cash balance of £14.1m for August 2024 which is £1.0m below plan. There was a decrease of £3.1m in month due to the variance to the revenue plan and other timing differences in payment of invoices.

Actions:

1. Specialist Services underperformance is predominantly due to lost theatre sessions in Trauma & Orthopaedics, and a recovery plan is in place. The YTD underperformance will be mitigated by increasing activity in other specialities, with a focus on the Leigh hub. Advice and guidance accrued at risk whilst under negotiation with commissioners.
2. Agency controls remain in place as part of measures for all temporary spend.
3. Further work around de-escalation of the hospital is planned via the programme with Newton Europe.
4. Cash management strategy in place with detailed cash forecasting. Current run rate forecasts indicate cash support required from Q4. Confirmation awaited around mitigations from GM ICB and revenue deficit support funding.

Assurance:

1. ERF is monitored at the Elective Recovery programme board and the divisional assurance meetings, both held monthly. The recovery plan for Specialist Services is executive led with updates provided to ETM.
2. Medical and Non-Medical Establishment Review Groups, Divisional Assurance Meetings, Finance and Performance Committee.
3. Monthly reviews of the de-escalation program of work at the discharge and flow program board, in addition to monthly divisional assurance meeting with the Medicine division.
4. Cash Management Group, Finance and Performance Committee. GM Capital and Cash Group (Ext.)

Change log

Ref	Metric	Change	Date	Requested by:
24/25 05	All Finance metrics	Finance metrics reported in £ms rather than £'000s to be consistent with the Trust Finance Report	16/09/2024	Director of Finance
24/25 04	2-hour Urgent Community Response	Reporting deadline moved to latest postion	18/08/2024	Community Division Director of Performance
24/25 03	Elective Recovery Plan - Inpatients & Day Cases Activity	Reported as at working day 1 in line with Finance figures	18/08/2024	Director of Finance
24/25 02	Escalation	Add new metric	16/07/2024	Director of Finance
24/25 01	ERF Income	Add new metric	16/07/2024	Director of Finance

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Thank you

Agenda item: [23]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Partnerships Report
Presented to:	Board of Directors
On:	2nd October 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 hour system partners and identifies several specific responsibilities for Trust Boards.

This report is the second biannual report to Trust board on system partnerships, following the first such report to Trust Board on the 7th February 2024.

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
Trust Board are requested to note the contents of 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 alongside 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. In 2024/25 there are specific partnership objectives: to improve the health and wellbeing of the population we serve (CO14); and to develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable (Corporate Objective 15). 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 care or 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 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.

As reported in the February report we are active participants within the GM Commissioning Oversight Group which is seeking reviewing the commissioning intentions for GM. It is doing 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. The initial outcome from this is due at the end of September. Bilateral commissioning meetings between WWL Executives and the ICB are also due to be reinstated shortly.

The Trust is also engaged in the GM Sustainable Services programme to develop more sustainable models of care for specialties including dermatology and microbiology. This is starting to deliver some successes, including the successful pilot of tele-dermatology services which have demonstrated a significant reduction in the number of face-to-face appointments required with a consultant dermatologist. We are also actively engaged in developing a hub and spoke model, with the Northern Care Alliance taking on a more significant role as lead provider given the relative size of their service.

In August 2024 Leigh Infirmary achieved surgical hub accreditation following a review by the NHS England Getting It Right First Time (GIRFT) programme. This followed on from Wrightington Hospital gaining the same accreditation in September 2023. This accreditation, along with the system capital funding which has been secured to develop both Leigh and Wrightington, cements the key role of these facilities in reducing waits for elective surgery for patients across Greater Manchester and provides further opportunities to collaborate with other providers to ensure that the capacity is fully utilised. One such opportunity is work that we have initiated with Manchester Foundation Trust to develop a shared ophthalmology consultant model for the Leigh Surgical Elective Centre.

The role of Leigh as a diagnostics hub for GM has been further developed since the last partnerships report to Board. An additional endoscopy room at Leigh has now opened as part of the investment in endoscopy facilities at both Wigan and Leigh, with a further two rooms to be completed at Leigh later in the autumn. This increase in diagnostic capacity will support earlier diagnosis, and an opportunity to reduce health inequalities both for residents of the Borough and GM.

Collaboration with Bolton NHS Foundation Trust

There are several challenges which threaten the sustainability of some of the services that we provide, including: workforce shortages; increasing demand and expectations; and financial pressures. Collaborative approaches to service change can potentially be difficult to achieve but in some cases, it is appropriate, and easier, to find and deliver bilateral solutions rather than rely on pan-system approaches to service change. There are several such areas where we already collaborate effectively on such solutions with Bolton NHS Foundation Trust (BFT).

It is planned to build further on this track record of collaboration with Bolton, underpinned by a few key principles as follows:

- Our focus is optimising functions rather than changing form, ensuring that we retain the ability for each organisation to act in a way that is responsive to the needs of the populations they serve. This is not a pathway to merger or creation of a group structure.
- We will actively encourage collaboration at all levels across our organisations and in all areas of business, ensuring that barriers to doing so are identified and overcome.
- Any proposed service change must not destabilise core service provision for our local populations.
- All clinical service changes will be clinically-led and organised around the delivery of shared and agreed outcomes for our patients and service users.
- We will involve our patients in any service redesign, ensuring that we remain patient focussed and that - wherever appropriate and possible - that we deliver services closer to home.
- Prioritise areas where there are opportunities to take out costs, not compromising on the quality of service provision.
- We will reduce health inequalities, rather than exacerbate them, through any changes to service provision that we make.

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. The Chief Executive co-chairs the Wigan Integrated Delivery Board with Director of Public Health from Wigan Council.

The Wigan locality ICB team have developed a new locality plan, with input from key stakeholders including WWL. This will set the priorities for the partnership and follows on from the approval of the Joint Strategic Needs Assessment by the Wigan Health and Wellbeing Board in December.

WWL were well represented at the recent “Progress with Unity” event for the Borough, which launched a new movement for change for the partnership between residents, business, public services and community organisations focussed on 2 key missions:

- Creating fair opportunities for all children, families, residents and businesses;
- Making all our towns and neighbourhoods flourish for those who work within them.

Tangible progress has been made in the development of a shared programme across Wigan Council, NHS GM ICB and WWL to support transformation of urgent and emergency care across the Borough. The co-designed programme has three key aims:

- To deliver the most independent outcomes and support more people to live at home
- To deliver simple and more effective care for people through collaboration and integration, critically eliminating the longstanding and unacceptable overcrowding of the Emergency Department (ED).
- To build an operationally and financially sustainable model of care for the residents of Wigan.

Newton Europe have now been contracted to support this programme, following on from the diagnostic work that they undertook towards the end of 2023 to identify a series of improvement opportunities across the patient pathway. Partners' commitment to the programme is encapsulated in a memorandum of understanding and the programme is currently in its mobilisation phase, with design work expected to begin in October.

Health Inequalities

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 (one of the fundamental "Progress with Unity" pillars) 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: an increase in the value of non-pay spend within the Wigan Borough (from £9.7m in 21/22 to £17.6m in 23.24) and across the GM region excluding Wigan (from £16.2m to £34.1m); 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; and increases in the number of apprentices. We are seeking to initiate some work with the Wigan Community Wealth Building partnership about how we measure the impact of our anchor initiatives across the whole Borough.

As previously reported to Trust Board 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. Following a joint workshop with partners the partnership have agreed to undertake a focussed piece of work in the Scholes area to undertake some deep engagement with the communities there to understand the root issues driving health inequalities, informing future service redesign. It is intended that this will become a blueprint to wider engagement and service redesign across the borough.

Recommendation
Trust Board are requested to note the contents of this report.

Agenda item: 24

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Trust finance report for August 2024 (month 5)
Presented to:	Board of Directors
On:	2nd October 2024
Item purpose:	Information
Presented by:	Tabitha Garder, Chief Finance Officer
Prepared by:	Senior Finance Team
Contact details:	E: Heather.Shelton@wwl.nhs.uk

Executive summary

The presentation provides the full finance report on the Trust financial position for month 5 (August 2024).

Please see slide 3 for key messages and slide 4 for key performance indicators.

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

Please see slide 15 for the current risk assessment.

Financial implications

There are no direct financial implications as it is reporting on the financial position (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.

Equality, diversity and inclusion implications

There are no direct equality, diversity and inclusion implications in this report.

Which other groups have reviewed this report prior to its submission to the committee/board?

The finance flash metrics report was reviewed by ETM on 5th September 2024. It was presented to the Finance and Performance Committee on 24th September 2024.

Wider implications

There are no wider implications of this report.

Recommendation(s)

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Trust Finance Report

Month 5 – August 2024

Contents

Main report

Key Financial Messages

For August 2024, the in-month position was a deficit of £1.4m, which was £0.4m adverse to plan. The YTD position is a deficit of £7.3m, which is £2.0m adverse to plan. The YTD deficit represents 52% of the full year plan (compared to 42% on a straight-line basis). The planned deficit for the full year is £14.2m.

The three main drivers of the YTD variance are: ERF underperformance £0.9m, CIP slippage £0.7m (primarily non pay) and industrial action £0.3m. The ICB introduced new metrics last month called 'red line' triggers. From our month 5 position, we would trigger on the recurrent CIP metric and the leases capital metric, which is the same as month 4.

Divisional core CIP is on plan in month with £2.3m delivered. However, the slippage from prior months remains a pressure at £0.6m. The focus needs to remain on the delivery of recurrent savings to support our longer-term financial sustainability.

Divisional ERF performance is £0.5m below plan in month 5 and £0.9m year to date. There is over performance of £0.3m in month (£1.1m YTD) in Surgery, which is offsetting an underperformance of £0.7m (£1.8m YTD) in Specialist Services. Income for Advice and Guidance of £0.4m has been accrued at risk in month 5 for YTD activity to mitigate the ERF underperformance; this is still in negotiation with commissioners.

The reduction in escalation expenditure has been maintained in August with expenditure of £0.6m.

There was an increase in pay costs due to temporary medical staffing. Pay expenditure is above plan by £0.9m in month and £2.1m YTD. Total WTE in August was 6,939 WTE, which is an increase of 31 WTE from July. For August, we are 39 WTE above the workforce plan of 6,900 WTE, with an increase in bank WTE associated with 1:1 care in month.

Non-Pay expenditure is beginning to increase (above expected inflation) predominantly in clinical supplies and drugs. A task and finish group focused on trauma and orthopaedics theatre non pay expenditure has been established. This has been mitigated by £0.4m non-recurrent balance sheet support in month 5.

Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the plan for 2024/25.	Red		The Trust is reporting an actual deficit of £1.4m for month 5 (August) which is £0.4m adverse to plan. Year to date, the Trust is reporting an actual deficit of £7.3m which is £2.0m adverse to plan. The adverse variance needs to be recovered by the end of the financial year to achieve the 2024/25 plan.
	Adjusted financial position: Achieve the plan for 2024/25	Red		
ERF Income	Achieve the elective activity plan for 2024/25.	Amber		Elective activity is £0.5m behind plan in month and £0.9m year to date. This activity shortfall needs to be recovered by the end of the financial year to achieve the 2024/25 plan. Advice & Guidance income of £0.4m YTD has been included in the non-divisional income position for diverted activity, this will reduce the YTD adverse ERF variance to £0.5m when the divisional split is confirmed.
Agency	To remain within the agency ceiling set by NHSE.	Amber		Agency expenditure is £1.0m in month 5 which is the highest in this financial year. This is marginally below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure.
Escalation	Sustained reduction in escalation spend for 2024/25.	Green		August saw a continuation of sustained de-escalation in the hospital, with reported escalation costs for August of £0.4m.
Capital expenditure	Achieve capital plan for 2024/25.	Green		Month 5 expenditure is £1.3m, which is £1.0m below plan. The CDEL plan of £9.3m is fully committed with schemes in flight. The YTD variance is due to timing of scheme expenditure. Further business cases for lease capital are seeking approval in September.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		The Trust has a closing cash balance of £14.1m for August 2024 which is £1.0m below plan. There was a decrease of £3.1m in month due to the variance to the revenue plan and other timing differences in payment of invoices.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red		In month 5, the Trust has delivered £2.3m CIP which was on plan in month. The year to date adverse variance of £0.6m relates to slippage in earlier months. As at month 5, there is an unidentified gap of £1.1m in year and £1.7m recurrently. Work is ongoing with all Divisions to close the gap.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Amber		BPPC performance to end of August is 93.4% by volume and 95.3% by value, which is a slight improvement to previous months.

Financial Performance

Headlines

- In month 5 (August 2024) we reported an actual deficit of £1.4m, an adverse variance of £0.4m to the planned deficit of £0.9m.
- Year to date, the actual deficit is £7.3m which is £2.0m adverse to the planned deficit of £5.4m.
- A forecast deficit of £14.2m has been reported to NHSE, based on delivery of the plan. NHSE have advised to exclude the impact of industrial action from the forecast.

Income

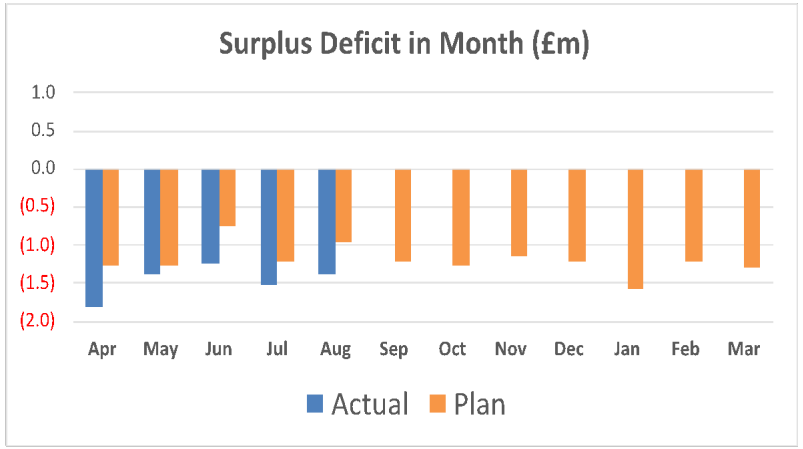
- Income is £0.6m favourable to plan in month 5.
- ERF underperformance of £0.2m in month (including £0.3m benefit from prior month coding) is offset by an over performance of £0.4m predominantly within Education income.
- Advice and guidance income has been included of £0.4m in month and YTD at risk, we are still awaiting guidance, and agreement of the baseline.

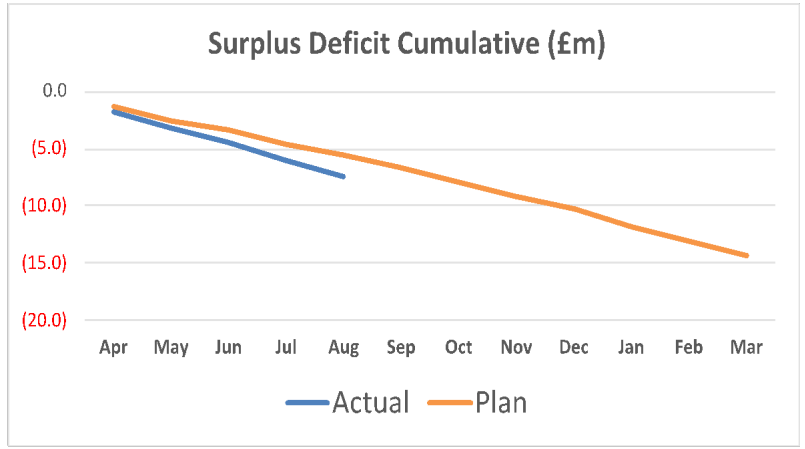
Pay

- Pay expenditure is £31.6m in month 5 which is £0.9m adverse to plan.
- Temporary medical staffing costs across various specialties amount to £0.7m in month, offset by CIP overperformance of £0.1m in month.

Non pay

- Non pay expenditure is £11.9m in month 5, which is £0.3m adverse to plan, £0.3m is clinical supplies and services.
- There is upwards creep in non-pay expenditure, particularly in clinical supplies and drugs, creating a pressure in clinical divisions.
- CIP shortfall within non-pay is £0.2m in month and £2.1m YTD.





Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	43,992	43,390	602	217,459	216,325	1,134	521,469
Pay	(31,619)	(30,755)	(864)	(155,898)	(153,760)	(2,138)	(370,355)
Non Pay	(11,857)	(11,532)	(324)	(59,263)	(57,719)	(1,545)	(140,768)
Financing / Technical	(1,894)	(2,060)	166	(9,667)	(10,302)	635	(24,725)
Surplus / Deficit	(1,378)	(958)	(420)	(7,369)	(5,456)	(1,913)	(14,380)
Adjusted Financial Performance *	(1,376)	(942)	(435)	(7,335)	(5,376)	(1,959)	(14,187)

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

Income

Division	In Month (£000)			Year to Date (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	167	26	141	689	776	(87)
Surgery	536	231	304	2,405	1,157	1,247
Specialist Services	639	1,585	(946)	4,068	5,771	(1,703)
Community Services	576	570	6	2,818	2,850	(32)
Non Divisional Income	40,787	40,300	487	201,662	200,851	811
Finance	16	11	5	80	56	24
Digital Services	7	7	(0)	34	36	(2)
Dir of Strat & Planning	224	225	(1)	916	1,127	(211)
Chief Operating Officer	0	0	0	0	0	0
Human Resources	32	1	31	139	5	135
Medical Director	68	51	17	486	256	230
Estates & Facilities	471	459	12	2,258	2,297	(39)
Nurse Director	138	64	75	644	318	326
Trust Executive	6	9	(3)	6	46	(40)
GTEC	175	209	(34)	1,028	1,168	(140)
Corporate	150	(359)	509	226	(391)	617
Reserves	0	0	0	0	0	0
Total	**43,992**	**43,390**	**602**	**217,459**	**216,325**	**1,134**

Division	In Month Variance £000's	Remove PP Transfer £000's	Normalised in Month Variance £000's
Specialist Services	(946)	382	(564)
Corporate	509	(382)	127
Total	**(437)**	**0**	**(437)**

Headline

- Income is £0.6 m favourable in month and £1.1m favourable YTD.

Specialist Services

- £1.0m adverse in month due to £0.5m underperformance on ERF income which includes a benefit of £0.2m due to prior months coding. The remaining £0.4m under performance is due to Private patient CIP that has been actioned and the budget offset is in corporate.

Medicine

- Income is £0.1m favourable in month due to benefit of compensation recovery unt income (CRU).

Surgery

- £0.3m favourable in month due to over performance on ERF.

Non-Divisional Income

- £0.5m favourable in month. £0.1m due to over performance on education income and £0.4m due to advice and guidance income that has resulted in diverting activity and reduced ERF activity.

Nurse Director

- £0.1m favourable due to over performance on education income.

Corporate

- £0.5m favourable in month. £0.4m due to T&O private patient CIP which is offset in Specialist Services and the remaining £0.1m is due to the apprentice levy funding.

Divisional ERF Activity and Income

Activity Plans

- The Trust has developed an internal elective plan for 2024/25, and this is being used to monitor the Divisions performance and for financial reporting.
- NHSE have released high-level provider ERF activity and financial targets for 2024/25.
- The Trust has followed the same methodology for the internal plan target value but have increased it by £7.3m FYE to include the internal business cases which are to be funded from an over performance on ERF.

ERF Performance

- In month 5, the Trust is £0.5m adverse to the internal ERF plan and £0.9m adverse YTD.
- Specialist Services are £0.7m adverse in month and £1.8m adverse YTD predominantly within Trauma & Orthopaedics, this is a result of not utilising all available theatre sessions.
- Surgery have over performed against their plan by £0.3m in month and £1.1m YTD.
- Medicine are £0.1m adverse to plan in month and £0.2m YTD.
- Advice and Guidance income of £0.4m has been included in the month 5 financial position, however it is not included in the above table as it is coded to Non-Divisional income until the split by Division is confirmed. This would reduce the YTD ERF adverse variance to £0.5m.

		In Month Activity			In Month (£000)			YTD Activity			YTD (£000)		
Division	POD	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,562	1,679	(117)	948	1,049	(101)	7,733	8,473	(740)	4,878	5,295	(417)
Medicine	Electives	62	27	35	78	41	37	152	136	16	242	208	34
Medicine	OP Proc New	142	196	(54)	49	66	(17)	624	990	(366)	205	331	(126)
Medicine	OP Proc FUP	460	363	97	82	70	12	3,158	1,833	1,325	564	354	210
Medicine	OPA New	2,221	2,266	(45)	526	534	(9)	11,781	11,438	343	2,838	2,698	140
Medicine Total		**4,447**	**4,531**	**(84)**	**1,683**	**1,761**	**(78)**	**23,448**	**22,872**	**576**	**8,728**	**8,887**	**(159)**
Specialist Services	Day Cases	667	765	(98)	992	1,214	(223)	3,467	3,771	(304)	5,453	5,966	(513)
Specialist Services	Electives	364	398	(34)	2,469	2,801	(332)	1,782	1,946	(164)	12,460	13,695	(1,235)
Specialist Services	OP Proc New	798	846	(48)	123	135	(12)	4,667	4,272	395	714	682	32
Specialist Services	OP Proc FUP	1,005	1,068	(63)	140	141	(1)	6,420	5,388	1,032	854	714	140
Specialist Services	OPA New	2,814	3,241	(427)	539	645	(106)	15,352	16,358	(1,006)	3,018	3,255	(237)
Specialist Services Total		**5,648**	**6,317**	**(669)**	**4,262**	**4,937**	**(674)**	**31,688**	**31,736**	**(48)**	**22,499**	**24,312**	**(1,813)**
Surgery	Day Cases	839	827	12	1,118	1,053	65	4,272	4,177	95	5,673	5,318	355
Surgery	Electives	244	119	125	597	445	152	951	602	349	2,631	2,245	386
Surgery	OP Proc New	1,741	1,681	60	351	347	4	8,968	8,483	485	1,834	1,749	85
Surgery	OP Proc FUP	3,297	3,036	261	621	546	75	16,266	15,324	942	3,084	2,757	327
Surgery	OPA New	3,868	4,052	(184)	743	779	(35)	19,971	20,454	(483)	3,862	3,930	(67)
Surgery Total		**9,989**	**9,715**	**274**	**3,430**	**3,169**	**261**	**50,428**	**49,040**	**1,388**	**17,085**	**15,999**	**1,086**
Divisional ERF Totals		**20,084**	**20,563**	**(479)**	**9,375**	**9,866**	**(491)**	**105,564**	**103,647**	**1,917**	**48,312**	**49,198**	**(886)**

Overperformance

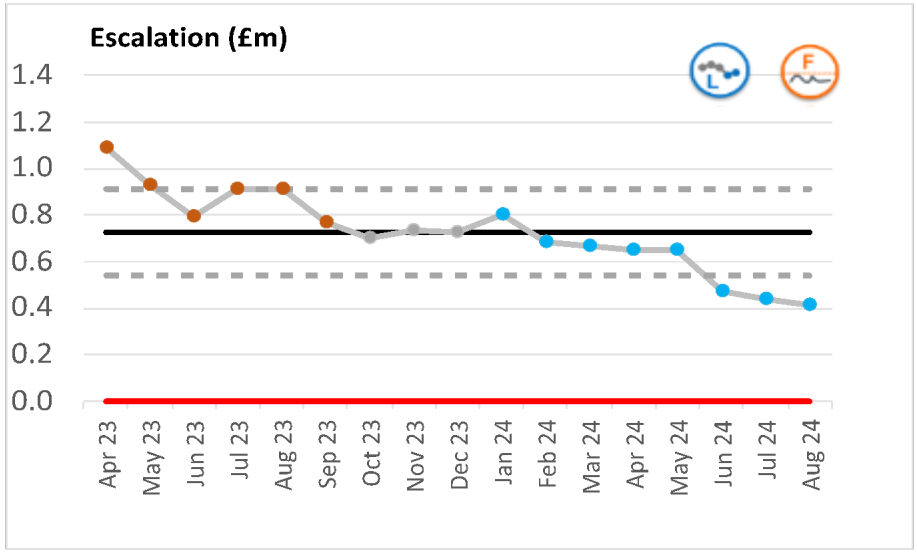
- Surgery £1.1m YTD

Underperformance

- Specialist Services £1.8m YTD
- Medicine £0.2m YTD

Escalation – Medicine Division

Escalation Costs – Division of Medicine Q4 2023/2024					2024-25 Escalation Costs						
Area	M10 Actual (£000)	M11 Actual (£000)	M12 Actual (£000)	Full year total (£000)	M1 Actual (re-stated) (£000)	M2 Actual (£000)	M3 Actual (£000)	M4 Actual (£000)	M5 Actual (£000)	YTD total (£000)	Full year Forecast (£000)
A&E Rota Issues	208	169	156	3,248	128	128	103	103	103	565	1,285
New ED Shifts				0	0	19	0	0	0	19	19
Paeds rota issues	78	78	78	1,014	67	67	67	67	67	335	803
Acute Rota Issues	51	51	51	809	51	51	51	51	28	230	374
Acute Outliers	26	26	26	517	26	26	26	26	26	131	315
AAA	5	0	0	129	79	77	68	0	0	224	224
Discharge Lounge	52	49	46	157	53	46	18	24	14	155	286
Corridor	203	159	164	1,748	92	48	28	46	21	237	237
Waiting room	31	31	31	374	31	31	31	31	31	155	372
1:1 Enhanced Care	149	122	113	1,724	123	154	84	87	125	573	1,182
Total	**803**	**685**	**666**	**9,721**	**650**	**647**	**476**	**435**	**416**	**2,624**	**5,097**
Winter Business Cases	92	114	124	570	140	140	148	148	148	724	1,908
Grand Total	**895**	**799**	**790**	**10,291**	**790**	**787**	**624**	**583**	**564**	**3,348**	**7,005**



Headlines

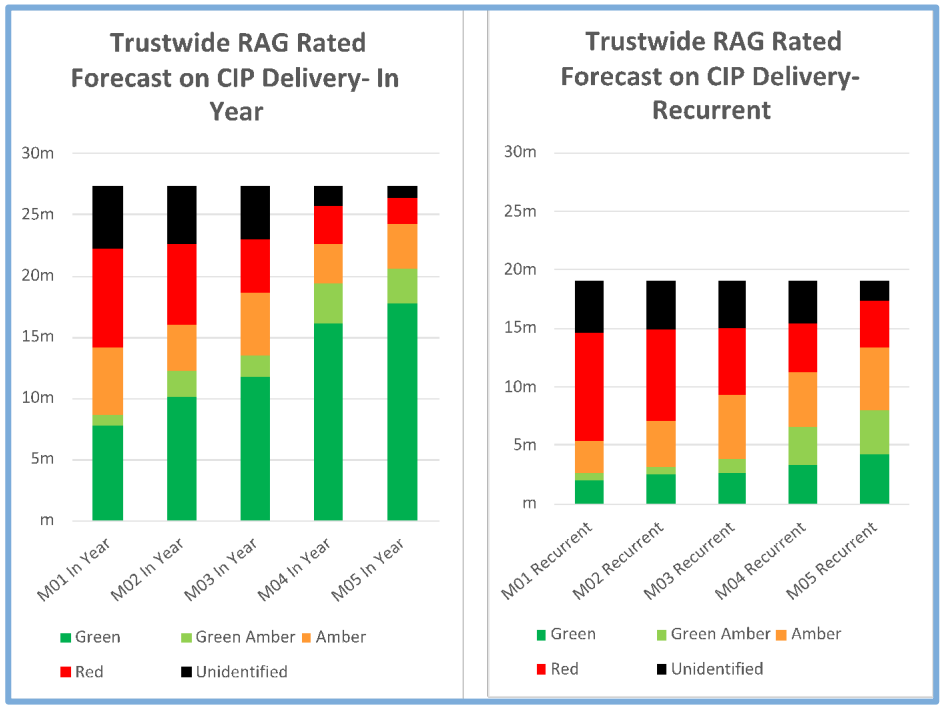
- The SPC analysis shows special cause improving variation, as escalation expenditure is on a downward trend.
- August saw a continuation of sustained de-escalation in the hospital, with reported escalation costs for August of £416k. Compared to month 1 this is a £234k per month reduction in costs.
- No costs were incurred for AAA escalation, for the second month in a row.
- Corridor and acute rota costs also reduced in month
- ED rotas and paediatric rotas remains static from a cost perspective within this financial year. Reduced costs across Acute Rota as changes have allowed the release of a locum SPR.
- 1:1 enhanced care increased across the assessment units and Astley ward.

Trustwide CIP Delivery 2024/25

2024/25 CIP Plans

The CIP Tracker currently includes schemes totalling £26.4m – 9% are categorised as high risk.

The total value unidentified is £0.95m – 4% of the total target of £27.3m. This is an improvement of £0.6m on the month 4 reported position.



August 2024 Reported Position

RAG	Value £'000
	952
	2,145
	3,586
	20,618
CIP Total	27,300

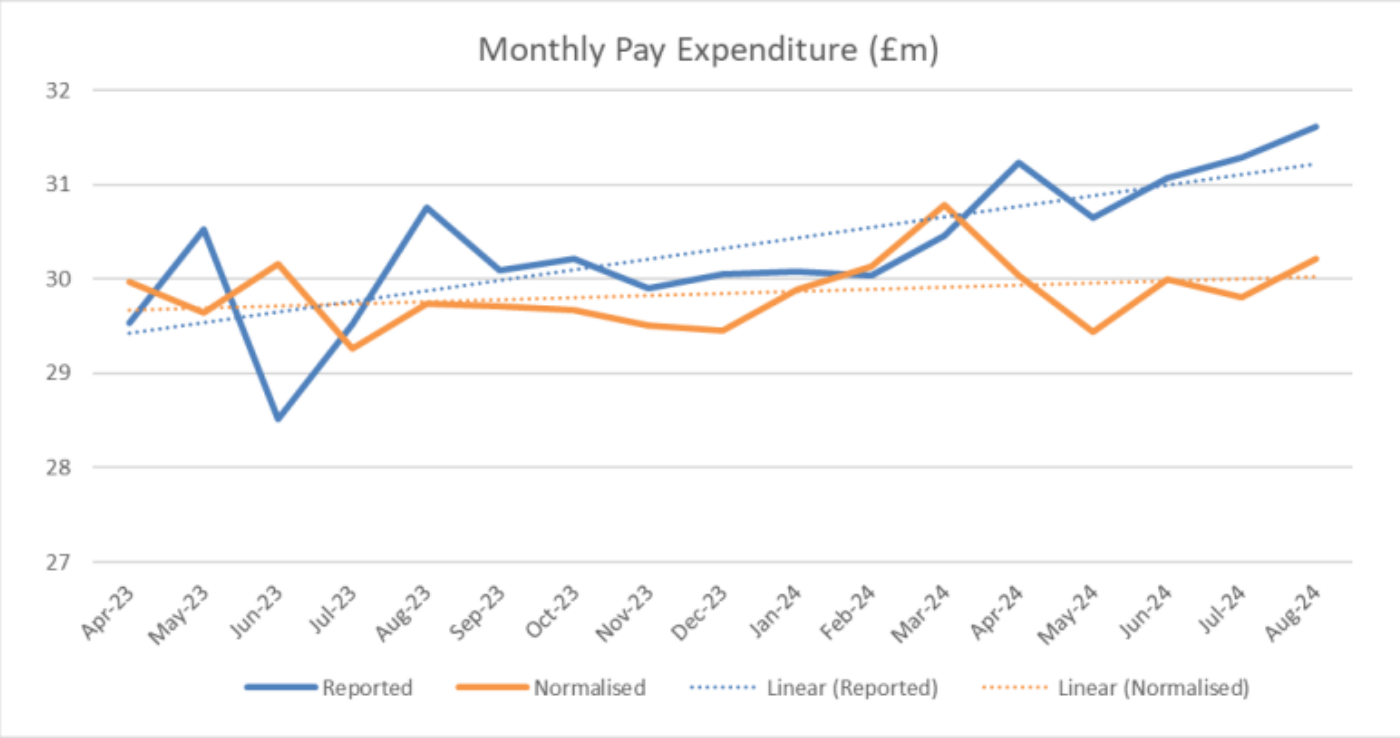
- £26.2m identified, £17.4m recurrent

July 2024 Reported Position

RAG	Value £'000
	1,576
	3,064
	3,321
	19,340
CIP Total	27,300

- £25.7m identified, £15.4m recurrent

Normalised Pay Expenditure



Normalised quarterly average

Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	M4-5 24/25
£29.9m	£29.6m	£29.5m	£30.3m	£29.8m	£30.0m

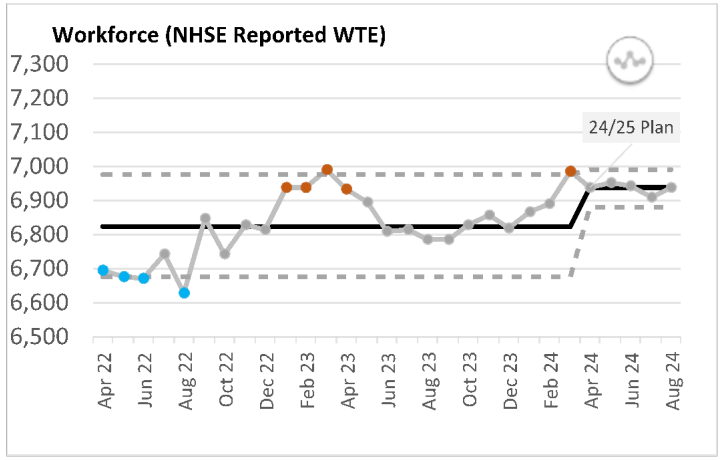
Key Messages

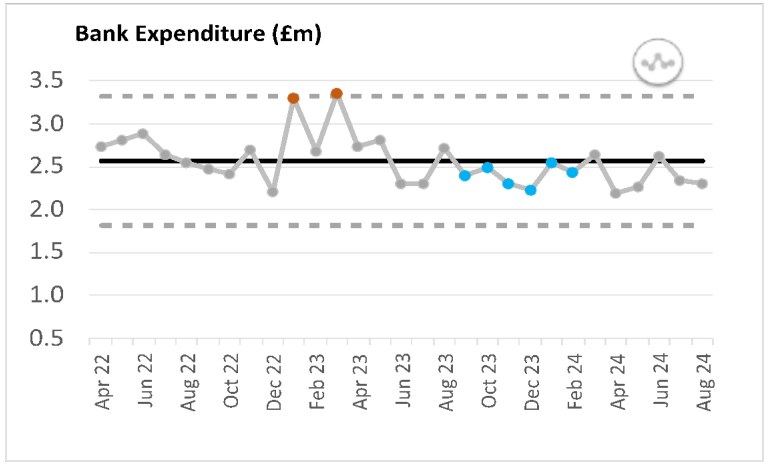
- The increase in the reported pay position is primarily due to pay awards, investment growth and other non-recurrent items.
- When these are normalised, the 'clean' pay position is static between April 2023 and August 2024.
- The Q1 normalised average for 24/25 is £0.1m less than Q1 23/24 (-0.3%).
- The first two months of Q2 indicate an increase of £0.2m per month compared to Q1, and an increase of £0.4m per month compared to Q2 23/24.
- There is no material reduction apparent yet from recurrent CIP delivery.

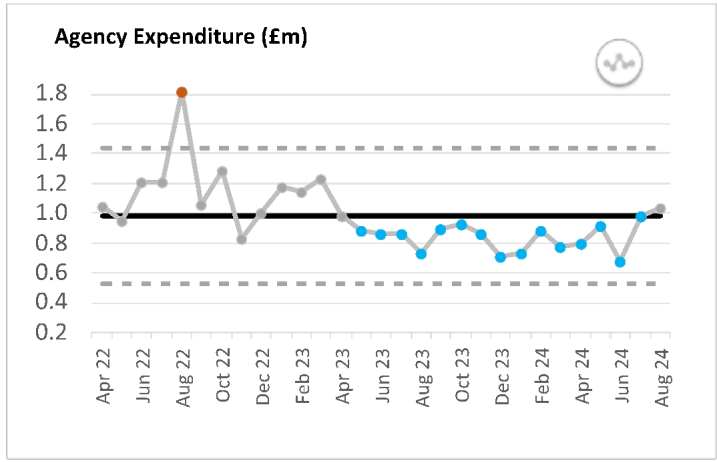
Normalising adjustments

- Industrial action excluded
- Balance sheet support excluded
- Pay awards:
  - 23/24 rephased across year to smooth impact of arrears
  - 24/25 assumed award and consultant/SAS reform excluded (to ensure comparable to 23/24)
- Investments excluded:
  - CDC
  - Virtual hub
  - Theatre 4, Leigh
  - Home First
- No adjustments made in respect of non-recurrent CIP (non-recurrent vacancies) on the basis that the transaction of non-recurrent vacancies doesn't impact on the run rate.

Workforce







Pay expenditure

- The in-month pay expenditure is £31.6m which is £0.9m adverse to plan.
- Medicine is overspent on pay £0.3m mainly due to costs of covering the back fill of vacant medical posts in various specialties.
- Surgery is overspent by £0.5m due to bank and agency staff supporting the fill of medical rota gaps in various specialties.
- This pay overspend has been offset with vacancies and non-recurrent pay CIP delivered across the divisions.

Workforce (WTE)

- The overall number of WTE increased in August by 31 WTE to 6,939 WTE, which is 39 WTE above the NHSE plan of 6,900 WTE.
- Substantive staffing has increased by 10 WTE with new starters in clinical roles.
- Bank staffing has increased by 21 WTE – NHSP bank 1:1 care in the division of medicine across various wards.
- Due to the intense scrutiny on WTE, the finance team have completed a review of WTE reporting. NHSP bank recording methodology has been reviewed and updated to better capture WTE worked in any given month. Whilst there have been no material discrepancies in reporting, there were timing discrepancies noted, and these have been addressed.

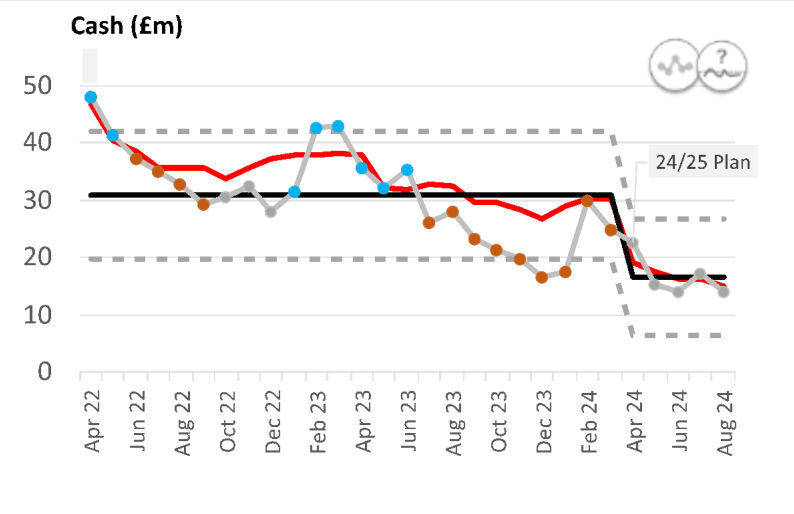
Bank expenditure

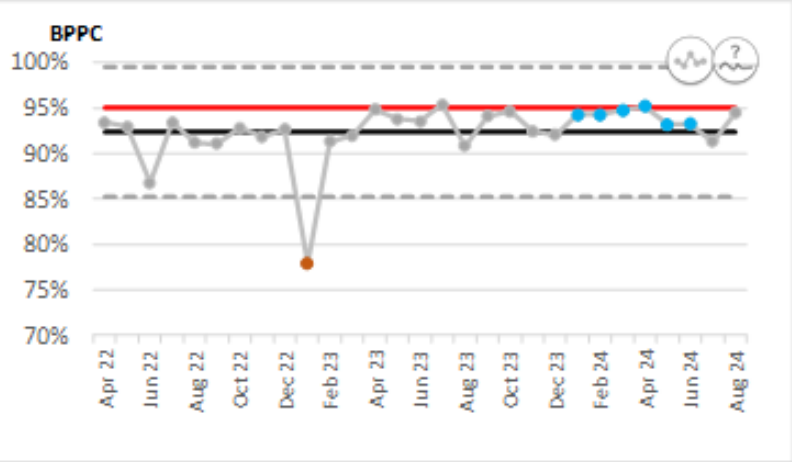
- During August bank costs were £2.3m.The trend is showing common cause variation within bank staffing expenditure, and over more recent months special cause improving variation in costs.
- The division of Medicine utilises the most bank staffing across registered and unregistered nursing as well as medical bank. These staff are supporting the escalated areas, covering industrial action (June), filling rota gaps, and providing 1:1 enhanced care.

Agency expenditure

- The trend is showing common cause variation. Although there has been slight increase in agency spend, this is within the normal range.
- Agency spend in August is £1.0m, which has increased since July.
- Agency spend in month is 3.1% of the total pay spend, which is just below the NHSE agency ceiling set at 3.2%
- Medicine continues to have the highest level of agency within the Trust.

Cash and BPPC





Current cash position

- Closing cash at the end of August was £14.1m, a decrease of £3.2m from July, £0.9m of this is prior year ERF clawback from Lancs and South Cumbria ICB adjusted in August.
- The closing cash balance is £1.0m below the plan of £15.1m largely due to the variance to the revenue plan and other timing differences in payment of invoices.

Cash forecast

- The improvement in the cash run rate forecast is remaining consistent. This has delayed the likelihood for revenue cash support from December of Q3 to January of Q4.
- The potential for the GM system to receive deficit funding (equal to the planned system deficit of £175m) is yet to be confirmed but would provide further cash support within year.

Better Payment Practice Code (BPPC)

- The performance by volume year to date is 93.4% which is slightly under the target, and above target by value year to date 95.3%.
- We are continuing to work on the action plan to improve and sustain the performance against the target of 95.0%.

Capital

	In Month (£000)			Year to date (£000)			Full Year (£000)	YTD Actual of Full Year Plan (%)
Scheme	**Actual**	**Plan**	**Var**	**Actual**	**Plan**	**Var**	**Plan**	
Operational capital (CDEL)	921	1,107	186	2,733	3,039	306	9,287	29%
Lease expenditure (IFRS16)	0	487	487	154	1,025	871	2,655	6%
Sub total internally funded	**921**	**1,594**	**673**	**2,887**	**4,064**	**1,177**	**11,942**	**24%**
National funding (PDC)								
Theatre 11, Wrightington	279	177	(102)	1,257	1,155	(102)	1,325	95%
Endoscopy	53	485	432	2,730	2,601	(129)	6,885	40%
RAAC Eradication Programme	5	0	(5)	5	0	(5)	711	1%
Sub total national funding	**337**	**662**	**325**	**3,992**	**3,756**	**(236)**	**8,921**	**45%**
Total capital programme	**1,258**	**2,256**	**998**	**6,879**	**7,820**	**940**	**20,863**	**33%**

Capital plan 2024/25

- Total capital plan for the financial year of £20.9m broken down as:
  - Internal operational CDEL £9.3m.
  - Lease expenditure £2.7m.
  - PDC £8.9m.
- CDEL plan of £9.3m includes £0.7m over commitment which has been mitigated in year.
- Additional PDC support of £0.7m was approved in month to eradicate Reinforced Autoclaved Aerated Concrete (RAAC), to be spent in this financial year.

Month 5 Headline

- Capital expenditure is £1.0m below plan in month and £0.9m below plan YTD, due primarily to lease capital. This is due to slippage on schemes which is expected to be recovered in year.

Internal CDEL

- £0.3m above plan year to date and £0.2m below plan in month.
- There is £0.2m slippage against medical equipment year to date, which is expected to be recovered.

PDC funded schemes

- £0.3m below plan in month and £0.2m above plan largely due to phasing of expenditure.
- The Endoscopy scheme has forecast slippage from 2024/25 into 2025/26 which will require mitigation across the wider capital programme. Options are being considered at the September Capital Strategy Group meeting.

Lease Expenditure

- Lease expenditure is £0.5m below plan in month and £0.9m below plan year to date.
- Revised lease plan of £2.7m submitted to NHSE 12th June 2024. This reduction of £0.9m supports the system over commitment against the lease envelope.
- Capital medical equipment group working through requirements, with OBCs expected to be presented to the Wider Leadership Team in September.
- All leases require GM ICB approval, due to the system overcommitment.

Full Year Forecast Scenarios

Bridge from straight line forecast to actual forecast. This sets out the assumption and improvement required to hit plan.

Straight line forecast £17.6m deficit	Remove non-recurrent items -£2.9m	Other items improvement +£0.9m	Improvement required to deliver plan +£5.5m	Current forecast £14.2m deficit (as per plan)
•Extrapolated from £7.3m YTD deficit	•Prior year income £0.5m •Industrial action expenditure £0.3m •Non pay mitigations £1.9m •Extrapolated impact of above £2.9m	•Winter expenditure (£0.5m) (within plan – phasing adjustment only) •Theatre 11 in year contribution following Q3 opening £0.3m •Private patient income seasonality £1.1m increase (based on divisional forecast)	•ERF improvement on run rate £1.4m, net of direct non pay, to deliver ERF plan in full (includes A&G) •CIP improvement on run rate £1.4m (to deliver plan in full and recovery YTD slippage); focus on workforce transformation & variable pay •Manage non-pay creep and inflationary pressures £2.7m	•As submitted to NHSE •All other pressures to be mitigated within existing plan •Assumes no further industrial action

Key assumptions to achieve plan

- Deliver ERF activity plan in full, with payment for advice and guidance
- Deliver CIP plan in full
- All other pressures to be mitigated within the existing plan
- Monthly run rate improvement of £0.5m required (from £1.5m YTD actual average deficit to £1.0m deficit per month)

High level scenarios for full year forecast

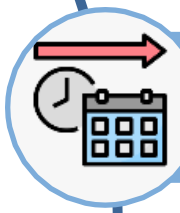
Worst Case	Mid Case	Best Case
£19.7m deficit (£5.5m adverse to plan)	£17.1m deficit (£2.9m adverse to plan)	£14.2m deficit (on plan)

Risk

Risk area	Risk description	Risk management approach/mitigating actions
Financial environment	The financial environment for 2024/25 for both revenue and capital is highly constrained, and the Trust is operating at a deficit. These may impact on the ability of the Trust to deliver its strategic objectives. NHSE have indicated that the change in government is not expected to generate any additional funding for the NHS within this financial year or next.	The GM ICS position is behind plan at month 4. The NHSE nominated lead has been working with PWC with the initial phase completed.
Revenue plan	The most material risks to delivery of the 2024/25 revenue plan are: • Delivery of the planned CIP of £27.3m. This includes the safe reduction in expenditure associated with escalation. • Delivery of the activity plan to meet the planned levels of income. • Impact of industrial action, with NHSE indicating that there will be no additional funding within 2024/25. • Management of other potential cost pressures in year, including non-pay creep. • Emerging growth in clinical supplies non-pay expenditure At present, we are forecasting to deliver our deficit plan of £14.2m for 2024/25.	Further work is ongoing within the internal transformation programmes, with additional support from the ICB and Wigan locality partners to address escalation. Internal check and challenge meetings are underway to identify further opportunities for CIP with a view to recover the YTD deficit through Q3.
Cash	The cash balance is declining, and external support may be required within quarter 4. This may be mitigated by NHSE deficit support however this has not yet been confirmed. Feedback from other providers is that access to cash drawdown is becoming stricter, as this is being used to increase regulatory oversight where Trusts are not delivering their plans. As part of the cash application process, NHSE are seeking assurance from provider Chair and CEOs that they are on track with their financial plan, have cash and cost controls in place, and can confirm that workforce plans are on track.	Awaiting confirmation on NHSE deficit support. Cash management strategy including daily cash forecasting Proactive relationship with lead commissioner NHSE have changed cash applications from quarterly to monthly from quarter 3.

Forward look

Following, the government announcement of the 2024/25 pay awards, it is expected the Agenda for Pay award will be processed via ESR in October salaries. The NHS Staff Council has ratified the recommendation of the NHS Pay Review Body (NHS PRB) to add an intermediate pay point in each of pay bands 8a and above; this will be processed in November salaries. The change in the cost uplift factor to income allocations has not yet been published.



NHSE have indicated that multi-year revenue and capital plans are likely to be required from the planning round for 2025/26. The national view is that 2025/26 will continue to be financially challenged.

National cost collection (NCC) packs have been shared with the clinical divisions. The Costing team have scheduled a series of meetings with the Divisions to explain the results and conduct deep dives into high-cost areas.

The procurement landscape is changing with the introduction of the Procurement Act 2023, which goes live in October 2024. This seeks to reform the UK's public procurement scheme post Brexit and replaces the Public Contracting Regulations 2015. The procurement team have been working with other GM provides to prepare for the changes.

Title of report:	Annual Report 2023-2024
Presented to:	Board of Directors
On:	02 October 2024
Item purpose:	[Information / discussion / endorsement / approval]
Presented by:	Kevin Parker-Evans Chief Nursing Officer
Prepared by:	Head of Patient Relations and PALS
Contact details:	T: 01942 773342 vicky.bolton@wwl.nhs.uk

Executive summary

This annual report provides the Executive and Non-executive board with both the high level and detailed analysis of the formal and informal complaints received into the Trust during the period of 1 April 2023, to the 31 March 2024[1]. This report provides data and assurance that the Trust has an appropriate complaints management process in place to ensure the standards are met in line with the NHS Complaints regulation (2009).

The annual report provides information on how the patient relations team have managed and responded to concerns, complaints and compliments and the learning identified from these. There are key metrics associated with both formal and non-formal complaints identifying divisional performance against the management of complaints, the trends relating to the subject matter, which is Clinical treatment, Communication, and Admissions and Discharges. There are also details of the PHSO involvement with the Trust, MIAA audit undertaken, and the survey results received from complainants on the complaints process.

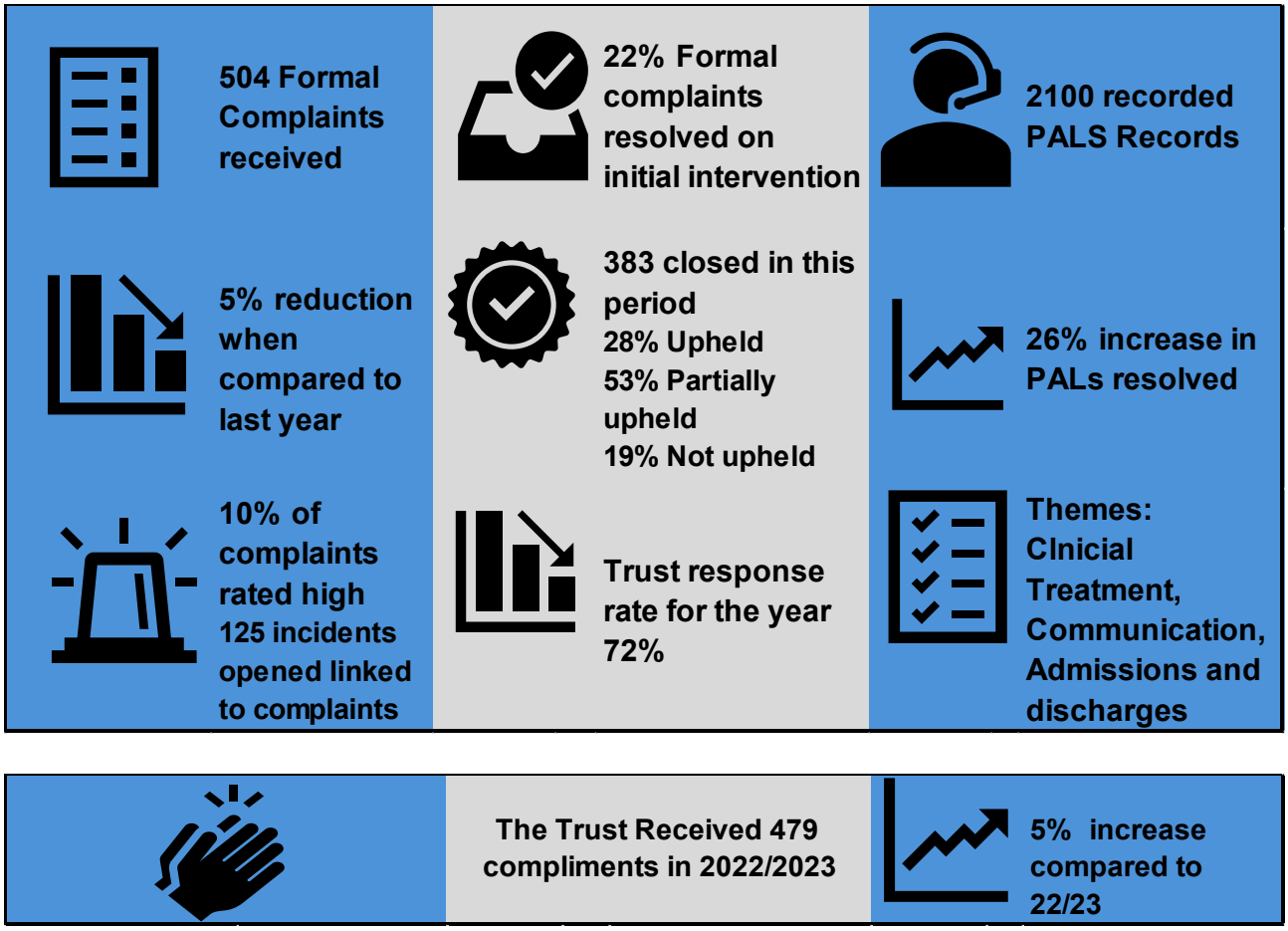
The overall Trust response rate for this period is 72%, which has not met the Trust's Performance Target. The Medicine and Urgent Care Division having the majority of concerns and complaints, with the operational pressures having an impact on the response rate. The Chief Nurse has commissioned a supportive integrated governance and key stakeholder weekly review of complaints compliance within the division which commenced in May 2024.

The Trust saw a 2% reduction in formal complaints received (504) when compared to last year (516)[2] 2022/2023 demonstrating that staff are answering complaints as early as possible as part of the Trust's commitment to listen, support and resolve concerns at source/when they happen.

[1] As at 18 June 2024 – changes can be made due to consent, withdrawn complaint, late informal resolution, or other.
[2] Figure changed when reported at that time, due to above reference 1

At the request of the Chief Nurse there has been an increased focus in the way in which plaudits and compliments are registered and held and the patient relations team are working closely with the ward and departments to record this robustly supporting a data set in the future which will enable the triangulated review of complaints and plaudits per 1000 bed days.

Complaints Performance at a Glance:



Patient Relation Successes Quarter 4.

Increased Face to Face meetings across the Trust	Maintained 3-day acknowledgment performance	Increase in recording of compliments
Developed intranet page which include you said we did	Task and Finish group to further improve Datix utilisation	QI Project- Embracing Excellence
You said we did- complaint meeting recordings are now available	Actively supporting ward level complaints	Listening remains the key skill
Mersey Internal Audit results: Substantial assurance	**Family Liaison Officer supporting Patient Safety incidents**	**improvement to the WWL internet page allowing neurodiverse users access**

Link to strategy
This covers all of the 4 Ps of Patients, People, Performance and Partnerships.

Risks associated with this report and proposed mitigations.
The Division of Medicine and Urgent Care in Q.4 overall compliance reduced significantly having an impact of the Trusts overall performance. Fragility of the leadership team and operational pressures throughout the quarter have created a risk for the overall complaint compliance. The Chief nursing has implemented an enhanced closer support to the division with relation to complaints management, reducing the backlog and planning a compliance trajectory that sees sustained compliance form Q.2 24.25 onwards.

Financial implications
There is significant evidence to suggest that poor care increases overall healthcare costs it is therefore essential that the Trust is learning from complaints and preventing the recurrence of complaints and development of themes and trends.,

Legal implications
None identified.

People implications
Whilst the report doesn't provide patient level detail, it is worth recognising that 69% of our staff live in our borough and are therefore likely to be patients within the Trust. Poor care either directly or with family members is likely to have an impact on our staff.

Equality, diversity and inclusion implications
The Trusts current Chief Nursing Officer was appointed in Q.4 of this annual report. Since commencing in post there has been a closer focus on the diversity and inclusion and ensuring equity with complaint responses. At the request of the Chief Nursing Officer thematic reviews of protected characteristics and

ethnic groups will both understand if underrepresented groups escalate concerns and to ensure that when they do they are answered accordingly.

Which other groups have reviewed this report prior to its submission to the committee/board?
Patient Engagement and Experience Corporate Group Meeting

Wider implications
An increase in complaints and poor management of complaints can create a regulatory red flag for the organisation.

Recommendation(s)
The group has been asked to:-

1. Note the contents of the report, and the work outlined in the improvement/proposals.
2. Note the risks associated with achieving the proposals.

1. Formal Complaints

Table 1. outlines the top themes highlighted from formal complaints received, with the trend of the theme in comparison to 2023/2024

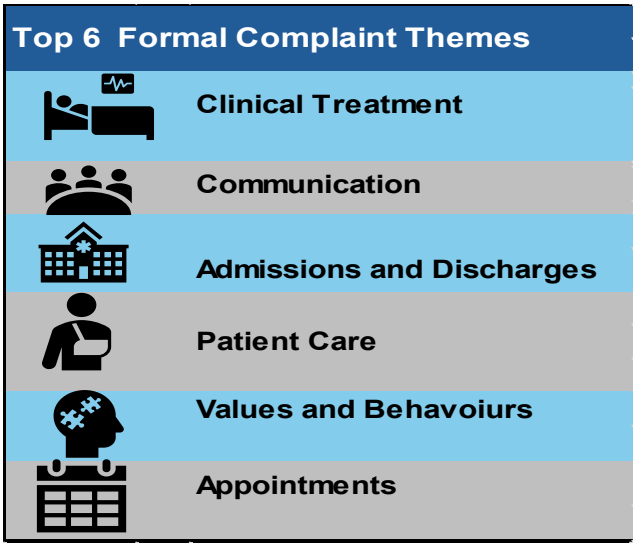


Table 1.

	Total	Compared to last year 2022/2023
ACCESS TO TREATMENT OR DRUGS	1	▼
ADMISSIONS & DISCHARGES (EXCL DELAYED DISCHARGE DUE TO ABSENCE OF A CARE PACKAGE)	56	▲
APPOINTMENTS	35	▲
CLINICAL TREATMENT	191	▼
COMMISSIONING	2	▼
COMMUNICATIONS	69	▲
END OF LIFE CARE	2	No change
FACILITIES	9	No change
MORTUARY	1	▲
OTHER	1	▼
PATIENT CARE	50	▼
PDW	6	▲
PRESCRIBING	8	▲
TRUST ADMIN POLICIES PROCEDURES INCL PATIENT RECORD MANAGEMENT	10	▼
VALUES AND BEHAVIOURS (STAFF)	44	▼
WAITING TIMES	19	▲
Total	**504**	

In summary, of the 504 formal complaints, the main themes emerging from complaints received (the main matter raised within the formal complaint) in the year 2023/2024 are Clinical treatment 38%, Communication 14% and Admissions and Discharges 11%.

The subject Values and Behaviours has shown a decrease of 23% when compared to last year, nevertheless, this is a subject that is closely linked to 'communications' subject, and therefore both subjects require monitoring. To provide assurance and support to both complainants and staff the Chief Nurse is developing two new ways of working to support the reduction of values and behaviours themed complaints:

- Structured, Documented reflection: on behalf of the Chief Nursing Officer a reflective practice document and template has been approved to support staff involved with complaints, this will involve a supportive conversation with their line manager, understand if there is a skills and/or knowledge gap and will involve the completion of a reflective template which will be kept on the member of staff's file (this is an informal supportive process and is **not** in line with or conjunction with any formal HR policies or procedures). For those members of staff who are registrants this reflective practice can be used as evidence for revalidation.
- A professional conduct panel: Nursing, Midwifery and AHP's involved in serious complaints, or those staff identified as being a trend within complaints and have completed the above exercise will be escalated to the professional conduct panel, whereby the panel can decide if there is further support and/or structured management required.

1b. Analysis of formal complaints recorded ethnicity and gender

Of the 504 formal complaints received where the subject was recorded as 55% female and 44% male, and <1% unknown. The majority of our service users are White British, 94%. This is largely unchanged from last year.

Table 3 – subject of complaints by recorded gender

Male	Female	Unknown
223	280	1

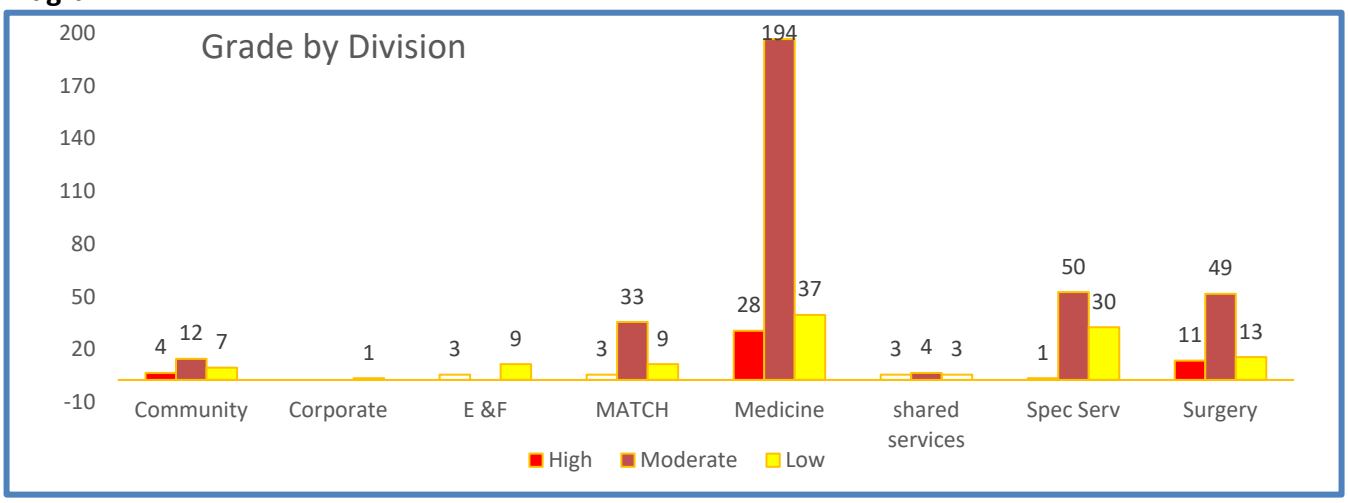
Table 4 – subject of complaints by recorded ethnicity

Ethnicity Background	Numbers	Percentage
White British	474	**94%**
White Irish	1	**0.20%**
White – other white	2	**0.40%**
Indian	1	**0.20%**
Pakistani	1	**0.20%**
Other Asian	1	**0.20%**
Black Caribbean	1	**0.20%**
Black African	2	**0.40%**
Other Black	3	**0.60%**
Chinese	1	**0.20%**
Other ethnic category	4	**0.80%**
Not stated	13	**3%**
Total	504	

The Trust promotes the services of an independent advocacy service, Healthwatch, who help and assist with people using our services. In addition to the work undertaken by the Inclusion and Diversity Service lead, helping the Trust to identify any barriers people may face when accessing our services.

Diagram 1. Outlines the grading of complaint by division. All formal complaints and grades of cases are triangulated with patient safety incidents, litigation, and governance, via the Learning from Patient Safety Events group. Red, Moderate and Low in numbers.

Diagram 1.



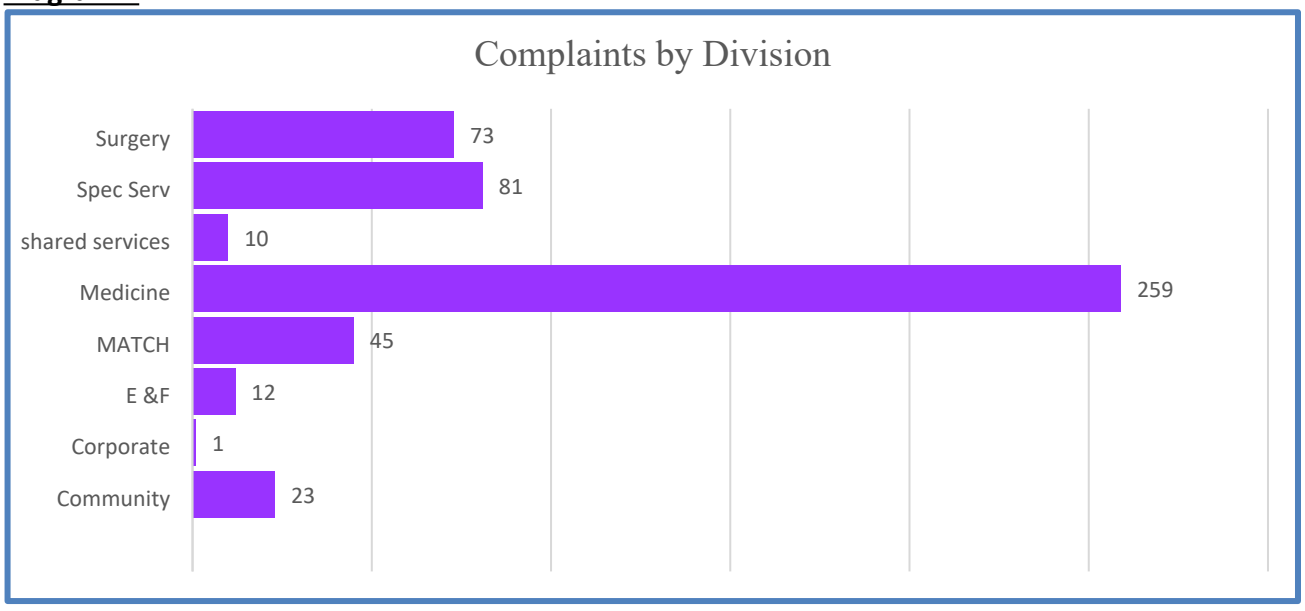
We will continue to link complaints to incident investigations which feed into complaint responses, when appropriate, ensuring that all questions raised by the patient, family or carer are answered fully and honestly. There are 125 incidents opened relating to the 504 complaints; the incident is either opened before the complaint is received, or divisional team will raise an incident on receipt of a formal complaint if it is considered that there is a potential incident raised by the complainant.

The team continue to work with the Patient Safety team, supporting families by acting as Family Liaison Officer. This role ensures we are providing updates and correspondence to families in a sensitive and compassionate manner which secures the confidence and trust of our patients and families, who have been informed an incident has been opened.

Whilst in its infancy the Chief Nursing Officer is reviewing the role of the matron in relation to the de-escalation and management of complaints at a ward and departmental level in real time. Matrons are being supported to be more visible across their wards and departments to support 'professional curiosity conversations' from both patients and their relatives.

Diagram 2 is a graph showing the amount of formal complaints by Division

Diagram 2



A further look back on formal complaints received yearly comparison can be found in Appendix 4.

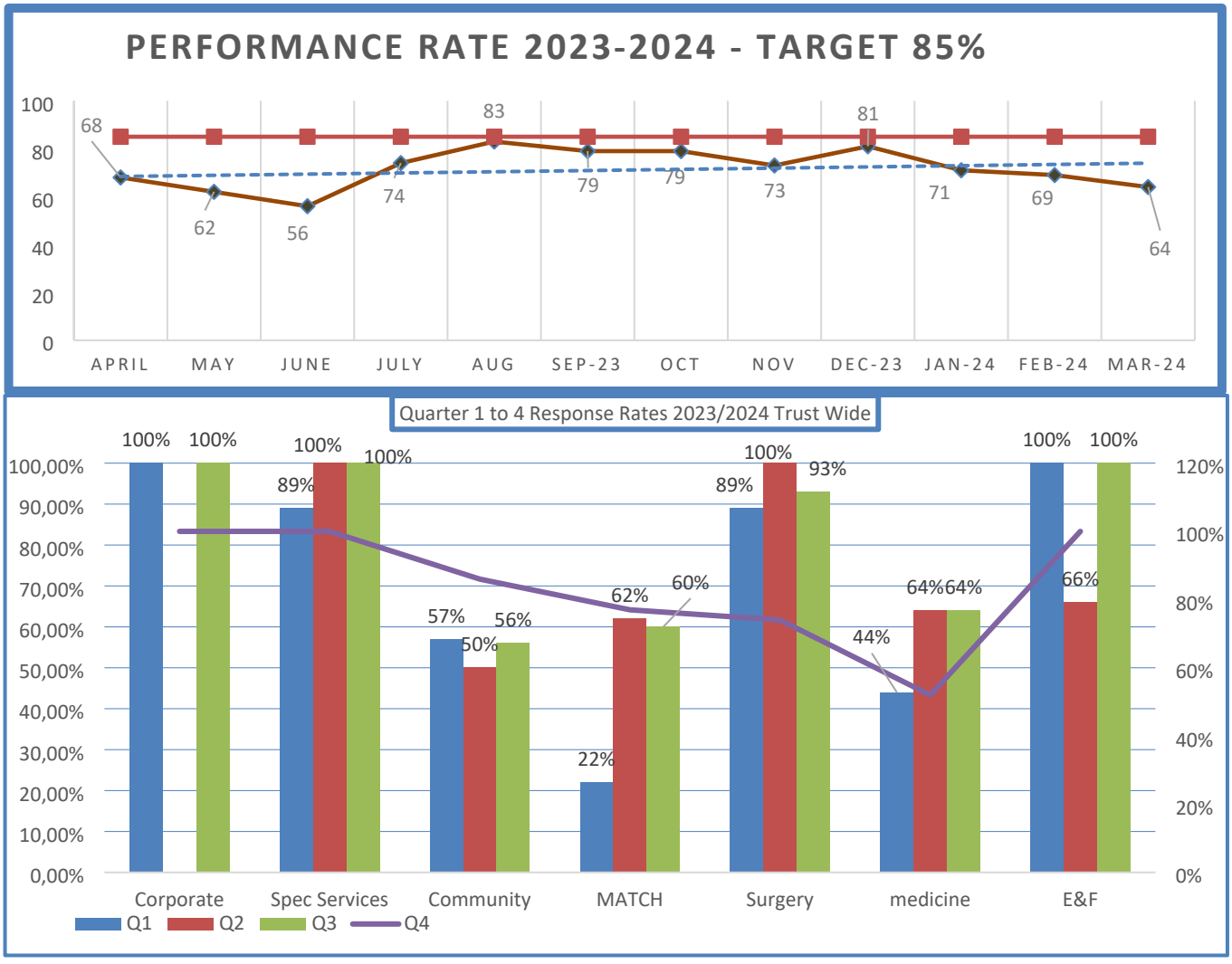
1c. Re-opened /second bites complaints (complainants who remain unhappy)

When a complainant remains unhappy with the response from the Trust, we ask that they let us know what they feel we have not responded to or what they do not agree with. A complainant may not revisit their response for a number of months; therefore, a reopened or second bite complaint may not be in the same reporting period as the original complaint was received. This reporting period received 26 reopened complaints (5%) of complaints responded to – compared to the reported figure in last year's report of 57 (11%). This is positive, as it means responses are of better quality and more adequately meeting the needs of the complaint.

1d. Trust Performance in responding to complaints (timescale)

Whilst the NHS Regulations (2009) stipulate that we have 6 months in which to answer a complaint, good practice and early response demonstrates that we are listening and learning. The Trust's overall response rate for 2023/2024 is 72%. This is a reduction in the Trust's compliance in responding to complaints; it is acknowledged that delayed responses can intensify a situation, risking further loss of confidence and Trust reputation.

Diagrams 3. Outlines the Trust Performance Response Rate



The Chief Nurse has instructed the governance teams to review their internal process for complaints management and requested a weekly progress check in meeting with the Medicine and Urgent Care Division to provide spotlight support with the turnaround and quality of their complaints. The Chief Nurse is also encouraging Matrons, Managers and Ward Leaders to own complaints by getting involved early to achieve prompt intervention to resolve complaints quickly and informally; early resolution demonstrates the Trust is taking concerns seriously and staff are committed to improving the patient's experience.

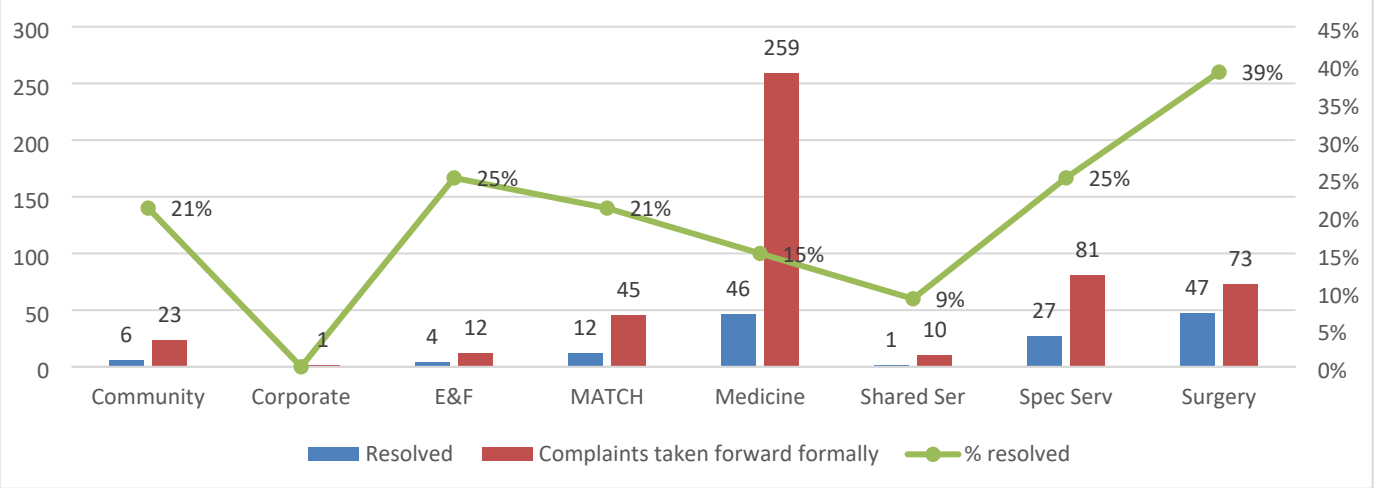
The Patient Relations team have provided training on how to respond to a complaint for 131 members of staff across divisions, the training will continue to embed and improve the quality of complaint management, how to respond to a complaint (providing suggested paragraphs and phrases) and increase confidence in responding in a timely manner, to improve this performance parameter. This will continue throughout the coming year. The team will be contacting those that have already attended the training to offer further support based on their requirements. Early look back on **reopened** cases shows a significant decrease demonstrating better quality of responses.

Medicine Division receive most concerns and complaints, for this reason patient relations attend their patient experience group each week to target support where it is required. Patient Relations and the Datix Administrator has utilised a module within Datix which can further monitor and provide a tracker for the divisional governance teams to use for their agreed internal timescales.

1e. Resolved Formal Complaints

The percentage of those formal complaints deescalated is demonstrated in **Diagram 4.** for example: Community Services received 29 formal complaints and resolved 6 (21%). The role of staff resolving concerns at source is key to a positive and timely outcome, builds rapport between our community who use our services and staff looking after our patients. Good complaints management, by using an initial telephone call from the local team, has supported in de-escalating complaints at an earlier stage.

Diagram 4. Formal complaints resolved and deescalated.



1f. Parliamentary and Health Service Ombudsmen (PHSO)

Following investigation of a formal complaint there is the opportunity for the complainant to come back to the Trust to re-review any outstanding concerns, however in each Chief Executive letter, the PHSO details are provided to the complaint at the first stage. The Trust aims to achieve local resolution however if the response(s) have not been met to the satisfaction of the complainant the PHSO will review the case

independently. Below are the cases that have been investigated and had recommendations provided to finally resolve the case.

- Case 1 – Patient unhappy with the clinical management of breast surgery. This case was partially upheld with apology required and acknowledgment of the failings.
- Case 2 - Patient had a genetic condition and was admitted with severe upper body pain – unhappy with the clinical management. This was partially upheld with apology required.
- Case 3 – Family had concerns regarding care, treatment, medication and discharge. This was not upheld.
- Case 4 - Family state patient was not offered any treatment after operation. Family believe that patient was let down. This was not upheld.
- Case 5 – Family unhappy with the diagnosis and knowledge of specific condition. The PHSO adopted the Early Resolution process in which they take forward a dispute resolution meeting; this was positive.

There was an additional request for notes regarding 4 cases, with no outcome provided presently. PHSO informed the Trust of 1 case they were not taking forward.

The PHSO, following the release of the NHS Complaint Standards in early 2021, identified recommendations in complaints handling. We as a department, are pleased to note that when we reviewed the standards, we were already undertaking a lot of the work, accountability, roles and responsibilities, early resolution, written response to formal complaints, and support for staff. Demonstrating learning is an area that requires development from the divisional teams, and currently patient relations is populating the 'improvement' field on Datix for completed responses, going forward for 2024/2025, the divisional teams will be completing this, ensuring improvements are owned by the area.

2. Recorded Concerns/PALs

Table 5. outlines are the subjects for the year 2023/2024 with the changes on the themes. Not all PALS queries are subjected because the team may provide information, support and guidance; admission or appointment queries, legal information, access to records requests, other Trust complaints/requests for information/report, Private Patients, and concerns dealt with by Human Resources. In total there was 2100 recorded PALS for this period.

Top Subjects

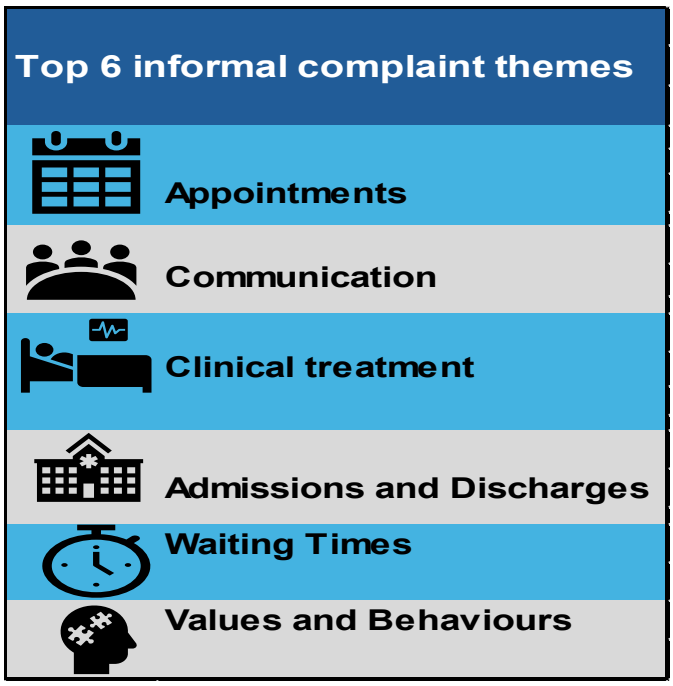


Table 5.

	Up and down Trend when comparing year 2023/2024
COMMUNICATIONS	decrease
ADMISSIONS & DISCHARGES (EXCL DELAYED DISCHARGE DUE TO ABSENCE OF A CARE PACKAGE)	increase
APPOINTMENTS	increase
CLINICAL TREATMENT	decrease
VALUES AND BEHAVIOURS (STAFF)	decrease
WAITING TIMES	decrease
FACILITIES	increase
OTHER	increase
PATIENT CARE	decrease
PDW	decrease
PRESCRIBING	increase
TRUST ADMIN POLICIES PROCEDURES INCL PATIENT RECORD MANAGEMENT	decrease
ACCESS TO TREATMENT OR DRUGS	decrease
END OF LIFE CARE	increase
STAFF NUMBERS	No change
RESTRAINT	No change
INTEGRATED CARE (INCL DELAYED DISCHARGE DUE TO ABSENCE OF A CARE PACKAGE)	increase
MORTUARY	increase
COMMISSIONING	decrease

The number of recorded PALS data requiring resource time to resolve in this year was 2100, a slight increase from 2022/2023 (5%). The main subject matter repeated in concerns recorded are Appointments, Clinical Treatment, and Communication.

Lost Property: the main subject 'Other' reports the subject involved lost personal property. For PALs and Complaints year 2022/2023 there was **32** direct main subjects, and the year 2023/2024 **31** was reported. Lost property is monitored through the Corporate Patient Experience meetings where this will be explored. There is a QI Champion currently leading on the development of a robust patient property pathway supporting new ways of working and documentation The Chief Nurse has requested that the human factors and lived experience voice of being in hospital without teeth, hearing aids and glasses and the detrimental impact this can have during a patient stay is at the forefront of the management of lost property. The Chief nurse is revisiting and relaunching the importance of the patient programme across the organisation in Q.2 2024/25

Because there can be multiple sub-subjects within a complaint, a further deep dive into the data will be provided to Patient Experience to include all sub subjects regarding lost property.

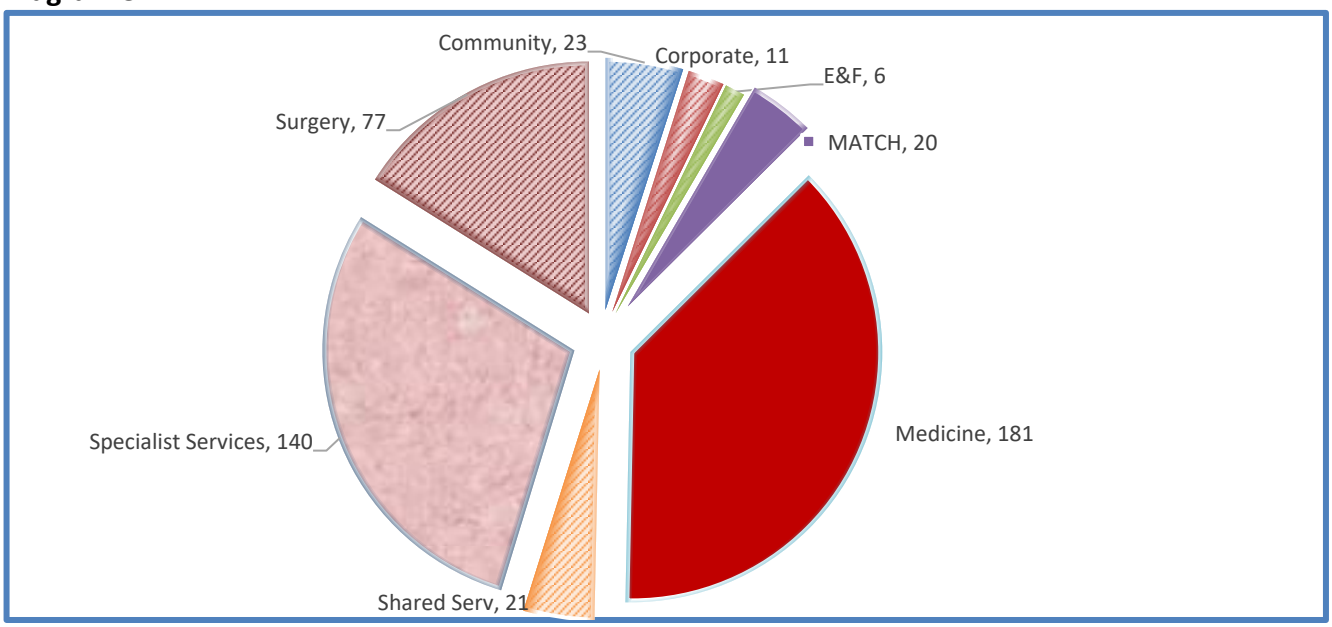
Analysis of the subject Admissions and Discharge has been undertaken to determine which is the most prevalent subject; discharge has the highest related concerns, relating to discharge arrangements, discharged too early, failed plan of discharge, discharged without discharge letter, discharge without medication.

Communication will be monitored to see whether complaints training, and the other workshops planned help to reduce the number of concerns in this respect. In respect of concerns relating to discharge, monthly data is provided to highlight trends and themes to the Discharge Group. Lay representative(s) to be recommended to the Divisional Director of Nursing leading Discharge group/Transformation team.

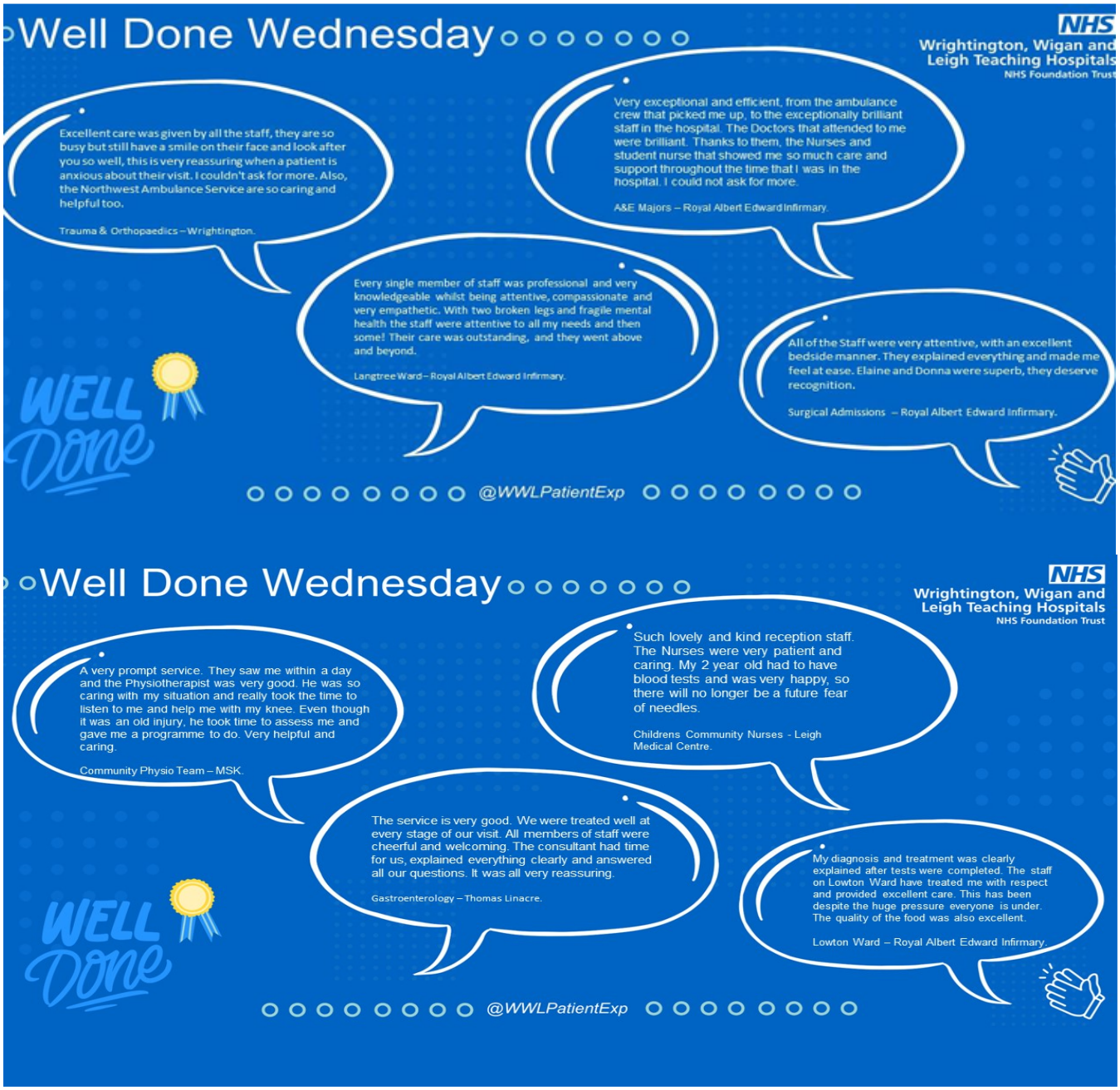
2a. Compliments and Plaudits

Diagram 5. Outlines compliments per division. The Chief Nurse has directed via the Chief Nurse start of the week the importance of managing, receiving and documenting plaudits and compliments and it anticipated that as this data increases it can be triangulated to provide substantial assurance with regards to the number of complaints received versus compliments per 1000 bed days.

Diagram 5.



Wellbeing Wednesday was launched in Quarter 4 of the year 2023/2024, using social media as a platform to feedback thanks, plaudits and compliments and is well received across the teams.



2c. Learning from complaints

Learning from complaints is fundamental in improving the quality of care and delivery of services by understanding the experiences and needs of our patients.

Trust wide shared learning, celebrating success and lived experience subject matter experience involvement are key to the delivery of a robust patient experience and patient relations strategy.

The patients voice when acting upon complaints is essential, and by welcoming complaints in a positive way, this is a valuable insight, and promotes a learning culture. The Chief Nurse is encouraging senior divisional representatives to facilitate open and transparent face to face approach to managing complaints as a first

line offer. The Chief nurse has also facilitated a number of complex complaint meetings during this quarter, which have been well received.

The Chief Nurse office have appointed an Associate Chief Nurse for Harm Free Care, Patient Quality and Experience who will commence in post in August 2024. A key objective of this post is working in close collaboration with the patient relations team and integrated governance teams will be to further develop and create a lived experience forum, panel and representation with the management of complaints. This post will also chair a newly formed learning from complaints group that will have Trust MDT attendance.

The patient relations team have drafted complaints review panel process which will provide a quarterly review of 10 complaints. They will be reviewed by an independent panel which will include a lived experience representative and will supportively scrutinise the response, any learning will be reviewed to ascertain whether this has been embedded, and improved patient experience.

Led by the Chief Nurse Quarter 4 saw the implementation of the Senior Nursing, Midwifery and AHP leadership walkabouts. Under the direction of the Chief Nurse any complaint themes that have been noted or action plans in relation to complaints are triangulated with senior leader visits.

Moving forward there has been the request that the triangulation of complaints is done so using ethnic minority, gender, areas of deprivation and areas of poor health inequalities to further learn and review complaints using an EDI lens. Examples of learning can be found in Appendix 2.

3. MIAA Audit – Complaints Management Review

As part of good corporate governance, the MIAA were asked to complete an audit of the Trust Complaints Management system to understand how this was being administered and managed. Following the MIAA's sample testing and robust review the final report was produced in January 2024, with the key findings stating there was a good system of internal control designed to meet the systems objectives, and controls were generally being applied consistently, resulting in 'substantial' assurance.

Summary of Recommendations Critical	**High**	**Medium**	**Low**	**Total**
0	0	0	3	**3**

Some key findings were highlighted in order to improve the overall management of complaints which are highlighted in Diagram 6.

Diagram 6. PALS and Complaints MIAA Audit Action Plan in response to risks identified

Risk	Recommendation	Risk	Planned action	Actioned Yes / no
Policy and SOP Policy was found to be out of date by one month	The Trust should ensure that the policies and procedures are reviewed and updated	Low	January 2024	yes
Visibility of Leaflets: Patient Relations leaflet not under the specific PALS section on the internet	The Trust should ensure that all complaint leaflets are also accessible within the Compliments, Complaints and concerns section on the Trust's website.	Low	January 2024	yes
Details on the systems: Some records not held on the system.	The Trust should ensure that the necessary documentation is, and detail is retained on the appropriate system in accordance with	Low	Task and finish group set up, March 2024, with	December 2024

	the Trust's policy and SOP. The Trust should consider implementing a reconciliation mechanism of complaints received to complaints recorded in DATIX		Divisional Governance teams	

4. Department survey

During the year surveys regarding the complaints process, and outcome/satisfaction to a response is undertaken, during the last year on the whole the feedback is positive. Of the 73 surveys undertaken 20 were received back with feedback (as shown in Appendix 3[3]).

5. Summary and Priorities for 2024/2025

The Patient Relations team will focus on training and ensure we meet the local targets for complaint responses. We will continue to capture learning, by encouraging the investigators to use the improvement / action plan module within DATIX. The department has continued their proactive role in the PALS service, resolving concerns in real time, thus resulting in more positive experience. Everyone is welcome to contact the department whether they are a patient, relative, carer or member of staff, as a friendly welcome is given to all. We have a wide range of leaflets and access to information to help where we can and during the day we respond to many requests for information and advice and signpost all who access our service in the right direction. Our remit remains *'if we don't know, we will find out who does'*.

The team continue to attend the ward and clinic areas as and when required. In addition, we provide support to the staff of the Trust to ensure that they are able to respond to concerns and complaints in a positive manner. For example; helping to resolve concerns as and when they happen; providing information to the patient with respect to internal processes, i.e. being involved in Multi-Disciplinary Team Meetings (MDT) and arranging attendance and guidance.

The Team continues to build on the relationships with the Divisions and encourage the empowering of staff to work with us proactively to resolve concerns at source. The team support staff, patients, carers and their relatives through difficult times without having to engage in the formal complaints process. This attains a speedy resolution and satisfaction to all concerned. The increase in activity through the PALS service from last year highlights the sound relationship with the staff in all areas and builds on the confidence of the Trust as a whole to meet the needs of our community.

Themes and trends continue to be consistent and so a focused approach is required in relation to learning from complaints and Trust wide shared learning.

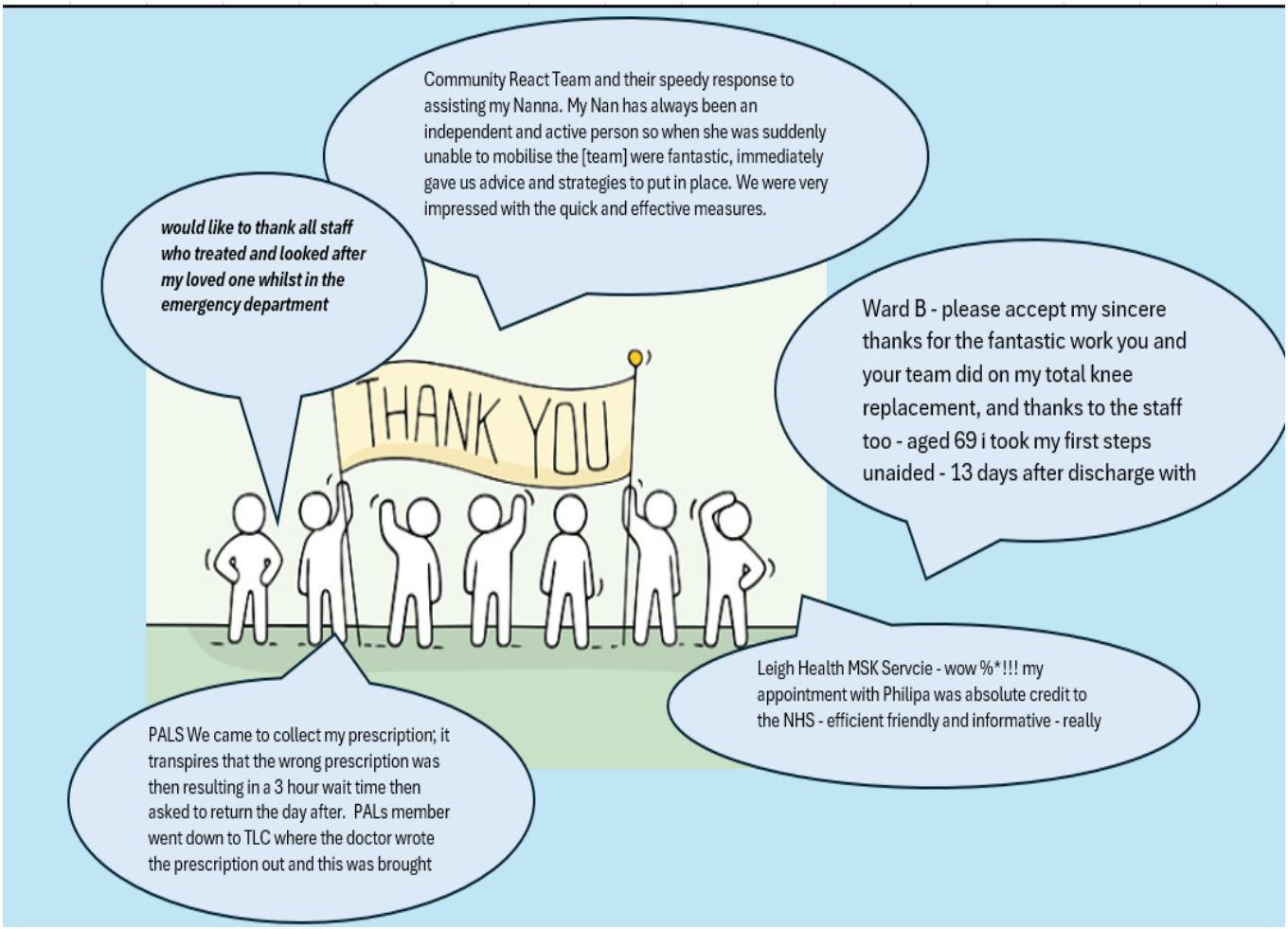
There has been an increase in the number of compliments and plaudits received following new ways of working led by the patient relations team.

The team will continue to improve our accessibility to ensure our community is provided with a fair inclusive culture.

Appendix 1 & 2 outline a number of plaudits received into the Trust during 2023/2024 and a number of 'you said we did' initiatives that have been implemented following learning from complaints.

[3] not all boxes are ticked when these are received in the department

Appendix 1.



Appendix 2
Examples of Lessons learned:

Division	Details of Complaint	Lessons learned – following complaint investigation
Medicine – Standish Ward	Patient deteriorated so quickly whilst in hospital, concerns pertaining to patient care and treatment whilst in hospital	The Trust has completed improvement work around pressure ulcer prevention awareness, and there is now in place a pressure ulcer steering group where the importance of education to patients and their families is a focus; the reintroduction of Dementia Champions this year and two Champions days have been held; introduce Tier 2 Dementia Training which goes into more specific areas of dementia care, and also hope to provide Immersive training using the Virtual Dementia Bus. This bus is a simulator that gives a person with a healthy brain an experience of what dementia might be like. Standish Ward have recently taken delivery of their new RITA (Reminiscence Interactive Therapy Activity) System

Community – District Nursing	End of life experience for patient: was not given end of life medication by District Nurses	District Nursing Leads will remind all staff to ensure they explore and clarify any potential difficulty in swallowing when commencing End of Life care anticipatory medications. The GP Out of Hours service have implemented regular and frequent audit of all temporary access cards used to access the clinical system. .
Estates and Facilities – Thomas Linacre Centre	Patient attended appointment at Thomas Linacre centre and on the way out the patient was knocked down by a mobility scooter which happened due to a barrier which is sited between the way in and exit and made it very difficult to see the other person and resulted in the collision and the patient falling to the ground.	The advertising board was first placed during the pandemic to indicate the entrance and exits, in order to maintain social distancing. After visit and view, the advertising board it is no longer necessary, and that it hinders line of sight when patients are exiting the building, which has now been removed.
Community Division	Patient has shoes measured and was invited to collect but unfortunately, they were not correct at the time and had to be sent back to manufacturers. unhappy with the waiting times.	More robust methods of communication and pathways have been agreed with the WWL Surgical Appliances Team and the Clinical Director & Consultant Orthotist to ensure effective review of any future complaints, concerns and issues raised by patients accessing the Surgical Appliances service. Surgical Appliances Team have improved escalation process for delays that support the team to highlight delays and the impact of delays on patients with WWL Teams involved.
Medicine – SDEC	Patient's drain was not managed correctly; risks of infection, with no replacement stitches	Staff to undergo suture training alongside the Hepatology specialist nurses, this will improve practice and avoid similar delays for our patients in the future.
MATCH	Patient unhappy with treatment provided during pregnancy and diagnosis given of unborn baby in lead up to patient giving birth	supporting leaflets regarding condition; ventriculomegaly, to be provided for parents
Specialist Services –	Patient had operation in 2019 and recently seen later last year, is suffering from severe pain since the operation; with a torn muscle and nerve damage.	review and improve the referral process for nerve conduction studies, to mitigate this risk.
Community	Family unhappy with care and treatment patient received from district nurses which led to the patient developing a large water blister on their calf.	TVN leading on training and development on wound care, leg ulcer care and weeping leg care in line with national guidance in DN service and Treatment room service.
MATCH	Patient was brought to A&E after visiting GP, multiple diagnosis and treatments recommended whist on A&E. Patient not offered medication whilst awaiting assessment.	Sepsis pathway will be presented within the Child Health Cabinet meeting in March to ensure all staff are up to date on the correct pathways

Medicine – Emergency Village	Patient needs a bariatric mattress when he attends the hospital and not sit in a waiting room up to 10 hours. Issues with compression bandages.	Review and establish a new process to support bariatric patients during attendance to the ED that will hopefully help prevent delays in equipment being available for patients.
Medicine	Assessments being undertaken on corridors.	Information posters displayed on the corridor to help direct staff on how to access the assessment cubicles

Corporate Learning

Ask do listen, feedback, concerns and complaints.

To improve experiences and outcomes for children and adults who are autistic or have a learning disability, their families and carers, NHS England are taking forward a service development improvement plan (SDIP) for all providers who offer services to people with a learning disability, autism or both (including children and young people). The Patient Relations department has used the resources provided by Ask Listen Do, to improve the posters, leaflets, and the Trust's Patient Relations' part of the Trust website to make it easier for people, families and paid carers to give feedback, raise concerns and complaints. Posters will include top 5 languages other than English (Kurdish, Arabic, Romanian, Farsi, Polish – which were the most interpreted during 2023/2024).

The Chief Nurse has asked the Deputy Chief Nurse to lead and develop this aspect and in Q1 'Learning Disability/autism/Neurodiversity effectiveness group' will launch. There will be an operational group and project groups also set up that will report into the tactical group.

Recording of meetings

Feedback from complainants regarding use of discs for recording of meetings – the option provided to electronically transfer the file using a secure system.

Lymes Disease

Awareness campaign run by a family member following a complaint; posters and information displayed in the entrance of Royal Albert Edward, to coincide with the Lymes Awareness month (May) pictures taken and put on display on the volunteers desk.

Family Liaison Officer (FLO)

The Patient Safety Incident Reporting Framework guidance ensures that the Trust engages and involves patients, families and staff following a patient safety incident. The Patient Relations team regularly take on this role; the FLO role is aligned to the Patient Relations' team skills, when they daily discuss concerns with patients and families, and provide support in a sensitive and compassionate manner.

Visiting times

Relatives concerned regarding visiting hours; not enough time with their loved one, and parking problems as there are fixed visiting times across wards. Following the directive from the Chief Nursing officer The Trust has implemented open visiting hours on all wards, to help our patient's and relatives experience.

Visual Information for Patients/Relatives/Carers in A&E

Banners have been erected in A&E to focus patients and relatives on getting involved in the patient's journey, asking if the patient has been offered a drink or may require pain relief.

In patient catering

It has been highlighted recently regarding appropriateness of hot soup as a starter, without additional/alternative options. Medicine matron is looking into this with the catering team to review alternative options to suit all patients, and those requiring additional needs.

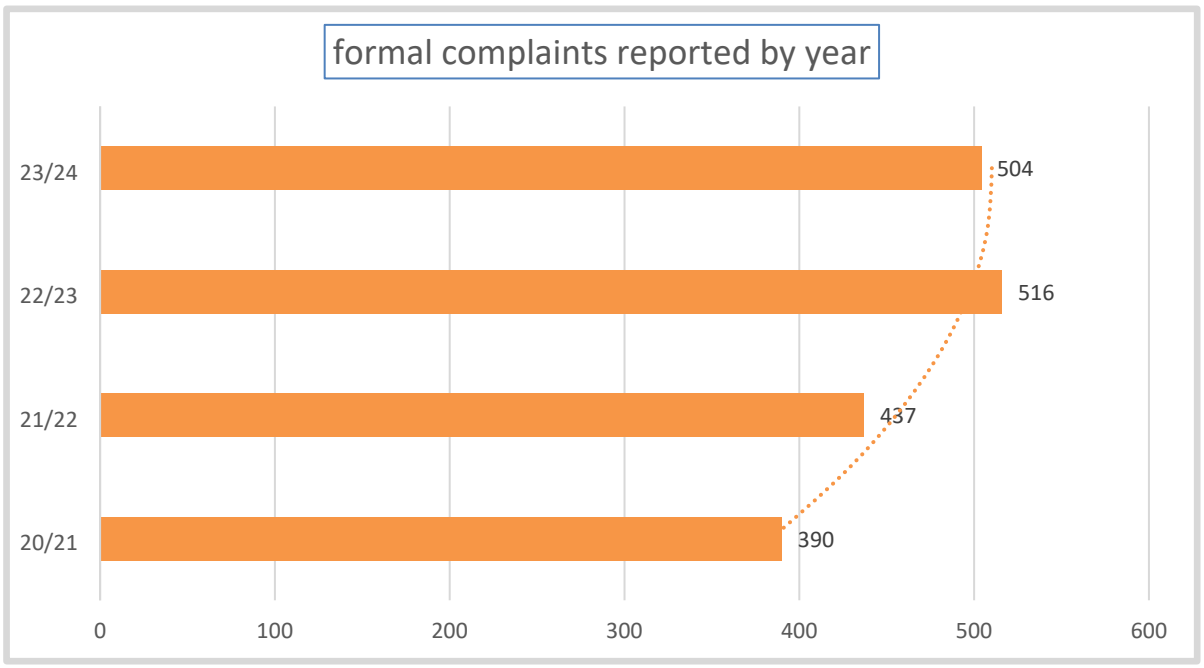
Out of Office Answer Machine Messages and Automated Emails

Due to an increase in aggressive tone and written language, the Patient Relations team have changed their message to ask complainants to be respectful when leaving a voicemail, and on the automated email response, to consider resubmitting their email should it include capitals, exclamation marks, or strong language.

Appendix 3 – Patient Relation Survey 2023/2024

Question	Yes	No	Not Applicable/Can't remember	PRD comments/actions
1. Did you find it easy to raise your complaint, i.e. enough information available to point you in the right direction?	17	3		Continue to promote early resolution
2. Did the Patient Relations Team help to summarise your points of concern?	15	4	1	Continue to discuss concerns with the complainant
3. Did you receive an acknowledgement to your complaint?	18		2	Ensure we continue to meet this target.
4. Did you receive a leaflet explaining the complaints process?	13	6	1	Ensure email correspondence contains the leaflet
5. Did we reply to you within timescale agreed with you?	15	2	3	Ensure timeframes are given to meet expectations
6. If no, did we contact you to explain the delay?		2	2	Ensure we correspond with the complainant to explain delays
7. Did our response address all your concerns?	13	6	1	Ensure the quality of responses answer questions posed
8. Was the outcome of your complaint explained to you in a way that you understood?	16	2	2	Engage with the divisional teams to develop the quality of responses
9. Were you happy with the outcome?	13	6	1	Listen to patient feedback to improve on this
10. Were you told about any changes or improvements made as a result of your complaint?	10	9	1	Develop Datix to ensure teams input improvements that can be communicated to the complainant
11. Were you confident that complaints help improve services?	10	8	2	
12. Do you think your treatment was adversely affected as a result of your complaint?	5	15		Provide assurance when speaking to complainants in respect of this
13. Did you understand what to do next if you were not happy with your response?	13	2		Continue to provide advise and support to our complainants
14. Thinking overall about your complaint how did you find the way we dealt with your complaint?	Very good ☐ 10 Good ☐ 5 Satisfactory ☐ 2 Poor ☐ 2 Very poor ☐ 1			Continue to receive feedback to improve what we are doing with the information from complaints

Appendix 4
Formal complaints received yearly



Agenda item: 26

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Assurance Framework (BAF)
Presented to:	The Board
On:	2 October 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.

Link to strategy

The risks identified within this report focus on 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 four 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 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.

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 sixteen key strategic risks is presented here for approval. The BAF is included in this report with detailed drill-down reports into all individual risks.

2.2 **Patients:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the Quality and Safety Committee Meeting on 11 September 2024. There have been no changes to the risk scores for the three existing risks since the last Board meeting in August 2024. No new risks have been escalated or removed from the BAF.

2.3 **People:** Current risks were reviewed and updated in line with the 2024/25 corporate objectives prior to the People Committee Meeting on 13 August 2024. There have been no changes to the risk scores for the three existing risks since the last Board meeting in August 2024. No new risks have been escalated or removed from the BAF.

2.4 **Performance:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the F&P Committee meeting on 24 September 2024. There have been no changes to the risk scores for the six existing risks since the last Board meeting in August 2024. No new risks have been escalated or removed from the BAF.

2.5 **Partnership:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the Board meeting on 2 October 2024. There have been no changes to the risk scores for the six existing risks since the last Board meeting in August 2024. No new risks have been escalated or removed from the BAF.

3. New Risks Recommended for Inclusion to the BAF

3.1 No new risks has been added to the BAF since the last Board meeting in August 2024.

4. Risks Accepted and De-escalated from the BAF since the last Board Meeting

4.1 No risks have been accepted and de-escalated from the BAF since the last Board meeting in August 2024.

6. Review Date

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

7. Recommendations

7.1 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

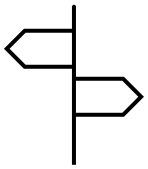
2024/25

The content of this report was last reviewed as follows:

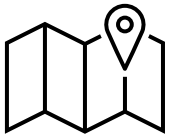
Board of Directors	August 2024
Quality and Safety Committee:	September 2024
Finance and Performance Committee:	September 2024
People Committee:	August 2024
Executive Team:	September 2024

> **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

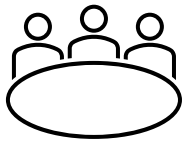


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

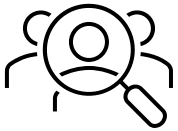


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

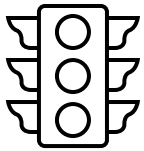
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have 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
Three Assurance Alarm Bells:	The first bell is triggered if the current risk score has not changed in 6 months. The second bell is triggered if actions are overdue or have not been identified to reduce the risk to target score. The third bell is triggered if the risk has not been reviewed since the last Board meeting.

Our approach at a glance

Our Strategy 2030

Our Values	People at the Heart	Listen and Involve	Kind and Respectful	One Team

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

FY024/25 Corporate Objectives

Patients

We will…

- improve the safety and quality of clinical services
- improve diabetes care for our paediatric population (up to age 19)
- improve the delivery of harm-free care
- promote a strong safety culture within the organisation
- improve the quality of care for our patients
- listen to our patients to improve their experience

People

We will…

- Enable better access to care by having the right people, in the right place, in the right number at the right time
- Ensure we improve experience at work by actively listening to our people, and turning understanding into positive action
- Have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish

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…

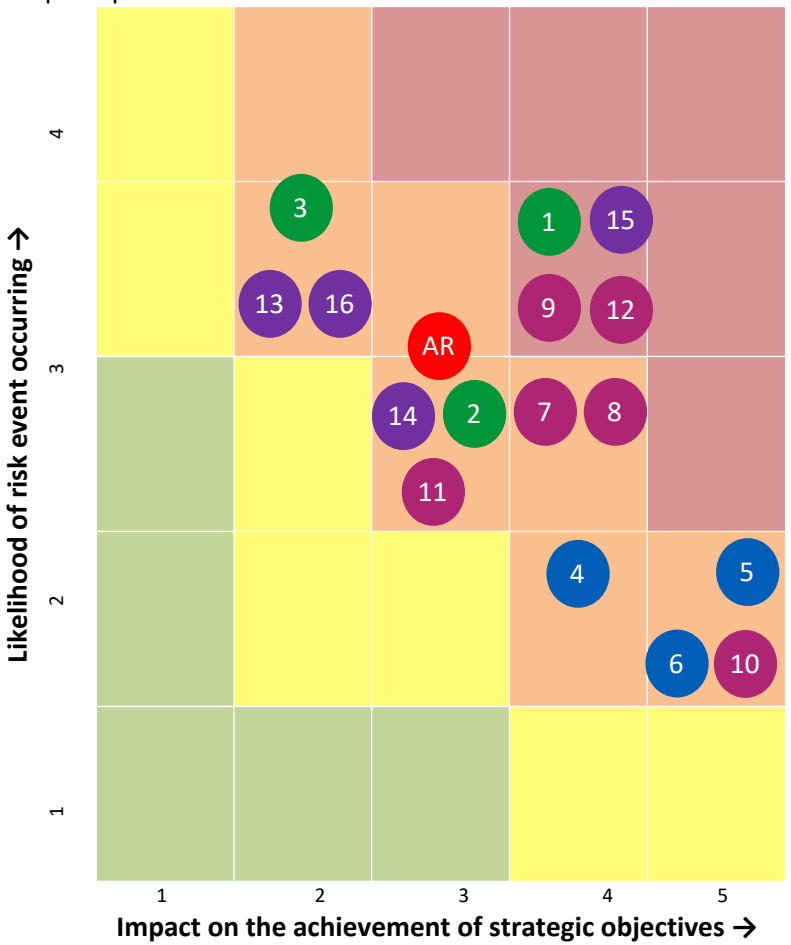
- improve the health and wellbeing of the population we serve
- develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable
- make progress towards becoming a Net Zero healthcare provider
- increase our research activities delivering high quality research with patients and partners across the Wigan Borough, strengthening our research capability and making 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
Hospital Demand, Capacity & 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

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

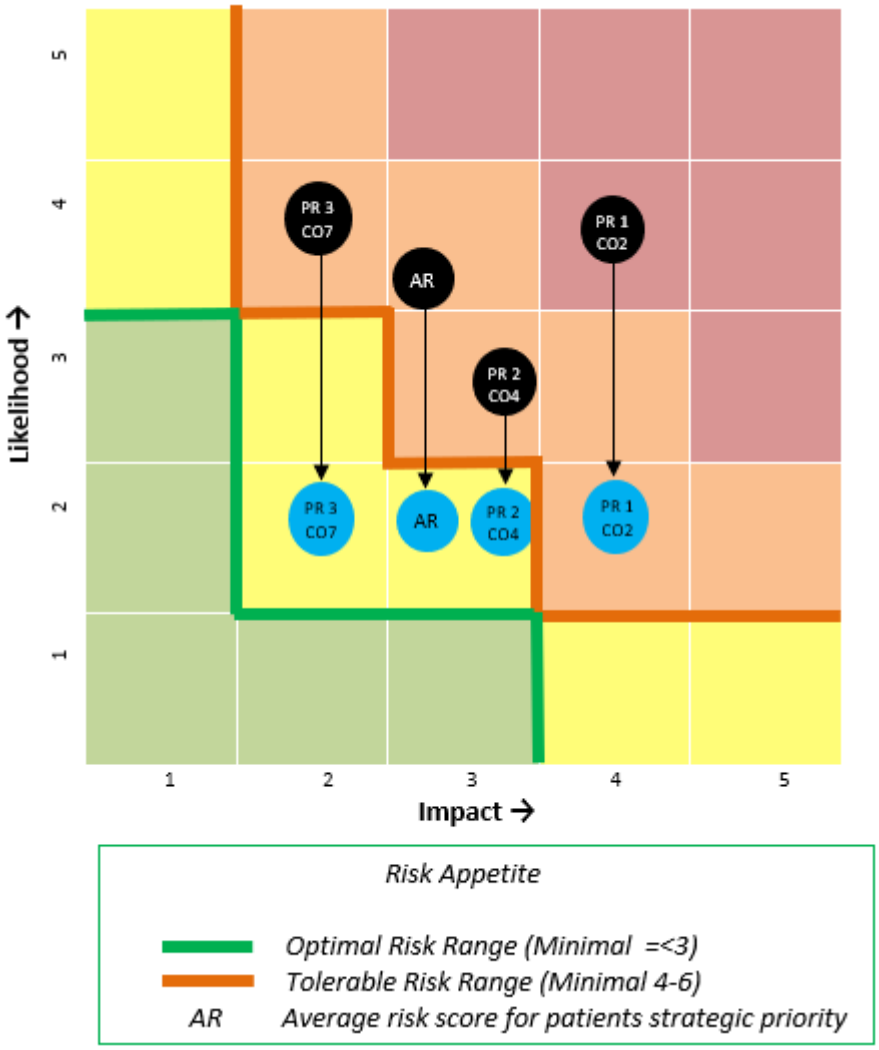
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

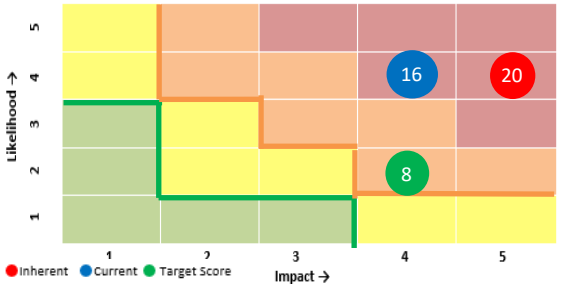
The following corporate objectives are aligned to the **patients** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Tracking
CO1	To improve the safety and quality of clinical services	To enhance patient care through digital transformation.	No risk currently identified
CO2 3805	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.	On Track – AQ data shows great progress
CO3	To improve diabetes care for our paediatric population (up to age 19)	To improve the care of paediatric patients with type 1 diabetes up to age 19 focussing on 5 care processes.	No risk currently identified
CO4	To improve the delivery of harm-free care	Continue improvements Pressure Ulcer Reduction. System Wide improvement for reducing pressure ulcers.	Off Track for zero 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.	On Track
CO6	To improve the quality of care for our patients	Continue and build upon the accreditation programme	On Track – potential risk due to long term absence of the lead for accreditation
CO7	Listening to our patients to improve their experience	Deliver timely and high quality responses to concerns raised by patients, friends and families.	Off Track for 90% of complaints responded to within our agreed timeframes.

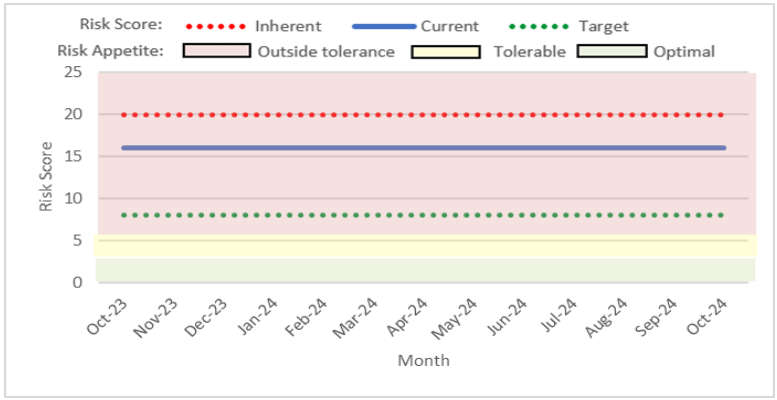
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



Corporate Objective: CO2 To improve the safety and quality of clinical services	1	2	3	**Overall Assurance level**	**Medium**

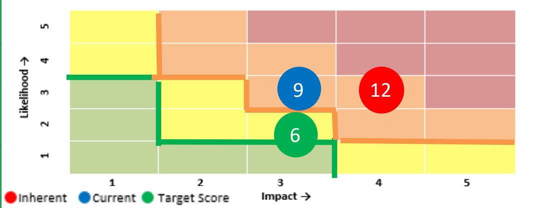
Principal risk	**Risk Title:**	**PR 1: Sepsis Recognition, Screening and Management**		
	Risk Statement:	There is a risk of the under diagnosing of patients with Sepsis, due to Health Care Professionals failing to recognise Sepsis in the deteriorating patient, which may result in patients not receiving 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 system risks**	-
Date of last review	**11.09.24**		**Risk treatment**	Treat

Risk Score Timeline



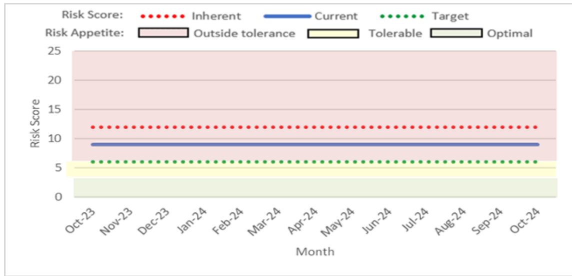
Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date By Whom
Threat: **(ID 3805)**	• Sepsis Nurse = High Visibility, Ward walk rounds. Recommenced by current Sepsis Lead Nurse. • Link Nursing in all wards and department have 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. • Improvements in recognition, audit and mortality data. • Sepsis Policy and Sepsis SOP – Live on the Intranet	• Sepsis/AKI Specialist Nurse has been appointment at a band 6 level. • Room booking and releasing staff due to operational pressures • 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. • Community SOP for Adults delayed due to absences within community teams. • New Sepsis e-learning module under construction.	**2nd Line:** • Quality & Safety Committee July 2024 • Board August 2024 • ECC Red Flag Sepsis Audit • AQ Audit	**2nd Line:** • None currently identified.	1. Sepsis E-Learning review to incorporate the new NICE Guidance and new policy information 2. Community SOP for Adults	March 2025 Sepsis Lead March 2025 Sepsis Lead

Corporate Objective: CO4 To improve the delivery of harm-free care			1	2	3	Overall Assurance level	Medium
Principal risk	**Risk Title:**	**PR 2: Harm Free Care - Avoidable Pressure ulcers**					
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.					
Lead Committee	**Q&S**						
Lead Director	**CN**						
Date risk opened	**19.10.21**						
Date of last review	**11.09.24**						



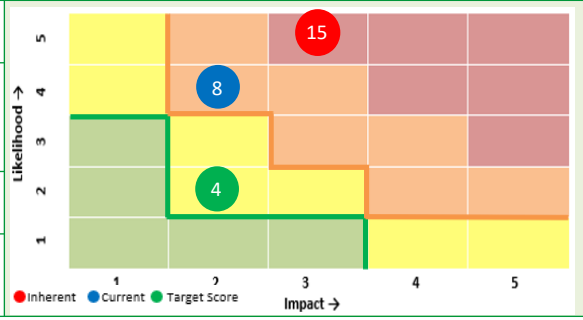
Risk Appetite	Minimal
Risk category	Safety, quality of services & patient exp
Datix ID / Links	Threat (ID 3322) No linked risks
Risk treatment	Treat

Risk Score Timeline

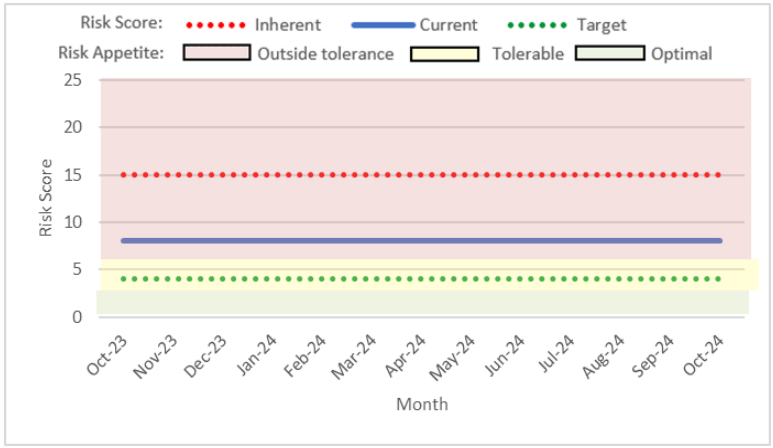


Existing controls	Gaps in existing controls	Assurances	Gaps	Risk Treatment	Due Date
• Pressure ulcer link nurses trained within all areas and extended to community care homes. • Human factors training to continue to be embedded within the organisation building on success of 2022/23. • Category 2/DTI Pressure Ulcer Review Panels (PURP) in place and aligned to PSIRF framework. • Category 3/4 & Unstageable Pressure ulcer panels 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 updated for 24/25 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. • Differential diagnosis training in Q4 has resulted in a marked reduction in PU being stepped down at PURP. • Wards fully established to agreed staff ratios. • Total bed management system rolled out. • Increased scrutiny in use of bank and agency staff. • Substantive workforce now in place. • Human factors training embedded within organisation. • Steering group monitoring through audit programme implementation of PURP action plans • Commenced the changes required in the category 3, 4 and unstageable panels to align to the Patient Safety Incident Response Framework (PSIRF framework). • Omissions in complex wound care included into the PURP process, to allow a forum for review and identifying learning, monitored through the pressure ulcer prevention steering group. • Unstageable category removed from 1st April 2024 in line with National Wound Care Strategy Programme recommendations and in line with PSIRF reporting. Further changes will be implemented later in the year when implementation resources are released from NHS England. • REPOSE overlay provision increased for the escalated areas in ED.	• Staff being able to be released to undergo training. • Escalated areas continue beyond winter 2023/2024 and into 2024/25. • 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. • Delay in MASD pathway being update in line with GM MMG, awaiting confirmation and printing of final version. • Redeployment of staff to support escalation areas. • HIS freeze stalling required changes in care planning and terminology in relation to PU prevention and care. • 2023/24 target not met to reduce category 2 & DTI PUs by 10% for HAPU =6%, • 2023/24 =45% reduction in Cat 3 & 4 PUs across trust but Zero target not achieved.	**2nd Line:** • Quality & Safety Committee July 2024 • Board August 2024	No gaps currently identified	• Further progress with Business Intelligence; developing a dashboard to illustrate PU data at a glance. • TV service to explore, the relationship between end-of-life skin changes (SCALE) and PU development in the community. • Roll of out the revised MASD pathway to acute and community services. • Review the Purpose T training package to prepare for implementation in the Trust. • System wide pressure ulcer prevention policy to be approved by the Adult Safeguarding board. • TV service to work with the HIS team to revise the referral process on HIS to reduce inappropriate referrals. • Review of the ED improvement plan for 24/25 to measure its effectiveness. • Repositioning chart to be combined with the Intentional Rounding Tool to reduce the end of bed paperwork and improve the compliance with repositioning. • Support the Medical Illustration team in the roll out of the SECTRA application to achieve timely photography of skin damage. • In 24/25 the focus will be on how to maintain a continued reduction in HAPUs throughout the winter months.	PU steering group March 2025

Corporate Objective: CO7 Listening to our patients to improve their experience	1	2	3	**Overall Assurance level**	**Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title**	**PR 3: 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 system risks**	No linked risks
Date of last review	**11.09.24**		**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. 01.04.23 to 31.03.24 – 39 records. • DATIX actions improvement has been used for each upheld or partially upheld complaint, a reduction for the top subjects will be realised as time passes. • Full day workshop (21 June) to complete Medicine's outstanding responses.	• There are currently no backlogs. • Requirement to source venues to run further training courses. • Despite training and good feedback from the session, staff are not coming back to us so that we can critic their work • Although there has been the introduction of the boxes, the Patient Relations and PALS team, have recommenced recording concerns when the patient relative have stipulated a record - patients/relatives are directed to Legal when all other resolutions have been explored (following the path of the patient and ringing round).	**2nd Line:** • Quality & Safety Committee July 2024 • Board August 2024 • Task and finish group set up so that divisions use functionalities within Datix.	• No gaps currently identified.	1. Training is continuing with high attendance and waiting list – so more dates are being provided after July.	March 2025 CN

People

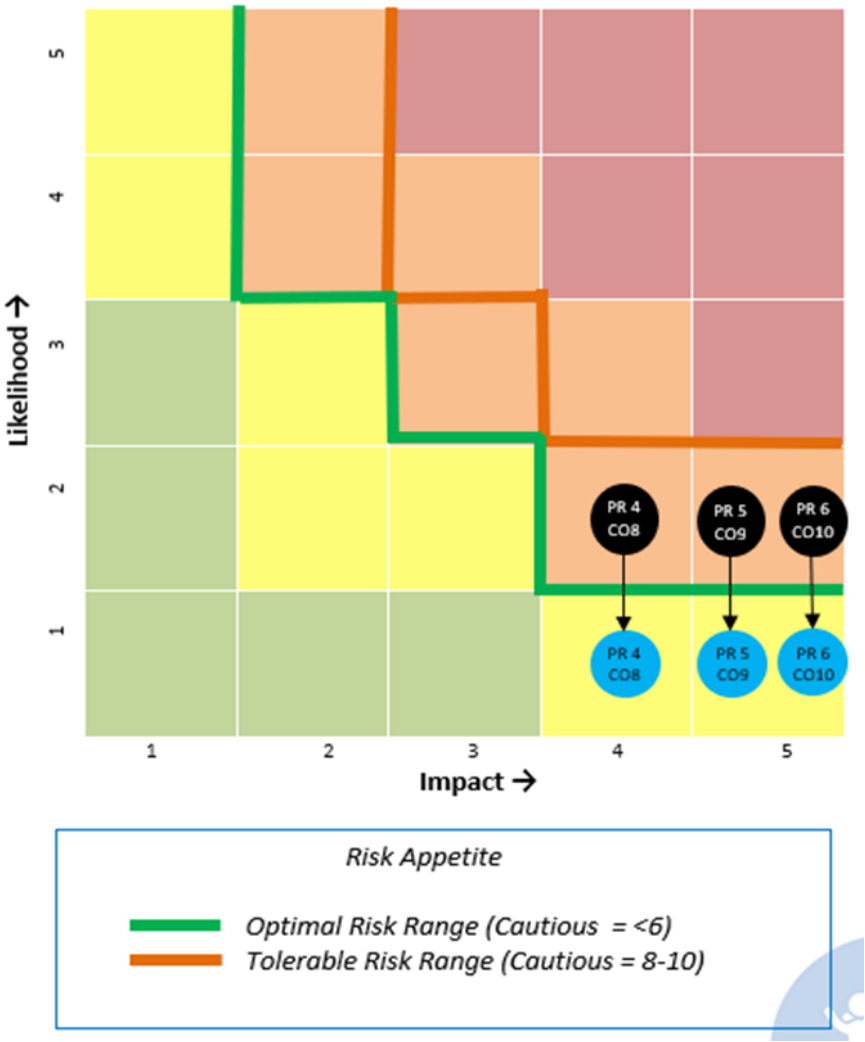
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

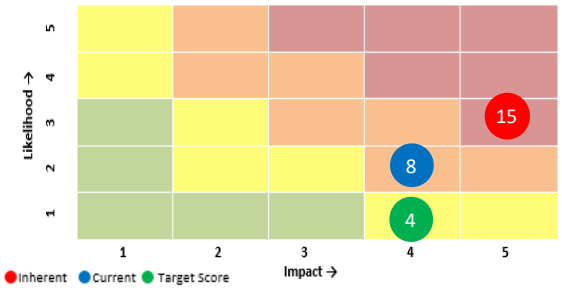
The following corporate objectives are aligned to the **people** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Status
CO8	To enable better access to the right people, in the right place, in the right number, at the right time.	• Produce a workforce plan that outlines the future demand of our workforce and how we will meet that demand, setting out how we will integrate new ways of working and new roles into our teams, particularly those that experience workforce supply challenges.	On Track
CO9	To ensure we improve experience at work by actively listening to our people and turning into positive action.	• Recognising the valuable role our Leaders play in staff experience, we will roll out a single programme that develops our leaders to operate with compassion and inclusivity, and supports improvement of their own wellbeing. • Support our staff to work flexibly. • Gather feedback from staff who may chose to leave WWL, or those who are thinking of leaving. • Develop a robust local "self-service" approach to recognition as well as an efficient scheme that recognises service with the NHS. • Meet the conditions outlined within the NHS Sexual Safety Charter. • Embed the new arrangements for Freedom to Speak Up, including a review against the NHS Board Self-Assessment framework. • Implement a streamlined and supportive approach to line manager and staff conversations. • Undertake a self-assessment against the NHS Health & Wellbeing Framework and put strategies in place that meets gaps.	On Track
CO10	We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.	• Establish formal governance mechanisms that will drive forward commitments outlined within the WWL EDI Strategy. • Deliver actions as outlined within the six high impact actions as set out in the NHS EDI Improvement Plan. • Improve experience of our black, Asian, minority ethnic workforce. • Improve the experience of our disabled workforce. • Increase the demographic of our workforce Band 7 and above. • Continue to grow and develop our Staff Networks.	On Track

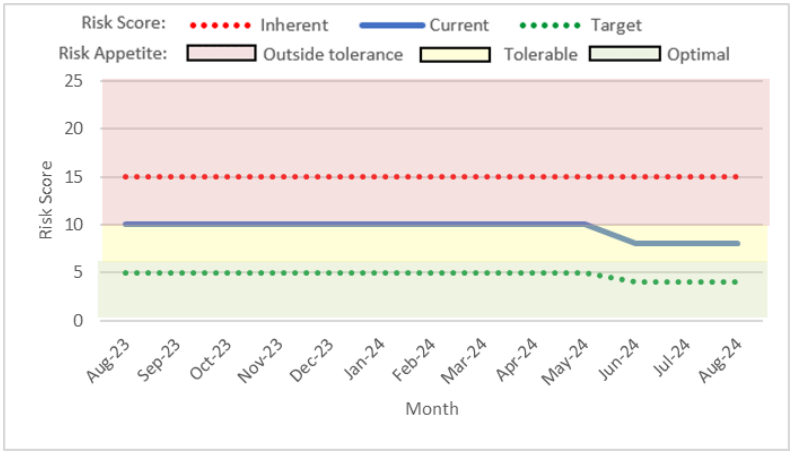
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for the people strategic risk:



Corporate Objective: CO8 To enable better access to the right people, in the right place, in the right number, at the right time	1	2	3	**Overall Assurance Level**	**Medium**

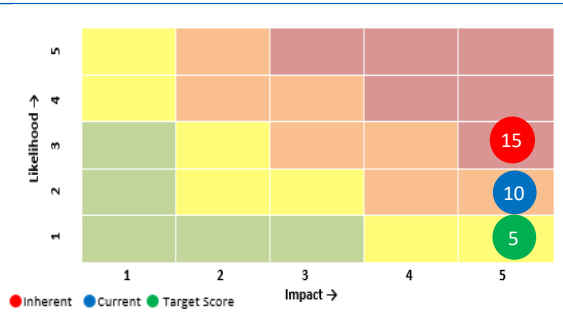
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 4 : Workforce Sustainability**		
	Risk Statement:	There is a risk that we may not deliver the workforce sustainability agenda objective, due to issues with staff retention and keeping colleagues well in work, 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 system risks**	LSR5: support and develop workforce
Date of last review	**26.07.24**		**Risk treatment**	Treat

Risk Score Timeline

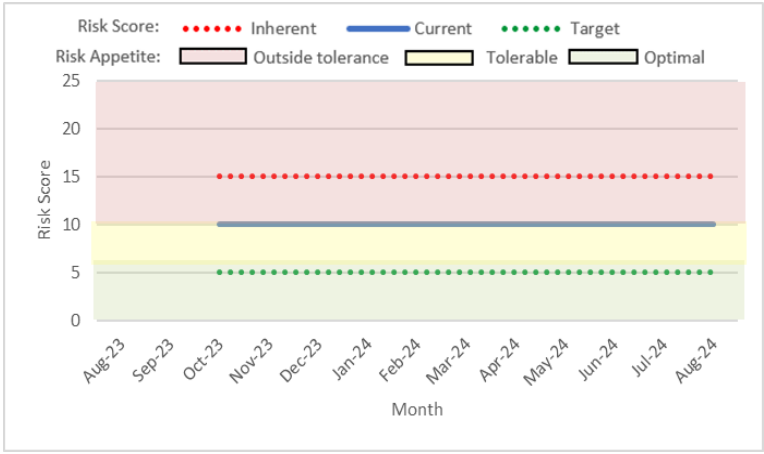


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3783**	• Workforce planning 2024/25 • Empactis relaunch • Civility Programme (just & learning culture) • People Dashboard refresh • Newton Europe Commission (pending) • National Staff Survey • ETM approved the establishment of 2 x workforce posts, including a Workforce Digital / Informatics Lead	• 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:** • Data produced by GM identify WWL as a lead performer in time to hire data. • Empactis relaunch reports to Transformation Board monthly under sustainable workforce workstream • Civility Programme now built into WWL work on Anti-Racism and actions defined within workstream. • Newton Europe Commission updates via ETM • Turnover benchmarks positively when compared to others in GM and nationally.	• Turnover reporting identifies that circa 25% of leavers, leave within the first 12 months of employment.	1. Deep dive work to be undertaken for those leaving within first 12 months and reasons for leaving, with associated action plan to be developed. 2. Development of a People Strategy to address overall workforce sustainability risk. First draft developed and presented to People Committee June 2024, further engagement and refinement underway to support final ratification at future Board Away Day. 3. Funding approved for a Workforce Transformation Lead and Digital Workforce Manager. Recruitment underway.	1. August 2024– D/CPO & AD for SE & W 2. September 2024 - CPO 3. August 2024 - CPO

Corporate Objective: CO9 To ensure we improve experience at work by actively listening to our people and turning into positive action.	1	2	3	**Overall Assurance Level**	**Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 5 : Staff Engagement**		
	Risk Statement:	There is a risk that we may not deliver the cultural development agenda objective, due to a lack of staff engagement and low morale.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.
Date risk opened	**02.11.23**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**26.07.24**		**Risk treatment**	Treat

Risk Score Timeline

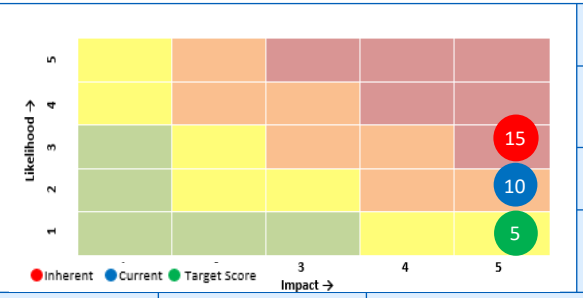


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3871**	• Actions contained within the Draft People & Culture Strategy • National Staff Survey • New Appraisal Framework "My Route Planner" • Local divisions to provide assurance on local staff engagement activities via Divisional Assurance Meetings.	• People Strategy, which will align and coordinate activity under development.	• 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 ranked high nationally in Morale score in 2023 National Staff Survey.	• Data linked to protected characteristics signifies lower staff experience for black, Asian and minority ethnic staff and Disabled staff.	1. Increase understanding of why staff leave through introduction of Exit Questionnaires 2. Development of a Leadership Development Strategy	1. September 2024 - Deputy CPO 2. December 2024 – AD SE

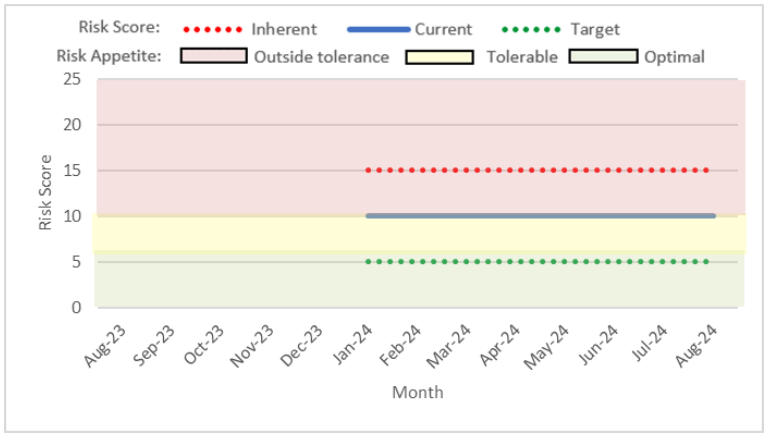
Corporate Objective: CO10 We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.

1 | 2 | 3

Overall Assurance Level **Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 6 : Workforce EDI**		
	Risk Statement:	The Trust has taken significant steps to fill ongoing qualified nursing gaps through the recruitment of over 450 internationally educated nurses. 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 also reports less positively with our Disabled workforce.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.
Date risk opened	**31.01.24**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**26.07.24**		**Risk treatment**	Treat

Risk Score Timeline



Strategic Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3928**	• Pastoral Support post within the Nursing Professional Practice Team, who will now be a qualified nurse with lived experience. • Mechanisms in place to enable feedback. • Understanding of data in WRES, WDES and Gender Pay Gap Report • NHSE EDI High Impact Improvement Targets • Board Development Workshop focussing on EDI 14.3.24 Workshop took place January 2024. • WWL accepted on national CNO Global Majority 90 Day Challenge. • EDI Strategy Group now established.	• EDI resource temporarily funded until November 2024.	• 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 arranged for Ward Leaders, Matrons and other senior nursing colleagues, in the form of Active Bystander training • New IEN Improvement Group established. • Staff network established. • EDI Steering Group first meeting scheduled for 22.4.24	• Actions are very early in implementation and it is difficult to measure and see success at this stage. • Further information required to support organisation review NHSE EDI Objectives.	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. 5. Develop business case for substantive EDI funding, or establish operating model for EDI moving forward 6. Develop WRES Action Plan with engagement of FAME Network 7. Develop WDES Action Plan with engagement of Disability Staff Network. 8. Implementation of EDI High Impact Objectives.	1. June 2024 (CPO/CFO) COMPLETE 2. June 2024 (CN) COMPLETE 3. June 2024 (CN) COMPLETE 4. October 2024 (CN/CPO) 5. August 2024 (AD SE & W) 6. August 2024 (EDI Lead) 7. August 2024 (EDI Lead) 8. August 2024 (CPO, EDI Lead)

Performance

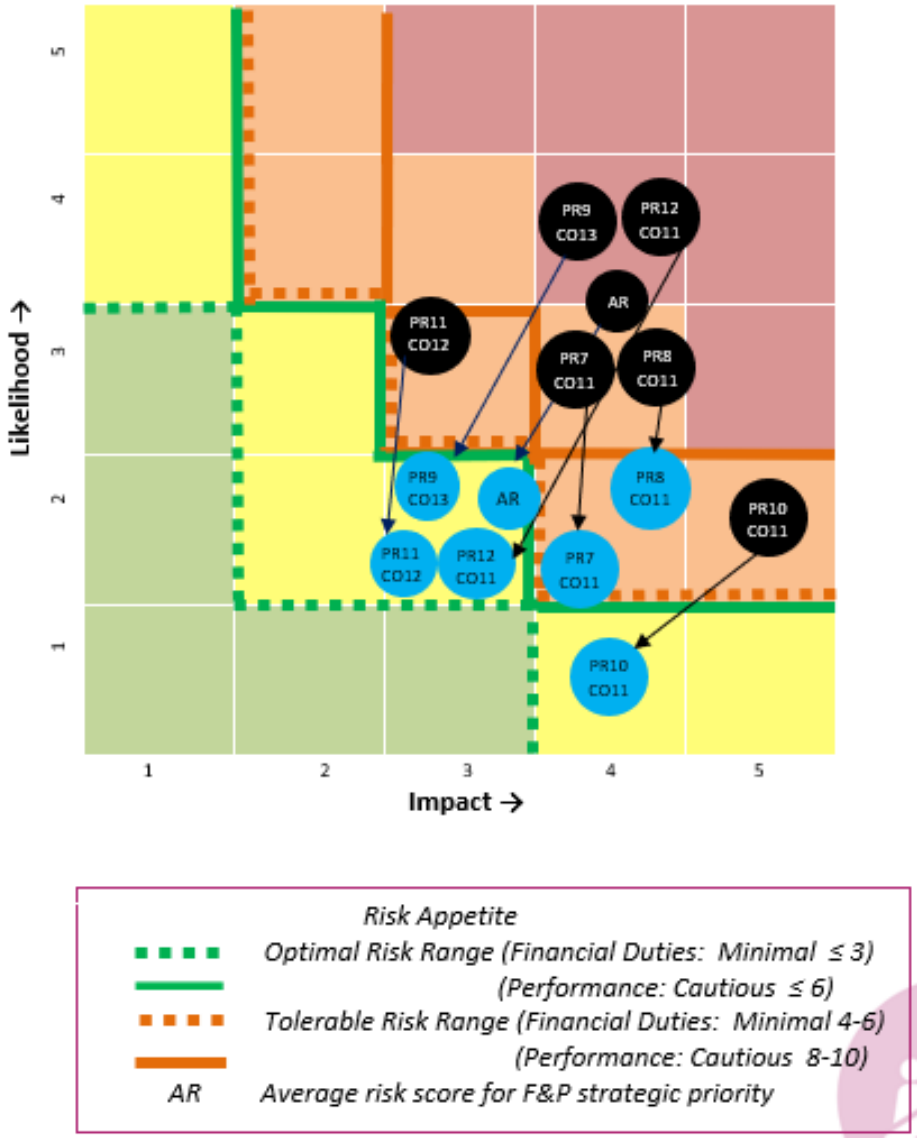
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

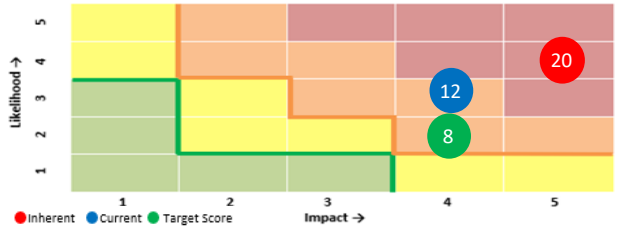
The following objectives are aligned to the **performance** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Status
CO11	To deliver our financial plan, providing value for money services	✓ Delivery of the agreed capital and revenue plans for 2024/25. ✓ Delivery of a medium to long term financial strategy focused on sustainability, positive value and success within a financially constrained environment.	On Track
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.	On Track
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.	On Track

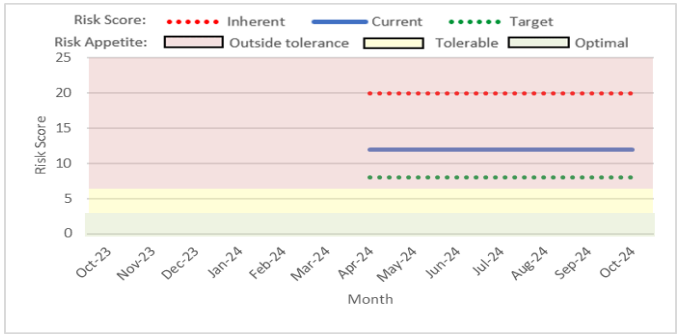
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

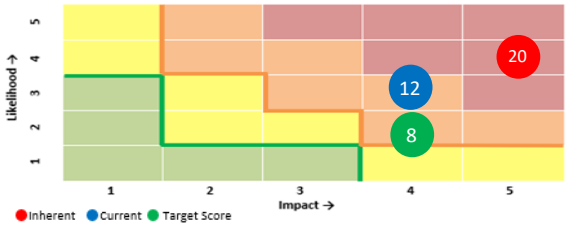
Principal risk	**Risk Title:**	**PR 7: Financial Performance: Failure to meet the agreed I&E position**		
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties. This includes ERF, CIP (see PR8), further impact of industrial action, inflationary pressures and any other unforeseen pressures arising in the year.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal
Lead Director	**CFO**		**Risk category**	Financial Duties
Date opened	**20.05.24**		**Threat: System risk**	ID 3292 LSR6 Financial plans
Date of last review	**24.09.24**		**Risk treatment**	Treat

Risk Score Timeline

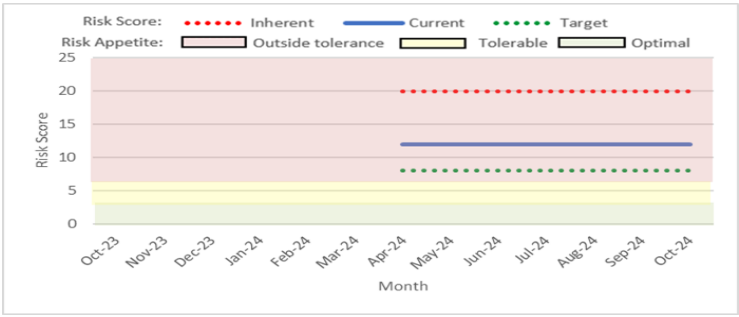


Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
• Final plan signed off by Board and submitted to NHSE – 2nd May 24. Resubmission on 12th June 24in line with GM ICS control total. • Draft and final plans scrutinised through monthly FPRM meetings with GM ICB, NHSE and PWC. • PWC led planning oversight process on behalf of GM ICB during Q4 2023/24 with significant scrutiny on assumptions (Ext) • Final plan is reflective of year 1 of the approved WWL Financial Sustainability Plan (FSP). • FSP was developed during 2023/24 and had F&P and Board Approval. • All divisions accepted budgets in April 24. • CIP target agreed with programme for delivery and actions. • Robust forecasting including scenario planning for worst, most likely and best case will continue from quarter 2. • Executive oversight and challenge of CIP & Financial performance through Divisional Assurance Meetings, Financial Improvement Group, Transformation Board. • Establishment control groups established for non medical and medical staffing 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. • Full review of financial position by locality partners. • GM standardised financial controls implemented in 2023/24 remain in place across WWL. • ERF baseline of 103.6% is in line with NHSE guidance – based on 2023/24 baseline before adjustments for industrial action. • Activity plans based on theoretical maximum capacity have been approved by divisions and submitted to NHSE on 2nd May 24. • ERF plan submitted in excess of baseline to include activity associated with NHSE approved developments • Revenue plan includes income in line with GM ICB contract offer excluding the growth on ERF for developments noted above • Improvement Director with operational portfolio continues to work with the Trust • Finance Improvement Group meeting monthly, chaired by Chief Executive • Monthly Provider Oversight Meetings established from May 24 (Ext) • GM Controls in place for new expenditure above £100k not within plan (STAR process) (Ext) • All headcount increases are required to be taken through an Exec led QIA process • Piloting GM vacancy control panel (Ext) • National Financial Improvement Programme established (Ext) • PWC engaged by GM to provide investigation and intervention support (Ext) • Year end scenario modelling – worst case, mid case, most likely – in place and reported through Trust Finance Report • AFC and Junior Doctor medical and dental pay awards confirmed August 24	• NHSE have not confirmed acceptance of the final GM ICS revenue plan (control total discussions ongoing) • GM system improvement plan not yet fully developed (Ext) • FSP to be refreshed quarterly throughout 2024/25 to ensure the 3 year trajectory for recovery is achievable • Funding through the Cost Uplift Factor to cover pay awards not yet confirmed (Ext) • No clarity on funding arrangements for industrial action in June 24. • No medium to long term resource confirmation or financial planning (Ext)	**1st Line:** Monthly Divisional Assurance meetings for all clinical divisions and Finance Improvement Group (FIG) **2nd Line:** Finance & Performance Committee September 2024. **External:** Monthly Provider Oversight Meeting with GM ICB (Ext)	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Ongoing review of existing grip and control measures 2. Organisational wide communication of the financial position, challenges and controls 2. GM System infrastructure established to support delivery of I&E position (Ext).	Q2 / CFO Throughout 2024/25/ CFO Q2 2024/25 / CFO

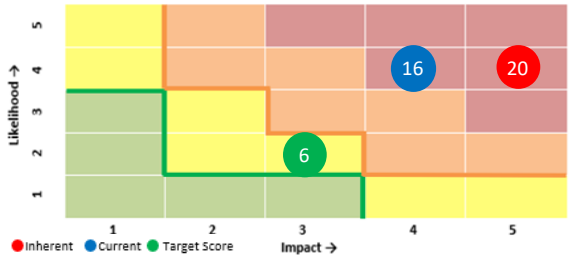
Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

Principal risk	**Risk Title:**	**PR 8: Financial Sustainability: Efficiency targets**		
	Risk Statement:	There is a risk that the CIP plan will not be achieved and/or will not be cash releasing, resulting in a significant overspend.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal
Lead Director	**CFO**		**Risk category**	Financial Duties
Date opened	**20.05.24**		**Threat: System Risk:**	**ID 3291** LSR6 Financial plans
Date of last review	**24.09.24**		**Risk treatment**	Treat

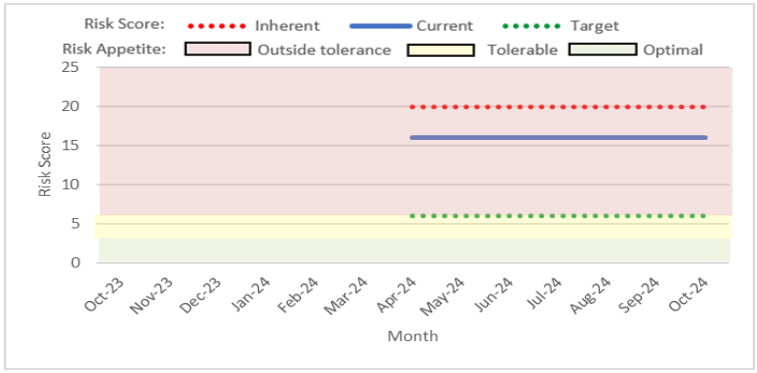
Risk Score Timeline



Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• Robust CIP divisional delivery approach and governance. • Monitored via Divisional Assurance Meetings, with additional escalation to Finance Improvement Group (FIG) • Further oversight at Executive Team, Finance Improvement Group, 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). • CIP plan for 2024/25 is made up of Transformation schemes, FSP schemes (Exec Led) and core divisional CIP • CIP Handbook developed providing guidance and oversight processes • MIAA review during 2023/24 gave substantial assurance • Transformation Board input & oversight of strategic programmes. • GM Provider CIP meeting established and meets monthly reviewing all schemes and potential opportunities (Ext) • Diagnostic completed with Newton Europe to address UEC pressures and escalation costs. Discussions ongoing with Wigan Council and ICB re. further work with Newton to implement the changes and deliver recurrent efficiency savings. • Divisional finance performance metrics include recurrent CIP delivery. • Clinical leadership established reviewing benchmarking opportunities for quality improvements through model hospital and GIRFT and reported through CAB, ETM and Divisional Assurance Meetings. • System savings group established across Wigan locality, to be chaired by Deputy Place Based Lead • CIP fully identified in year • Finance Improvement Group meeting monthly with agreed workplan • Executive led Divisional task and finish groups implemented where escalation required • Established QIA process led by Chief Nurse and Medical Director • CIP delivery proposals discussed at ETM June 24 and additional Exec led CIP/FSP schemes identified • Consultancy support engaged to review current approach to project management to ensure that we have the right processes and infrastructure to both maximise delivery and provide assurance • PWC investigation and intervention support will have a key focus on Robustness 2024/25 efficiency programmes and the governance supporting these (Ext) • Newton Europe contract signed August 24 to mobilise UEC transformation project from September 24	• Limited mechanisms to facilitate delivery of system wide savings. • GM Sustainability plan not yet finalised • Limited PMO resource internally to support delivery of CIP plans	**1st Line:** Monthly Divisional Assurance meetings for applicable divisions and monthly finance improvement group (FIG) **2nd Line:** Finance & Performance Committee September 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).	Throughout 2024/25 CFO/COO Throughout 2024/25 CFO/COO

Corporate Objective: C11 Deliver our financial plan, providing value for money services					1	2	3	**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 9: 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	**20.05.24**		**Threat: System Risk:**	**ID 3295** LSR6 Financial plans					
Date of last review	**24.09.24**		**Risk treatment**	Treat					

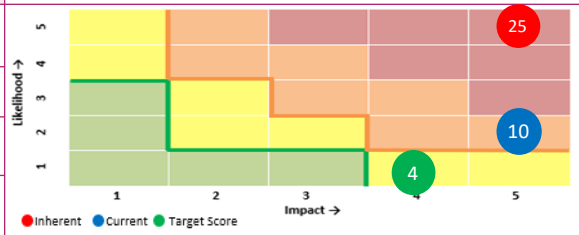
Risk Score Timeline



Strategic Opportunity / Threat Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• 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. • Strategic capital group meeting monthly with oversight of full capital programme. • Operational capital group meeting monthly to manage the detailed programme. • GM Capital and Cash group established, reporting to the Financial Advisory Committee (Ext). • GM Capital Resource Allocation Group (CRAG) established to support prioritisation of capital in 2024/25. • Programme Boards established for major capital schemes. • Design work undertaken for schemes aligned to strategic priorities to support bids for national PDC funding. • Exploring options with commercial partners to facilitate capital investments outside of CDEL in line with strategy. • Cash balances split between revenue and capital, with capital plans below depreciation, to ensure there is sufficient cash balance to support the capital plan. • Five year forward view developed internally to support medium term capital planning and prioritisation • GM ICB required to sign off all new right of use leases (Ext.) • Strategic scheme governance document developed to provide guidance and support decision making. • WWL capital plan is within operational CDEL envelope • Peer review process established for 2024/25 plans focused on clinical, operational and financial risk (Ext) • 10 year infrastructure plan completed and submitted to GM August 24.	• Impact of inflation in terms of project costs and timescales. • GM CDEL plan currently overcommitted by £42.5m (Pennine transaction £42.5m; 5% planning over commitment £7.4m) – discussions ongoing with NHSE (Ext) • GM lease plan (IFRS16) overcommitted against envelope. • Further work required on five year forward view to refine plan. • System capital allocations from 2025/26 onwards not confirmed.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - September 2024 **External:** GM Capital and Cash Group	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring of Capital spend in line with trajectory. 2. Development of capital reporting through the refreshed DFM App. 3. Discussions ongoing between GM ICB and NHSE national team to confirm whether additional CDEL will be made available to cover GM overcommitment (Ext)	Throughout 2024/25 CFO Q2 2024/25 CFO Q2 2024/25 GM ICB (Ext)

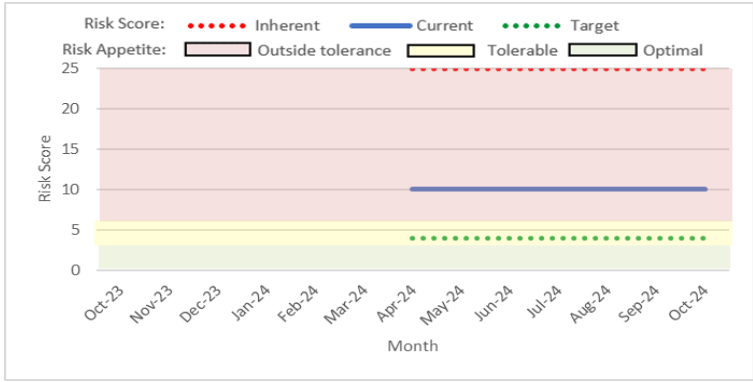
Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

Principal risk	**Risk Title:**	**PR 10: Cash Balance**
	Risk Statement:	There is a risk a that the Trust may have insufficient cash balance to meet normal business activities on a day-to-day basis, due to cash balances potentially becoming too low, resulting in the need to request additional support, financial obligations not being met, or the capital programme being restricted.
Lead Committee	**Finance & Performance**	
Lead Director	**CFO**	
Date opened	**20.05.24**	
Date of last review	**24.09.24**	



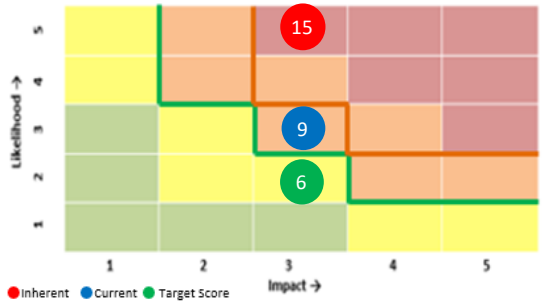
Risk Appetite	Minimal
Risk category	Financial Duties
Threat: System Risk:	**ID 3998** LSR6 Financial plans
Risk treatment	Treat

Risk Score Timeline

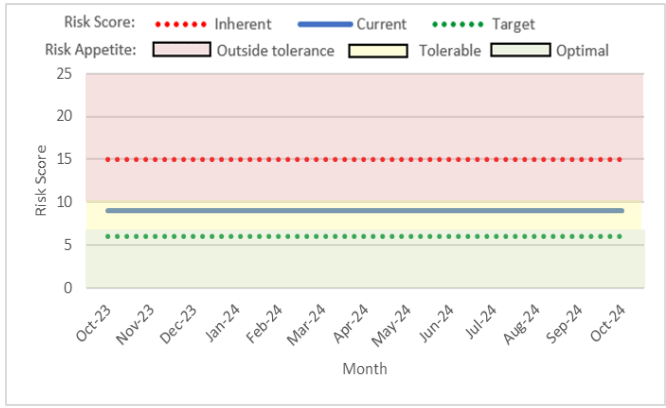


Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• NHSE process exists for providers requesting cash support which is done ahead of each financial quarter. There is an additional mechanism to draw down emergency cash support within the quarter is this becomes necessary, which is subject to additional authorisation. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT. • Enhanced balance sheet reporting including cash metrics to SFT and within monthly finance report. • GM Capital and Cash Group established (Ext.) • Internal cash management group established and strategy developed. • Cash forecast reviewed with no support required in Q1 or Q2 2024/25. • Cash is a standing item on the F&P Committee agenda with papers providing an assessment of the cash position, forecast and mechanism for accessing cash support. • GM cash planning ongoing as part of Trust Provider Collaborative (Ext). • GM ICB continue to make contract payments on 1st of month (rather than 15th) to support cash management. (Ext) • All GM ICB payments outside of contract to be made in a timely manner (Ext) • GM ICB paying additional ERF based on plan (Ext) • See PR 8 for additional controls to ensure that CIP delivery is cash releasing.	• Awaiting clarification on whether the GM deficit plan will be cash backed if revised control total agreed.	**1st Line:** Cash management Group **2nd Line:** Finance & Performance Committee September 2024 **External:** GM Capital and Cash Group	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring and forecasting of the cash balance 2. Application to NHSE in advance of each quarter if cash support may be required	Throughout 2024/25 CFO Throughout 2024/25 CFO

Corporate Objective: **CO12** To minimise harm to patients through delivery of our elective recovery plan	1	2	3	**Overall Assurance level**	**Medium**

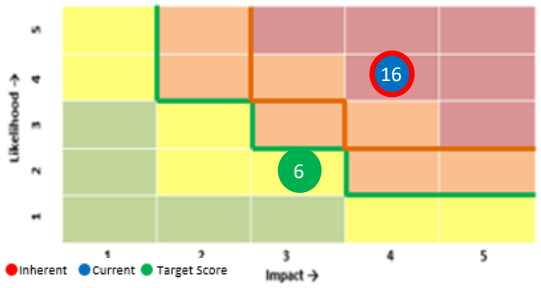
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 11: Elective services**			
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting in a reduction in demand and insufficient diagnostic capacity to deliver elective waiting times, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious	
Lead Director	**COO**		**Risk category**	Performance Targets	
Date risk opened	**19.10.21**		**Linked system risks**	LSR8: Statutory duties including the NHS Constitutional targets	
Date of last review	**24.09.24**		**Risk treatment**	Treat	

Risk Score Timeline

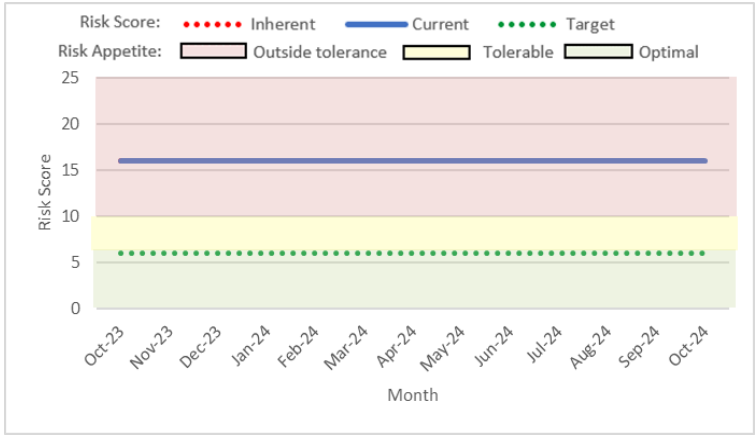


Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: (ID 3289)	• On track to eliminate waits over 65 weeks, except for Gynaecology patients. Exploring options for mutual aid. • Bi weekly meetings with ICB. • 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. • Digital validation of waiting lists.	• 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. • Increase productivity to meet organisational targets • Impact of Estates issues on elective activity.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – September 2024 • Elective activity and efficiency board chaired by CFO.	•No gaps in assurance currently identified.	1. Revised endocrine clinic templates agreed. 2. Exploring mutual aid and insourcing options for Gynaecology. 3. GM pilot of external referral management.	March 2025 March 2025 March 2025

Corporate Objective: CO13 Improve the responsiveness of urgent and emergency care	1	2	3	**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 bed base in comparison to Acute Trust's across GM and nationally, resulting in longer waits, delayed ambulance handovers, reduced patient flow and more scrutiny through NHS England.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious	
Lead Director	**COO**		**Risk category**	Performance / Hospital Demand, Capacity and Flow	
Date risk opened	**05.09.22**		**Linked system risks**	LSR8: Statutory duties including the NHS Constitutional targets	
Date of last review	**24.09.24**		**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: **(ID 3533)** Linked risk on corporate risk register: **3423** ED – insufficient patient flow	• Emergency Care Intensive Support Team (ECIST) and Newton Europe programme of works to support the existing hospital transformation programme. • A&E 4 hour performance is improving • GM Super Multi agency Discharge Event (MaDE) took place 6th to 12th September. • Flagged to the system that WWL bed base per population is considerably lower than the rest of GM. • Delay in ambulance handovers within 60 minutes has increased due insufficient capacity. • No right to reside recording has been reviewed in line with national guidance which will result in a reduction in number reported. • Hospital Discharge and Flow Programme led by COO. • The urgent and emergency care transformation board supports system wide change. • Full capacity protocol. • Urgent Care Village rated as 'good' at recent CQC assessment.	• Insufficient capacity with over 100% occupancy rate. • Corridor care in spells rather than consistent, but is still occurring. • Work required further upstream regarding higher acuity of patients in borough.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – September 2024 • Discharge and Flow chaired by COO	•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 2025 COO

Partnerships

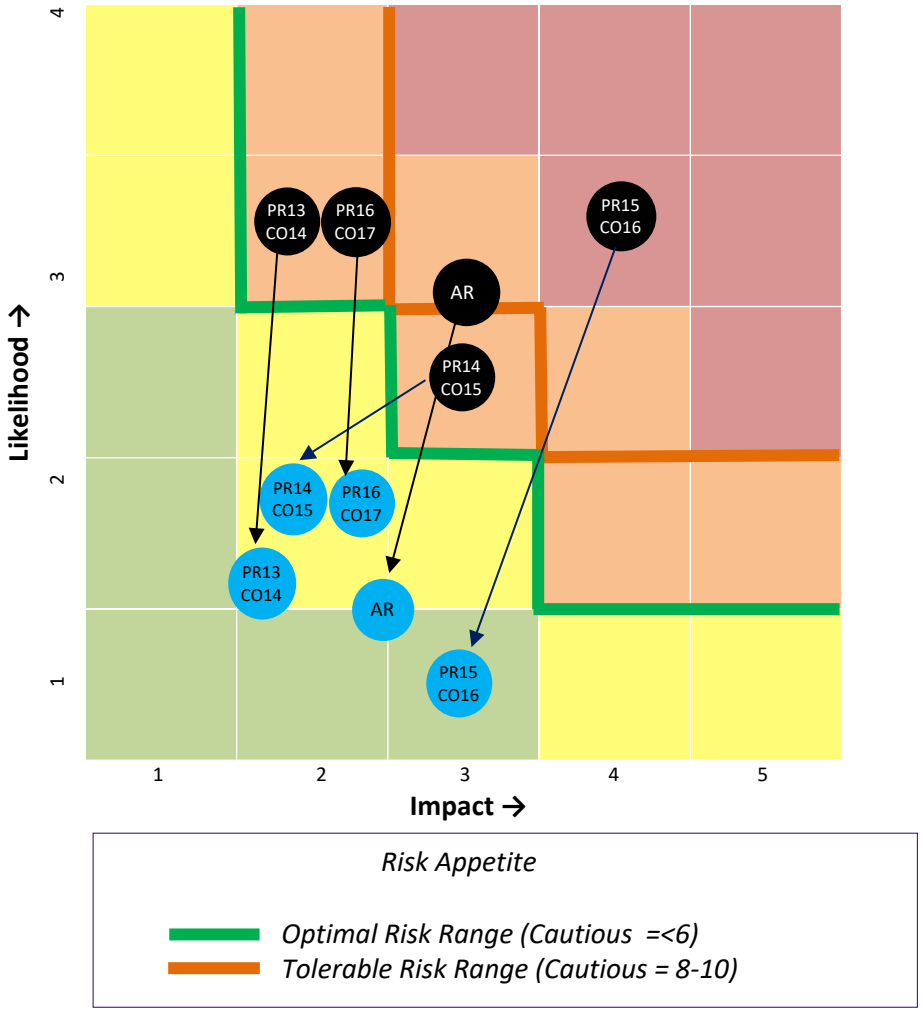
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

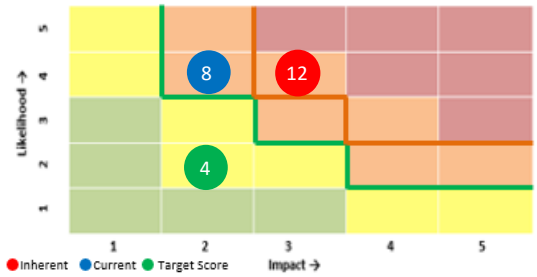
The following objectives are aligned to the **partnerships** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Status
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. ✓ Playing an active role in the Healthier Wigan Partnership to develop and deliver programmes which reduce health inequalities	On Track
CO15	To develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable	✓Work with partners across GM to develop and implement plans which deliver efficient corporate services ✓Work with partners across GM to develop and implement clinical service strategies which deliver services that are clinically and financially sustainable. ✓Work with our partners across the Wigan locality to deliver system transformation programmes aligned to agreed priorities.	On Track
CO16	To make progress towards becoming a Net Zero healthcare provider	✓Implementation of priority actions following completion of carbon footprint analyst and heat decarbonisation plan.	Off Track
CO17	To increase our research activities delivering high quality research with patients and partners across the Wigan Borough, strengthening our research capability and making progress towards our ambition to be a University Teaching Hospital.	✓Increase research taking place across the Trust and Primary Care. ✓Increase number of commercial trials delivered with high performance meeting national KPIs. ✓Increase research knowledge and capability to deliver research. ✓Increasing NIHR funded research studies/programmes led by WWL. ✓Increasing the number of WWL honorary clinical academics employed substantively with EHU.	On Track

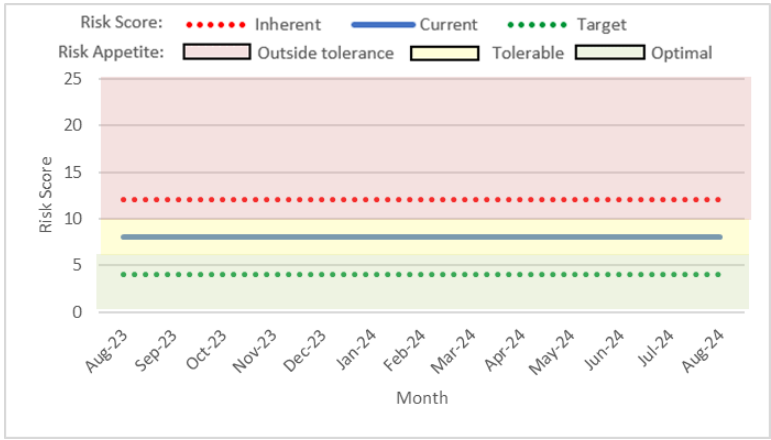
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



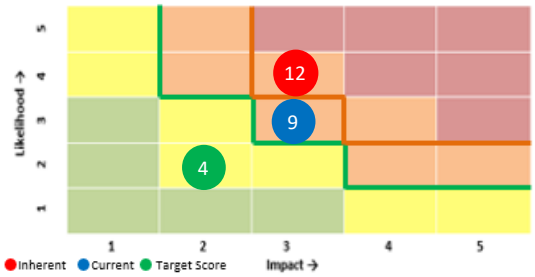
Corporate Objective: **CO14** To improve the health and wellbeing of the population we serve	1	2	3	**Overall Assurance level**	**Medium**

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 system risks**	SR6 Financial plans	
Date of last review	**16.09.24**		**Risk treatment**	Treat	

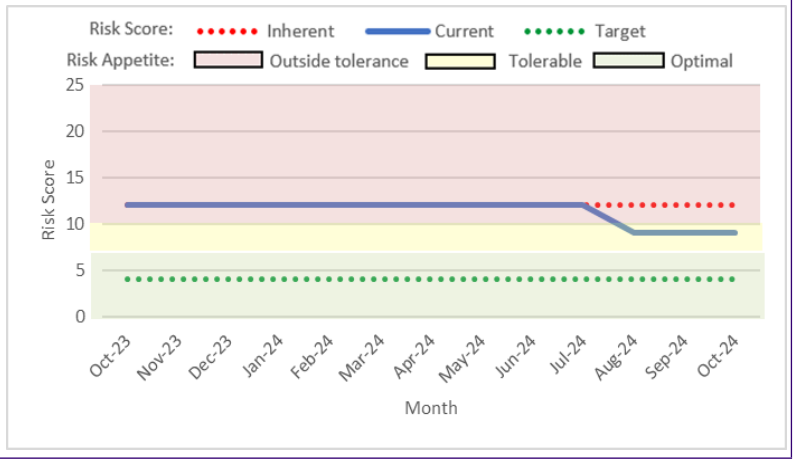
Risk Score Timeline



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:** • Bi-monthly Anchor Institution Steering Group • Bi-annual report to Trust Board	•None currently identified	1. Wigan and Leigh College have agreed to support a non-recurrent role to support our Talent4Care programme. 2. Review current and potential widening access to employment schemes through the Anchor Institution Steering Group 3. Consider development of approach to business cases which take into account quantifiable social benefits.	March 2025 - DSP

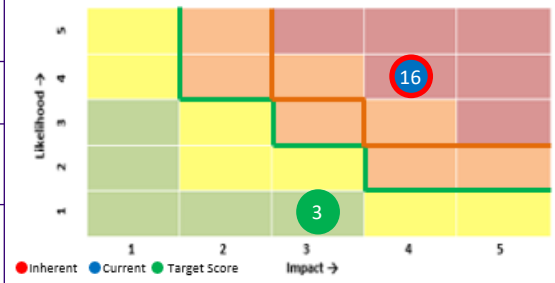
Corporate Objective: **CO15** To develop effective partnerships across GM and the Wigan Locality					1	2	3	**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 14: Partnership working - CCG changes**							
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.							
Lead Committee	**Board of Directors**			**Risk Appetite**	Cautious				
Lead Director	**DSP**			**Risk category**	Strategy				
Date risk opened	**19.10.21**			**Linked risks**	SR7 - system leadership				
Date of last review	**16.09.24**			**Risk treatment**	Treat				

Risk Score Timeline

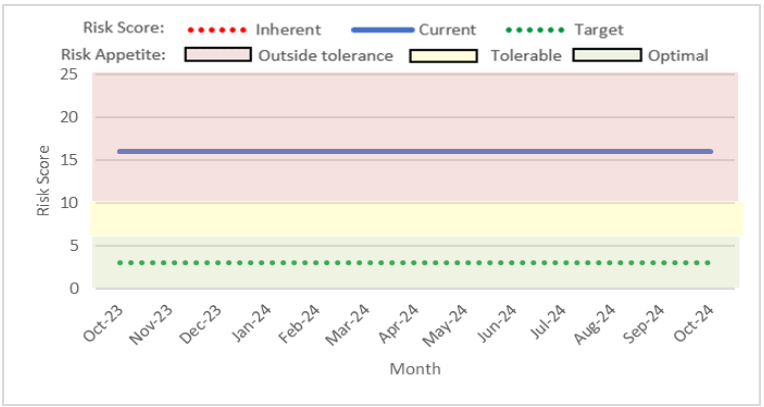


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3300**	• Locality meeting structures in place to support lasting corporate knowledge. • Development of locality UEC transformation programme – expected to begin in September 2024 subject to final approvals, bringing in external support from Newton Europe.	• 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. • Reduced locality capacity is currently having a much more material impact on managing patient flow and on our system finances. The impact of this should reduce as the UEC transformation programme progresses.	**2nd Line:** • Board of Directors – bi-monthly • **External:** System Board meetings – monthly	Uncertainty around CCG changes, in particular responsibilities and resources held centrally in GM versus those delegated to localities.	1. Attendance at System Board meetings with Partners.	DSP - Monthly

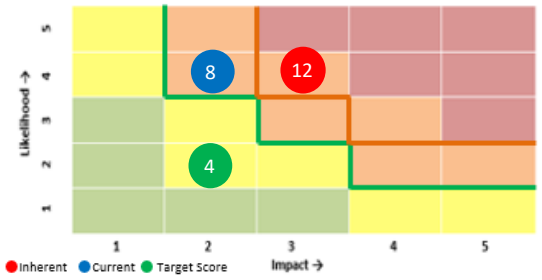
Corporate Objective: C16 Progress towards becoming a Net Zero healthcare provider	1	2	3	**Overall Assurance level**	**Medium**

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 system risks**	SR9 – Drive innovation
Date of last review	**16.09.24**		**Risk treatment**	Treat

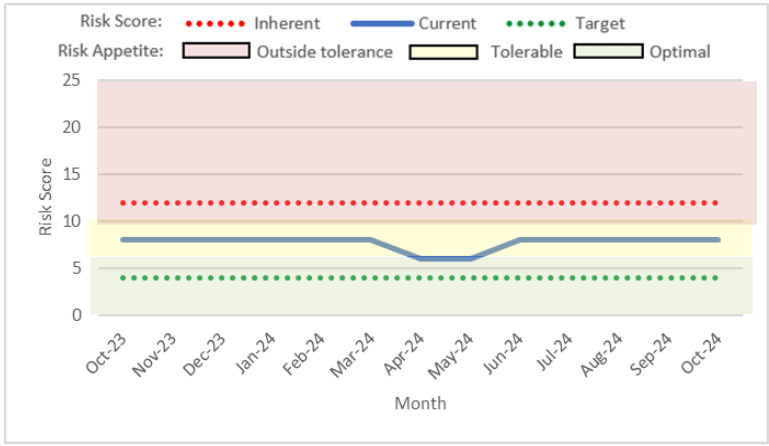
Risk Score Timeline



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. Have not been successful in appointing to post. • Climate Change Adaptation Plan is in development. • Heat Decarbonisation Plan has been produced. • Sustainable Travel Plan has been produced. • 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 expected to be included in corporate objectives process for 2024-25.	• Department is under-resourced and has no resilience. The Environmental and Sustainability Officer has resigned. The sustainability manager is acting as energy manager and administrator which takes up the majority of the working week. • Climate Change Adaptation Plan development has paused due to resourcing issues • Sustainability Impact Assessment has been developed but has not been adopted into the QIA process despite requests to. • Capital funds required to fund adaptation measures. Funds this year have been reallocated to next financial year. This places us significantly behind target. • Lack of functioning sub meters to monitor energy use • Struggling to recruit B7 energy manager. Advertised as an apprenticeship post through UCLans matching scheme. Chosen applicants did not respond to our requests to interview. • Our carbon footprint is increasing and investment into sustainability has been cancelled this year. We are significantly behind having any impact on reducing our environmental impact.	**2nd Line:** • 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	**2nd Line:** • 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 2025 / DSP

Corporate Objective: **CO17** To increase our research activities delivering high quality research with patients and partners across the Wigan Borough					1	2	3	**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 system risks**	SR9 – Drive innovation				
Date of last review	**16.09.24**			**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 • 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 this is 13 individuals) 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 – October 2024	• None currently identified.	The key actions for increasing University employed research Principal Investigators. Current status: Target – 13. (Based on 217 wte Consultants in post). 6 clinical academics in place (2024 appointments - Diabetes (Banerjee) and Surgery (Lamb - with University of Bristol). 1 (recruitment in progress) EHU/WWL Clinical Academic in Infectious Diseases. Therefore 7 appointments required in final 1.5 years to achieve target of April 2026 for UHA application.	AR/AW March 2025

Appendix 1: Summary of Wigan Locality Strategic Risk Register Risks

Risk Reference	Risk Description
SR1	Maintain and improve the quality and safety of patient care
SR2	Failure to plan effectively for a pandemic situation or other significant business interruption event including digital resilience
SR3	Failure to improve population health and care outcomes and to reduce health inequalities
SR4	Failure to implement and manage effectively the systems, processes, and culture which enhances our reputation with our communities and stakeholders
SR5	Failure to support and develop our workforce
SR6	Achieving our financial plans and to maintain financial balance
SR7	Discharging our system leadership responsibilities and supporting the effective integration of the locality's health and care system
SR8	Statutory duties including the NHS Constitutional targets
SR9	Opportunity to drive innovation and maximise digital opportunities to deliver system transformation

Agenda Item: 27

Title of report:	Freedom to Speak Up report to date
Presented to:	Board of Directors
On:	2nd October 2024
Item purpose:	Information and review
Presented by:	Freedom to Speak Up Guardian, WWL
Prepared by:	Selina Morgan
Contact details:	Selina.morgan@wwl.nhs.uk

Freedom To Speak Up Quarter 1 Report,

Date: 17th Sept 2024

Subject: **Freedom to Speak Up**

Author: Selina Morgan - Freedom to Speak Up Guardian

Accountable Executive: Juliette Tait, Chief People Officer

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1. Purpose and Aim.

The purpose and aim of this report is to provide an update on the Freedom to Speak Up Guardian's (FTSUG), activity and development during Quarter 1.

Provides an update on FTSU progress since the FTSU Guardian came into post on the 1st March 2024 and next steps.

2. Background and context.

The role of the Freedom to Speak Up Guardian was created in response to recommendations made in – The Francis Report published in 2015 after failings at Mid-Staffordshire NHS Foundation Trust. http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf The aim of the report was to provide advice and recommendations to support all staff in raising concerns, confident that they would be listened to and that the concerns would be acted upon, equipping NHS organisations in adopting and creating the right environment for staff to speak up.

3. Updated guidance on recording cases and reporting data.

The NGO (National Guardian Office) have published revised guidance, The revised guidance came into effect on 1 April 2024. It applies to cases raised with Freedom to Speak Up Guardians from this date onwards. It was revised to more effectively meet the needs of Freedom to Speak Up Guardians by enhancing the clarity, rational and accessibility of the guidance on recording cases and reporting data. They have also expanded the information regarding recording cases including gathering protected characteristics of those speaking up.

As good practice the FTSU Guardian has always recorded protected characteristics of each person speaking up, where this data is available, and now this is a requirement from the NGO, it will be reported in future quarterly submissions.

4. WWL cases recorded in Quarter 1.

The data for Q1 2023/24 as seen below has been submitted to the NGO.

In Quarter 1 (April, May and June) 29 cases were reported and recorded.

The FTSU Guardian records cases on a confidential tracker. Matters spoken up about are themed into a subcategory to enable an improved level of analysis.

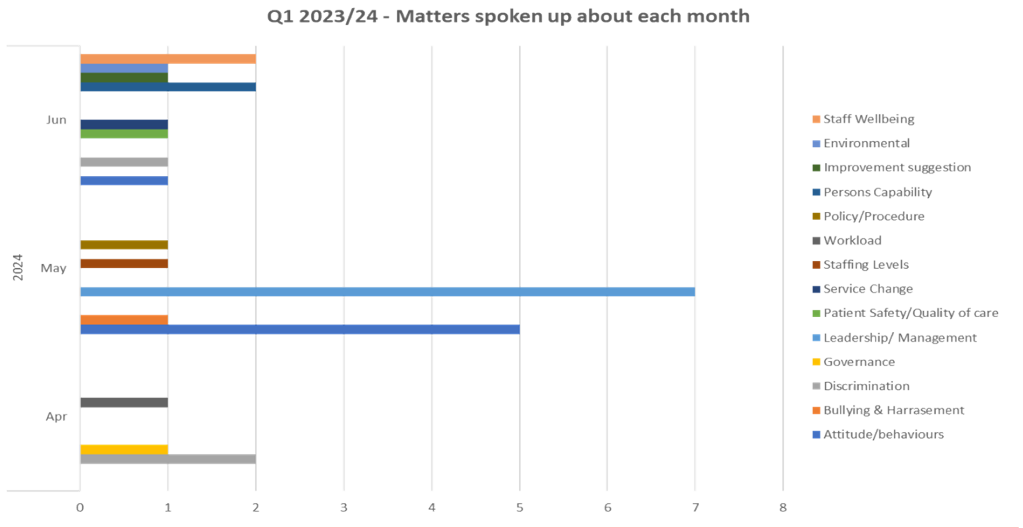
Themes and Learning

The two themes from this quarter, and aligns with previous, that have become apparent are around:

1. Quality of leadership and management and
2. A potential culture of fear of staff being identified. If staff, see things are getting resolved or they are feeling heard, this will eventually build trust and reassurance that matters are being looked into without the fear of detriment.

   To address learning from themes:

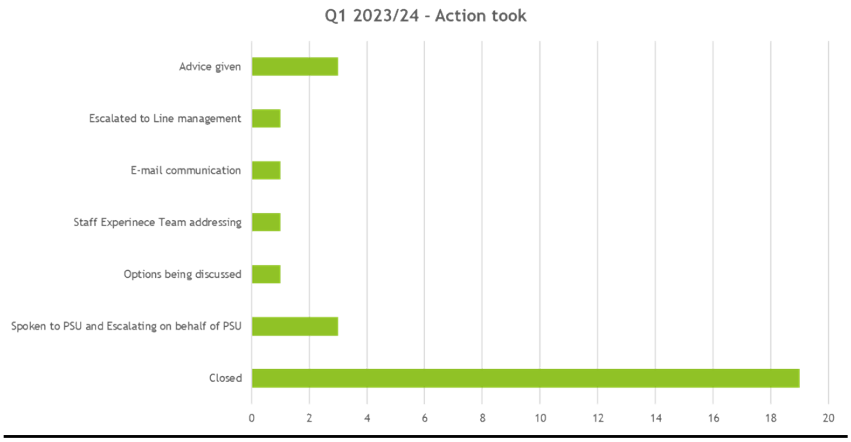
   - People Committee will be having early sight of the Leadership Development Strategy which will incorporate how leaders can ensure environments feel psychologically safe.
   - The Feedback Questionnaires will be given to those people with an extra question asking why they wanted to remain anonymous. This will give us an indication as to why those people did not want to be identified, discuss that further with them, and also enable solutions to be put in place.



The themes recorded are in-line with those reported to the NGO.

Action for People Speaking Up

Action is sought by the FTSU Guardian at the earliest opportunity and usually, depending on the case immediately after contact.

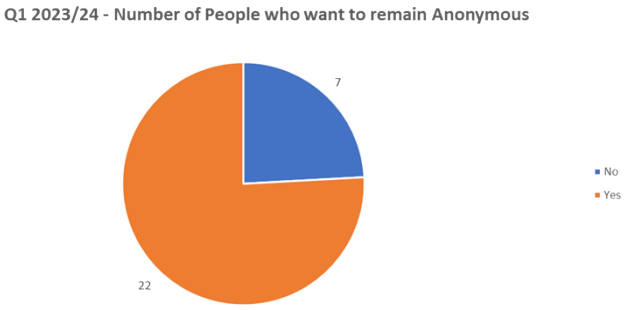


Closed

Of the 29 cases recorded in Q1, 19 are now closed and 10 remain open. A case is only closed after resolution and with the PSU (persons speaking up) consent. Progress on each live case is logged and captured on the FTSU Guardians tracker. Action took per case is also logged and followed up by the FTSU Guardian before month end.

Anonymous

Out of the 29 staff who used the FTSU Guardian service in Q1 24.14% wanted to remain anonymous.



Staff can raise concerns anonymously through an e- link in the FTSU Guardians e-mail signature and accessible on the FTSU intranet page.

Anonymous concerns are highlighted to the relevant Senior Leader by the FTSU Guardian, and steps agreed for resolution even though it is not possible to give feedback.

5. Progression of Freedom to Speak Up

A positive development within the last 6 months has been the development of a FTSU Champion network with 20 FTSU Champions to date, from across the Trust appointed to support the FTSU Guardian in developing a strong speak up culture for staff to enable them to be supported and signposted appropriately. The FTSU Champions have all undertaken training to carry out the role.

The FTSU Guardian continues to work closely with the Communications, Staff Experience team, Steps 4 Wellness, Staff Side representatives, community, hospital and other colleagues to promote and encourage speaking up. The aim is to promote a culture where staff are comfortable raising concerns with their line manager in the first instance, as part of business as usual.

Proactive awareness raising and development work completed since the last FTSU Board report includes:

- Continued attendance to Inductions and Awareness sessions with various teams.
- Freedom to Speak Up training programme for Champions.
- Ensuring that FTSU Champions are reflective of the diversity of the workforce they support.
- Inclusion of Speaking Up in Trust-wide communications e.g Executive Vlogs
- Freedom to Speak Up Newsletter.
- Freedom to Speak Up work programme including significant actions completed.

6. FTSU Feedback from users of the service

Once cases are closed the FTSU Guardian will send out Feedback forms to request feedback from individuals, this is important to ensure we learn from cases and act upon what staff are telling us to continuously improve, depending on the matter raised this could be learning and development for individuals or teams, robust engagement with individuals or teams. Feedback also helps monitor the impact FTSU is making. Qualitative data is highlighted below and the quantitative summary of responses will be provided in future Trust Board reports as the response rates to the questionnaire grows.

Individuals can complete the questionnaire anonymously. The responses to one question; “would you speak up again?” are required to be collected for the NGO.

As part of the feedback, FTSU Guardian asks responders to answer and rate four questions (1=Poor and 5=Excellent) including:

1. Would you speak up again? All responders chose ‘Yes’ from the dropdown box.
2. How would you rate the response of the freedom to speak up guardian on a scale of 1-5? (1=Poor and 5=Excellent) All responders, responded ‘Excellent’ to this question.
3. How would you rate the overall response to the matters you spoke up about on a scale of 1-5? (1=Poor and 5=Excellent) All responders responded ‘Excellent’ to this question.
4. Have you experienced any repercussions, or have you felt victimised because you spoke up? All responders chose ‘No’
5. Is there anything that could have made your experience better? Please explain your response. This gives the FTSU Guardian the chance to act upon responses to continuously improve the service available to staff.

Responses received to the questionnaire, include:

'Selina was excellent and full of signposting knowledge she was able to take a wider stepped back approach to support me and was a friendly person to listen to my concerns about how I was being treated when I was going through an extremely stressful time in work. Can't recommend her enough.
Freedom to speak up guarding service should be publicised more within WWL to support other colleagues going through problems at work I had to go looking through the policies to support me. Would be good to feature in the WWL newsletter every few months.' 10/06/24

'Selina was a huge help - not only listened to my concerns but was a peer-to-peer support during this time when I raised my concern. Selina was new in post; however, this did not stop her supporting me and also getting to the bottom of the items I raised. Selina went above and beyond to support me during my concern, and I would not hesitate to go back to Selina if required- I do hope not. Thank you so much for your help'. 18/07/24

'The response was swift and dealt with professionally. I have been informed I can contact the Professor at any time if I feel things are slipping. The clinical lead was supportive and sent out an email regarding civility and treating all staff respectfully'. 29/07/24

7. Proposal and Next Steps

- The Trust continues to maintain focus on developing a positive Speak Up culture.
- Provision of training or drop-in sessions to all managers to enable them to effectively respond and handle difficult conversations. (The NGO Leaders Guide is embedded in the work programme).
- Continuous Promotion, including Freedom to Speak Up month in October 2024.
- Working with key stakeholders to identify opportunities for improvement and promotion across the organisation.
- Networking by attending regional and national meetings, training and events.
- Development of triangulation between departments.
- Q2 data added to FTSU dashboard.
- The FTSU Guardian continues to recommend and encourage all staff to complete the Speak Up and Listen Up modules on the e-learning portal to increase compliancy rates and where appropriate Managers to complete the Follow Up module available.

8. Recommendations

The board is asked to note contents of the paper and support the current approach.

Agenda item: [29]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Risk Management Framework for ratification
Presented to:	Board of Directors
On:	2 October 2024
Presented by:	Director of Corporate Affairs
Prepared by:	Head of Risk
Contact details:	T: 01942 822027 E: paul.howard@wwl.nhs.uk

Executive summary

The Risk Management Framework (RMF) is presented to the Board for ratification, following review and approval by the Audit Committee on 26th September.

This three yearly review recommends minor amendments to the current RMF document in line with 24/25 MIAA Insight – Assurance Framework Benchmarking, Gov.uk Orange Book: Management of risk - Principles and Concepts (2023) and ISO 31000:2018. The RMF has been updated to encourage communication channels across the trust and with system partners. Minor amendments are highlighted in yellow within the document.

The linked Risk Management Policy and Process document, containing detailed responsibilities and processes, is due to be presented for approval to the Risk Management Group in October 2024, before being sent to PARG (Policy Approval and Ratification Group) for ratification.

Link to strategy

The RMF contains the Risk Management Strategy 2024–2027 Implementation Plan.

Risks associated with this report and proposed mitigations

The framework identified within this document provides the structure for the management of risks within the Board Assurance Framework, health and safety risks and the corporate risk register.

Financial implications

None

Legal implications

None

People implications
None

Wider implications

The framework encourages joint working with our system partners to escalate and manage risks.

Recommendation(s)

The Board are asked to:

- ratify the Risk Management Framework.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

POLICY NAME:	**Risk Management Framework 2024-2027**
POLICY ID NUMBER:	**TW10-002**
VERSION NUMBER:	**Version 17**
APPROVING COMMITTEE:	**Audit Committee**
DATE THIS VERSION APPROVED:	**26 September 2024**
RATIFYING COMMITTEE	**Board of Directors**
DATE THIS VERSION RATIFIED:	**2 October 2024**
AUTHOR (S) (JOB TITLE)	**Head of Risk**
DIVISION/DIRECTORATE:	**Corporate Affairs**
LINKS TO ANY OTHER POLICIES/PROCEDURES:	**Risk Management Policy (TW18-002)** **Health and Safety Risk Assessment and Risk Management Framework (TW24-031)**
CONSULTED WITH:	**Risk Management Group**

DATES PREVIOUS VERSION(s) APPROVED	**Version:** **14:** **15:** **16:**	**Date:** **November 2016** **April 2018** **September 2021**
NEXT REVIEW DATE:	**October 2027**	
MANAGER RESPONSIBLE FOR REVIEW (Must be Authors Line Manager)	**Director of Corporate Affairs**	

VERSION CONTROL

Version	Date	Amendment
17	September 2024	Minor amendments in 3 yearly review. Appendices updated.

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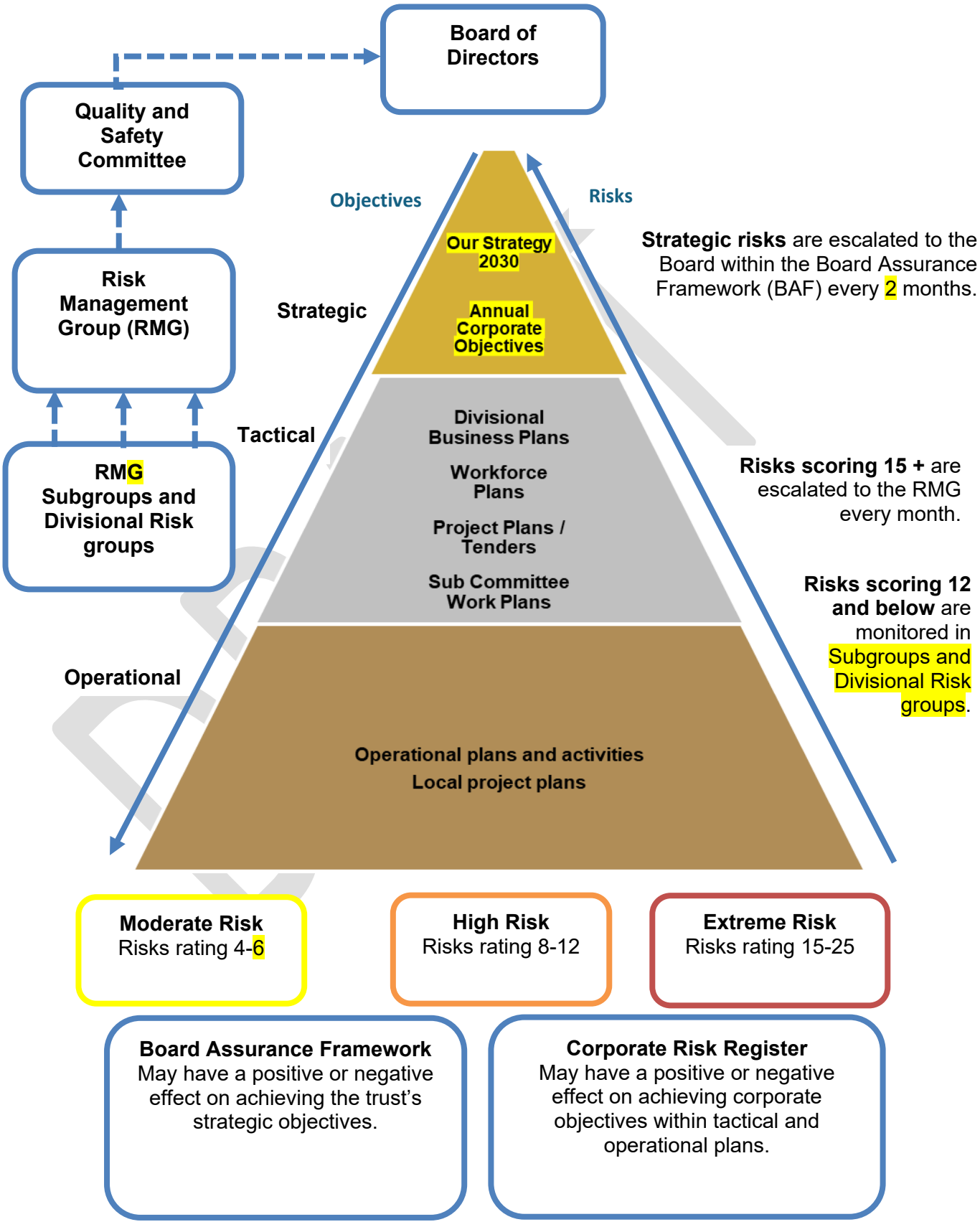
1 POLICY ON A PAGE

Risk Management Framework 2024-2027



2 INTRODUCTION

2.1 It is the vision of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) to be a provider of excellent health and care services for our patients and the local community. Underpinning delivery of our strategic ambitions are our trust values: People at the Heart, Listen and involve, Kind and Respectful and One Team. To achieve our vision, we have three strategic priorities: improving, integrating, innovating and four ways to focus our objectives: Patients, People, Performance and Partnerships, which encapsulate the areas on which we want to focus our development and improvement. This ambition is set within the context of the external and internal environment and is underpinned by our Strategy 2030 and the annual corporate objectives. Implementing the Risk Management Framework ensures that we embed risk management in our trust activities and that we manage risks effectively and efficiently to deliver our vision.

2.2 SCOPE, CONTEXT AND CRITERIA

Risk Management Process (adapted from Gov: The Orange Book 2023 and ISO 31000:2018)

2.3 The Risk Management Framework supports the consistent and robust identification and management of opportunities and risks within desired levels across WWL, supporting openness, challenge, innovation and excellence in the achievement of objectives.

3 MAIN PRINCIPLES

3.1 MAIN PRINCIPLE A: Risk management shall be an essential part of governance and leadership, and fundamental to how the trust is directed, managed and controlled at all levels.

3.1.1 The Audit Committee have delegated responsibility to review and approve the Risk Management Framework. The trust board is corporately accountable for ratifying, adhering to, and delivering the Risk Management Framework. The board will determine and continuously assess the nature and extent of the principal risks that the trust is exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision-making reflects this assessment.

3.1.2 The accountable officer, supported by senior management, will demonstrate leadership and articulate their continual commitment to, and the value of, risk management through developing and communicating the Risk Management Framework to the trust and system partners, which will be periodically reviewed.

3.2 MAIN PRINCIPLE B: Risk management shall be an integral part of all organisational activities to support decision-making in achieving objectives.

3.2.1 The Trust will:

3.2.2 be open and transparent about its understanding of the nature of risks and about the process it is following in handling them.
3.2.3 seek wide involvement of those concerned in decision-making processes.
3.2.4 act proportionately and consistently in dealing with risks.
3.2.5 base decisions for intervention on relevant evidence, including expert risk assessment; and
3.2.6 place responsibility for managing risks to those best able to control them.

3.3 MAIN PRINCIPLE C: Risk management shall be collaborative and informed by the best available information and expertise.

3.3.1 Effective communication can only be achieved if there are channels up, down and across the trust and system partners, to receive, escalate, disseminate information specific to risks. These channels allow staff to participate in, or be effectively represented in, decisions about managing risk.

3.3.2 The trust will ensure that appropriate and effective methods of communication are in place including:

3.3.3 accurate and clear information flows that are accessible to all.
3.3.4 communication channels exist from Ward to Board
3.3.5 time is allocated to discuss, manage and challenge risks in line with the Risk Management SOP.
3.3.6 plans are formulated by Divisions to ensure risks and safety critical messages are clear and cascaded to their wider team.
3.3.7 staff are competent to contribute to their local risk management processes and encouraged to identify risks and formulate control measures.
3.3.8 by introducing key actions to improve communicating risks effectively, the understanding of risk appetite and tolerance will improve.
3.3.9 bring together different functions and areas of professional expertise in the management of risks.
3.3.10 ensure that different views are appropriately considered when defining risk criteria and when analysing risks.
3.3.11 provide sufficient information and evidence to facilitate risk oversight and decision making; and
3.3.12 build a sense of inclusiveness and ownership among those affected by risk.
3.3.13 Subject matter leads will provide expert judgement to advise the trust's committees to:
3.3.14 set feasible and affordable strategies and plans.
3.3.15 evaluate and develop realistic programmes, projects and policy initiatives.
3.3.16 prioritise and direct resources and the development of capabilities.
3.3.17 identify and assess risks that can arise and impact the successful achievement of objectives.
3.3.18 determine the nature and extent of the risks that the trust is willing to take to achieve its objectives.
3.3.19 design and operate internal controls in line with good practice; and

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3.3.20 drive innovation and incremental improvements.

3.4 MAIN PRINCIPLE D: Risk management processes shall be structured to include:

3.4.1 **risk identification, analysis, and evaluation as part of a risk assessment** to determine and prioritise how the risks should be managed.
3.4.2 the selection, design and implementation of **risk treatment** options that support achievement of intended outcomes and manage risks to an acceptable level.
3.4.3 the design and operation of integrated, insightful and informative **risk monitoring and review**; and
3.4.4 timely, accurate and useful **risk recording and reporting** to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.

3.5 RISK IDENTIFICATION AND ASSESSMENT

3.5.1 RISK IDENTIFICATION

3.5.1.1 Risk identification activities provide an integrated and holistic view of risks, organised into categories relating to the four principal objectives: patients, people, performance and partnerships.

3.5.1.2 The trust will establish risk management activities which cover all types and sources of risk.

3.5.1.3 The aim is to understand the trust's overall risk profile. The trust will use a range of techniques for identifying specific *risks* that may potentially impact on one or more objectives. Risk prioritisation is supported by risk assessment, which incorporates risk analysis and risk evaluation.

3.5.2 RISK ANALYSIS

3.5.2.1 The purpose of risk analysis is to support a detailed consideration of the nature and level of risk. The risk analysis process uses a common set of risk criteria to foster consistent interpretation and application in defining the level of risk, based on the assessment of the *likelihood* of the risk occurring and the *impact* should the *uncertain event* happen.

3.5.2.2 The level of risk will be determined at three stages:

1) The **inherent risk level** - without control measures in place or if current control measures fail.

2) The **current risk level** is the risk level at which the trust is currently operating.

3) The **target risk level** is the level of risk with identified actions completed.

3.5.3 RISK APPETITE AND RISK TOLERANCE

3.5.3.1 The success of the trust is a result of effectively managing our risks, which in turn support the achievement of our objectives. The trust acknowledges that an element of risk exists in all activity it undertakes.

3.5.3.2 Within this framework, risk appetite will be referred to as a concept. Within this concept, we will refer to optimal and tolerable risk positions using the following definitions:

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- **Optimal risk position**: the level of risk with which the trust **aims** to operate. This is informed by the trust's strategic objectives.

- **Tolerable risk position:** the level of risk with the trust is **willing** to operate, given current constraints.

3.5.3.3 The Trust Board will agree the risk appetite statement for the trust as part of the annual strategic planning process.

3.5.3.4 A risk leader from the Executive Management Team will be designated for each high-level risk on the Board Assurance Framework. Appropriate managers will be designated for all other risks. Risk leaders will ensure that their risk management plan addresses the risks identified and will be required to monitor the status of their risks through the relevant meetings.

3.5.4 RISK EVALUATION

Following the risk assessment, an evaluation of the risk will be undertaken. The evaluation is to determine whether the risk level is within risk appetite, or whether the risk requires further control measures to reduce its level, known as risk treatment. The evaluation process involves considering the level of risk and the time, cost and effort involved in reducing the risk rating further.

3.5.4.1 Risks scoring 15 or above will be escalated to the Risk Management Group. The trust's willingness to tolerate a risk above the risk appetite level will depend on which of the principal objectives is at risk and the positive or negative impact that the risk would have on objectives, should it materialise. Therefore, the risk evaluation referred to above must be completed by managers with sufficient knowledge and authority. Health and safety risks shall be assessed and evaluated in line with the Health and Safety Risk Assessment and Risk Management Framework (TW24-031).

3.5.4.2 Those managers and groups that should be involved in deciding if a risk level is acceptable will be identified in the Risk Management Policy to enable the trust to make an informed decision on accepting levels of risk.

3.6 RISK TREATMENT

3.6.1 Selecting the most appropriate risk treatment option(s) involves balancing the potential benefits derived in enhancing the achievement of objectives against the costs, efforts, or disadvantages of proposed actions. Justification for the design of risk treatments and the operation of *internal control* is broader than solely economic considerations and should consider all the trust's obligations, commitments and partner views.

3.6.2 As part of the selection and development of risk treatments, the trust will specify how the chosen option(s) will be implemented, so that arrangements are understood by those involved and effectiveness can be monitored. This will include:

3.6.2.1 the rationale for selection of the option(s), including the expected benefits to be gained.
3.6.2.2 the proposed actions.
3.6.2.3 those accountable and responsible for approving and implementing the option(s).
3.6.2.4 the resources required, including contingencies.
3.6.2.5 the key performance measures and control indicators, including early warning indicators.

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3.6.2.6 the constraints.
3.6.2.7 when action(s) are expected to be undertaken and completed; and
3.6.2.8 the basis for routine reporting and monitoring.

3.6.3 Where appropriate, contingency, containment, crisis, incident and business continuity management arrangements will be developed and communicated to support resilience and recovery if risks crystallise.

3.7 RISK MONITORING AND REVIEW

3.7.1 Monitoring will play a role before, during and after implementation of risk treatment. Ongoing and continuous monitoring will support understanding of whether and how the risk profile is changing and the extent to which internal controls are operating as intended to provide reasonable assurance over the management of risks to an acceptable level in the achievement of the trust's objectives.

3.7.2 The results of monitoring and review will be incorporated throughout the trust's wider performance management, measurement and reporting activities.

3.7.3 THREE LINES OF DEFENCE

3.7.3.1 The "three lines of defence" model sets out how these aspects will operate in an integrated way to manage risks, design and implement internal control and provide *assurance* through ongoing, regular, periodic and ad-hoc monitoring and review. Importantly, the accountable officer and the board should receive unbiased information about the trust's principal risks and how management is responding to those risks.

3.8 RISK REPORTING

3.8.1 The Board, supported by the Audit Committee, will specify the nature, source, format and frequency of the information that it requires. Factors to consider for reporting include, but are not limited to:
3.8.1.1 differing partners and their specific information need and requirements.
3.8.1.2 cost, frequency and timeliness of reporting.
3.8.1.3 method of reporting; and
3.8.1.4 relevance of information to organisational objectives and decision-making.

3.8.2 The information will support the Audit Committee and the Board to assess whether decisions are being made within the trust's risk appetite to successfully achieve objectives, to review the adequacy and effectiveness of internal controls, and to decide whether any changes are required to re-assess strategy and objectives, revisit or change policies, reprioritise resources, improve controls, and/or alter their risk appetite.

3.8.3 Clear, informative, and useful reports or dashboards will promote key information for each principal risk to provide visibility over the risk, compare results against key performance/risk indicators, indicate whether these are within risk appetite, assess the effectiveness of key management actions and summarise the assurance information available. Reports will include qualitative and quantitative information, where appropriate, show trends and support early warning indicators. Understanding and decision-making will be supported through the presentation of information in summary form and the use of graphics and visualisation.

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3.8.4 Principal risks will be subject to "deep dive" reviews by the Audit Committee, with those responsible for the management of risks and with appropriate expertise present at an appropriate frequency depending on the nature of the risk and the performance reported.

3.9 MAIN PRINCIPLE E: Risk management shall be continually improved through learning and experience

3.9.1 The trust will continually monitor and adapt the risk management framework to address external and internal changes. The trust will also continually improve the suitability, adequacy and effectiveness of the risk management framework. This will be supported by the consideration of lessons based on experience and, every three years, a review of the risk management framework, with a mid-point check at 18 months to ensure that information included is still relevant.

3.9.2 All strategies, policies, programmes and projects will be subject to comprehensive but proportionate evaluation, where practicable to do so. As relevant gaps or improvement opportunities are identified, the trust will develop plans and tasks and assign them to those accountable for implementation. A risk management training programme will be developed to ensure staff have capacity to handle risk in a way appropriate to their authority and duties and to support continual improvement through learning and experience.

4 RESPONSIBILITIES

The Risk Management Policy (TW18-002) sets out the respective duties and responsibilities for specific committees, groups and individual members of staff.

5 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been considered in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

6 INCLUSION AND DIVERSITY

The document has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as we are aware, there is no impact on any protected characteristics.

7 MONITORING AND REVIEW

This document will be reviewed every 3 years or as and when changes or legislation which affects the document are introduced.

8 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g., large print, Braille, and audio cd.
For more details, please contact the HR Department on 01942 77 3766 or email equalityanddiversity@wwl.nhs.uk

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Appendix 1

Risk Appetite Statement

Our 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
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 & 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

Appendix 2

Risk Management Strategy 2024–2027 Implementation Plan

CORE ELEMENT:	WHERE WE WANT TO BE:	PRIORITIES: FY 24-27	24/25	25/26	26/27
GOVERNANCE AND LEADERSHIP	Risk management will be an essential part of governance and leadership, and fundamental to how the trust is directed, managed and controlled at all levels.	1. BAF to be presented for approval at bi-monthly board meeting.	✓	✓	✓
		2. BAF risks relating to specific strategic 4Ps objectives to be presented for approval at appropriate Board subcommittee meetings.	✓	✓	✓
		3. Corporate and Health and Safety risks scoring 15 and above to be raised and discussed at the monthly RMG meeting.	✓	✓	✓
		4. Health and Safety risks to be discussed at OSHG and divisional meetings.	✓	✓	✓
		5. Corporate risks scoring 12 and below to be raised and discussed at divisional risk group meetings with periodic deep dive presentations at RMG.	✓	✓	✓
		6. AAA Reports containing risks discussed and new risks identified to be produced following subgroups meetings and shared at RMG to provide assurance and escalation.	✓	✓	✓
		7. Review of corporate risk register at each RMG meeting utilising a three alarm bell assurance approach.	✓	✓	✓
		8. Audit Committee to review register at each meeting including a bi-annual deep dive.	✓	✓	✓
		9. ETM to receive a monthly Risk Update report following RMG meetings.	✓	✓	✓
		10. Monthly Divisional risk report to be produced and sent to divisional governance leads.	✓	✓	✓

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CORE ELEMENT:	WHERE WE WANT TO BE:	PRIORITIES: FY 24-27	24/25	25/26	26/27
	Risk Appetite and Tolerance Levels clearly defined for each principal risk to inform decision making.	The Board will be invited to review the risk appetite statement, which details the Board's appetite and tolerance for risk taking and is mapped against the Strategic Objectives, on an annual basis.	✓	✓	✓
	Effective Board Assurance Framework (BAF)	The BAF template will be reviewed and revised annually to reflect the core elements of this framework.	✓	✓	✓
	Clear Risk Management Oversight	1. MIAA review of Assurance Framework to evaluate the effectiveness of the Board's Assurance Framework 2. MIAA review of risk management core controls to provide assurance that core risk management controls have been established and are adequately maintained.	✓ ✓	✓ ✓	✓ ✓
INTEGRATION	Risk management will be an integral part of all organisational activities to support decision-making in achieving objectives	Risk register scoring matrix will be annually reviewed to integrate risk categories with all organisational activities.	✓	✓	✓
COLLABORATION AND BEST INFORMATION	Risk management will be collaborative and informed by the best available information and expertise.	1. Risk management training calendar will be arranged within learning hub with bespoke training also available on request. 2. Bespoke BAF training available on request. 3. The Board of Directors must allocate appropriate resources for training and the development of enhanced risk awareness. 4. Collaborate with system partners to produce the locality risk register.	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓

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CORE ELEMENT:	WHERE WE WANT TO BE:	PRIORITIES: FY 24-27	24/25	25/26	26/27
RISK MANAGEMENT PROCESS	Risk management processes will be **structured** to include: a. **risk identification, analysis, and evaluation as part of a risk assessment** to determine and prioritise how the risks should be managed. b. the selection, design and implementation of **risk treatment** options that support achievement of intended outcomes and manage risks to an acceptable level. c. the design and operation of integrated, insightful and informative **risk monitoring and review**; and	1. Review and update RISK 1 Form. 2. Review and update RISK 2 Form. 3. Introduce an escalation form template. 4. Review and update risk guides. 5. Undertaken review to ensure all divisions are following the same risk reporting process to ensure consistency across the organisation		✓ ✓ ✓ ✓	✓

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CORE ELEMENT:	WHERE WE WANT TO BE:	PRIORITIES: FY 24-27	24/25	25/26	26/27
	d. timely, accurate and useful **risk recording and reporting** to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.				
CONTINUAL IMPROVEMENT	Risk management will be continually improved through learning and experience.	1. Annual review of RMG terms of reference to ensure the group membership enables effective escalation and assurance of risks. 2. Annual cycle of business to be implemented for RMG.	✓ ✓	✓ ✓	✓ ✓

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Appendix 3

Equality Impact Assessment Form

STAGE 1 - INITIAL ASSESSMENT

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	**Sex** (male / female / transgender)	**Age** (18 years+)	**Race / Ethnicity**	**Disability** (hearing / visual / physical / learning disability / mental health)	**Religion / Belief**	**Sexual Orientation** (Gay/Lesbian/	**Gender Re-Assignment**	**Marriage / Civil Partnership**	**Pregnancy & Maternity**	**Carers**	**Other Group**	**List Negative / Positive Impacts Below**
Does the policy have the potential to affect individuals or communities differently in a negative way?	n	n	n	n	n	n	n	n	n	n	n	
Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities.	y	y	y	y	y	y	y	y	y	y	y	
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	n	n	n	n	n	n	n	n	n	n	n	**If Yes**: Please state how you are going to gather this information.

Job Title	**HEAD OF RISK**			**Date**	09.09.24

IF 'YES a NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp

Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an Equality Impact Assessment. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation.

Appendix 4

POLICY MONITORING AND REVIEW ARRANGEMENTS

Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
Risk Management Strategy Implementation Plan	Annual update at RMG meeting	Head of Risk	Annual	Risk Management Committee	Report	Minutes and papers from meeting.

Agenda item: 30

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Appraisal & Revalidation Annual Report
Presented to:	Board of Directors
On:	2 October 2024
Item purpose:	Consent
Presented by:	Professor Sanjay Arya
Prepared by:	Kathryn Heffernan
Contact details:	T: 01942 822026 sanjay.arya@wwl.nhs.uk

xecutive summary

This report covers the appraisal cycle of 1 April 2023 – 31 March 2024.

The template format of the report has been provided by the NHS England Revalidation Team. All Trusts have been requested to use the template and submit the full report which includes the Compliance Statement to NHS England before 31 October 2024.

The purpose of this report is to provide assurance that appraisal systems are robust, support revalidation and are operating effectively, whilst acknowledging that there are further improvements to be made. The report forms part of the Medical Director's duties as Responsible Officer.

On 31 March 2024 there were a total of **471 doctors** who had a prescribed connection to Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust.

The People's Committee is asked to note the contents of this paper for submission to the Trust Board for approval of compliance in Section 4 of this report.

Link to strategy and corporate objectives

Patients – We continue to ensure our medical appraisal and revalidation process is a key part of assuring our patients of the safety and effectiveness of medical professionals. Whilst medical revalidation aims to give confidence to the public that doctors are well supported and monitored and that there is a system for responding to concerns about a doctor's practice.

People – to ensure that all doctors have an annual appraisal to ensure they are up to date and fit to practice.

Performance - Appraisal provides key information to the responsible officer on the fitness to practise of each doctor and their commitment to remaining up to date. The recommendations that responsible officer make to the GMC on doctors' fitness to practise are made using outputs from appraisal and other information available to them from local clinical governance systems.

Partnerships – we continue to engage with all our partners associated with appraisal and revalidation our doctors, appraisers and associated departments within WWL; NHS England and GMC.

Risks associated with this report and proposed mitigations

None to report,

Financial implications

None to report.

Legal implications

Not applicable.

People implications

None to report.

Equality, diversity and inclusion implications

None to report.

Which other groups have reviewed this report prior to its submission to the committee/board?

People's Committee.

Recommendation(s)

The Board have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) as per page 23.

2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

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

	Name	Contact Information
Responsible Officer	Prof Sanjay Arya	Sanjay.arya@wwl.nhs.uk
Medical Director	Prof Sanjay Arya	Sanjay.arya@wwl.nhs.uk
Associate Medical Director	Prof Nirmal Kumar	Nirmal.kumar@wwl.nhs.uk
Medical Appraisal Lead	Dr Jenny Wiseman	Jenny.r.wiseman@wwl.nhs.uk
Appraisal and Revalidation Manager	Mrs Kathryn Heffernan	Kathryn.heffernan@wwl.nhs.uk
Additional Useful Contacts		
Appraisal and Revalidation Admin Support Officer	Mrs Catherine Sefton	Catherine.sefton@wwl.nhs.uk

Service Level Agreement

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

No

If yes, who is this with?

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

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and conclusion Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Prof Sanjay Arya will be Responsible Officer for next year, supported by Associate Medical Director (RO), Prof Nirmal Kumar, Appraisal Lead WWL, Prof Ayaz Abbasi, Appraisal Lead MCH/ITF, Prof Raj Murali and Medical Appraisal & Revalidation Manager, Kathryn Heffernan.
Comments:	As above.
Action for next year:	Will recruit an additional member to the Appraisal & Revalidation Team, a part-time admin support officer to assist the Medical Appraisal & Revalidation Manager & the Team.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes	
Action from last year:	Single Appraisal & Revalidation Manager in place with no back up/admin support. No resilience in the current system. This is being looked into.
Comments:	Business case and vacancy approved, and job will be advertised.
Action for next year:	Appointment to be made as soon as possible.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	No action from last year.
Comments:	The Appraisal & Revalidation Manager monitors and updates the connection list with all starters and leavers and monitors all new connections. All inappropriate or incorrect connections are reviewed and where appropriate declined by the Appraisal & Revalidation Manager. Any issues identified are referred to the GMC Connect if clarification is required.
Action for next year:	As above

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Appraisal & Revalidation Policy The policy was due to be updated by Oct 2023.
Comments:	Policy was not updated in Oct 2023 but has since been updated and waiting review by Responsible Officer before submitting to LNC Committee for approval.

Action for next year:	LNC to approve in July 2024 and policy to be ratified by PARC

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	No current plans, however, Responsible Officer attends NHSE RO Events and Appraisal & Revalidation Manager chairs regional peer group (x 4 meetings per year).
Comments:	Peer Review took place with Royal Bolton on 12 March 2024, visit by Wigan Team to Royal Bolton to take place on 14 May 2024.
Action for next year:	No further plans at this stage.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Carry on with current process.
Comments:	When notified, the Appraisal & Revalidation Manager contacts all locum or short-term placement doctors to make sure they are aware of the appraisal process and requirements. All are invited to meet the Manager for training on appraisals. For those with a prescribed connection to WWL as their designated body, the doctors will undertake an annual appraisal and be supported through revalidation by the Trust if required. For those doctors without a prescribed connection, we offer any support required for revalidation and this varies on a case-by-case basis. In-house locum bank system called TempRe has been set up. A & R Manager is emailed any new bank doctors from the TempRe admin team who then contacts the individual doctor to inform and train on the requirements of appraisal and revalidation.
Action for next year	Continue with current process.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information

relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	All doctors complete annual appraisal covering their whole scope of practice.
Comments:	All doctors complete annual appraisal covering their whole scope of practice using the electronic appraisal system.
Action for next year:	Continue as above.

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	
Comments:	If a doctor is not due an appraisal during the period April – March the reason is documented on the master spreadsheet held by the Appraisal & Revalidation Manager.
Action for next year:	Continue as above.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Update Appraisal & Revalidation Policy.
Comments:	Appraisal & Revalidation has been updated and due to go to LNC meeting in July 2024.
Action for next year:	Circulate updated policy and update on Intranet.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Continue to recruit new appraisers to all specialties
Comments:	Currently 106 appraisers in total. 10 new appraisers recruited during this period.
Action for next year:	Continue to recruit as many new appraisers as possible.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	Appraisal Update Meetings held twice a year.
Comments:	Appraisal Update Meetings held twice a year (attended by 60+ consultants). Held in May 2023 and November 2023.
Action for next year:	Session planned for May 2024 and December 2024.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	As below.
Comments:	Every year the Appraisal Lead reviews two appraisals per appraisee using the PROGRESS Tool form. Feedback is sent to each appraiser at the end of the cycle. Every year the Appraisal Lead and Appraisal & Revalidation Manager run two Appraiser Update Sessions which is monitored by the Responsible Officer. Attendance at these sessions is monitored. Each appraiser must attend one session per year to ensure they are up to date with their role. Appraisers who are unable to attend are provided with content of the presentation.
Action for next year:	Continue as above. This report is submitted every year to the People's Committee then to the Trust Board.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol,

within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Process GMC recommendations.
Comments:	All recommendations to the GMC are made in a timely manner. 77 recommendations this year, 64 positive and 13 deferrals made. Reasons for deferral are recorded on the Revalidation Checklist form.
Action for next year:	Continue to process GMC recommendations timely.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	1 April 2022 – 31 March 2023 71 doctors due for revalidation last year, 57 positive recommendations, 13 deferred, 1 recommendation submitted after due date.
Comments:	1 April 2023 - 31 March 2024 77 doctors due for revalidation, 64 positive recommendations, 13 deferred.
Action for next year:	All recommendations made on time.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Established processes are in place.
Comments:	Any concern or issue with a doctor is discussed at the quarterly Doctors Concerns Meeting with the Responsible Officer, Deputy RO; Workforce Director; Strategic HR Lead & Appraisal & Revalidation Manager. Any complaints or never events are emailed to the appraisee and they are requested to include this in their next appraisal and discuss with their appraiser.
Action for next year:	Continue process.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Well established processes are in place.
Comments:	Processes are in place ie: MHPS; Duty of Candour, Freedom to speak up Guardian. Medical Director/Responsible Officer, Associate Medical Director (RO) and the Appraisal & Revalidation Manager have regular meetings with the GMC ELA (every 4 months). If required, discussions are held with the Practitioner Professional Advise

	Services to discuss individual cases. All doctors are requested to add relevant information in their appraisal. In addition, the Responsible Officer, Appraisal & Revalidation Manager, Associate Medical Director (RO), Chief People Officer and Strategic HR Lead hold a Doctors Concerns Meeting every quarter to discuss and review any issues with our current doctors.
Action for next year:	Continue above process

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	All relevant organizational information is included in the portfolio by the Appraisal & Revalidation Manager.
Comments:	Consultants are provided with complaints, legal, audit attendance and number of study leave days. This is uploaded directly into their online appraisal.
Action for next year:	Continue with process and ensure it is included in their portfolio.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Established processes are in place.
Comments:	The Trust has a Maintaining High Professional Standards Policy (MHPS) which provides a process around all steps and considerations for when a concern arises in relation to a medical practitioner. Medical Director/Responsible Officer, Associate Medical Director (RO) and the Appraisal & Revalidation Manager have regular meetings with the GMC ELA (every 4 months). If required, discussions are held with the Practitioner Professional Advise Services to discuss individual cases. All doctors are requested to add relevant information in their appraisal. In addition, the Responsible Officer, Appraisal & Revalidation Manager, Associate Medical Director (RO), Chief People Officer and Strategic HR Lead hold a Doctors Concerns Meeting every two months to discuss and review any issues with our current doctors.
Action for next year:	No change, continue process.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of

primary medical qualification.

Action from last year:	As below.
Comments:	MHPS summary information is reported to the Board as per the annual reporting timeline. Minutes from Medical Director led Doctor Related Concerns meetings, held Bi-monthly are recorded for any audit purposes if required.
Action for next year:	Continue process.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	RO to RO communication is completed via the Medical Practice Information Transfer (MPiT) form via email.
Comments:	No change to above. RO to RO communication is completed via the Medical Practice Information Transfer (MPiT) or equivalent form via email.
Action for next year:	Continue as above.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	All cases where a concern has been raised by doctors practice are reviewed by the appropriate personnel. If a formal investigation is undertaken a case manager and independent case investigator with HR Support are appointed.
Comments:	No change to above.
Action for next year:	Continue as above.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	Ensure all doctors engage and complete mandatory training.
Comments:	All doctors are encouraged to attend their departmental/divisional meetings. All have allocated study leave. Mandatory training needs to be completed by all doctors and is

	updated when necessary, eg: Oliver McGovern training must be completed by all staff.
Action for next year:	Ensure mandatory training is completed for all doctors.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	New section in 23/24 in AOA, however this has formed part of the appraisal process in previous years.
Comments:	Annual job planning Mandatory training Compliance adherence to GMP through appraisal process.
Action for next year:	Continue as above.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Pre-employment checks are carried out by the Medical HR Dept. All doctors are recruited to the Trust (whether substantive or fixed term) are subject to the same pre-employment checks as defined by NHS Employment Check Standards. All references are reviewed by the Deputy Medical Director (RO). References for the MCh/ITF Doctors are reviewed by the GTEC Team.
Comments:	Continue as above.
Action for next year:	No changes, continue as above.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Updated Trust Values

Comments:	At WWL, we want to make sure that every member of staff feels valued and our vision is for WWL to be a provider of excellent health and care services, delivering safe and compassionate care to our patients, and being an inclusive and person-centred place to work, where everyone can flourish. Having shared core values is integral to creating a foundation of our culture at WWL, and how together, we will achieve our vision. We listened and involved staff through focus groups, online idea boards and paper suggestion boxes, along with 'gate crashing' regular forums, to develop a set of WWL Trust Values that embody what it means to be a WWL colleague and how together, we do the right thing. 
Action for next year:	Continue to promote our WWL values and vision.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	N/A
Comments:	The Trust has a Maintaining High Professional Standards Policy which provides a process around all steps and considerations for when a concern arises in relation to a medical practitioner. The Responsible Officer applies compassion when any staff is involved in an incident and ensures any action is fair and proportionate.
Action for next year:	Continue as above.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	N/A
Comments:	FTSU Guardian of Safe Working Trust Values Steps for Wellness/Well-being Staff Engagement Reports for FTSU and GOSW are taken to People Committee.
Action for next year:	Continue as above.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	N/A
Comments:	System for recording concerns is long established via excel tracker held confidentially within HR system – tracker is updated in line with updated requirements of Board, local and national reporting as required. Bi-monthly Doctor Related Concerns meetings take place

	to discuss all informal and formal concerns raised to Medical Director or HR to ensure consistency and appropriate advice sought to agree any action. Meeting attendees are Medical Director, Deputy Medical Director (RO), Chief People Officer, Strategic HR Lead.
Action for next year:	Continue as above.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	No action.
Comments:	EDI data is held confidentially within HR systems and only used for demographic and governance processes, such as comparison and assurance reports for the Board or as part of national/local reporting requirements and Freedom of Information requests, that meet the legal criteria for disclosure.
Action for next year:	As above.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Continue attending network events.
Comments:	Medical Director/Responsible Officer, Associate Medical Director (RO) and the Appraisal & Revalidation Manager have regular meetings with the GMC ELA (every 4 months). Medical Director/Responsible Officer, Associate Medical Director, Appraisal Lead & Appraisal & Revalidation Manager attend NHSE North West Network Meetings.
Action for next year:	Continue to attend NHSE NW Network Meetings and all other appropriate meetings/conferences.

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	471

2B – Appraisal

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

Total number of appraisals completed	341
Total number of appraisals approved missed	99
Total number of unapproved missed	31

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	77
Total number of late recommendations	0
Total number of positive recommendations	64
Total number of deferrals made	13
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	33
Total number of trained case managers	16
Total number of new concerns registered	0

Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March	0

Median duration of concerns processes closed	0
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	134
Number of new employment checks completed before commencement of employment	134

2F – Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	Ongoing
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Two Appraisers Update Sessions run Nov 2023 featuring the new GMP 2024 and May 2024 featuring an element on complaint responses. Advert sent out for recruitment for new Appraiser Lead Clinical Director – completes his term in June 2024 and for a new Admin Support Officer (to be appointed in June 2024) Improvement made in appraisal rates for all groups.
Actions still outstanding
Work ongoing on the update on the Appraisal & Revalidation Policy, with plans for discussion at LNC in July 2024 and ratification by PARC in August 2024.
Current issues
Continue to recruit new appraisers to all specialties
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
1. Will recruit an additional member to the Appraisal & Revalidation Team, a part-time admin support officer to assist the Medical Appraisal & Revalidation Manager & the Team – in June 2024. 2. To take the nearly completed Appraisal & Revalidation Policy to the LNC in July 2024, followed ratification by PARC in August 2024. 3. Appraiser Update Meetings to be held in May 2024 and December 2024.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust

Name:	Mrs Mary Fleming
Role:	Chief Executive
Signed:	
Date:	

Title of report:	GOSWH Annual Report 2023-2024
Presented to:	Board of Directors
Date of paper:	02 October 2024
Item purpose:	Information
Presented by:	Consent agenda
Prepared by:	Abigail Callender-Iddon, Guardian of Safe Working Hours
Contact details:	T: (01942 822626) E: Abigail.callender-iddon@wwl.nhs.uk

Executive summary

For the period 1st April 2023- 31st March 2024 (Quarter 4), there have been:

- 246 exception reports submitted for the year (186 exception reports in the previous year).
- 215 hours and 20 minutes of overtime claimed.
- 119 ERs- FY1; 59 ERs- FY2; 49 ERs- ST1-3; 19 ERs- ST4-8
- General Medicine- 123 ERs; General Surgery- 22 ERs; Trauma and Orthopaedics- 38 ERs; Obstetrics and Gynaecology- 29 ERs; Paediatrics- 12 ERs; Cardiology- 5 ERs, A&E- 2 ERs, Gastroenterology- 3 ERs, Rheumatology- 5 ERs, Acute Medicine- 1 ER; Geriatric Medicine- 2 ERs, Psychiatry- 1 ER; Anaesthetics- 1 ER, ENT- 1 ER.
- The main reasons for exceptions reported for overtime included ward workload, staffing shortages, unable to attend or late for teaching, completing jobs and unwell patient
- 8 Immediate Safety Concerns: 7 in General Medicine; 1 in O&G (de-escalated); 1 in Trauma and Orthopaedics
- 16 Breaches (6.5%)

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.

Equality, diversity and inclusion implications

Which other groups have reviewed this report prior to its submission to the committee/board?
LNC, JDF, TMEC and People's Committee.

Recommendation(s)

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

1. Introduction

This is the Annual 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 2023- March 2024

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: 89.
International Training Fellows: 37.
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- April 2023- March 2024

Total number of Exception Reports for the period: 246
Category of Exception Report:

- Hours/Overtime- 190 (77%)
- Educational- 38 (15%)
- Service Support- 9 (4%)
- Pattern-8 (3%)
- Rest-1

Number reported as an Immediate Safety Concern: 8
Total number of work schedule reviews: 1

3.1 Exception Reporting by Speciality

General Medicine- 123 (50%)

General Surgery- 22 (9%)

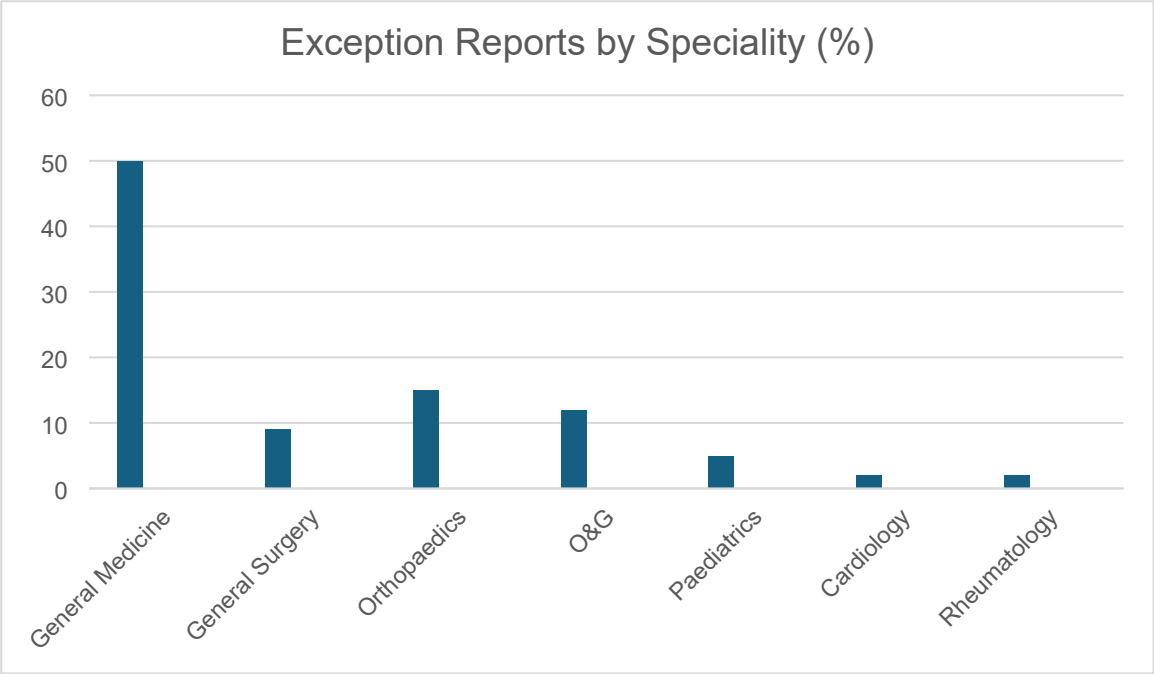
Trauma and Orthopaedics- 38 (15%)

Obstetrics and Gynaecology- 29 (12%)

Paediatrics- 12 (5%)

Cardiology- 5 (2%)

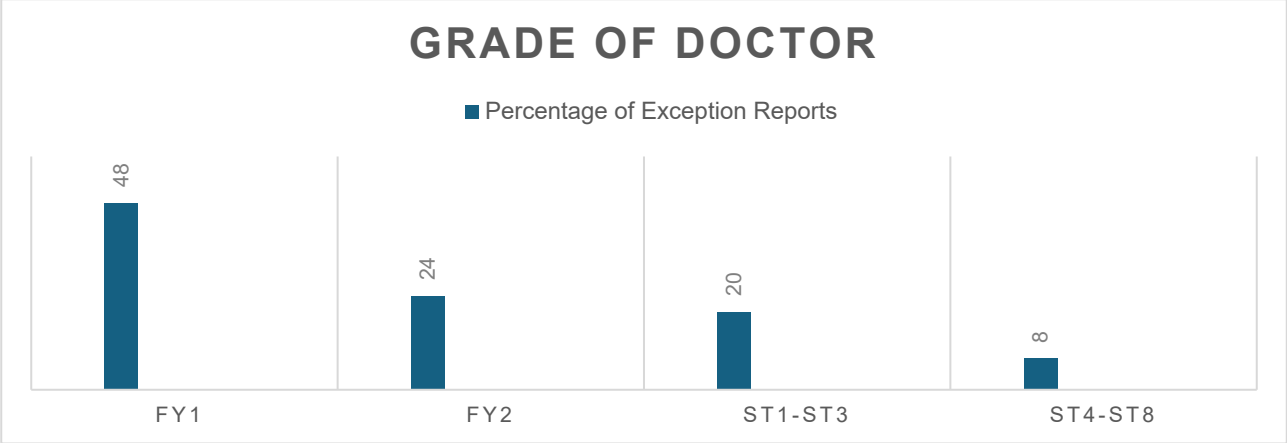
Rheumatology-5 (2%)



General Medicine had 50% of the exception reports. This was followed by Trauma and Orthopaedics with 15% of the Exception reports. General Medicine surpassed the other specialities by far in terms of the number of Exception reports.

3.2 Exception Reports by Doctor's Grade

Foundation Year 1- 119 (48%)
Foundation Year 2- 59 (24%)
Specialist Trainee 1- ST3- 49 (20%)
ST 4-ST8- 19 (8%)

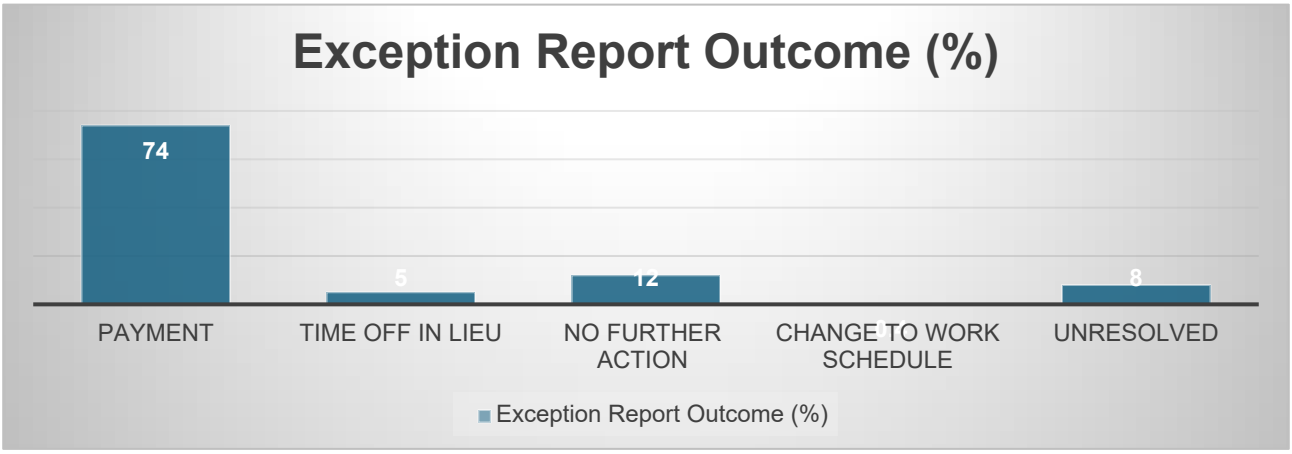


Nearly half of the exception reports for the year, were submitted by FY 1 doctors.

3.3 Exception Report Outcomes

Payment- 183 (74%)
Time off in Lieu- 12 (5%)

No further Action- 30 (12%)- exception reports submitted under the categories of service support and rest
Change to Work Schedule- 1
Pending/ Unresolved- 19 (8%)- mainly educational ERs



The majority of the submitted exception reports result in payment to the doctor for the overtime worked.

Total number of overtime hours claimed:

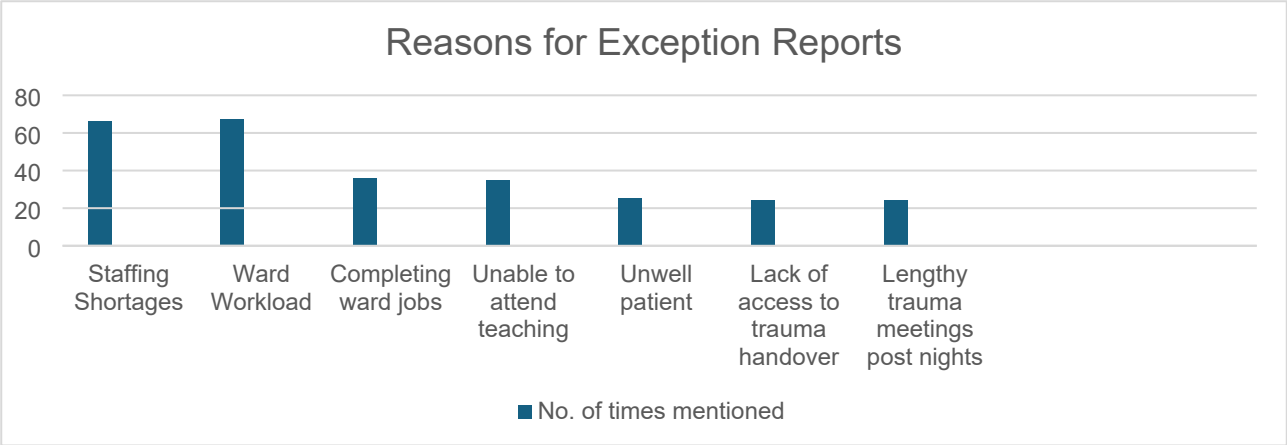
- Extra normal hours: 195 hours 10 minutes
- Extra premium hours: 16 hours 10 minutes
- Total: 211 hours 20 minutes

On average doctors were working an extra 12 minutes per week per doctor.

3.4 Reasons for Exception Reports in this period 1st April 2023- 31st March 2024

Please note that one exception report might have included more than one reason. These are the main themes:

- Staffing shortages- 66
- Ward workload- 67
- Unable to attend teaching/late for teaching- 35
- Unwell patient- 25
- Completing ward jobs- 36
- Lack of access to trauma handover- 24
- Lengthy trauma meetings post nights- 24



3.5 Immediate Safety Concern

Eight exception reports were highlighted as Immediate Safety Concerns for the period 1st April 2023- 31st March 2024.

- 6 in General Medicine:
  - Themes: Staffing shortages (no medical registrar, locum registrar cancelled, no ward SHO, staff sickness). FY1 acting up to SHO, holding 2 crash bleeps, numerous bleeps, HIS Outage
- 1 In Obstetrics and Gynaecology:
  - One doctor highlighted that he was the SHO in the labour ward and he felt overwhelmed by the high workload. This was de-escalated as there were no staffing shortages that day.
- 1 in Trauma and Orthopaedics:
  - No support on ward round, however seniors contactable.

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

Breaches and Levied Fines- 1st April 2023- 31st March 2024

Date	Department	Time/min	Doctor (£)	Guardian Fund (£)	Total Fine (£)
13/05/2023	Surgery	45	24.48	40.83	65.31
04/05/2023	Surgery	10	5.44	9.07	14.51
02/05/2023	Surgery	30	16.32	27.22	43.54
13/09/2023	Medicine	15	9.45	15.75	25.20
06/09/2023	Medicine	15	9.45	15.75	25.20
29/10/2023	Medicine	45	24.48	40.80	65.28
28/10/2023	Medicine	45	20.69	34.48	55.17
04/10/2023	Medicine	15	8.16	13.60	21.76
04/10/2023	Medicine	15	6.90	11.50	18.40
29/10/2023	O&G	10	6.30	10.50	16.80
25/11/2023	Paediatrics	15	15.04	25.06	40.10
01/01/2024	Paediatrics	30	30.08	50.13	80.21
11th and 12th Nov 2023	Trauma and Orthopaedics	420	288.8	481.45	770.33
12/05/2023	Gastroenterology	No breaks	0	604.56	604.56
12/05/2023	Obstetrics and Gynaecology	Breach of 11 hours rest	37.99	62.99	100.78

Total addition to Guardian Fund- £1443.69

Total fine to trust- £1947.15

3.7 Vacancies

Speciality	Vacancies	LTFT % gap
Anaesthetics	6	80%
A&E	7	50%
Medicine	4	70%

Paediatrics	**4**	**120%**
Surgery	**4**	**0**
Trauma and Orthopaedics	**2**	**20%**
Obstetrics and Gynaecology	**5**	**60%**
Rheumatology	**1**	**20%**
Radiology	**4**	**100%**

3.8 Feedback From the National GOSWH Conference 2023

A few Interesting Topics of discussion:

- Self- Rostering: helping to solve NHS challenges with a workforce first approach. Discussed benefits of self-rostering in a busy A&E setting. The concept was based on the ability to choose when one works. The process involved calculating the number of PAs the department required. The benefits included:
    - Same number of doctors working everyday
    - No more swaps required
    - No need to apply for annual leave
    - It eliminated the 6-week rule
    - Helped with recruitment
    - Saved money as no locums required unless last minute sickness

  Ultimately it helped to improve patient outcomes, enhance the well-being of the workforce and drive financial efficiency.

- Fatigue and Welfare: The role of the GOSWH in influencing effective fatigue risk management.
    - The power nap during the night shift
    - Sleep pods
    - Accommodation after a set of night shifts if driving a long distance
- GMC- updated Good Medical Practice
- NHS Long term Workforce plan: the educator workforce strategy as currently the biggest increase in training numbers.
- Implementation of Self-Development time. It should be rostered.

3.9 My Frist Year as GOSWH for WWL

- Writing the quarterly reports/annual reports
- Charing the quarterly JDF
- Attendance at TMEC, LNC and People's Committee to present reports and answer any questions
- Attendance at the Northwest regional GOSWH meetings
- Meetings with the medical director
- Meetings with the exception reporting team
- Raising awareness about exception reporting: presentation at the Education/Clinical Supervision training course.
- Setting up Cost code for the Guardian Fund

Title of report:	GOSWH Quarterly Report (Apr-June 2024) Quarter 1
Presented to:	Board of Directors
Date of paper:	02 October 2024
Item purpose:	Information
Presented by:	Consent agenda
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 April-June 2024 (Quarter 1), there have been:

- 80 exception reports submitted by 29 doctors (40 ERs & 14 doctors respectively for Q4).
- 62 hours and 45 minutes of overtime claimed (34h 45min for Q4).
- 71% submitted by FY1 doctors and 14% submitted by FY2 doctors (63% FY1; 10% FY2 for Q4).
- General Medicine (46%) had the most exception reports (65% for Q4).
- The main reasons for exception reported for overtime included staffing shortages, unwell patient, workload/ward pressures, unable to attend grand round (similar reasons as Q4).
- 0 Immediate Safety Concerns (ISCs): (3 ISCs in Q4).
- 8 Breaches: 8 fines to be levied (1 breaches in Q4).

Overall, there has been an increase in the number of exception reports with general medicine still having the highest number of exception reports. There has also been a significant increase in the Exception reports for General Surgery (38% versus 10 % in Q4). Some improvement in the proportion of ERs for General Medicine (46% versus 65% in Q4).

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.

Equality, diversity and inclusion implications

Which other groups have reviewed this report prior to its submission to the committee/board?

LNC, JDF, TMEC and People Committee.

Recommendation(s)

The Board of Directors are asked to note the contents of the report
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 first Quarterly report for the financial year 2024/2025, 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 Apr-Jun 2024

Total number of doctors/dentists in training on 2016 TCS: 202
Total number of Full-time doctors/dentists in training: 164
Total number of Less than Full-Time doctors/dentists in training: 38
Total number of locally employed junior doctors: 85.
International Training Fellows: 40.
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 (Apr-Jun 2024)

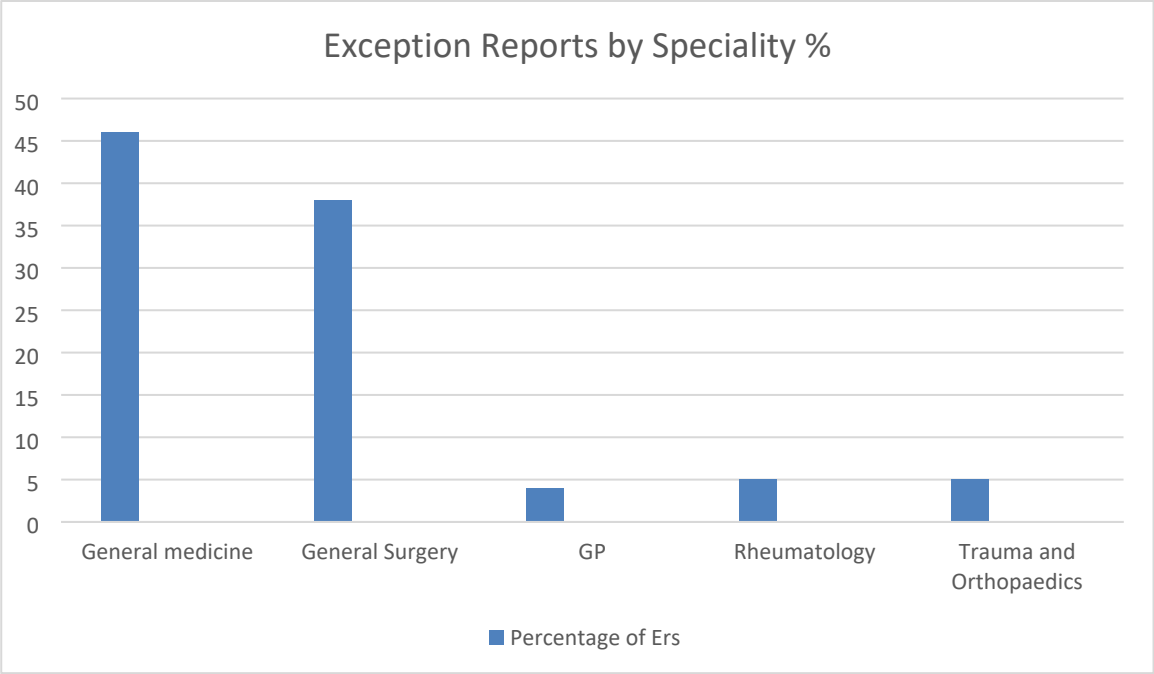
Quarter 1 (Apr-Jun 2024)	**Quarter 4 (Jan-Mar 2024)**
Total number of ERs: 80	**40**
Breach Type	
Hours/Overtime: 54	**26**
Educational: 19	**11**
Service support: 4	**3**
Pattern: 3	**0**

The number of doctors who engaged with Exception Reporting: 29 doctors (14%) generated 80 exception reports (Q4: 19 doctors, 10%, generated 40 exception reports in Q4)
Number reported as an Immediate Safety Concern: 0 (3 in Q4)
Total number of work schedule reviews: 0
8 Breaches this quarter (1 in Q4): 2 General Medicine, 3 General Surgery, 3 Trauma and Orthopaedics.

3.1 Exception Reporting by Speciality:

Quarter 1 (Apr-Jun 2024) **Quarter 4 (Jan-Mar 2024)**

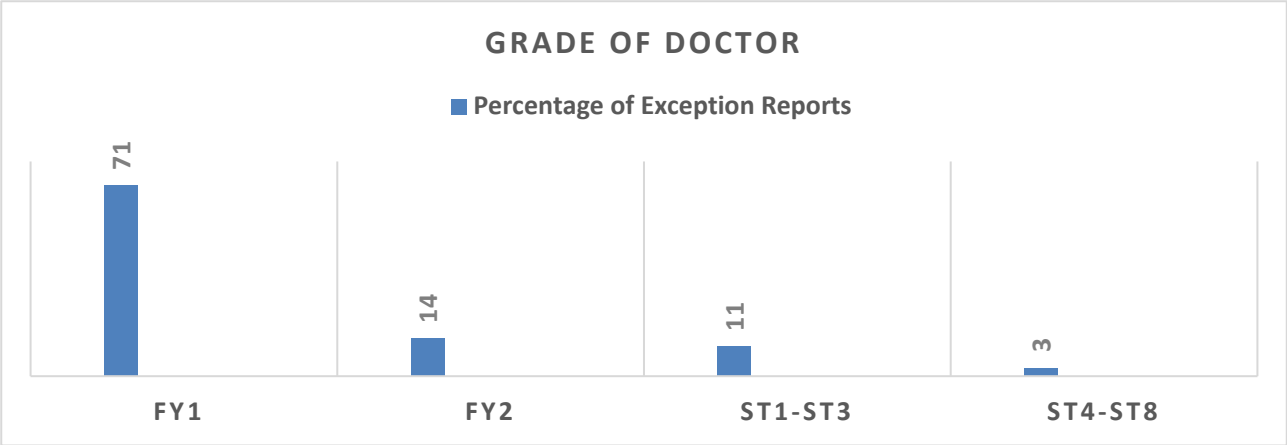
General Medicine- 46% (37)	65% (26)
General Surgery- 38% (30)	10% (4)
Paediatrics- 1% (1)	10% (4)
Anaesthetics- 0	2.5% (1)
Obs & Gynae - 2% (2)	2.5% (1)
Rheumatology- 4% (3)	5% (2)
Acute Medicine- 0	2.5% (1)
A&E- 0	2.5% (1)
General Practice 3 (3%)	0



There has been a significant rise in the number of General surgery ERs (38%) versus 10% in the previous quarter. The main reasons included staffing shortages, unable to take breaks, ward pressures/workload and covering multiple specialities.

3.2 Exception Reports by Doctor's Grade

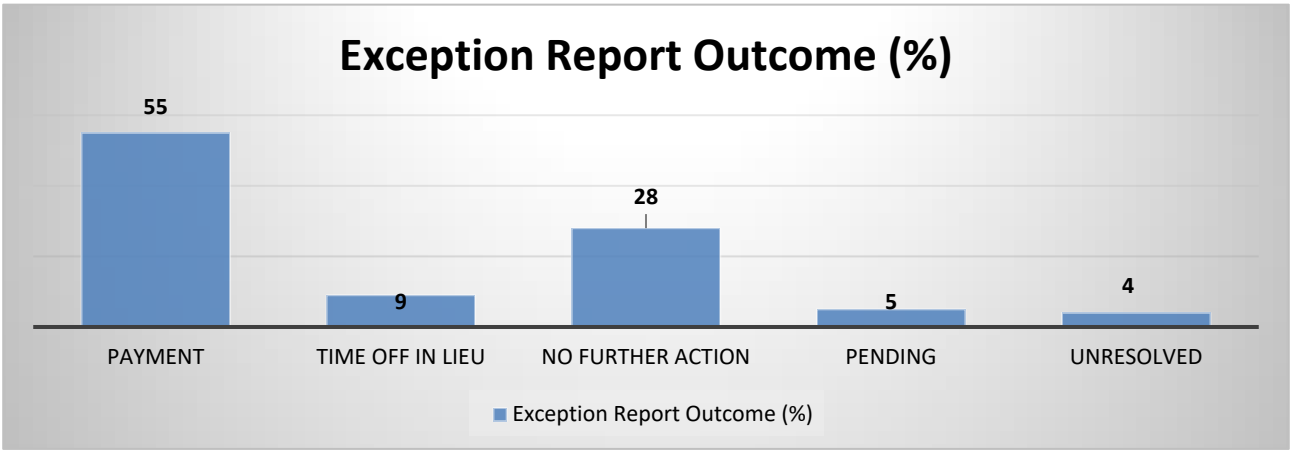
Quarter 1 (Apr-Jun 2024) (80 ERs)	Quarter 4 (Jan-Mar 2024) (40 ERs)
Foundation Year 1- 71%(57)	63% (25)
Foundation Year 2- 14% (11)	10% (4)
Specialist Trainee 1- ST3- 11% (9)	10% (4)
ST 4-ST8- 4% (3)	18% (7)



FY1 doctors continue to submit the most ERs.

3.3 Exception Report Outcomes

Payment- 55% (44)
Time off in Lieu- 9% (7)
No further Action- 28% (22)- mostly Educational Exception reports
Unresolved/ Submitted in error- 4% (3)
Pending- 5% (4)



Total number of overtime hours claimed:

- Extra normal hours: 56 hours (31h 55min in Q4)
- Extra premium hours: 6 hours 45 minutes (2h 50min in Q4)
- Total 62 hours 45 minutes (34h 45min in Q4)

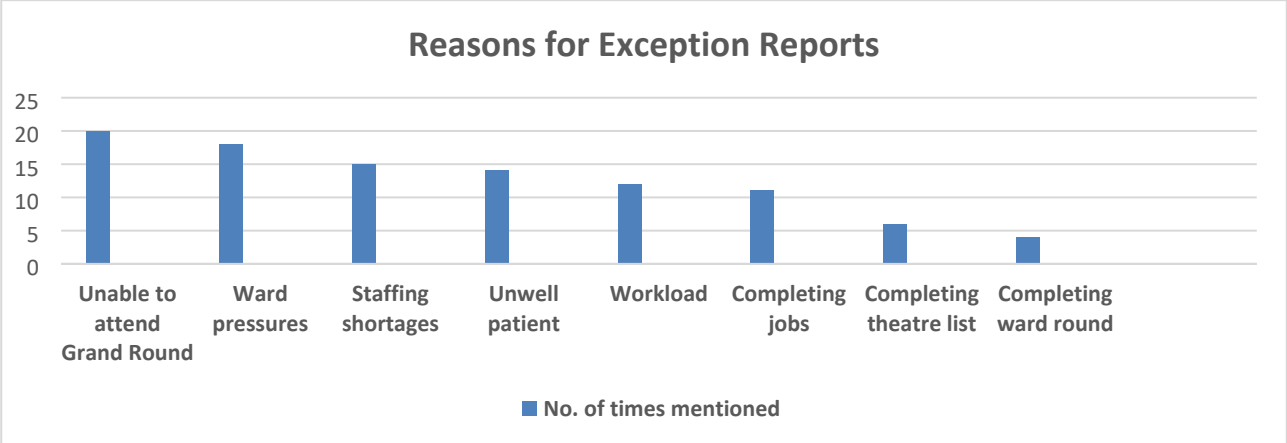
On average doctors were working an extra 10 minutes per week per doctor (8.4min in Q4).

3.4 Reasons for Exception Reports in this period (very similar to Q4)

Please note that one exception report might have included more than one reason.

- Supporting patient with mental health needs (1)
- Doing procedure (3)
- Staff sickness (4)

- Nursing issues (2)
- Multiple discharges (1)
- Unwell patient (14)
- Staffing shortages (15)
- Discussions with families (2)
- Completing jobs (11)
- Emergency transfer (2)
- Covering another speciality (3)
- Workload (12)
- Completing theatre list (6)
- Unable to attend Grand Round (20)
- Ordering investigations (1)
- Discussions with seniors/other teams (2)
- Ward pressures (18)
- Completing Ward Round (5)
- Cardiac arrest and death (1)
- Distribution of workload (1)
- Both registrars in clinic (1)
- Feels CAU not adequately staffed on Fridays (2)
- Awaiting arrival of registrar from clinic/theatre (4)
- Staff lateness (1)
- First on call (1)
- Advanced care planning (1)
- Unable to attend clinic (1) *- 1 clinic attended in 4 months
- Helping to organise cover (3)



3.5 Immediate Safety Concern

There were no ISCs this quarter.

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

Breaches for the Period Apr-Jun 2024: Breaches of the Maximum 13-hour shift

- 8 for this quarter 1 (Apr-Jun) versus 1 for Quarter 4 (Jan-Mar).
- General Medicine- 2 (emergency transfer of unwell patient, bedside ECHO, night registrar did not come for shift)
- Trauma and Orthopaedics- 3 (Completing documentation and jobs following registrar review, updating handover sheet, struggled with workload being new to job)
- General Surgery-3 (Staffing shortages, assisting in emergency theatre, helping to find night SHO).

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.

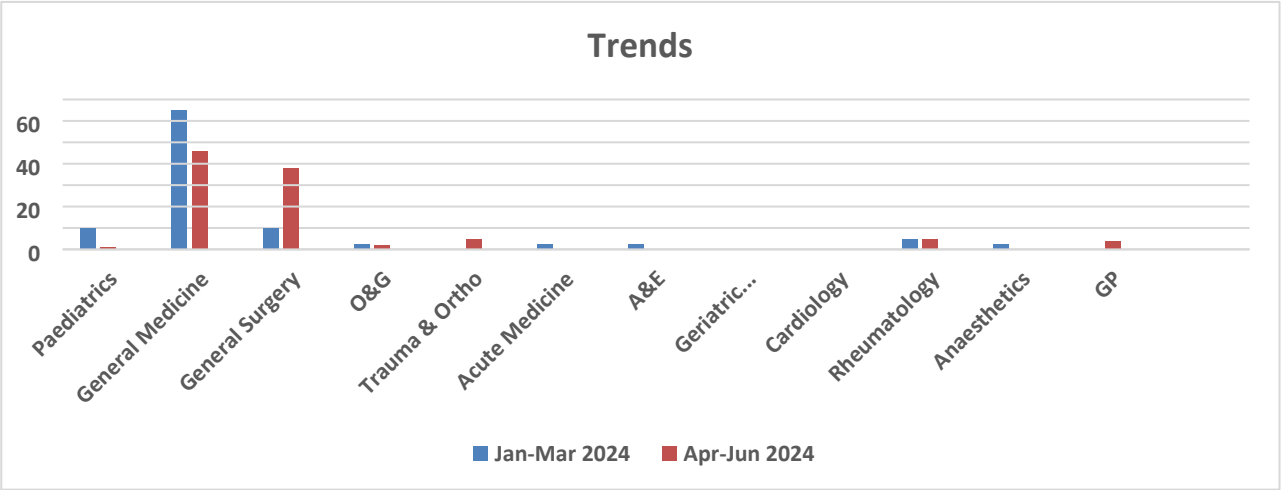
	Total Value of Penalty	**Hourly Penalty Rate Paid to the Doctor**
Additional hours worked attract a basic rate	X 4 the basic hourly rates	X 1.5 of the basic hourly locum rate
Additional hours worked attract an enhanced (night) rate	X 4 the enhanced hourly rate	X 1.5 of the enhanced hourly locum rate

Breaches and Fines to be Levied for Quarter 1 (Apr-Jun 2024)

Date	Department	Time/min	Doctor (£)	Guardian Fund	Total Fine (£)
06/06/2024	Medicine	5	5.01	8.35	13.37
11/04/2024	Medicine	40	40.10	66.83	106.93
25/04/2014	Orthopaedics	30	18.90	31.50	50.39
23/04/2024	Orthopaedics	30	18.90	31.50	50.39
20/04/2024	Orthopaedics	30	18.90	31.50	50.39
28/03/2024	Surgery	60	32.64	54.44	87.08
27/03/2024	Surgery	60	32.64	54.44	87.08
25/03/2024	Surgery	60	32.64	54.44	87.08

Total addition to Guardian Fund- £333.00
Total fine to trust- £532.71

Comparison of Quarter 4 (Jan-Mar 2024) with Quarter 1 (Apr-Jun 2024)



3.7 Speciality Specific Trends: Comparison Oct-Dec 2023 with Jan-Mar 2024

General Medicine- 46% (37 exception reports) 65% in Q4

Doing procedure (3), discharge letters (2), Unwell patient (11), Staffing shortages (11), Covering multiple wards (1), discussions with families/ Advanced care planning (2), Ward pressures/workload (5), Backlog of jobs (4), Staff sickness (4), Nursing issues (2), Emergency transfer (1), Discussions with speciality teams (3), Discussions with senior (2), Reviewing patient at end of shift (1), Completing ward round (3), Completing jobs (2), Unable to attend clinic (1), shift pattern (1), cancelled clinics (1), no night registrar (1)

General Surgery- 38% (30 exception reports) 10% in Q4

Covering multiple specialities (8), Staffing shortages (10), Unable to take breaks (9), Theatre overrun (5), Missed Grand Round (6), Ward pressures/workload (9), Ongoing Ward round (4), Completing jobs (3), Unwell patient (2), Holding extra bleeps (5), Car accident- colleague (4), Locum has no NHS experience (4), Backlog of jobs (1), Organising cover (1)

General Practice 4% (3 exception reports)

Supporting patient with mental health needs (1), completing urgent tasks (2), referring patient (2), longer consultation (1)

Trauma and Orthopaedics 5% (4 exception reports)

Ward pressures/workload (1), awaiting registrar to review patients (3), documenting /jobs post registrar review (3), night SHO late (2), updating handover sheet (3)

Obstetrics and Gynaecology 2% (2 exception reports)

Distribution of workload (1), workload (1), surgery/theatre (1)

Acute Medicine (1 Exception report)

Unwell patient (1), Staffing shortages (1), Ward pressures/workload (1)

Rheumatology- 4% (3 exception reports)

Missed grand round (1), ward pressures (1)

Gastroenterology (1 Exception report)
Ward pressures (1), staffing shortages (1), unwell patient (1)

Geriatric medicine (1 Exception report)
Staffing shortages (1), unable to attend grand round (1), ongoing ward round (1), ward pressures (1)

Cardiology (9 Exception reports)
No break (1), Staff sickness (1), Staff shortages (3), workload (4), unable to attend grand round (5), Ongoing/late ward round (3), Unwell patient (2), Cardiac arrest (1)

Paediatrics (1 Exception Report)
Unable to attend teaching (1), busy shift (1), Procedures (1), covering neonates and post-natal ward (1)

ENT (1 Exception Report)
Colleague had internal interview (1), workload/ ward pressures (2), unable to attend grand round (1), ward round finished late (1), senior had to go to another site (1)

3.8 Recommendations

General Surgery:
SHO stayed following long day shift to help organise cover for the night shift. This happened 3 nights in a row. Some discussion over managing scenarios when night staff do not show up for work that does not involve the day doctors staying back after their shift to help organise cover.

Cardiology, Geriatric Medicine, General medicine
A few exception reports were submitted around not being able to attend Grand Round because of ongoing ward round (mentioned in Cardiology, geriatric medicine and General Medicine). Discussion about how best to manage these scenarios that allows the juniors to attend the teaching without compromising the safety of the patients.

Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

STATEMENT OF COMPLIANCE

Wrightington, Wigan and Leigh Teaching Hospitals Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, Wrightington, Wigan and Leigh Teaching Hospitals Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisation's Annual Report

Ref	Doma n	Standard	Deep Dive question	Supporting evidence including examples of evidence	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) Not ev denced in EPRR arrangements. Amber (part a y compliant) Not evidenced in EPRR arrangements but have plans in place to include in the next 12 months Green (ful y compl ant) Ev denced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Cyber Security and IT related incident response (NOT INCLUDED WITHIN THE ORGANISATION'S OVERALL EPRR ASSURANCE RATING)										
DD1	Deep Dive Cyber Security	Cyber Security & IT related incident preparedness	Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.	-Cyber security and IT teams engaged with EPRR governance arrangement and are represented on EPRR committee membership (TOR and minutes) - Shared understanding of risks to the organisation and the population it serves with regards to EPRR - organisational risk assessments and risk registers -Plans and arrangements demonstrate a common understanding of incidents in line with EPRR framework and cyber security requirements. -EPRR work programme -Organisational EPRR policy	EPRR Group ToR EPRR Risk Register Monthly DQEC Report SIRO Minutes EPRR Policy	Fully compliant				
DD2	Deep Dive Cyber Security	Cyber Security & IT related incident response arrangements	The organisation has developed threat specific cyber security and IT related incident response arrangements with regard to relevant risk assessments and that dovetail with generic organisational response plans.	Arrangements should: -consider the operational impact of such incidents -be current and include a routine review schedule -be tested regularly -be approved and signed off by the appropriate governance mechanisms -include clearly identified response roles and responsibilities -be shared appropriately with those required to use them -outline any equipment requirements -outline any staff training needs -include use of unambiguous language -demonstrate a common understanding of terminology used during incidents in line with the EPRR framework and cybersecurity requirements.'	TW20-012 SOP - Managing a Cyber Incident Cyber Incident Response Plan NHS Cyber Incident Exercise Improvement Plan - tracker SIRO Minutes Monthly SIRO IT Update	Fully compliant				
DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents	The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.	Arrangements should consider the generic principles for enhancing communications resilience: 1. look beyond the technical solutions at processes and organisational arrangements 2. identify and review the critical communication activities that underpin your response arrangements 3. ensure diversity of technical solutions 4. adopt layered fall-back arrangements 5. plan for appropriate interoperability https://www.england.nhs.uk/wp-content/uploads/2019/03/national-resilient-telecommunications-guidance.pdf	Examples of SnapComms IT Outage notifications Radio contract New telephone system	Fully compliant				
DD4	Deep Dive Cyber Security	Media Strategy	The organisation has Incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents	- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts. - Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents. - Documented process for communications to regional and national teams - Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.	Comms templates for IT/Cyber incidents Comms process for incidents	Fully compliant				
DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	2024 Cyber Exercise Report	Fully compliant				
DD6	Deep Dive Cyber Security	Continuous Improvement	The organisation's Cyber Security and IT teams have processes in place to implement changes to threat specific response arrangements and embed learning following incidents and exercises	- Cyber security and IT colleagues participation in debriefs following live incidents and exercises - lessons identified and implementation plans to address those lessons -agreed processes in place to adopt implementation of lessons identified - Evidence of updated incident plans post-incident/exercise	TW20-001 - IT System Patching RCA Process Change Management Process Cyber Incident Response Plan	Fully compliant				
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	3rd party cyber security provider	Fully compliant				
DD8	Deep Dive Cyber Security	EPRR Training	The oranisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	-Cyber security and IT related incidents and emergencies included in EPRR awareness training package	EPRR Incident Response Training Presentation EPRR Training Prospectus	Fully compliant				
DD9	Deep Dive Cyber Security	Business Impact Assessments	The Cyber Security and IT teams are aware of the organisations's critical functions and the dependencies on IT core systems and infrastrucure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	AAA Systems Annual Report AAA List of services & suppliers	Fully compliant				
DD10	Deep Dive Cyber Security	Business Continuity Management System	Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)	-Reflected in the organisation's Business Continuity Policy -key products and services within the scope of BCMS -Appropriate risk assessments	BCMS Policy IT Services BIA & BCP	Fully compliant				
DD11	Deep Dive Cyber Security	Business Continuity Arrangments	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	TW18-012 - IT Systems Disaster Recovery Policy Business Continuity Plans Cyber Incident Response Plan	Fully compliant				

Please select type of organisation: **Acute Providers**

Click button to format the workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	11	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	55	7	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	11	0	0
Total	11	11	0	0

Overall assessment:	Substantially compliant

Instructions:

Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 6: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 7: In the Action Plan tab, click on the 'Format Action Plan' button.

				uppor ng I ng e pl
Domain 1 - Governance				
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans				
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control				
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising				
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response				
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing				
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation				
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004
Domain 9 - Business Continuity				
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme

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52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
Domain 10 - CBRN				
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning

Ref	Domain	Standard name	Standard Detai	Support ng Informat on - nc uding examples of ev dence

Agenda item: 32

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	NHS EPRR Core Standards Framework 2024
Presented to:	Board of Directors
On:	2nd October 2024
Item purpose:	Information
Presented by:	Accountable Emergency Officer
Prepared by:	Head of Resilience
Contact details:	T: 0300 707 3858 E: mark.taylor1@wwl.nhs.uk

Executive summary

This paper is a report from the annual NHS Core Standards for EPRR self-assessment for 2024. This year the Trust has self-assessed as **Substantially Compliant** against the 62 applicable core standards in the framework, this is an increase from partial compliance in 2023. This process has identified the areas in which the Trust have improved in over the last 12 months and also the areas that still require improvement and which will form the 2024 NHS Core Standards for EPRR improvement action plan for the next 12 months.

Link to strategy and corporate objectives

None

Risks associated with this report and proposed mitigations

None

Financial implications

None

Legal implications

There are legal implications linked to this in that the Trust are not currently fully complaint with statutory duties as set out in the Civil Contingencies Act and NHS EPRR Core Standards Framework. However, an improvement plan is being developed to move back to a compliant status by September 2025.

People implications

None

Recommendation(s)

The Trust Board of Directors are asked to acknowledge the contents of this report and the 'in-year' increase in the compliance rating from 2023. Also noting the reasons for non-compliance, acknowledge the process timeline and the assurance visit to be arranged by NHS GM EPRR and subsequent review by GM-LHRP.

Report Purpose:
NHS England requires all NHS organisations to annually assess their ability to meet their Emergency Preparedness, Resilience & Response (EPRR) statutory obligations. This assurance is sought each autumn, and Trust Management Team and Boards are to be made aware of the level of preparedness achieved. This report shows the results of our self-assessment for 2024.

Self-Assessment Statement:
The self-assessment for 2024 shows that overall WWL is substantially compliant with the EPRR Core Standards for 2023, having fully completed 55 out of the 62 standards required (equating to 89%). In addition, the Trust is partly compliant in 7 standards, and there are zero standards where we have no level of compliance (see diagram below). The areas where we are not fully compliant relate mainly to:

- Management of CBRN Countermeasures
- Business Continuity and CBRN exercising
- Internal audit
- Assurance of suppliers and contractors

Dashboard:

Please select type of organisation: **Acute Providers**
Click button to format the workbook: Format Workbook

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	11	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	55	7	0

Overall assessment:	Substantially compliant

Deep Dive:
Each year, NHS England also identify a specific area of the core standards that they require a 'deep dive' assessment. Whilst not forming part of the formal Trust compliance score it provides a more in-depth assessment into particular areas of concern, this year the deep dive was on Cyber Security.

With the full support of IM&T, the deep dive for Cyber Security was completed and the Trust came out as 100% compliant against the 11 deep dive areas.

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	11	0	0
Total	11	11	0	0

Assurance Timeline:
The timeline for the NHS EPRR Core Standards assurance process is:

- July to August Trust undertakes self-assessment
- 23/08/24 AEO Informed of initial self-assessment outcome
- 30/08/24 Full report to AEO for sign-off
- 16/09/24 Report to EPRR Group for agreement
- 17/09/24 Draft Board Report and send to Co. Secretary
- 30/09/24 Submit self-assessment to GM-ICB
- 02/10/24 Report presented to public board meeting
- October-24 Assurance visits to Trust by GM EPRR
- 14/11/24 LHRP Review of GM Assessments
- 15/11/24 GM Submission into LHRP

The Head of Resilience, on behalf of the Accountable Emergency Officer has scrutinised the self-assessment and identified the following areas for improvement against which a 12-month action plan will be developed, overseen by the EPRR Group, to ensure compliance to the standards in 2024.

- CBRN Countermeasures distribution arrangements with Pharmacy support.
- Identify in-hours and out-of-hours Loggist cadre and deliver training.
- Develop and deliver a schedule of BC exercises, including appropriate reports and learning logs.
- Engage with Internal Audit to undertake independent audit of BC arrangements.
- Develop a system to be able to assess the BC arrangements of commissioned providers/suppliers.
- Develop and deliver an annual CBRN decontamination exercise.

APPENDIX 1: Trust Statement of Compliance

Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) Assurance 2024-2025

STATEMENT OF COMPLIANCE

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core Standards self-assessment tool.

Where areas require further action, Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned an EPRR assurance rating of **Substantial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

02/09/2024

Date signed

16/09/2024	02/10/2024	_____
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisation's Annual Report