Board of Directors - Public Meeting

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

Agenda

13. Declarations of Interest

Information *Mark Jones*

Verbal item

14. Minutes of the previous meeting

Approval *Mark Jones*

14. Minutes_Board of Directors - Public Meeting_050624.pdf (6 pages)

15. Action Log

Mark Jones

15. Public Board Action Log - Jun 2024 v1.pdf (1 pages)

16. Chair's report

Information *Mark Jones*

17. Chief Executive's report

Information *Mary Fleming*

17. APPROVED CEO Board Report July 2024.pdf (3 pages)

18. Agenda item not used

19. Committee chairs' reports

Information *Non Executive Directors*

19.1. Quality and Safety

Information *Francine Thorpe*

19.1. AAA Q&S July 2024.pdf (2 pages)

19.2. Finance and Performance

Information *Julie Gill*

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

19.3. Audit Committee

Information *Ian Haythornthwaite*

- 19.3. AAA - Audit Committee - 26 Jun 2024.pdf (1 pages)

19.4. People Committee

Information *Lynne Lobley*

- 19.4. AAA People - Jun 2024.pdf (2 pages)

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20. Maternity reports

Kevin Parker-Evans

20.1. Maternity Dashboards

Information

- 20.1. Maternity Dashboard report June 24.pdf (6 pages)
- 20.1a. Maternity Dashboard - June 2024.pdf (4 pages)
- 20.1b. Neonatal Dashboard - June 2024.pdf (4 pages)

20.2. Neonatal Staffing review

Approval

- 20.2. NNU Staffing Paper July 2024 MIS Safety Action 4 final version.pdf (10 pages)

20.2.1.

20.3. Perinatal Surveillance Report

Information

- 20.3.Maternity Perinatal Quality Surveillance Q1 24-25 (For Board).pdf (30 pages)
- 20.3a. Perinatal Dashboard - June 2024.pdf (2 pages)
- 20.3b. Perinatal Exception Report - June 2024.pdf (1 pages)

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21. Integrated performance report

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

- 21. Board of Directors M3 2425 IPR.pdf (3 pages)
- 21a. Board of Directors IPR M3 2425.pdf (19 pages)

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22. Finance report

Information *Tabitha Gardner*

- 22. Trust Finance Report June 2024 Board.pdf (2 pages)
- 22a. Trust Finance Report 24-25 June Month 3 Board.pdf (14 pages)

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23. Board Assurance Framework

Information *Paul Howard*

- 23. BAF Report Board August 2024final.pdf (29 pages)

24. Reflections on equality, diversity and inclusion

Discussion *Mark Jones*

Consent Agenda

25. Committee terms of reference

Approval

- 25. ToR - People Committee 2024.pdf (4 pages)
- 25. DRAFT F&P Committee ToR 2024.pdf (4 pages)
- 25. DRAFT ToR - QS 2024 NG EH amends v1.pdf (6 pages)

26. Date, time and venue of the next meeting

Information

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

Board of Directors - Public Meeting

Wed 05 June 2024, 14:15 - 16:15

Boardroom, Trust Headquarters

Attendees

Board members

Mark Jones (Chair), Sanjay Arya (Medical Director), Clare Austin (Non-Executive Director), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Paul Howard (Director of Corporate Affairs), Lynne Lobley (Non-Executive Director), Mary Moore (Non-Executive Director), Kevin Parker-Evans (Interim Chief Nurse), Juliette Tait (Chief People Officer), Francine Thorpe (Non-Executive Director), Claire Wannell (Interim Chief Operating Officer)

In attendance

Chris Clark (Director of Strategic Transformation), Aydin Djemal (Development Non-Executive Director), Nina Guymer (Deputy Company Secretary (Minutes)), Member of the public (1), Member of the public (2)

Presenters

Selina Morgan (Freedom to Speak Up Guardian, Present at: 98)

Meeting minutes

88. Declarations of Interest

Information

Mark Jones

No declarations of interest were made.

89. Minutes of the previous meeting

Approval

Mark Jones

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

Minutes_Board of Directors - Public Meeting_030424.pdf

90. Action Log

The Director of Strategic Transformation advised that there is no public version of the joint strategic needs assessment available yet but advised that this will be included on WWL's website when it is.

It was **AGREED** that action 56/24 could be closed since the People Committee will report back to the board through a 'AAA' report.

21a. Public Board Action Log - April 2024.pdf

91. Chair's report

Information

Mark Jones

The Chair begun by declaring the meeting quorate and therefore duly convened and constituted.

He went on to advise the Board of two new recent non-executive appointments, being the incoming People Committee and Audit Committee chairs.

He then moved to describe his stakeholder engagement activities since the last meeting.

- The previous week, himself and Mrs M Moore had met with other chairs and non-executives to discuss health inequalities at system level. He was pleased to report how the Greater Manchester system recognises this areas as a significant issue and that trusts have begun working more collaboratively. together to tackle this as a whole system - indeed, WWL is already working to address most of these areas.
- He had also attended a recent Healthier Wigan Partnership meeting with Mrs. F Thorpe which allows him to see the inequalities issues in the borough through the place lens.
- Finally he reported upon a Greater Manchester chairs and non-executives meeting where the matter of climate change has been discussed.

He reported upon a number of walkabouts which he had done since the last meeting, including a visit to the podiatry team; the Leigh site and to the Thomas Linacre Centre following a power outage. He noted how welcoming the staff had been across the sites.

He finished by advising that the following day, himself and the Chief Executive would be meeting with the locality Place Lead.

The Board received and noted the update.

92. Chief Executive's report

Information

Mary Fleming

The Chief Executive began by reiterating the Trust's sincerest apologies which has been shared with the bereaved family of a patient who had unfortunately passed away as a result of an incorrectly placed naso-gastric (NG) tube.

The Medical Director added that now at WWL doctors without NG tube training have been prevented from checking the placement of tubes; all doctors are mandated to undertake NG tube training and until training is completed, the relevant consultant radiologist will be responsible for checking and reporting upon placement of any tubes.

The Chief Executive went on to advise that urgent and emergency care system transformation programme will proceed in partnership with the Greater Manchester Integrated Care Board and the local authority.

She provided a summary of the report which had been shared in advance of the meeting and highlighted what had been a successful international nurses day along with the recent anti-racism declaration which the Trust had made.

The Board received and noted the update.

23. CEO Board Report June 2024_FINAL.pdf

93. Committee chairs' reports

Information

Non Executive Directors

The non-executive assurance committee chairs presented their respective reports.

93.1. Quality and Safety

Information

Francine Thorpe

In response to a query from the Chair, it was clarified that resuscitation trolley audits had not been audited regularly enough. Mrs L Lobley, the Non-Executive Resuscitation Lead for WWL, added that a report will come back to Quality and Safety Committee, to advise on updates to the current strategy associated with changes made to address this issue.

24.1. AAAQ&SMay24.pdf

93.2. Research

Information

24.2. AAA - Research - Jun 2024.pdf

Clare Austin

93.3. Finance and Performance

Information

24.3. AAA F&P - May 2024.pdf

Julie Gill

93.4. Audit Committee

Information

24.4. AAA - Audit Committee - 29 Feb 2024.pdf

Ian Haythornthwaite

93.5. People Committee

Information

Lynne Lobley

The Chief Executive noted the positive work one with Wigan and Leigh College and highlighted the opportunities to be seized by promoting non clinical roles through higher and further education institutions, in terms of development and future proofing of WWL's workforce and also in fulfilling it's role as an anchor institution.

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

24.5. AAA People - April 2024.pdf

94. Safe nursing staffing biannual review

Information

Kevin Parker-Evans

The Chief Nurse presented the report which had been shared prior to the meeting.

Prof C Austin asked whether the trust is working in line with the Royal College of Nursing (RCN) staffing ratios or is utilising other staff groups to satisfy these ratios.

The Chief Nurse noted that the RCN is working to provide guidance around more flexible ratios, utilising alternative staffing models through associated professionals, which is likely to be swiftly provided flowing the election.

In terms of enhanced care Mrs L Lobley asked whether there are any plans to change the care model.

The Chief Nurse noted that this is currently approached as a one-to-one service but that moving forwards, involvement of key professionals will be the preferred approach, rather than a ratio being allocated. He went on to advise that there will be live oversight of safe staffing moving forwards.

Mrs F Thorpe reinforced the triangulation with the quarterly safe staffing reports which the Quality and Safety Committee receive and that there have been no alerts raised to the Board resulting form these reports.

The Board received and noted the paper, endorsing its content.

25. March 24 Bi-annual staffing Review KPE FINAL.pdf

95. Maternity reports

Approval

Kevin Parker-Evans

The Chief Nurse presented the report which had been shared prior to the meeting and had been previously reviewed by the Quality and Safety Committee. He highlighted the progress made with mothers' smoking cessation and the slight increase in acuity and occupancy of the neonatal intensive care unit in the previous two months, which he clarified had seen no resulting harms.

Mrs M Moore noted the importance of internal assurances being provided, in spite of any CQC rating, in respect of which WWL had received a 'good' rating, particularly since the CQC are under review in terms of their processes.

The Chief Nurse advised that at Greater Manchester 'GM' level there have been several trusts which have been downgraded for similar reasons which have all been identified and a review carried out, with no related concerns raised in respect of care provided by WWL. He noted maternity safety champions, staff listening events,

Mrs L Lobley offered congratulations to the colleagues who had provided the report as well as the rest of the maternity team, for progress. However, she noted that staff were without training on new born life support. The Chief Nurse noted that one member of staff has achieved status as a trainer and that in house training is being considered.

The Board received and **APPROVED** the maternity and neonatal dashboards and the perinatal quality surveillance report, dashboard and exception report.

- 26. Maternity Dashboard Report April 24.pdf
- 26a. Maternity Dashboard - April 2024.pdf
- 26b. Neonatal Dashboard - April 2024.pdf
- 26c. Optimisation Dashboard - April 2024.pdf
- 26d. Maternity Perinatal Quality Surveillance Q4 (For Board).pdf
- 26e. Perinatal Dashboard - April 2024.pdf
- 26f. Perinatal Exception Report - April 2024.pdf

96. Integrated performance report

Information

Claire Wannell/Sanjay Arya/Juliette Tait/Kevin-Parker Evans

The Interim Chief Operating, Chief People Officer, Officer, Medical Director and Chief Nurse presented their respective quadrants of the score care and associated narrative.

Mrs F Thorpe was disappointed to see the dip in performance in respect of complaints resolution and asked how this has transpired.

The Chief Nurse noted that this is in part due to some sickness in the medical division, which does handle more complaints as a division but that he has asked the Associate Director of Governance to consider what support the divisions may need to handle complaints particularly in the early stages.

The Medical Director highlighted the positive trend in the level of the summary hospital-level mortality Indicator (SHMI) and that WWL are now the best performing trust in GM in respect of this metric.

Following discussion of the finance quadrant Mrs L Lobley raised a query around support for the divisions to generate and follow through with cost improvement programme (CIP) schemes.

The Chief Executive advised that the transformation directors who had recently worked with the trust to support in this areas has advised that a establishing a project management function would be helpful in better supporting the divisions with this work and that this is therefore being actioned. It was noted that each division approached this differently but that all report through their divisional assurance meetings ensuring that there is executive oversight in respect of each division regarding CIP progress.

The Board received and noted the update.

- 27. M1 2425 IPR Report.pdf

97. Finance report

Information

Tabitha Gardner

The Board noted the report which had been shared in advance of the meeting.

- 28. Trust Financial Report 23-24 March Month 12 Board.pdf
- 28a. Trust Financial Report 24-25 April Month 1 Board.pdf

98. Freedom to Speak up Biannual Report

Information

Selina Morgan

The Freedom to Speak Up Guardian (FTSU) joined the meeting and presented the report which had been shared prior to the meeting.

The Chief People Officer noted that soft intelligence has shown thus far that more staff are becoming aware of the service and also feel supported and able to raise and progress concerns through the new guardian. She noted the themes identified but highlighted that non of these concerns relate to patient safety, which, in line with the Francis report, is the fundamental purpose of the FTSU service.

The Chief Nurse added that the FTSU process is about giving staff the confidence to escalate concerns around potentially unsafe patient care and suggested that the Freedom to Speak Up Guardian attends as many clinical forums as possible to reinforce this message.

It was clarified that the role is to support, advise and signpost and to consider, where a concern is raised, whether this has any patient safety related consequences. In response to a query from the Medical Director she reported that she had seen staff's confidence in approaching their line manager increase.

The board noted the need to triangulate the data from FTSU with complaints to identify themes and areas where more assurance may be required.

The Board received and noted the update.

29. FTSU Biannual-report-010324 to 210524 Final.pdf

99. Board Assurance Framework (BAF)

Information

Paul Howard

The Director of Corporate Affairs summarised the report, noting that changes to risk profiles and ratings are mainly data driven. He noted that the risk appetite statement has been updated for the new financial year and that risks to the locality BAF have now been included within the report.

The Board reviewed the document and accepted the position articulated.

30. BAF Report Board June 2024 v2.pdf

100. Reflections on equality, diversity and inclusion

Discussion

Mark

The Board noted that discussions had been had around health inequalities across the system and how improvements to reduce these will be monitored moving forwards - it expressed a keenness to support these improvements moving forwards.

Mrs M Moore observed that there could be a richness of data in respect of the demographics of those raising FTSU issues and asked if it would it be possible to extract this confidentially.

The Chief Executive agreed and commented that identifying any themes amongst specific groups would allow the Trust to act to rectify issues which in turn would aid staff retention. She reminded the board of a recent piece of work which was done to improve the experience of internationally educated nurses and pointed out that, had this type of data been available, their concerns may have been identified at an earlier stage. She asked the Chief people Officer to take this forwards.

ACTION: J Tait

The Chief People Officer noted the Trust's keenness to be intentionally inclusive and that report cover sheets had been updated to provide authors the space to identify how the content has been considered through this lens.

101. Going concern declaration

Resolution

The Director of Corporate Affairs reminded the Board that it had **RESOLVED** virtually to make the following self-certification against the Provider Licence condition CoS 7: availability of resources:

After making enquiries the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of a going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The Board noted the resolution.

102. Consent Agenda

The Board having **AGREED** in advance to the following items appearing on the consent agenda, then proceeded as follows:

103. Corporate Objectives

Noting

The Chief People Officer noted prior agreement to the objectives by the relevant monitoring committees.

The Board **ENDORSED** the updated document, following review in April 2024.

32. Trust Board paper - 2024-25 Corporate Objectives 05-06-24.pdf
32a. Corporate Objectives 2024-25 - Final version for Trust Board 05-06-24.pdf

104. Annual Declarations of Interest Report

Information

The Board noted the register provided.

33. Directors DoIs - 2024.pdf

105. Changes to Standing Financial Instructions

Approval

The revised document was **APPROVED** by the Board, following approval by the Audit Committee at its last meeting.

34. SFI Changes.pdf
34a. SFIs 23-24 after changes.pdf

106. Date, time and venue of the next meeting

Information

3 August 2024, 1:15pm Boardroom, Trust HQ

Action log: August 2024

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
7 Feb 2024	20/24	System partnerships report	Add the joint strategic needs assessment to the anchor institution landing page.	R Mundon	3 Apr 2024	**Action complete**
3 Apr 2024	65/24	Modern Slavery and Human Trafficking statement	Clarify for the People Committee the processes in place where concerns are raised in line with the statement.	P Howard	Referral to People Committee	**Action complete.** The People Committee reviewed and were satisfied with this report.
5 Jun 2024	100/24	Reflections on equality, diversity and inclusion	How can we better use FTSU data to assist with staff retention by ensuring that themes identified with staff of particular demographic groups are explored.	J Tait	7 Aug 2024	**Action complete.** The FTSU Guardian will ensure that information relating to protected characteristics and specific demographics is built into the next report for the Board of Directors.

Agenda item: [17]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	07/08/2024
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

The purpose of this report is to update the Board on matters of interest since the previous meeting.

Link to strategy

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications arising out of the content of this report.

Legal implications

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

People implications

There are no people risks associated with this report.

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

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

Report

In June, I was delighted to confirm the substantive appointments of both our Chief Nursing Officer and Chief Operating Officer at WWL. Kevin Parker-Evans, who held the position of Interim Chief Nurse at the Trust since January 2024, has been confirmed as the substantive Chief Nursing Officer in June 2024, assuming his new role with immediate effect. With a 23-year-career as a registered adult nurse and a previous role as Deputy Chief Nurse at Tameside and Glossop Integrated Care NHS Foundation Trust, Kevin has both clinical and leadership experience of acute medicine, emergency care and operational leadership and management. Kevin has said his priority at WWL is to help the Trust become a flagship organisation for the delivery of excellent care, putting patients and their carers at the centre of their care.

Sarah Brennan will also join us later in the summer as our new Chief Operating Officer, following a rigorous recruitment process. Sarah brings with her a wealth of knowledge and experience, joining WWL from her previous role in the same position at Bridgewater Community Healthcare NHS Foundation Trust, which she has held for the past four years. A pharmacist by background, Sarah has worked both across the NHS and private sector, and has a particular interest in working with children and families. Both of these appointments now complete the Executive Team and I look forward to leading this team on our WWL journey to Outstanding.

WWL marked the 80th D-Day Anniversary in June with the official opening of our Veteran Garden at the Royal Albert Edward Infirmary (RAEI). The garden, which took WWL staff and volunteers a year to create, has been designed to become an area where Veteran patients and their loved ones can enjoy some time out of the clinical environment, and become a place for peace and reflection. The garden was officially opened by the Mayor of Wigan Borough, Councillor Deborah Parkinson, with attendance from Veterans and members of the Armed Forces community who gathered alongside our staff. On this same day, I was proud to re-sign the Armed Forces Covenant at the special occasion, caring for our Veterans and Armed Forces community is of the upmost importance to me and our colleagues, on both a personal and professional level. It was an honoured to sign the covenant for another three years, making clear that the Trust pledges to support the community, who are known to have difficulties accessing healthcare, both due to the Armed Forces culture, and the physical and mental injuries sustained during service.

Operationally, we welcomed NHS England to Leigh Infirmary for our accreditation visit of our Leigh Surgical Hub. It is our aim for Leigh Infirmary to achieve Surgical Hub Accreditation from the Getting It Right First Time programme of which Wrightington Hospital achieved within the last 12 months. The outcome of the visit to Leigh Infirmary is expected during the Summer; I would like to thank NHS England for taking the time to visit us and to all the team who proudly showcased the excellent facilities we have at Leigh Infirmary.

In terms of elective recovery, our plan is coming together to make sure no patient waits more than 65 weeks for their planned surgery or procedure by the end of September. Gynaecology is our biggest challenge; we have a good plan coming together to make sure no one is waiting this length of time, and to keep waiting times down. Other specialities across the Trust also have plans in place to ensure no patient waits more than 65 weeks, and our end goal is to have no one waiting more than 52 weeks by the end of 2024. It’s vital that patients are seen and treated in a timely manner, and so it is great to see the hard work being done across the Trust to mitigate long waiting times.

Earlier in July, our Community Services Division supported the SEND (Special Educational Needs and Disabilities) Thematic Review, which included inspectors visiting the RAEI site for four days. The evidence they collated during the visit will be compiled into a national report, expected to be published in the autumn. The review focused on what the locality is delivering to support children and young people with SEND to prepare for adulthood across five broad key areas; employment, independence, inclusion, health and strategic planning. The initial feedback has highlighted excellent examples of our nursing and therapy teams working to provide person-centred care in partnership with other organisations across the system, including Continuing Health Care, Primary Care, Parent Carer Forum and Education. The commitment and passion across services who support children

and young people has been phenomenal, and our teams have gone above and beyond to support the research. The division is planning recognition for all staff involved within our staff engagement sessions.

In July, we also welcomed Regional Chief Nurse for the North West, Jackie Hanson. Jackie's visit included a welcome from our Chief Nursing Officer, Kevin, and his team, a series of presentations from our Emergency Department, and a look at the 90 Day Anti-Racism Challenge. Jackie was also given a tour of the site at RAEI, before awarding our Assistant Director of Safeguarding, Carlene Baines, a National Safeguarding Star Award. This is an incredibly prestigious award which the National Safeguarding Team across England present, following a nomination submitted by the Trust for all the work that Carlene has done to safeguard our patients and population across the system.

More colleagues from across the Trust have been recognised for national awards over the coming months. In September, the 2024 Health Service Journal Patient Safety Congress Awards ceremony is taking place, with both our Sepsis Team and Virtual Ward Team shortlisted. The Sepsis Team have been recognised for the Deteriorating Patients and Rapid Response Initiative of the Year, while the Virtual Wards Team have been shortlisted in the Virtual or Remote Care Initiative of the Year category. WWL Midwife Emily Childs is also nominated for the Gill Adgie Members Champion Award at the Royal College of Midwives Awards, taking place in October. I wish all colleagues who have been shortlisted the best of luck in your awards and we are very proud of you.

We also celebrated our Junior Doctors and Trainers with our Celebrating Excellence in Medical Education Awards in July, showcasing those who provide excellent care, leadership and education across the Trust. The eleven categories included the Andrew Foster Quality Improvement Award, named after our late former Chief Executive and Chairman, presented by myself and Andrew's wife Sara, and the Chairman of Wigan Warriors Rugby League, Professor Chris Brookes, was our guest speaker of honour. Congratulations to all colleagues who were both nominated and award winners on the day, for your outstanding commitment and dedication to serving others.

Agenda item: 19.1

Committee report

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

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

ALERT

- The Specialist Services deep dive highlighted:
  - A risk in relation to intermittant failure of theatres on the Wrightington site due to the quality of the estate. This has led to patient cancellations and compromises the elective recovery programme. Mitigating actions were outlined however the risk score remains at 15.
  - Challenges in the delivery of the Best Practice Tariff for patients admitted with a hip fracture in terms of ensuring patients are cared for on the right ward and timely access to theatre. A meeting has been scheduled to progress actions around this issue.
- As anticipated, the Lost to Follow Up Working Group continues to identify issues as they systematically review information at a speciality level. Progress is being made to address concerns as they arise, the Committee has scheduled regular updates to track progress.
- Feedback from the Deteriorating Patient Group highlighted some improvement in compliance with recording early warning scores however it was noted that audits of the escalation protocol are required to identify whether appropriate actions are being taken. Regular updates from this group are scheduled.
- The maternity reports highlighted ongoing issues with the Euroking system. This is a national problem and WWL have implemented local solutions to maintain patient safety; however these remain time consuming and rely on the use of paper based systems. Timescales for resolution were outlined.

ASSURE

- The Specialist Services deep dive highlighted:
  - Good progress in implementing the patient safety incident response framework demonstrating thorough investigation of incidents and a robust approach to shared learning.
  - 100% complaints responded to within agreed timescale.
  - Improvement programmes in relation to patient access, theatre utilisation, length of stay reduction and use of digital technology to improve patient experience .

- A comprehensive review of 3 never events relating to misplaced nasogastric tubes over the past 5 years was received. This included robust actions that have been implemented in relation to reporting of x-rays and additional training to minimise the risk of any further incidents.
- An analysis of all never events reported over the last 3 years (9 in total) was received that did not indicate highlight any common themes and provided assurance on actions taken to address issues identified.
- The sepsis report demonstrated steady improvement in the Advacing Quality measures.
- The maternity biannual staffing report provided assurance that women are receiving one to one care whilst in labour and with a small number of exceptions we are achieving supernumery status of shift co-ordinators. The report highlighted low vacancy rates and good progress in recruitment and retention of midwives.
- Reports from maternity and neonatal services outlined:
  - Expected progress in the implementation of action plans following the CQC inspection in 2023 and the LMNS Assurance visit in March 2024.
  - Sustained improvement in measures aligned to the GM dashboard.
- A biannual update was received on the overview and scrutiny of quality impact assessments that provided assurance on the processes in place. Discussion around this item confirmed that Equality Impact Assessments are part of this process.
- Reports from the Patient Safety Group highlighted:
  - 92% compliance with NICE guidelines.
  - The establishment of an Escalation Assurance Group which has full oversight of the full capacity protocol and will review any patient safety issues in relation to pressures across the Trust. This will ensure that the committee maintains a focus and oversight on quality of care and experience in pressurised services as outlined in a recent letter to all Trusts from NHSE.

ADVISE

- The AAA report from the Patient Experience Group provided an overview of the ongoing work to ensure that patients with neurodiversity are appropriately supported. Further work is required to ensure compliance with NHSE statutory reasonable adjustments.
- The Trust is progressing with the implementation of Martha's Rule and the Medical Director recently arranged for Martha's mother to speak to staff in relation to the importance of this piece of work.
- The work programme for the Deteriorating Patient Group has been reviewed and now includes oversight of the implementation of Martha's Rule.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the board assurance framework were reviewed; reduction of the risk relating to achieving CO2 (sepsis) was considered however it was agreed to wait until data for Q1 has been shared.
- The Specialist Services Divisional risks were presented as part of their deep dive. Mitigating actions were highlighted for those scoring 15 or above.

Agenda item: 19.2

Committee report

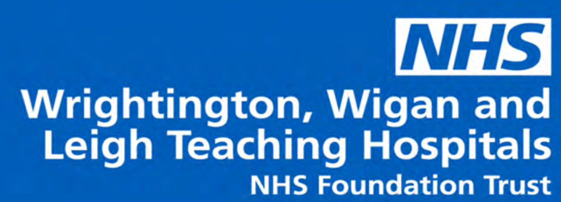
Report from:	Finance and Performance Committee
Date of meeting:	30 July 2024
Chair:	Julie Gill

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

ALERT
▪ The potential risk to the CIP (cost improvement programme) position was noted, with slippage on delivery of £0.7m and reliance on non-recurrent rather than recurrent delivery. This impacts on WWL's ability to deliver a financially sustainable plan. However, the mitigation outlined, including the commitment to the work under contract with Newton Europe, was noted. ▪ The specialist services division's activity plan is not currently being delivered with regular check-ins being scheduled through executive led meetings. ▪ Changes in WWL's approach to workforce planning which will need to focus on alternative workforce and leadership models, will support its transformation plans moving forwards. ▪ On consideration of risks to delivery of corporate objective 11 (the financial plan and value for money services) the committee agreed that any changes to associated BAF risk profiles would be recommended for consideration by the board, given that they would have a such far reaching effect. None were recommended at this stage in light of the mitigations outlined - the committee will consider this further at its next meeting. ▪ The cash position was noted and approval granted to make an application to NHSE for cash should this be required in quarter four. The committee emphasised the need for WWL to remove itself from a position where these applications continue to be required, with several being seen this year thus far.
ASSURE
▪ Community divisional performance was noted to be on track both internally and on a system basis. ▪ The committee received benefits realisation report following approvals for nursing and additional workforce support within the emergency department, it was noted that the cases had delivered as had been projected. ▪ The committee noted that there has been a reduction in spend on escalated areas but that positively, in tandem, there has been an improvement in several quality metrics. ▪ A cross divisional CIP group has been established to allow for wider discussions and support for initiatives which have the ability to effect positive change across all divisions.
ADVISE

▪ The committee received the deep dive report from the medical division and were content with the measures set out to mitigate overspend and performance issues. ▪ Agreements to take forward the Wigan System Urgent and Emergency Care business case, including the signing of a memorandum of understanding between the three local partners who have approved it was noted, with the agreements set to be signed in August 2024. As noted, the committee elected not to recommend a change to any associated BAF risk profile at this stage whilst progress with this programme is monitored through the initial stages. ▪ The current position at Bedford Care home was discussed and the committee were pleased to hear that WWL have offered support for the team there to undertake its ASPIRE ward accreditation scheme training. ▪ Several discussions were had around pieces of work which WWL is undertaking to reduce health inequalities, particularly in terms of waiting times.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ As outlined above.

Agenda item [19.3]



Committee report

Report from:	Audit Committee
Date of meeting:	26 June 2024
Chair:	Ian Haythornthwaite

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

ALERT
▪ No alerts were raised.
ASSURE
▪ The committee took assurance from the reports provided
ADVISE
▪ The committee approved: - The annual accounts, for submission to NHSE and to be laid before parliament - The annual report, which would be submitted to NHSE - The management representation letter, to be signed by the Chief Executive ▪ The committee received the external auditors' ISA260 and annual report.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ No risks were raised.

Agenda Item: 19.4

Committee report

Report from:	People Committee
Date of meeting:	11 June 2024
Chair:	Lynne Lobley

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

ALERT

- The committee noted through the community division's deep dive report that they have an aging workforce. This was specifically noted so that they are able to consider mitigations to this in more detail moving forward. An increased pressure on the division's workload was noted, which was impacting negatively on turnover and sickness absence, being a result of longer life expectancy and an associated need for support.

ASSURE

- The committee reviewed the processes for dealing with concerns arising from the Modern Slavery and Human Trafficking Statement and took assurance from the systems in place.
- The Divisional Director of Operations for Community Services led on the divisional deep dive which gave assurance around the strength of leadership within the division, in particular in relation to divisional strategies and initiatives which have been put in place to deal with the particularly unique demographic of staff working there.
- The revised appraisal strategy is now finalised, noting adaptations made for 2024/25 following lessons learnt from the previous year
- The committee reviewed WWL's response to NHSE's letter around improving the working lives of doctors in training and were pleased to see what resulting actions have been taken forwards.
- WWL has positive scores in respect of the 'we are safe and healthy' People Promise element of the National Staff Survey. WWL's score was the highest in GM and 13th Nationally.
- The committee noted a positive message from the staff story around the assistance received by a staff member who required reasonable adjustments and support for a long term health condition, which triangulated well with several pieces of work which the board has been briefed on recently.
- Nursing, midwifery and Allied Health Professional revalidation has been successfully completed for 2023/24.
- The committee noted a strong focus on equality, diversity and inclusion (ED&I) throughout many of the papers which had been provided.
- The ED&I Strategy Group is now fully operational with appropriate governance in place.
- The revised version of the people dashboard was noted to bring additional assurance.

ADVISE
▪ The first iteration of the draft People and Culture Strategy was well received. ▪ There has been a reduction in WWL's target for turnover, which was previously 10%, down to 8.5%, due to WWL consistently achieving the original target. ▪ The national review of core skills framework, reporting groups' minutes, fair experience for all; Freedom to Speak Up Guardian (FTSU); and audit and risk reports were noted. ▪ The learning needs analysis and talent management programmes have been updated and key changes reported upon to the committee. ▪ WWL has gained support from Manchester Business School to develop its talent management tool and this is due to be released in quarter two of 2024/25. ▪ The new terms of reference for 2024/25 were agreed.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ The committee noted a reduction in the BAF level risk from a score of 10 to 8 in respect of workforce sustainability.

Agenda item: [20]

Title of report:	Maternity and Dashboard Report
Presented to:	Trust Board
On:	07/08/24
Item purpose:	Information
Presented by:	Chief Nurse
Prepared by:	Digital Midwife for Divisional Director of Maternity & Child Health
Contact details:	gemma.weinberg@wwl.nhs.uk cathy.stanford@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

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

Our Values

Recommendation(s)

The board are asked to note the June 2024 dashboard and overview of indicators as outlined below.

Maternity and Neonatal Dashboard June 2024

Introduction

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

It should be noted that the method of reporting has been changed in this dashboard. Some metrics are shown as rate per 1000 and others as a percentage. This is to align the metrics with the way the GM figures are reported. The report will highlight how many each figure relates to where required.

June 2024 Exception Report - Maternity
Summary

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

- There was one midwifery red flag reported. It should be noted here that the method of collecting red flag reports has changed. We are now pulling these figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. The shift coordinator was able to remain supernumerary in June. There is a separate red flag report which investigates the red flags in more detail.
- 1:1 care is at 99.44% in June.
- There were 2 Maternity complaints received in June, and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

Steis reportable Incidents

There was one Steis incidents reported in June. This incident was in May but reported in June. The incident was a never event where a swab was left in situ at delivery.

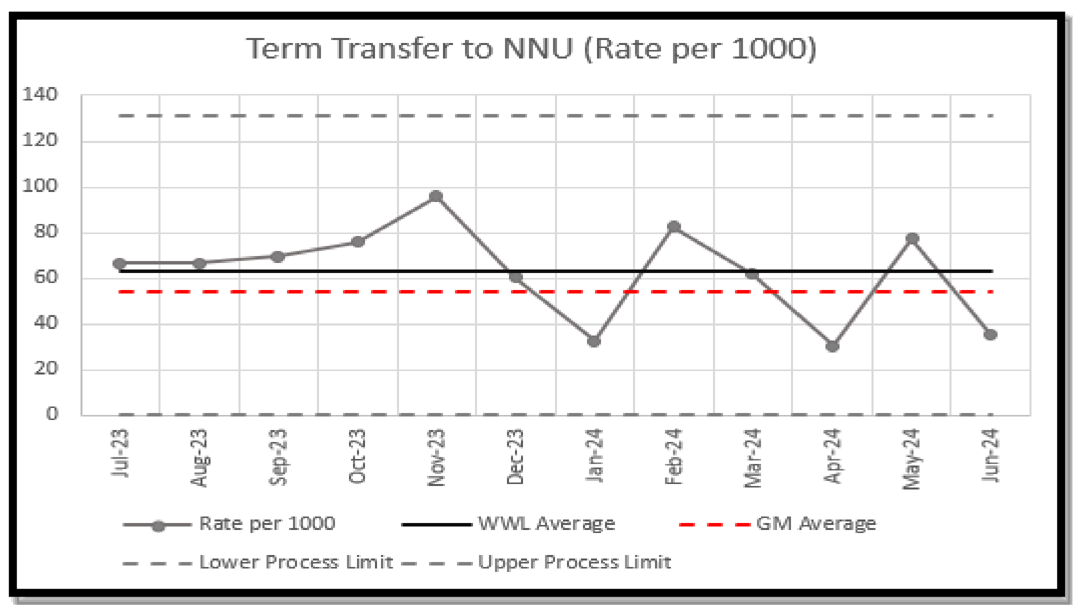
Green

Women booked by 12+6 weeks (%) This saw a drop into amber levels in January but the months following have seen hr metric return to normal levels and have remained green for 5 months.

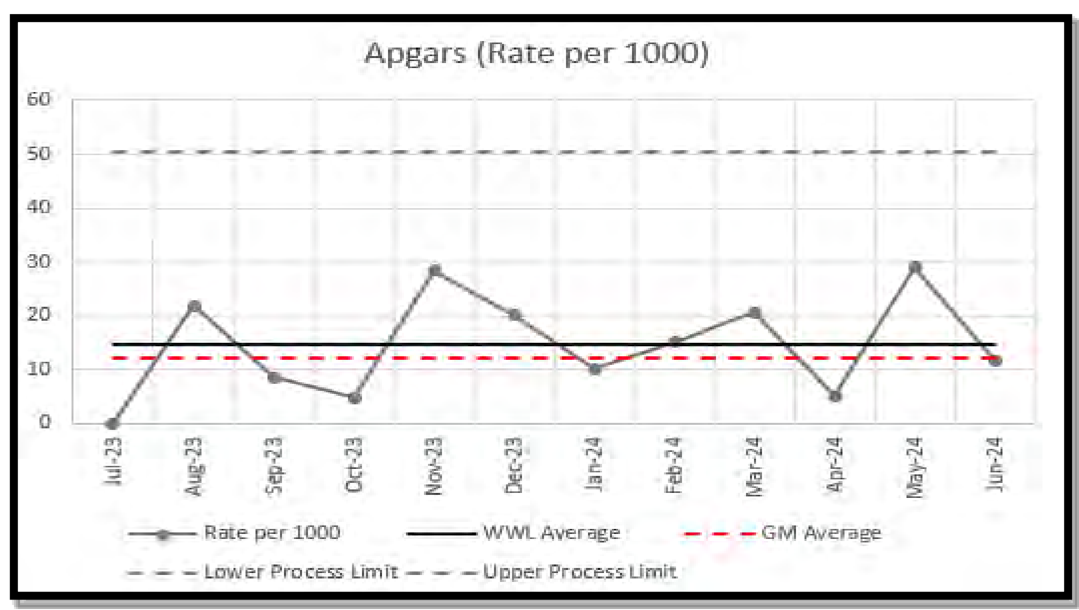
Skin to skin contact (%) This metric saw a small dip in April, but it returns to normal levels in May and June. Work continues to improve this metric.

Supernumerary Shift coordinator (%) – There were no shifts in June where the shift coordinator was unable to remain supernumerary.

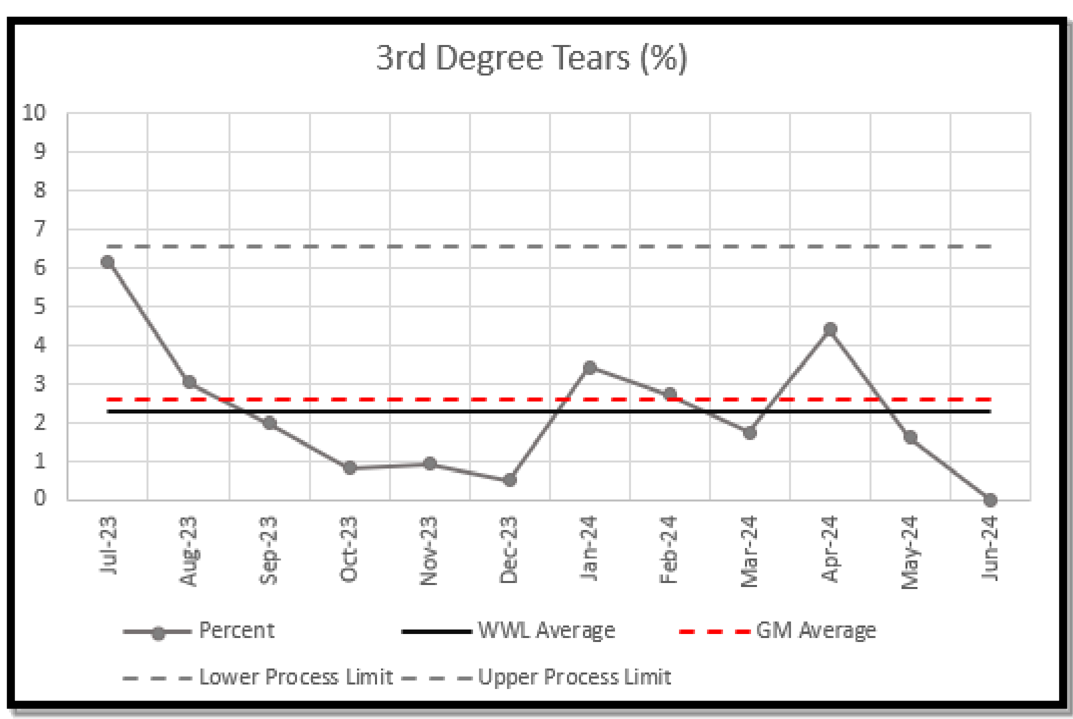
Term admissions to NNU (rate per 1000). This metric saw a rise in May but sees a significant decrease in June. This figure is recorded as rate per 1000 and equates to 6 babies in June. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate and to try to improve the figures in this metric. The below is an SPC chart showing our rates in comparison to the GM average (red line).



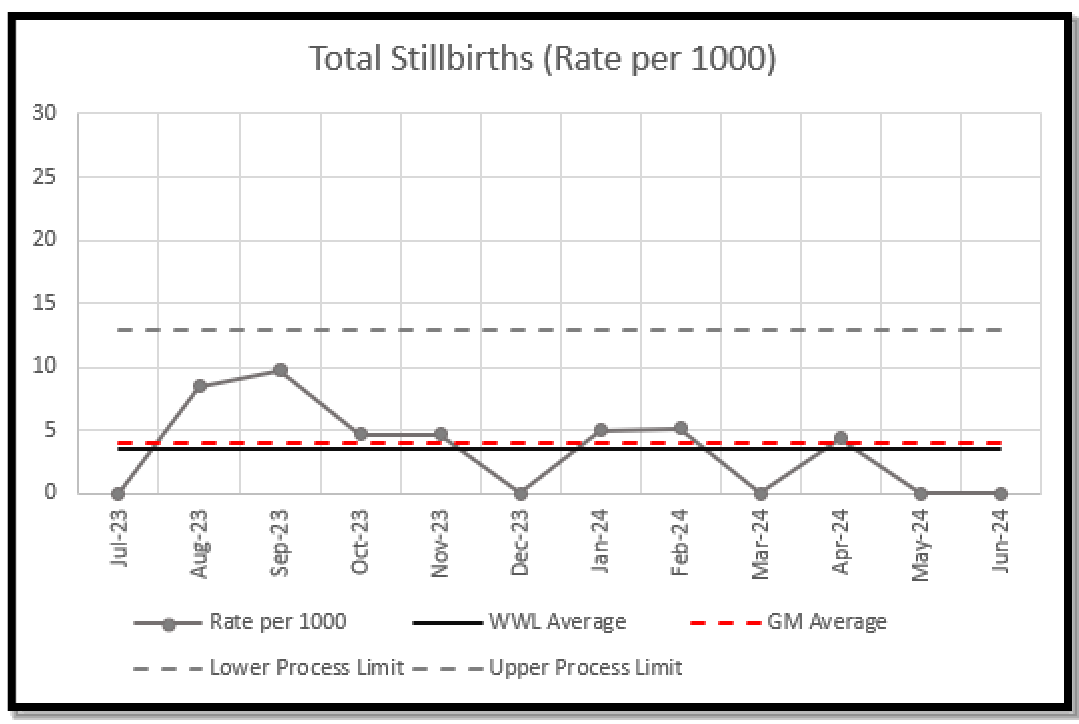
All infants with Apgar's less than 7 (rate per 1000). This metric saw a rise into red levels in May, but June sees it return to normal levels. The rate per 1000 in June equates to 2 babies. All cases are fully investigated. The below SPC chart shows how our figures compare to the GM average (red line).



3rd / 4th degree tear (%). The figure is recorded as a rate per 1000. There were no women who had a 3rd degree tear in June. The below SPC chart shows how we compare to the rest of GM for this metric.

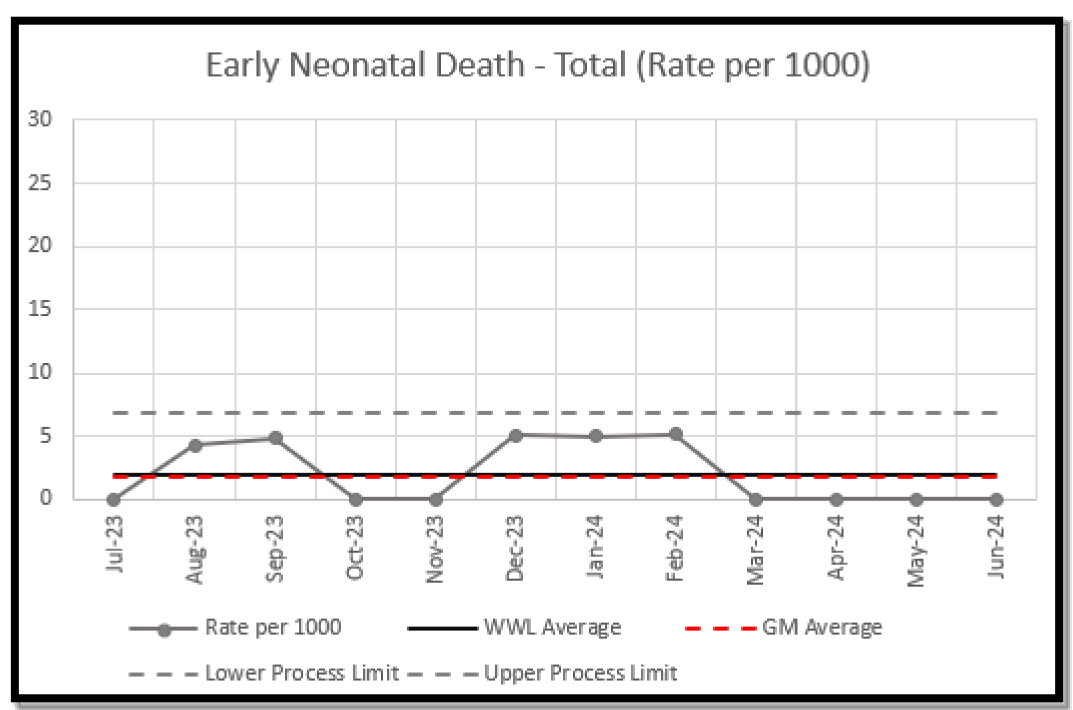


Number of stillbirths (rate per 1000). This figure is recorded as a rate per 1000. There were no stillbirths in June. The below SPC chart shows how WWL compare with GM (red line).



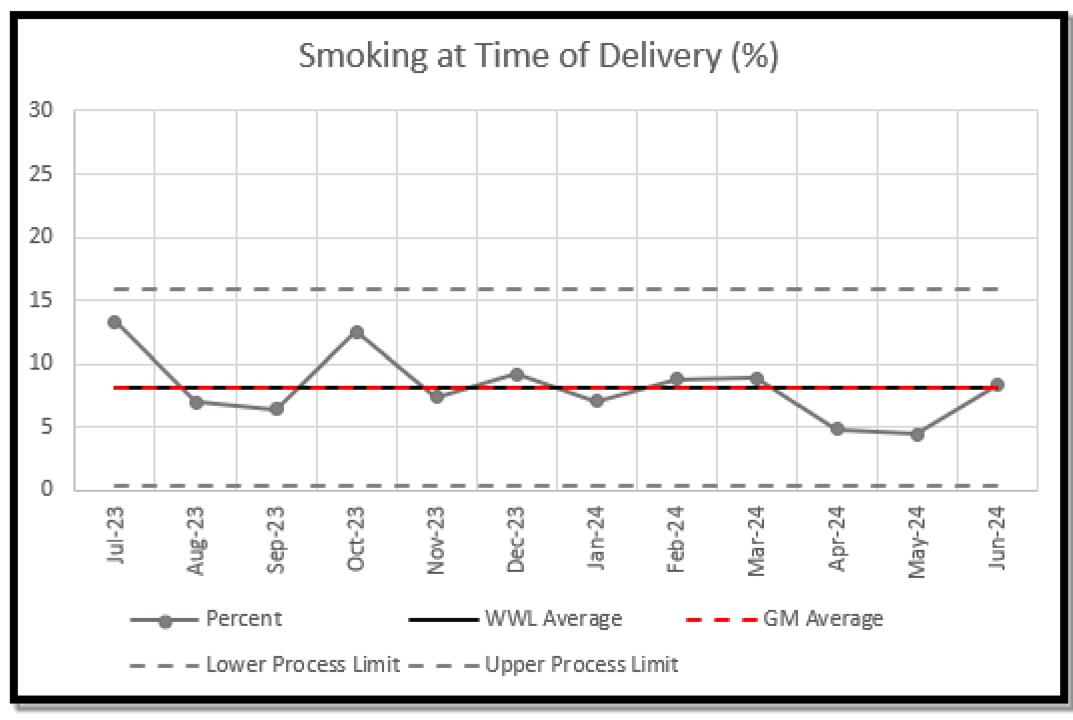
Women readmitted within 28 days of Delivery (rate per 1000). There were 4 maternal readmissions to the obstetric unit in June. Two were for possible DVT, One for possible sepsis and one for a blood patch. There were 2 non obstetric readmission which are not included in this figure. No omissions in care were noted.

Number of Neonatal Deaths (rate per 1000). The figure is recorded as a rate per 1000. There were no ENND in June. The below SPC chart shows how WWL compare with GM (red line).



Category 1 Caesarean Sections with no Delay in Knife to Skin (%). This had seen a drop into amber levels in May but returns to green level in June. Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and knife to skin. The June figure equates to 1 out of 12 women having a delay of more than 30 mins. There is an audit underway looking at the March and May figures for CS delay.

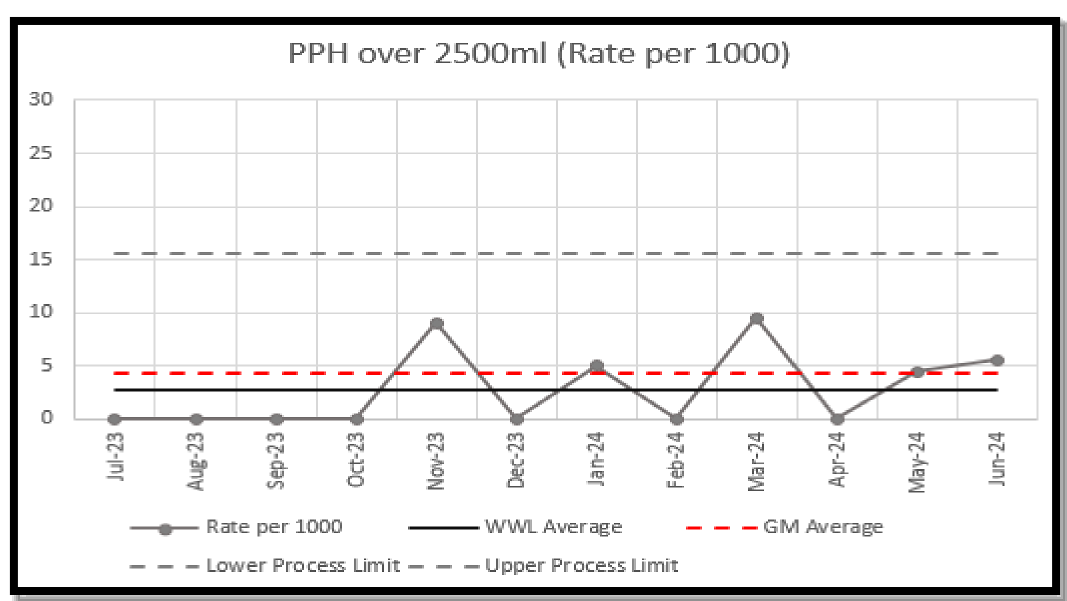
Smoking at the time of Delivery (SATOD) (%). This metric has seen a significant improvement in April and May. The figures were at the lowest recorded on these dashboards. June sees an uptick in this metric. Work continues to promote and encourage smoking cessation throughout pregnancy. The below SPC chart shows our % SATOD rates in comparison to GM (red line).



Amber

The number of mothers who have opted to breastfeed (%) –May saw the highest figure since it started being recorded on the dashboard. June sees a slight dip in this metric. Work continues to improve this metric.

PPH over 2500mls (rate per 1000). There was 1 woman who had a PPH of over 2500mls in June. The below SPC chart shows how WWL compare with GM (red line). The figures for this metric are recorded as rate per 1000.



Red

1:1 care in labour (%). This figure has dropped below 100% as one woman had a BBA so did not receive 1:1 care in labour.

Induction of Labour (IOL) – (%) These levels have been very up and down over the past few months. June sees a rise into red levels. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes. There is an imminent audit as to whether the new NICE guidelines to offer IOL at T+7 are having any effect on these metrics.

Category 2 Caesarean Sections with no Delay in Knife to Skin (%). This sees a rise into red levels for May and June. Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and knife to skin. This equates to 5 out of 21 women having a delay of more than 75 mins. There is an audit underway looking at the March and May figures for CS delay.

Conclusion

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

Safety Dashboard 2024

Maternity

		Goal	Red Flag	Measure	Jan 2024	Feb	Mar	Apr	May	Jun	Jul	Aug	Q1 2024	Q2	Q3	Trend
Activity	Bookings (Total bookings)				254	231	217	242	232	236			702			
	Booked by 10 weeks (as % of total bookings – Exclude transfer to area)				51.18%	58.44%	64.02%	54.04%	56.77%	59.66%			57.88%			
	Booked by 12+6 weeks (as % of total bookings – Exclude transfer to area)	Above 90%	Below 80.9%		88.58%	90.04%	92.52%	93.61%	91.27%	93.56%			90.38%			
	Registerable births				199	194	213	207	222	180			606			
	Planned home births (as % of all births)				0.00%	0.51%	0.46%	1.93%	1.80%	1.11%			0.32%			
	Unplanned home births (as % all births) – BBA				3.01%	0.00%	0.00%	0.00%	0.00%	0.56%			1.00%			
	NVD (as % of total births)				51.20%	47.93%	43.19%	42.03%	49.10%	48.33%			47.44%			
	Instrumental deliveries (as % of total births)				7.53%	8.76%	10.33%	12.56%	6.31%	5.00%			8.87%			
	Total number of Caesarean Sections (all categories – as % of total births)				41.70%	43.29%	46.01%	44.93%	44.59%	46.67%			43.67%			
	Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour				2	4	10	4	6	4			16			
	Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour				22	16	23	24	25	19			61			
	Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS				8	8	10	12	11	12			26			
	Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour				0	0	0	0	1	5			0			
	Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour				4	7	10	2	7	3			21			
	Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS				4	9	6	8	7	8			19			
	Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy				25	24	19	25	24	22			68			
	Robson Group 6: Nulliparas; single breech pregnancy				5	9	7	4	5	2			21			
	Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus)				4	3	2	6	1	3			9			
	Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus)				2	0	5	3	4	0			7			
	Robson Group 9: All women with a single oblique or transverse pregnancy (including women with a scarred uterus)				0	1	0	0	2	2			1			
	Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus)				7	3	6	5	6	4			16			

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	2024 Q1	Q2	Q3	Trend
Activity	Number successful VBAC				3	3	2	3	3	0			8			
	% of Category 1 Caesarean Sections with no Delay in Knife to Skin (over 30 minutes) – as % total cat 1 CS	Above 90%	Below 80.9%		90.90%	100.00%	61.11%	90%	81.81%	91.66%			84.00%			
	% of Category 2 Caesarean Sections with no Delay in Knife to Skin (over 75 minutes) – as % total cat 2 CS	Above 90%	Below 80.9%		86.20%	86.20%	64.10%	87.09%	75%	76.19%			78.83%			
	Number of Caesarean Section at Full Dilatation				3	3	8	5	2	6			14			
	IOL (as % of all women delivered – excluding pre labour SROM)	Under 35.9%	Above 40%		39.20%	39.18%	42.72%	34.78%	39.64%	42.78%			40.36%			
	Number of women induced when RFM is the only indication <39 weeks				1	2	0	2	1	2			3			
	Number of women induced for Suspected SGA				14	14	16	6	13	14			44			
	Number of In-utero transfers in from other units				4	4	4	5	4	4			12			
	Number of In-utero transfers out to other units				0	2	0	1	2	0			2			
	Average Postnatal Length of Stay				1.7	1.7	1.8	1.7	1.8	1.5			1.73			
Maternal Morbidity	3rd and 4th degree tears (as % vaginal births)	Under 2.5%	Above 3.5%		3.45%	2.73%	1.75%	4.42%	1.63%	0.00%			2.64%			
	Of which 4th degree tears (number)				0	0	0	0	0	0			0			
	PPH 1500 – 2500 mls (Rate per 1000)				25.12	56.99	43.06	34.13	22.83	33.33			41.72			
	PPH > 2500mls (Rate per 1000)	Under 4	Above 6		5	0	9.56	0	4.5	5.55			4.85			
	Number of Women Requiring Level 2 Critical Care				1			1	1							
	Number of Women Requiring Level 3 Critical Care				0			0	0							
	Number of Blood Transfusions > 4 Units					0	0	0					0			
	Number of Maternal deaths				0	0	0	0	0	0			0			
	Number of women re-admitted within 28 days of delivery (Rate per 1000)	Under 25	Above 35		15.22	15.46	4.78	19.6	18.26	22.22			11.82			
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis (Number)				0	0	1	2	1	1			1			
Neonatal Morbidity & Mortality	Total stillbirths (as rate per 1000)	Under 3.5	Above 4		5.02	5.15	0	4.83	0	0			3.39			
	Stillbirths (excluding MTOP as rate per 1000)				5.02	5.15	0	4.83	0	0			3.39			
	Number of stillbirths (excluding MTOP)				1	1	0	1	0	0			2			
	Early neonatal deaths (as rate per 1000)	Under 1	Above 1.77		5.02	5.15	0	0	0	0			3.39			

Section	Indicator	Goal	Red Flag	Measure	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Q1 2024	Q2 2024	Q3 2024	Trend
Neonatal Morbidity & Mortality	Early neonatal deaths (excluding MTOP as rate per 1000)				0.00	5.15	0	0	0	0			1.72			
	Number of Early Neonatal Deaths (excluding MTOP)				0	1	0	0	0	0			1			
	Number of babies born below 37 weeks				14	12	19	9	14	9			45			
	Shoulder Dystocia (as % of total births)				1.51%	1.0%	0.93%	1%	0.45%	2%			1.16%			
	Number of singleton babies born under 27 weeks				0	0	0	0	0	0			0%			
	Number of multiple babies born under 28 weeks gestation				0	0	0	0	0	0			0			
	Number of above babies where transfers out not facilitated				0	0	N/A	N/A	0	N/A			0			
	Number of women delivered under 34 weeks (livebirth)				2	4	4	1	3	0			10			
	% of Mothers who delivered under 34 weeks who received a complete course of AN steroids				50%	50.00%	50%	100%	33%	N/A			50.00%			
	% of Mothers who delivered under 34 weeks who received AN Magnesium Sulphate				100%	75%	75%	100%	100%	N/A			83.00%			
	Number of women delivered under 30 weeks (livebirth)				1	1	1	1	0	0			3			
	% of Mothers who delivered under 30 weeks who received AN Magnesium Sulphate				100%	0.00%	100.00%	100.00%	N/A	N/A			67.00%			
	% of Mothers who delivered under 30 weeks who received a complete course of AN steroids				0%	0.00%	100.00%	100.00%	N/A	N/A			33.00%			
	Number of mothers who delivered under 34 weeks who received a partial dose of steroids				1	1	2	N/A	1	N/A			4			
	Number of mothers delivered under 34 weeks who did not receive any course of steroids and omissions in care noted				0	0	0	N/A	0	N/A			0			
	% of babies who had delayed cord clamping (% of total births)				84.85%	89.7%	88.73%	89%	91.44%	93.89%			87.76%			
	% of babies born <37 weeks whose mother received intrapartum IV Antibiotics (% of births under 37 weeks)				7.14%	16.7%	3.09%	2%	43.75%	2.92%			8.96%			
	Neonates with Apgars <7 at 5 minutes (>_37 weeks gestation) - Rate per 1000	Under 15	Above 21		15.07	16.48	20.62	5.08	28.99	11.70			17.38			
	Term Admissions to NNU (births >_ 37 weeks gestation) - Rate per 1000	Under 54	Above 65		32.79	82.4	61.86	30.46	77.29	35.09			59.01			
	Number of babies re-admitted with 28 days of birth				13	16	14	13	18	13			43			
	Number of babies born < 3rd centile				14	15	12	9	9	14			41			
	Number of babies born < 3rd centile >_ 38 weeks				7	6	7	6	4	8			20			
Public Health	% women smoking at time of booking (as % of total bookings)				5.12%	11.7%	8.41%	7.23%	7.42%	9.44%			8.41%			
	% women smoking at time of delivery (as % of total births)	Under 8.5%	Above 10%		7.04%	8.8%	8.92%	4.41%	4.50%	8.33%			8.24%			
	Babies in Skin-to-Skin within 1 hour of birth	Above 75%	Under 65%		82.91%	75.26%	78.4%	74%	82.43%	81.11%			78.86%			

		Goal	Red Flag	Measure	2024								2024			
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Q1	Q2	Q3	Trend
Public Health	Percentage of Women Initiating Breastfeeding	Above 58%	Under 50%		60.80%	54.12%	57.28%	60%	66.67%	57.22%			57.40%			
	Number of women who report that they are drinking alcohol at booking				0	1	0	0	1	0						
Workforce	1:1 Care in Labour (as % all births - excluding El CS and BBA)		Under 100%		100%	100%	100%	99.5%	100%	99.44%			100.00%			
	Percentage of shifts where shift Co-ordinator able to remain supernumerary		Under 100%		100%	100%	100%	98.33%	100%	100%			100.00%			
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	1	1	0			0			
	Sickness (as % of overall staffing) – report quarterly															
	Number of vacancies				7.63	6.17	6.31	8.13	8.91	7.07			6.7			
	Midwife : Birth Ratio				1.28	1.28	1.28	1.28	1.28	1.28						
	Prospective Consultant hours on Delivery Suite				60	60	60	60	60	60			180			
	Number of Midwifery Red Flags Reported				0	3	5	5	8	1			10			
Incidents	Number of incidents reported				78	75	55	70	86	64			208			
	Number of MNSI Investigations				0	0	0	0	0	0			0			
	Number of StEIS Reported Incidents				1	0	0	1	0	1			1			
	Number of Complaints received in the month				1	0	4	3	0	2			5			
	Number of Letters of Claim Received in the month				0	0	0	0	0	0			0			
	HIE 2 &3 > 37 weeks (rate per 1000)			GM average 2023 0.555/1000	0	0	0	0	0	0			0			

					2024								2024			
		Goal	Red Flag	Measure	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Q1	Q2	YTD	Trend
Safety	% of Shifts Staffed to BAPM	100.00%	< 90%	Badger	98.39	84.21	48.39	58.33	71.19	94.74	.	.				
Safety	% of Shifts with Supernumeary Shift Leader	100.00%	< 50%	Badger	91.94	77.19	48.39	46.67	59.32	96.49	.	.				
Safety	Unit Closed Due to Capacity	0	≥ 1	Datix	0	1	1	0	3	0						
Safety	Unit Closed Due to BAPM/Staffing	0	≥ 1	Datix	0	0	0	1	0	0						
Admissions	Number of Births from Maternity			Maternity Data	199	194	213	207	222	180						
Admissions	Admissions Under 27 Weeks to NNU	< 1	≥ 1	Badger	0	0	0	0	0	0						
Admissions	Admissions 27+1 – 34 Weeks to NNU			Badger	2	7	7	1	2	0						
Admissions	Total Admissions to Neonatal Unit			Badger	23	25	32	20	31	12						
Admissions	Transitional Care Admissions: 34 – 36+6			Badger	2	4	0	2	1	2						
Admissions	Transitional Care Admissions: 37+			Badger	4	8	6	8	7	5						
Admissions	Total TC Admissions			Badger	6	12	6	10	8	7						
Admissions	Number of unexpected Term Admissions to NNU				6	15	12	6	16	6						
Admissions	Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)	5.40%	6.50%	Maternity/Badger	3.27%	8.24%	6.18%	3.46%	7.29%	3.50%	.	.				
Admissions	Unexpected Term Admissions to NNU (*as % of Total Admissions*)			Badger/ NWNODN	26.08%	60%	37.50%	30%	50%	50%						
NNAP	Mothers Eligible for AN Steroids (< *34 Weeks*)			NNAP/ NWNODN	2	4	4	1	3	0						
NNAP	% of Mothers Who Received Full Course of Antenatal Steroids	≥ 93%	< 89%	NNAP/ NWNODN	50%	25%	50%	100%	33.33%	N/A	.	.				
NNAP	Mothers Eligible for AN $MgSO_4$ (< *30 Weeks*)			NNAP/ NWNODN	1	1	1	1	0	0						

		Goal	Red Flag	Measure	2024								2024			
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Q1	Q2	YTD	Trend
NNAP	% of Mothers Receiving Antenatal $MgSO_4$	≥ 85%	< 73%	NNAP/ NWNODN	100%	0.00%	100%	100%	N/A	N/A						
NNAP	Babies Eligible for Delayed Cord Clamping			NNAP/ NWNODN	2	5	7	1	3	0						
NNAP	% of Babies Receiving Delayed Cord Clamping	≥ 85%	< 73%	NNAP/ NWNODN	50.00%	80.00%	71.42%	100%	100%	N/A						
NNAP	Babies Eligible for Temperature on Admission (< *32 Weeks*)			NNAP/ NWNODN	2	5	7	1	3	0						
NNAP	% of Babies With Temperature Within First Hour of Admission (< *32 Weeks*)			NNAP/ NWNODN	100%	80%	71.40%	100%	100%	N/A						
NNAP	% of Babies With Temperature on Admission of 36.5°C – 37.5°C (< *32 Weeks*)			NNAP/ NWNODN	100%	80%	71.40%	100%	100%	N/A						
NNAP	Babies Eligible for Senior Review			NNAP/ NWNODN	18	17	28	15	27	10						
NNAP	Number of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	18	17	28	12	25	10						
NNAP	% of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	100%	100%	100%	80%	92.59%	100%						
NNAP	Total Ward Rounds Where Parents Present			NNAP/ NWNODN	17	20	31	15	25	258						
NNAP	% of Ward Rounds Where Parents Present			NNAP/ NWNODN	100.00%	100.00%	100.00%	100.00%	96.20%	75.70%						
NNAP	% of Eligible Babies Reciving Retinopathy Screening (*ROP*)			NNAP/ NWNODN	100.00%	100.00%	100.00%	0.00%	60.00%	100.00%						
NNAP	% of Babies With Central Line Blood Infections			NNAP/ NWNODN	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%						
NNAP	Babies Eligible for Follow-Up At 2 Years			NNAP/ NWNODN	1	2	0	0	2	0						
NNAP	% of Babies Receiving Follow-Up At 2 Years			NNAP/ NWNODN	0.00%	50.00%	N/A	N/A	50.00%	N/A						
Incidents	Number of Incidents Reported			Datix	5	28	27	39	32	9						
Incidents	Number of Network Exception Reports			NWNODN	1	1	1	0	0	1						
Incidents	Number of Concise Investigations	0	≥ 1	Datix	0	0	0	0	0	0						
Incidents	Number of StEIS Reported Incidents	0	≥ 1	Datix	0	1	0	0	0	0						
Incidents	Number of Complaints	< 2	≥ 2	Datix	0	1	0	0	0	0						
Incidents	Number of Letters of Claim Received	0	≥ 1	Datix	0	0	0	0	0	0						

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	2024 Q1	Q2	YTD	Trend
Breastfeeding	% of Mothers Expressing Breast Milk in First 24 Hours Following Baby's Admission to NNU			Unicef/ NWNODN	26.10%	20.00%	21.90%	5.00%	9.40%	25.00%						
Breastfeeding	% of Babies Receiving Human Milk in First 24 Hours Following Admission to Neonatal Unit			Unicef/ NWNODN	17.40%	16.00%	15.60%	10.00%	9.40%	25.00%						
Breastfeeding	% of Babies Receiving Human Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	7.70%	53.10%	33.30%	55.20%	65.40%						
Breastfeeding	% of Mothers Expressing Breast Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	7.70%	0.00%	0.00%	0.00%	53.80%						
Breastfeeding	% of Mothers Breastfeeding on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	3.80%	50.00%	26.70%	27.60%	38.50%						
Breastfeeding	Number of Babies Eligible to Receive Breast Milk in the First Two Days of Life (< *34 Weeks*)			NNAP/ NWNODN	2	5	7	1	3	0						
Breastfeeding	% of Babies < 34 Weeks Receiving Breast Milk in First Two Days of Life			NNAP/ NWNODN	100.00%	40.00%	71.40%	100.00%	100.00%	N/A						
Breastfeeding	Number of Babies < 34 Weeks Eligible for Breast Milk at Day 14			NNAP/ NWNODN	2	1	7	1	5	4						
Breastfeeding	% of Babies < 34 Weeks Receiving Breast Milk at Day 14			NNAP/ NWNODN	50.00%	100.00%	85.70%	100.00%	80.00%	100.00%						
Breastfeeding	Number of Babies < 34 Weeks Eligible for Breast Milk at Discharge			NNAP/ NWNODN	4	3	8	1	8	6						
Breastfeeding	% of Babies < 34 Weeks Receiving Breast Milk at Discharge			NNAP/ NWNODN	50.00%	66.70%	75.00%	100.00%	75.00%	100.00%						
Activity	Care Days ICU (*HRG1*)			Badger	4	4	20	7	5	1						
Activity	Care Days HDU (*HRG2*)			Badger	46	54	96	106	124	56						
Activity	Care Days SC (*HRG3, HRG4, HRG5, and code9*)			Badger	181	183	202	216	219	146						
Activity	Cot Capacity ICU %			Badger	12.90%	13.79%	64.50%	23.30%	16.10%	3.33%						
Activity	Cot Capacity HDU %			Badger	49.46%	62.06%	103.22%	117.77%	133.33%	62.22%						
Activity	Cot Capacity SC %			Badger	58.37%	63.10%	65.16%	72.00%	70.64%	48.66%						
Activity	Overall Cot Capacity %			Badger	53.22%	59.35%	73.27%	78.33%	80.18%	48.33%						
Activity	Care Days TC (*HRG3*)			Badger	0	0	0	0	0	0						
Activity	Care Days TC (*HRG4*)			Badger	27	42	31	57	46	34						

		Goal	Red Flag	Measure	2024								2024			
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Q1	Q2	YTD	Trend
Activity	Care Days TC (*HRG5*)			Badger	0	0	2	0	0	2						
	Care Days TC (*code 9*)			Badger	0	2	2	4	0	0						
	Total TC Care Days			Badger	27	44	35	31	46	36						
	Overall TC Cot Capacity %			Badger	21.77%	37.93%	26.12%	50.80%	37.09%	30.00%						
Training	NLS Accrediated	≥ 70%	< 70%	WWL	86.80%	86.10%	86.10%	86.10%	86.10%	94.87%						
	NLS In-House	≥ 90%	< 90%	WWL	97.60%	95.10%	95.10%	95.10%	95.10%	90.00%						
	Qualified In Speciality of Intensive Neonates	≥ 70%	< 70%	WWL	92.10%	94.90%	94.90%	94.90%	94.90%	88.88%						
	Foundation In Neonates	≥ 70%	< 70%	WWL	.	.	.	.	.	.	.	.				
	Family Intergrated Care	≥ 85%	< 85%	WWL	100.00%	100.00%	88.40%	88.40%	88.40%	88.40%						
	Unicef BFI	100%	< 80%	WWL	100.00%	97.80%	95.70%	95.70%	100.00%	100.00%						
	Perinatal Mental Health	≥ 80%	< 80%	HEE	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%						

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Neonatal staffing Review **July 2024**
Presented to:	Trust Board
On:	7 August 2024
Item purpose:	Information / approval
Presented by:	Kevin Parker-Evans Chief Nurse/ DIPC
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	T: 01942 773107 E: Cathy.stanford@wwl.nhs.uk

Executive summary

All trusts are required to undertake an annual Neonatal Unit staffing review against the Neonatal Nurses Association and British Association of Perinatal Medicine (BAPM) staffing recommendations. The findings of the review must be submitted to the Maternity Incentive Scheme, a key requirement of this submission is oversight by Trust Board.

This 2024 report details the nursing staffing tool methodology and subsequent gap analysis of the staffing within WWL Neonatal Unit, to provide assurance of safe staffing. The vision for neonatal services across England as outline in **The Neonatal Critical Care Review Service Specification (March 2024)** is for a seamless, responsive, and multidisciplinary service built around the needs of new-born babies and the involvement of families in their care. It has been identified Allied Health Professionals (AHP) inclusion not only benefits the neurodevelopment of the baby during critical periods of early life it also results in long term quality of life and family cohesion. Neonatal Critical Care is organised around Operational Delivery Networks (ODNs) in close alignment with maternity services (Local Maternity and Neonatal Systems (LMNS's).

WWL is commissioned to provide a Local Neonatal Unit (LNU), and this covers all the services provided by Special Care Units(SCU) , but in addition LNUs will provide:

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

• Neonatal services commensurate with national guidelines and professional standards where; singleton births are anticipated after 26+6 weeks gestational age (or after 27+6 weeks gestational age for multiple births) providing the anticipated birth weight is above 800g.
• High dependency care and special care for their local population.
• Care for local babies repatriated from neonatal units who require ongoing high dependency or special care.
• Ongoing care for local babies who have undergone specialist surgery following repatriation from a surgical NICU.
• Referrals from within network neonatal units who are unable to undertake high dependency care and special care, due to capacity reasons and/or network guidelines.

Current Nurse Vacancy Position (Staffing figures correct at 19.07.2024)

	Band 5/6	Band 7	Band 8a and above	Total
Clinical Vacancies	**1.27**	**0.94**	**0**	**2.21**
Upcoming vacancies in next 3 months	**0**	**0**	**0**	**0**
Additional Quality Roles (Not currently funded	**5.58wte**			

Quarter 1 2024 Turnover	From	To	WTE	Head Count
New Starters	01/04/2024	30/06/2024	1.92	2
Leavers	01/04/2024	30/06/2024	0	0
Net Gain / Loss	01/04/2024	30/06/2024	**1.92**	**2**
Turnover (%)	01/04/2024	30/06/2024	**0%**	**0%**
Current vacancies (WTE)	01/04/2024	30/06/2024	**2.21**	
Maternity Leave (WTE) in quarter	01/04/2024	30/06/2024	2.92	
			WTE	**Rate (%)**
Sickness days (WTE) in quarter	01/04/2024	30/06/2024	1.09216	**3.2%**
			WTE	**Hours used**
Bank Usage (WTE) in quarter	01/04/2024	30/06/2024	**3.7**	1709
Agency Usage (WTE) in quarter	01/04/2024	30/06/2024	**0.0**	0

Current Allied Health Professionals Vacancy Position (Staffing figures correct at 09.07.2024)

**Awaiting agreement with Community Services*

ALLIED HEALTH PROFESSIONALS & PSYCHOLOGISTS					
	Band	**Required**	**WTE Budget**	**WTE in post**	**Head Count in post**
Dietitian	7	0.22	0.00	0.00	0
Pharmacist	8	0.25	0.13	0.13	1
Physiotherapist	7	0.70	0.20	0.20	0*
Occupational Therapist	7	0.50	0.20	0.20	0*
Speech & Language Therapist	7	0.50	0.20	0.20	0*
Psychologist	8	0.60	0.20	0.20	1

Link to strategy and corporate objective
Delivering safe, personalised, and compassionate care, leading to excellent outcomes and patient experience.

Risks associated with this report and proposed mitigations
Achieving National recommendations

Financial implications
There is a cost implication associated with increased staffing requirements if all recommendations implemented

Legal implications
There are no direct legal implications with this report

People implications
None

Equality, diversity, and inclusion implications
None

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

Recommendation(s)

The Board are requested to review the findings of the report, outlining the current establishment and existing vacancies in line with The Maternity (and Perinatal) Incentive Scheme Safety Action 4 and receive an annual staffing report for Neonatal Services.

Report

Background

One in thirteen babies are born prematurely and require care within a neonatal unit, this equates to approximately 60,000 babies born before 37 weeks gestation each year. Babies that are born 28-32 weeks are classified as extremely premature.
Neonatal services are inextricably interdependent with maternity services and are a key part of the Maternity Transformation Programme, established to implement Better Births. Together, they form a programme to improve outcomes for women and babies using maternity and neonatal services, ensuring that implementation of both neonatal and maternity transformation plans remain coordinated and proceed together is an important part of national, regional, and local planning. (**Implementing the Recommendations of the Neonatal Critical Care Transformation Review NHSE&I 2021**).

Service Specification

LNUs are expected to admit more than 25 very low birth weight (VLBW) (i.e. birth weight <1500g) babies per year, undertake at least 500 combined intensive and high dependency days per year and be making progress towards undertaking more than 1000 combined intensive and high dependency days per year.
Maternity care is organised around Local Maternity and Neonatal Systems (LMNSs) and is inextricably linked to neonatal care. Neonatal ODNs and LMNSs work closely together to deliver the best outcomes for women and their babies who need specialised care, whilst ensuring that high quality care is provided and delivered as close to home as possible
Each NNU must implement or work towards an agreed plan with commissioners for nurse staffing levels based on the following staff to baby ratios for direct patient care, as described in the **Toolkit for High Quality Neonatal Services (2009) and recommended by the British Association of Perinatal Medicine (BAPM) and the Neonatal Nurses Association (NNA):**

- Intensive Care 1:1 staff-to-baby ratio[a]
- High Dependency 1:2 staff-to-baby ratio[a]
- Special Care 1:4 staff-to-baby ratio[b]

• Transitional Care 1:4 staff to baby ratio[b] (babies will be cared for alongside their mother either on a dedicated TC or PN bed). (TC is based on THE Maternity Post Natal Ward)

• A minimum of one nursing coordinator per shift i.e. a supernumerary team leader additional to the staff caring for the babies on each shift.

([a]registered nurse with specialised training in neonatal care (Qualified in Specialty (QIS)), or training for the same and under supervision of QIS staff)
([b]registered nurse or midwife, or non-registered staff with NVQ level 3 or Foundation degree under supervision of QIS staff.)

Additionally, each NNU should ensure that non-direct patient-facing roles additional to direct patient care ratios include provision for a:

- Designated lead nurse.
- Clinical nurse educator.
- Supernumerary shift co-ordinator.
- Discharge planning / outreach co-ordinator,
- Patient safety and governance nursing lead.

Neonatal Out-Reach / In-Reach or Community Services support should be provided by an integrated hospital-community neonatal team or an identifiable team of specifically trained community health professionals.

These staff should feel confident and able to provide consistent and appropriate advice to parents / carers supported by the appropriate information ahead of discharge, including details of any particular arrangements identified in the baby's care plan, in order to best support families' care for their babies at home. 3. Units should enable parents / carers to meet with the community team supporting them at home before the baby is discharged from the hospital.

Additional quality roles as identified within the Neonatal Critical Care review and BAPM are recommended for:

- Breastfeeding/Infant feeding support
- Developmental Care
- Family support and Education(FiCare)
- Safeguarding
- Palliative care/ Bereavement
- Infection Control

Neonatal units require key contributions from an essential group of Allied Health Professionals (AHPs),

- Psychologists
- Pharmacists who have special expertise in their discipline.
- Physiotherapy
- Speech and Language professionals(SALT)
- OT Specialists
- Dietetics

To be able to facilitate Family Integrated care (FiCare) parents require support from a service that provides appropriately trained nursing and/or AHP staff, working alongside medical and nursing teams. Parental support involves education for parents in the specialised needs of their baby and training of all staff in the provision of developmentally sensitive care from a multidisciplinary team. (CCR 2019).

Methodology

This paper outlines the annual staffing and skill mix review and the further requirements for Neonatal services to work towards the integration of Allied Health Professionals into the Multi-disciplinary team to enhance care and provide a holistic approach to neonatal care that is fully supportive of Family Integrated Care (FiCare).
The Neonatal Nursing Workforce Tool (2020) has been adapted from the CRG Workforce Calculator (Dinning) Tool (2013) and has been developed with the National Lead Nurses Group. **(See Appendix 1)**

Staffing requirements are based on 80% occupancy with an overall uplift of 25% included in the BAPM tool.

The tool supports neonatal nurse managers by providing a consistent method for the calculation of nursing establishment requirements which meet national standards i.e. NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010). All recommend an adequate and appropriate workforce, with the leadership and skill mix competencies to provide excellent care at the point of delivery for babies receiving medical and surgical interventions.

DH (2009) stipulates that:

- 70% of the nursing establishment must be ‘qualified in specialty’ (QIS)
- There should be a supernumerary team leader additional to the staff caring for the babies on each shift.

Tier 1 Medical Staffing shortfalls

There is an agreed plan within the Division to recruit to Advanced Neonatal Nurse Practitioners which will support cover of the Tier 1 shortfalls going forward and provide additional skilled senior support to the Neonatal unit.
This is not an immediate solution as staff will need to be trained through an accredited Training Programme which will take 12 months to complete.
The recruitment of this component of the workforce is an ongoing national issue and therefore WWL are currently looking at all suitable options to increase compliance with the Tier 1 medical rota. Currently there are 2 Nurse’s undertaking the Advanced Neonatal Nurse Practitioner course and will complete in early 2025. The Tier 2&3 Medical staffing rota’s are fully covered.

Training and Development

Professional Competence, Education and Training:

• Appropriate and specific training programmes for all trained and untrained staff are in place with regular neonatal specific update training where required.
• A minimum of 70% (special care) and 80% (high dependency and intensive care) of the nursing and midwifery establishment hold NMC registration.
• A minimum of 70% of registered neonatal nursing establishment hold a post registration qualification in specialised neonatal care (QIS)
• A minimum of 70% of registered neonatal nursing establishment hold Newborn Life Support Accreditation.
• All registered neonatal nursing establishment have been assessed yearly and have attended the inhouse British Association of Perinatal Medicine (BAPM) Neonatal Airway Safety/Difficult Airway Training Day to comply with the new BAPM Neonatal Airway Safety Standard.

• Staff providing community support for babies recently discharged from neonatal units should undertake specific neonatal training and have skills and competencies for neonatal out / in-reach.

Staff training compliance is closely monitored by the Practice Educator alongside the senior management team and recorded on the Training data Base.

Summary

The outcome of the review is that the neonatal unit at WWL has the right level of leadership in place, however, there are staffing shortfalls within the Allied Health Professional roles and Quality Roles as recommended by the Neonatal Critical Care review. **Funding would be required for 1.83 wte Band 7/8 to fully support these roles within the unit in line with recommendations.**

Work remains ongoing to identify funding for these roles and in the interim service provision is provided on a smaller scale basis in order that babies are receiving some input from the AHP services to improve overall care and provide the best possible outcomes for the neonates within the unit.

Nurse staffing vacancies remain low at 2.21 wte with low attrition and turnover rates. Sickness rates have improved significantly and are currently at 3.2%.(vacancies are currently being recruited to)
If all the quality roles were implemented as recommended this would require a further 5.58wte Nurses. (Currently quality roles are supported through protected time when staffing levels allow).

There is no additional Nurse staffing ask at this current time as activity and acuity is in line with the budgeted establishment, however when additional funding should be available it is requested that the establishment is increased to meet the recommendations for Quality roles and AHP positions.

Appendix 1 Neonatal Nursing Workforce Summary: Wigan

Activity period Q1	01/04/23		End date:
	HRG 1 (IC)		HRG 2 (HD)
Activity by care level	120		771
Commissioned cots by care level	1		3
Role Title	**Band**	**WTE Budget**	**WTE in post**
Supernumerary Shift Coordinator	7	6.38	5.44
Sister / Charge Nurse	6	5.38	5.36
Staff Nurse QIS	5 QIS	11.40	11.68
Subtotal QIS		**23.16**	**22.48**
Staff Nurse NON-QIS	5 NON-QIS	3.74	3.74
Subtotal non-QIS		**3.74**	**3.74**
Healthcare Support Worker	3	3.69	2.08
Subtotal non-Reg		**3.69**	**2.08**
TOTAL DIRECT PATIENT CARE		**30.59**	**28.30**
TOTAL NURSING WORKFORCE		**36.34**	**34.13**
Total inclusive of 25% Uplift			

NON-DIRECT PATIENT CARE -				
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Recommended**
Matron	8a	0.5	0.5	0.5
Ward Manager	7	1	1	1.17
Governance Lead Nurse	7	0	0.32	0.84
Practice Development / Education Lead	7	0.8	0.8	1.17
Outreach Registered Nurse	6	2.6	2.36	
TOTAL NON-DIRECT PATIENT CARE		**5.75**	**5.83**	
Ward Clerk	2	0.85	0.85	1.00
Data Entry& System Administrator	4	0.0	0.0	0.80
Bereavement / Palliative Care Lead	6 /7	0.0	0.0	0.05
Infant Feeding Lead	6/7	0.0	0.0	0.84
Family Integrated Care Lead (FiCare)	6/7	0.0	0.0	0.42
Discharge Coordinator	6/7	0.0	0.0	0.42
Infection prevention and control	6/7	0.0	0.0	1.40
Developmental Care	6/7	0.0	0.0	0.28
Emotional and Psychological Support	6/7	0.0	0.0	0.28
Safeguarding	6/7	0.0	0.0	1.00

ADVANCED NEONATAL NURSE PRACTITIONER				
	Band	**WTE Budget**	**WTE in post**	**Head Count in post**
Trainee ANNP	7	1	2	2
ANNP	8a	1	1	1
Transitional Care				
Nurse	5	5.38	5.38	

References

Implementing the Recommendations of the Neonatal Critical Care Review. NHS England and NHS Improvement (Dec 2019).

Neonatal Nursing Workforce Tool(2020)

A workforce strategy for Northwest Neonatal Units 2021-2026.

Working together to provide the highest standard of care for babies and families. Mainwaring & Waters (August 2021)

Neonatal Critical Care Service Specifications (March 2024)

British Association of Perinatal Medicine Neonatal Airway Safety Standard, A framework for Practice. BAPM (April 2024

Agenda item: [20.3]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Perinatal Quality Surveillance Full Report (Q1 2024-2025, Apr-Jun 24)
Presented to:	Trust Board
On:	7th August 2024
Presented by:	Kevin Parker-Evans Interim Chief Nurse
Prepared by:	Eve Broadhurst Head of Governance Maternity and Child Health for Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	T: 01942 822993 E: eve.broadhurst@wwl.nhs.uk

Executive summary

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

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

Incidents

In Q1 there was 1 moderate or above harm incident. Statutory Duty of Candour has been served. Escalated to LfPSE. Scheduled for presentation 4/7/2024. WEB161467 Neonatal transfer to Level 3 unit – therapeutic cooling at 35 weeks gestation.

The highest reported maternity incident sub-categories continue to be undiagnosed SGA, term admissions to NNU and PPH >1500mls.

Review of undiagnosed SGA cases shows fundal height (FH) measurement and scan plotted correctly. Scan accuracy is also investigated; no issues identified within any category. Face to face training for FH measurement and plotting, grow 2.0 digital plotting is mandatory.

The new MDT PPH review group was commenced in Q1. Learning/themes will be collated with an overarching action plan to inform QI.

The ATAIN workstream continues to review all term admissions to the NNU and there has been an overall downward trend in admissions with ongoing QI work.

Staffing incidents were the highest reported neonatal sub-categories.

Exceptions - 132 incidents are 'under investigation' across maternity and neonatology (data pull 9/7/2024). All incidents have been triaged in Division. Ongoing support to staff to complete within 10 days of incident.

Investigations

The report details all learning from approved investigations and actions will be monitored via Trust LfEG.

There have been no eligible MNSI cases for referral to NHS Resolution since 15.8.2023.

Exceptions - 1 overdue PMRT investigation. This has been escalated to the Head of Governance at Liverpool Women's Hospital as they are the host of the joint PMRT. Scheduled July 24.

Feedback and complaints

In Q1 24/25, 5 complaints have been received for maternity services, which is equal to the number received within the Q4 23/24.

2 of these complaints were resolved as a concern due to the timely intervention of our community midwifery staff.

0 complaints were received for neonatal services.

A wealth of positive feedback has been collated from service users and has been fed back to staff. FFT

From the 30th June 24 'Voices for Choices' will manage the MNVP services within GM, the chair has had an increase of hours from 8 hours per week to 22.5hrs per week. There is also funding for an additional 16 hours per month for an engagement role. The Public and Patient Engagement Midwife is working closely with the MNVP on the Picker Survey action plan.

A Dads Matters representative have been welcomed to the Maternity unit and a plan of work with them completed to promote their service. There has been a Dads matters representative attending the Maternity ward and NNU regularly to speak with new fathers to offer support and signpost to services.

The PPE midwife has visited 44 ladies on the Maternity Ward who have had emergency procedures during their birth. In Q1 24/25 there has been 98% positive feedback given about the care that had been received. Themes of positive feedback were values and behaviour, clinical treatment and good communication.

13.5% identified areas for improvement for the Maternity service, themes were lack of information, communication and the timing of taking consent for epidural and caesarean section. Proposed actions are tabled in the report.

Exceptions - There has been an upward trend in the number of formal complaints for maternity services over the last 12 months with themes continuing around communication and clinical treatment.

SCORE survey

WWL Maternity services has undertaken the SCORE staff survey to get a better understanding of team culture. This closed on the 21/04/2024 and results are pending. Analysis of the data will be undertaken when the results are shared with view to implementing meaningful actions as required.

Risks

The Risk Register has been included for maternity and neonatal services. At the end of Q1 24/25,

0 risks under review.
1 risks awaiting approval
MAT 4003 Inability to provide ultrasound scanning within 24 hours (SBL 3 requirement) - 10
0 risk approved
3 risks closed
NEO 1978 Access to a Neonatal dietician (merged with NEO 1977)
MAT 3616 Risk of non-compliance with CNST Yr. 5
MAT 2581 Sustainability of Maternity Services

Exceptions - The Risk register has been added to the respective Maternity and Child Health Patient Safety Group agendas and progress is being made to address overdue risk actions and progress risks through to tolerated risk status as a team in live time. There are 6 risks scoring 6 or less which are under review to establish if can be tolerated.

Ockenden 2

Q1 has seen some progress against the Ockenden actions and 4 outstanding actions remain.

MIAA Ockenden audit has been completed which concluded that we have provided *substantial assurance.*

Exceptions - 4 actions remain, all are in progress.

Maternity Incentive scheme

MIS Yr.6 was published on the 2nd April 2024 and we are working closely with the LMNS for shared oversight and quality assurance. Leads appointed and work against Safety Action continues.

No exceptions

ATAIN

In Q4 23/24, the total number of term admissions to the NNU was 5.92% of total term live births. This is a decrease from Q3. Unexpected term admissions to the NNU accounted for 5.74% of total term live births. This is a decrease from Q3.

There is still work to be done with 7 (21.8%) of total admissions being potentially avoidable and QI work is ongoing.

The findings and recommendations from audit are shared in the body of the report

No exceptions

Mortality and PMRT

There was 1 stillbirth in Q1 24/25. There were no immediate care or service delivery issues identified which likely affected the outcome.

Await PMRT.

There was 1 Neonatal death in Q1 24/25 at 17+2 weeks gestation. Under care of pre-term birth clinic. No care issues affecting outcome. A neonatal death at this gestation would not be eligible for PMRT or MBRRACE data.

Themes

Low numbers make thematic analysis difficult. However all data is logged to allow analysis over time. We continue to monitor ethnic origin and social deprivation index for all mortalities. Black Caribbean origin and Decile 2 (low socio-economic group) were noted for the stillbirth in Q1.

There is currently no enhanced maternity service for those women living in Decile 2 or those women of black or ethnic origin who speak English. WWL maternity services are currently reviewing the enhanced team model to optimise the support given to vulnerable women in the Borough.

Raised BMI and maternal age ≥33 years is noted in both stillbirth and neonatal death data in Q1 24/25.

No exceptions

Saving Babies Lives 3

WWL areas of improvement have been recognised and SBL action plans provided. The report provides a full gap analysis of our progress against SBL 3 targets.

GMEC LMNS Ambition

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

WWL will monitor its progress against the GMEC ambition. Over the rolling 12 period April 23-March 24 stillbirth data has seen a steady decline. Data for the rate of serious brain injury (HIE) is incredibly positive and it is vital that we continue to monitor, learn and improve to sustain this figure.

Mandatory training

Midwifery mandatory training is compliant >90%

There has been a decline in compliance for obstetric Fetal Physiology training.
x2 obstetricians are allocated to training in July 24.

Feedback from staff following PROMPT training high-lights not enough obstetricians present per session. The Practice Education team will work with the roster master to ensure an even spread on training dates.

Workforce/ Safe staffing

At the end of Q1 24/25 there were 9.9 WTE midwifery vacancies.
8.32 Band 5 WTE and 1.58 Band 6 WTE posts went out for recruitment.
There are 2.8 WTE MSW vacancies and these posts are out to recruitment.

There are 3.64 WTE nursing vacancies on the neonatal unit. Plan to go out for recruitment for 0.94 WTE Band 7 post in Q2 24/25.
There is a 0.97 WTE HCA vacancy and this post is out to recruitment.

GMEC benchmarking (latest available data on Tableau)

In Q4 23/24, WWL has performed better than the GMEC average in rates of 3rd/4th degree tears, stillbirth, pre-term births, neonates diagnosed with HIE 2 and 3 at term, and smoking at the time of delivery.

In Q4 23/24, WWL has performed worse than the GMEC average in term admissions to NNU, early neonatal death, neonates with Apgars <7 at 5 at term, term admissions to the NNU and major haemorrhages >2.5 litres.

It is important to note that current recommendations are that Trusts do not benchmark the rate of Emergency Caesarean Sections.

While we remain outside the GMEC average for some parameters in the rolling 12 month period above, we are making progress and consistently improving rates of smoking at the time of delivery, stillbirth, neonatal death, term admissions to the NNU, 3rd and 4th degree tears and HIE 2 and 3 at term.

There were 2 neonatal deaths in this period. As per the last report both were 20 weeks gestation, below the age of viability, and will not be eligible for PMRT or included in MBRRACE neonatal death statistics. Immediate review is carried out on all deaths and there were no care or service delivery issues identified.

While we celebrate our own success, even making a splash in the Wigan Post, with a downward trend in smoking at the time of delivery, there is still work to be done to reach the national ambition set by NHS England of <6%.

SPC charts (until end Q1 24/25)

SPC charts provide a more up to date and useful tool to review our own progress and position against GMEC average over time. The charts give assurance of continued improvement and QI work continues in all areas and themes and trends monitored.

In the last 12 months the only parameters outside GMEC are for term admissions to the NNU and Apgars <7 at 5 minutes.

Themed analysis is underway to identify areas for improvement in relation to Apgars <7 at 5 minutes. ATAIN reviews are undertaken weekly with an overarching action plan to drive improvement work and a downward trend in the number of admissions is noted with the foot remaining firmly on the pedal as the improvement drive expands to support Transitional Care.

No exceptions

LMNS Outlier Assurance

Outlier assurance was provided to the LMNS in May 24 for stillbirth data. WWL triggered against the England and GMEC average 3 times within a 6 month period. Analysis of the stillbirth data between Nov 23 and May 24 showed that,

- WWL total stillbirth data is in line with the GMEC average over time.
- WWL data is below GMEC average when data adjusted for MTOP over time.

- 66% (2 out of 3) of stillbirths were to white British mothers.
- 100% (3 out of 3) of stillbirths were to mothers who live in areas of high social deprivation.
- 33% (1 out of 3) of stillbirths were due to anomaly (MTOP).
- 0% (3 out of 3) of women who had a stillbirth smoked cigarettes.
- 66% (2 out of 3) of women who had a stillbirth had a BMI ≥30.
- 66% (2 out of 3) of women who had a stillbirth were aged >30 years of age at booking.
- 33% (1 out of 3) of women who had a stillbirth had diabetes (gestational).

- 100% (3 out of 3) of initial stillbirth reviews did not find learning that affected the outcome.
- 33% (1 out of 3) of initial stillbirth reviews found important but incidental learning.

Learning - any proteinuria indicates need to offer PIGF test (pre-eclampsia).
- GMEC guideline is overdue an update

No exceptions

Recommendations

It is requested that the Board of Directors and Executives review the contents of this paper to provide oversight and assurance that there are effective systems of clinical governance and monitoring of safety for Maternity and Neonatal services.

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Maternity Perinatal Quality Surveillance Full Report

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

1. Obstetrics/Maternity incidents in Q1 – Severity (data pull 09/07/2024 - DATIX)

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
No Harm	91	67	69	66	80	40	62	67	48	64	71	45
Low	7	7	5	7	5	4	0	6	2	10	7	15
Moderate	1	1	1	0	1	0	0	0	0	0	1	0
Severe	0	0	0	1	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total	**99**	**75**	**75**	**74**	**86**	**44**	**62**	**73**	**50**	**74**	**79**	**60**

1.1 Neonatal incidents in Q1 – Severity (data pull 09/07/2024 – DATIX)

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
No Harm	1	8	10	3	10	9	3	18	21	42	26	8
Low	0	1	0	1	0	2	0	2	1	1	3	1
Moderate	0	0	0	0	0	0	0	1	1	0	0	0
Severe	0	0	0	0	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**9**	**10**	**4**	**10**	**11**	**3**	**21**	**23**	**43**	**29**	**9**

There was 1 moderate or above harm incident.

WEB161467 Neonatal transfer to Level 3 unit – therapeutic cooling.
Transfer of antenatal care from Derby Hospital at 34+ weeks, booked in community clinic. High risk pregnancy with plan for 2 x weekly doppler scans. Care plan not noted and therefore scans not booked in line with plan. Presented with abdominal pain and abnormal CTG. Both doctors in gynaecology theatre. Bleeped X 2. Birth Suite co-ordinator not asked to attend. Transfer to Birth Suite. 10 mins off monitor for transfer. CTG recommenced. Matron attended, crash bleep - Category 1 LSCS. Transfer for cooling. Changes on MRI.

Immediate learning

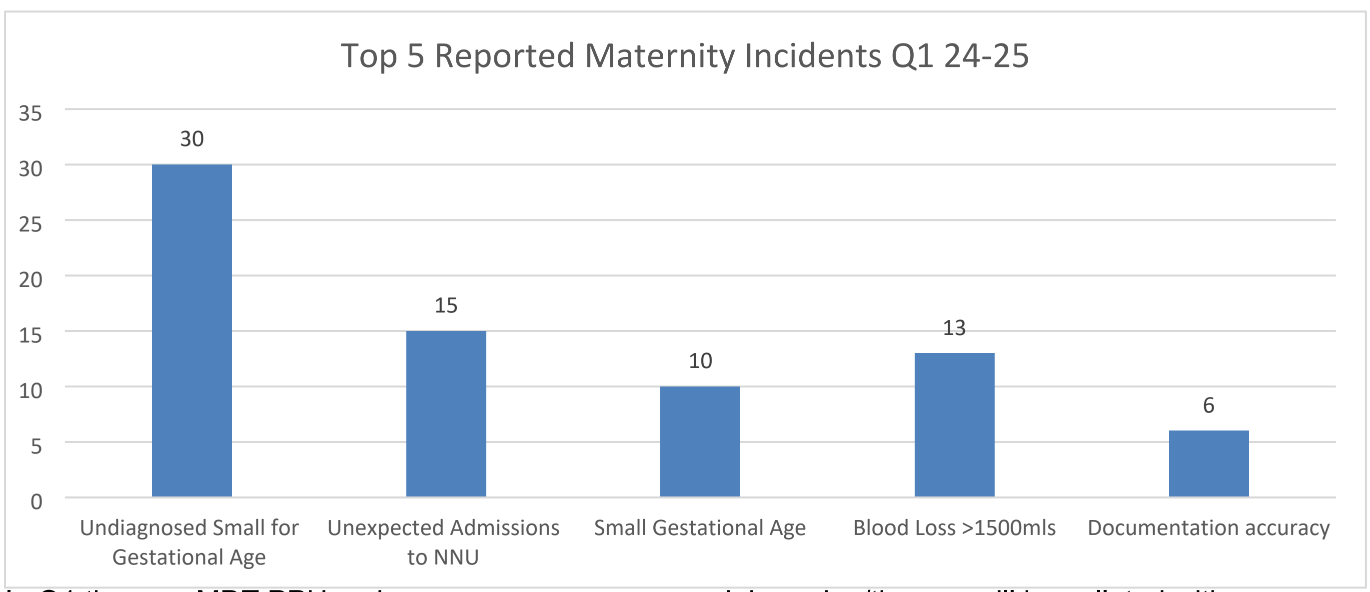
- Derby Hospital to strengthen communication when high risk patients transfer care.
- Ensure Birth Suite co-ordinator is informed if both doctors are in theatre.
- Ensure Birth Suite co-ordinator is informed if abnormal CTG on Triage.
- Support staff to transfer to theatre directly from Triage in the presence of abnormal CTG.

Statutory Duty of Candour has been served. Escalated to LfPSE. Scheduled for presentation 4/7/2024.

Exceptions

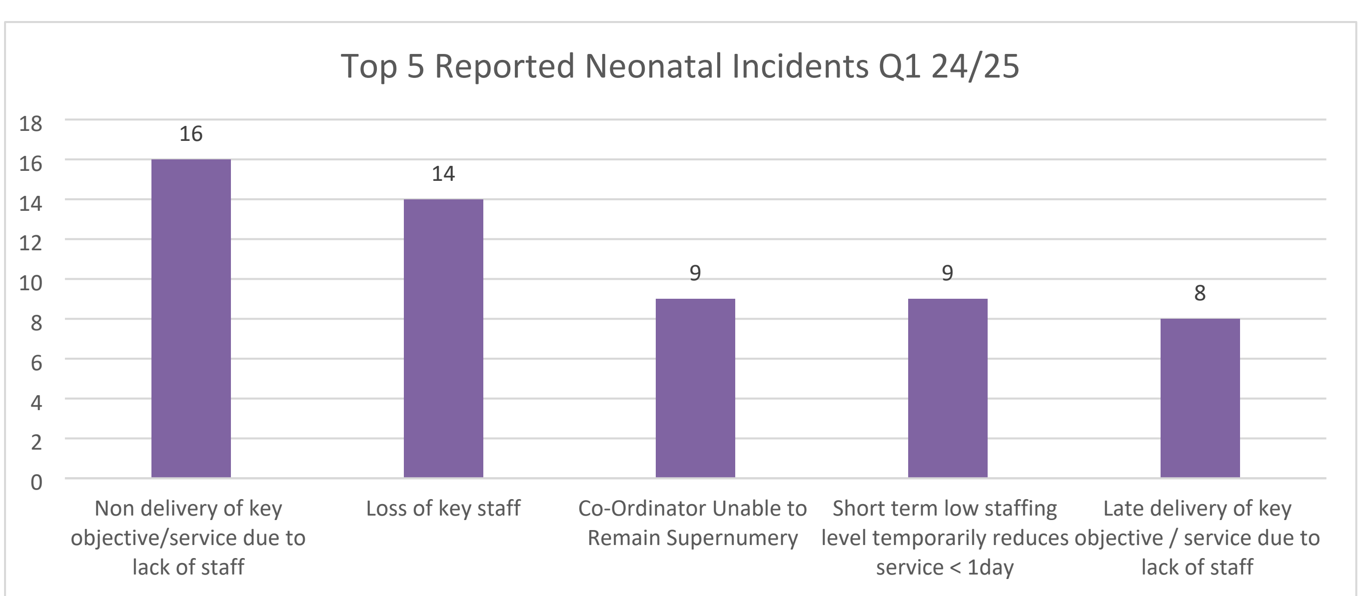
132 incidents are 'under investigation' across maternity and neonatology. All incidents have been triaged in Division. Ongoing support to staff to complete within 10 days of incident.

1.2 Top 5 Reported Incidents Maternity– Q1 24/25



In Q1 the new MDT PPH review group was commenced. Learning/themes will be collated with an overarching action plan to inform QI.
The ATAIN workstream continues to review all term admissions to the NNU and there has been an overall downward trend in admissions with ongoing QI work.

1.3 Top 5 Reported Incidents Neonatology – Q1 24/25



Staffing incidents continue to be the highest reported neonatal sub-category. All incidents were reported as no/low harm.

1.4 Serious Incidents reported to 'StEIS' and external agencies Q1 24/25

1.5 MNSI overview

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Incidents reported to StEIS	3	1	0	1	3	0	0	0	1	2	0	1
HSIB referrals	1	1*	1	1	1	0	0	0	0	0	0	0
Accepted HSIB referrals	1	1	1	0	0	0	0	0	0	0	0	0
Cases referred to NHS R	1	0	1	0	0	0	0	0	0	0	0	0

WEB/StEIS	Date	Incident	Date StEIS	Immediate Learning	PSIRF tool
WEB156568 StEIS 2024/3444	10/2/2024	Unexpected Death	2/4/2024	Handover of safe-guarding concerns from tertiary centres.	RR. For PMRT
WEB157774 StEIS 2024/3611	6/3/2024	Unexpected Death	6/4/2024	Documentation of Vitamin K. TC processes including lack of robust handover and standardised documentation.	RR. Now on hold. Police investigation
WEB161666 StEIS 2024/5484	24/5/2024	Never Event – Retained Swab	13/6/2024	Potential for increased human error during the night.	RR. For PSII

WWL Case Summary

Cases to date	
Total referrals	24
Referrals / cases rejected	11
Total investigations to date	13
Total investigations completed	13
Current active cases	0
Exception reporting	0

There are no open MNSI cases at the end of Q1 24/25.

Trust top recommendations*

13 completed reports:
4 reports *did not have* recommendations for the primary healthcare provider.
9 reports *did have* recommendations for the primary healthcare provider.

*Based on the year of report publication. The number of top recommendations listed may vary depending on their frequency.
**2024/25 is not a full financial year (Apr-Mar).

1.6 MNSI /NHSR assurance Maternity Incentive Scheme Yr. 6 reporting period

There have been no eligible cases for referral to MNSI/NHS Resolution since 15/8/2023. MIS Yr.6 was published on the 2nd April 2024 and assurance data will continue to be provided as cases occur.

No Exceptions

1.7 Learning from completed investigations

In Q1 24/25, 3 completed investigations were approved at LfPSE. Action plans will be monitored via LfEG.

WEB number	Date	Incident	Investigation tool	Learning
WEB117402 StEIS 2023/20166	Oct 2021	Meconium Aspirate	Concise Divisional Investigation MNSI	Be aware not all Trusts have fully implemented GROW protocol. Review of the customised growth chart should be part of a risk assessment. The on-call consultant should be contacted when activity and acuity is high and review of mothers cannot be undertaken in a timely way. When there are concerns about fetal heart rate, undertake a holistic review so that plans of care are based on thorough, accurate risk assessment.
WEB147679 StEIS 2023/18407	Aug 2023	HIE 2-3	MNSI	Placentas to be sent for pathological examination, including histology, in line with national guidance. The shoulder dystocia proforma was not utilised to support documentation. There were multiple attempts at intubation without sedation. The optimal timeframe for MRI is 5-14 days. MRI undertaken at Bolton on Day 2 and may not be accurate.

WEB156790 StEIS 2024/2667	Feb 2024	Delay in responding to alarm on the NNU	PSII	Postnatal staff should be supported to feel safe and comfortable to support nasogastric tube feeding on TC in the event that the NNU nurse is called back to NNU. The TC SOP should include clear escalation processes to support re-deployment in the event that BAPM acuity is high. The SOP needs to consider the impact on postnatal ward staff Alarms are inaudible from the drug room and other key areas on the unit. This needs a technological solution. Impromptu handovers from Birth Suite staff should take place over the telephone or in the main area on the NNU when it is safe to do so, to avoid loss of oversight on the NNU. Staff need to be supported to have cover when clinical duties need to performed away from the cubicles to avoid loss of oversight and babies being unsupervised. The available technology needs to be utilised and embedded to allow monitors to be seen by another staff member when necessary to improve oversight. The Trust to work with the North-West Neonatal Operational Delivery Network (NWNODN) to assess if staffing exceeds the requirements of BAPM due to the estate.

1.8 Investigation progress – overview of open investigations

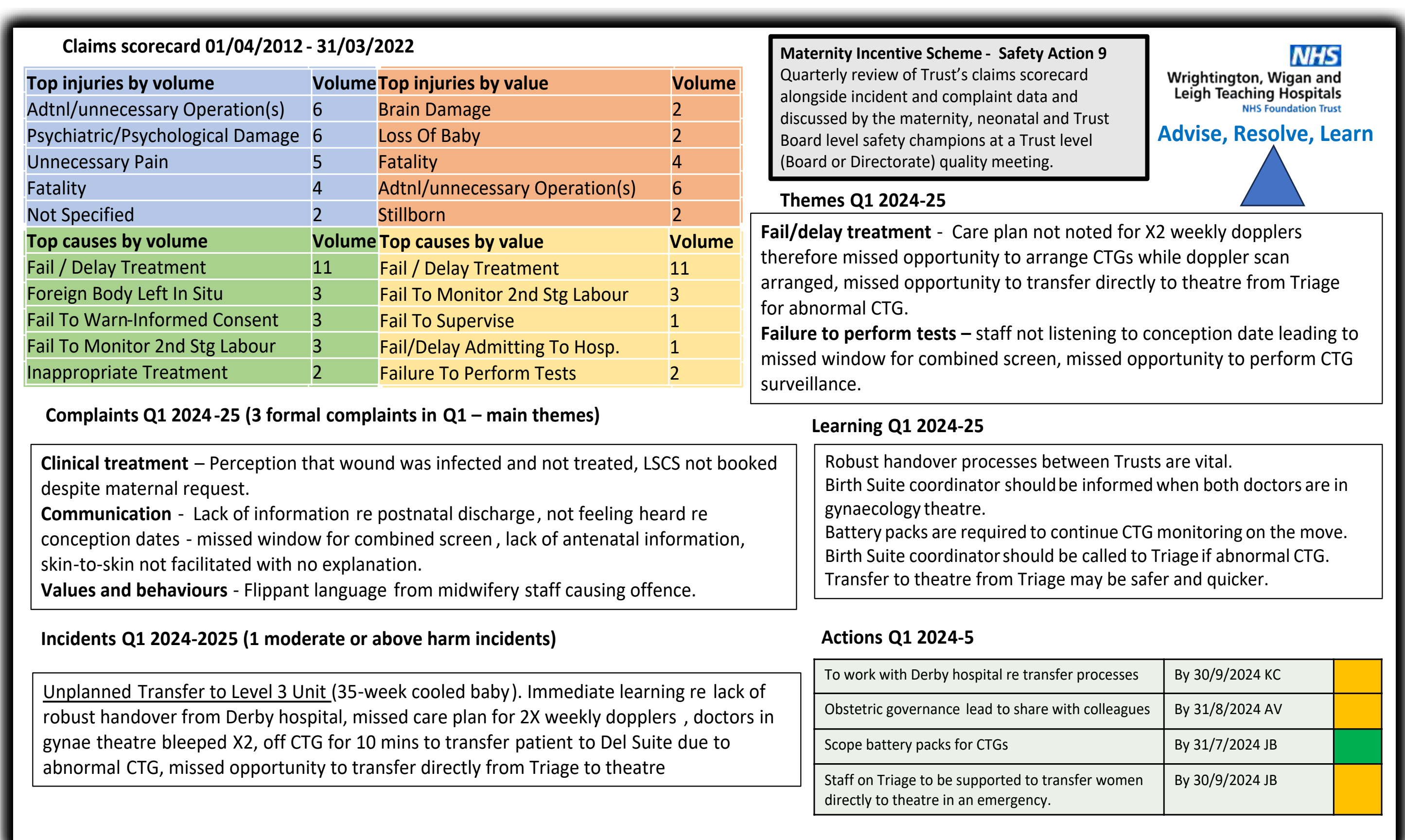
At the end of Q4, **6** serious incident investigations are open.					
WEB number	Date	Incident	Progress	Stage	Plan
SIF					

WEB145195 StEIS 2023/16382	Aug 2023	Neonatal death (22+6) (Joint PMRT)	Preliminary PMRT held	Awaiting Final PMRT	Liverpool Women's Hospital scheduled for July 2024.
PSIRF					
WEB156568 StEIS 2024/3444	Feb 24	Suspected co-sleeping death at home	RR presented at LfPSE	On hold. Await Police investigation.	For joint PMRT with Royal Bolton Hospital.
WEB157774 StEIS 2024/3611	Mar 24	Unplanned Neonatal Transfer to Level 3 Unit (Death).	Detailed RR & Timeline presented at LfPSE	On hold. Await Police investigation.	For joint PMRT with Royal Oldham Hospital.
WEB161666 StEIS 2024/5484	May 24	Never Event – Retained swab	RR presented at LfPSE	PSII in progress - interviews	For submission to Division 12/8/2024

Exception

1 overdue PMRT investigation which pre-dates the introduction of PSIRF. This has been escalated to the Head of Governance at Liverpool Women's Hospital as they are the host of the joint PMRT and a date has been set for July 2024. We have met with the family and shared our findings in view of the significant delay. WWL findings have been presented at LfPSE and actions generated. ICB updated.

1.9 Triangulating data slide – Claims, Incidents, Complaints



2. Patient Experience - MNVP and Service-user Feedback

A wealth of positive feedback has been collated from service users and has been fed back to staff.

From the 30th June 24 'Voices for Choices' will manage the MNVP services within GM, the chair has had an increase of hours from 8 hours per week to 22.5hrs per week. There is also funding for an additional 16 hours per month for an engagement role. The Public and Patient Engagement Midwife is working closely with the MNVP on the Picker Survey action plan.

A Dads Matters representative have been welcomed to the Maternity unit and a plan of work with them completed to promote their service. There has been a Dads matters representative attending the Maternity ward and NNU regularly to speak with new fathers to offer support and signpost to services.

The PPE midwife has visited 44 ladies on the Maternity Ward who have had emergency procedures during their birth. In Q1 24/25 there has been 98% positive feedback given about the care that had been received. Themes of positive feedback were values and behaviour, clinical treatment and good communication.

13.5% identified areas for improvement for the Maternity service, themes were lack of information, communication and the timing of taking consent for epidural and caesarean section.

Improvement Required	Action	Date for completion
Lack of information	Information folders to be developed for Induction of Labour Bay, Maternity Ward and for women who have had a Caesarean Section.	30/9/2024
Communication: o baby care on TC o care of baby for medical review	Maternity TC lead appointed. TC processes to be reviewed.	30/9/2024
Consent for epidural and emergency sections	To improve the accessibility of information regarding risks of epidural in the antenatal period. To explore the timing of when information of the risks of caesarean section would best be provided.	30/9/2024

Friends and Family Test

	Responses	Positive
Antenatal	18	17
Birth	28	28
Postnatal Community	14	14
Postnatal Ward	16	14
Total	**76**	**73**

73 of 76 responses are positive, which gives an overall 96.1% positive response rate.

The postnatal care has been fantastic. The midwives do a brilliant job and nothing is too much trouble.

Couldn't have asked for anything more than what the staff did for us. They were absolute angels and I could not have done it without them all, especially midwife Tracy - a true angel.

I felt extremely well looked after. I was overwhelmed and exhausted after my labour ending in an emergency c-section but the staff were so supportive helping me with breastfeeding and pain management. I never felt judged for not knowing what to do and everything was always explained clearly to me and my choices were always respected. I honestly can't thank every member of staff for their help and support during such a vulnerable, life-changing time. Thank you!

I think the Daisy team are brilliant and they have given me loads of support.

Attentiveness of staff. No question felt silly, nothing ever felt like too much effort. Cared for with empathy, especially on difficult days. Every member of staff has left us feeling extremely supported and has helped to transition to parenthood. Forever grateful.

Midwife Monika took very good care of me and my baby, I am very grateful to her.

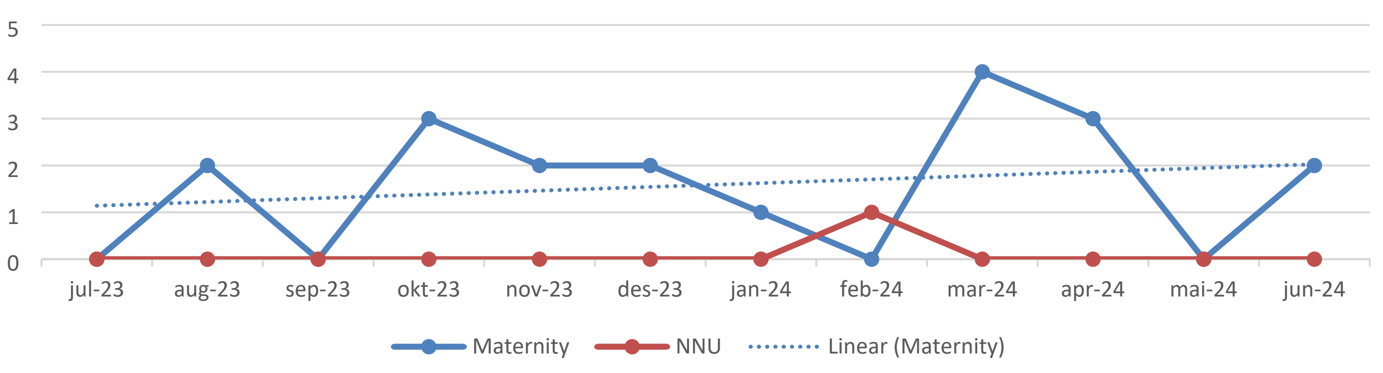
All the staff were absolutely excellent and amazing. Can't thank you all enough. Can't remember all the names but I few that I can remember were Molly, Chelsea, student midwife with Chelsea in delivery suite and Emma in discharge from maternity ward. They were brilliant!!!!

Angela my midwife was wonderful and so softly spoken and reassuring! She really put my mind at ease and is such a lovely professional midwife.

Zoe and Rachel have been extremely supportive throughout and helped me get ready for the arrival of our baby.

2.1 Complaints

Formal Complaints	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Maternity	0	2	0	3	2	2	1	0	4	3	0	2
NNU	0	0	0	0	0	0	0	1	0	0	0	0



In Q1 24/25, 5 formal complaints have been received for maternity services, which is equal to the number received within the Q4 23/24.

2 of these complaints were resolved as a concern due to the timely intervention of our community midwifery staff (one received in April 2024 and another received in June 2024).

0 complaints were received for neonatal services.

Themes from complaints

Q4	Apr	May	Jun	Total
Communication	3	0	2	**5**
Clinical Treatment	1	0	1	**2**
Patient Care	1	0	0	**1**
Values and Behaviours	1	0	0	**1**

Clinical treatment:

Communication:

1. Concerns around a lack of care following an emergency caesarean section when patient was left on Maternity Ward with her baby, with further miscommunication leading to a false impression that a discharge was imminent.
2. Concerns raised around feeling ignored when sharing information around possible conception dates.
3. Concerns raised over breakdown of information, particularly in concern to mental health notes being made in midwifery records.

4. Concerns raised around antenatal communication, a lack of openness regarding possible complications and the reasons for labelling a pregnancy as high-risk.
5. Concerns raised around patient's wishes not being followed leaving her not feeling heard.

Clinical Treatment

1. Concerns over possible caesarean wound infection and lack of treatment.
2. Concerns over decision-making and reasons for not booking a caesarean section despite maternal request.

Patient Care

1. Concerns raised around slow response from midwives and a lack of information provided prior to discharge.

Values and Behaviours:

1. Concerns raised around comments made by midwifery staff around possible future pregnancies.

Exceptions

An upward trend of complaints received has been noted over the rolling year in Maternity services. The number of formal complaints for the Neonatal services remains low. It is positive to see that timely communication led to 2 complaints being managed as concerns. The introduction of the Patient, Public and Staff Engagement Midwife aims to improve our oversight and response to concerns and progress will continue to be monitored.

3. Risk register – Maternity and neonatal services

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

Under review	-	-	-	-
Awaiting approval	MAT	4003	Inability to provide ultrasound scanning within 24 hours (SBL 3)	10
Approved	MAT	3772	Euroking System Error	20
	MAT	3604	Obstetrics and Gynaecology On-Call Availability Risk	15
	MAT	3802	Obstetrics/Gynaecology Tier 2 Staffing Shortages	12
	MAT	3605	Obstetricians and Gynaecologists on call rotas not allocating compensatory rest	12
	NEO	1977	Specialist AHP services should be available in all units for neurodevelopment and family integrated care	12
	MAT	3780	Maternity Ligature Risk	10
	MAT	3727	Euroking To PAS Error Risk	9
	MAT	3732	Entonox Risk	9
	MAT	3880	Daisy team future funding uncertain	9

	MAT	1469	The risk of abduction from the maternity unit	8
	MAT	3362	Midwifery Staffing Shortages	8
	MAT	3756	Medical Devices Training	8
	MAT	3667	Emergency Evacuation from Maternity Birthing Pool	8
	MAT	3669	Potential inability to undertake more than 1 emergency delivery at a time due to number of theatres available.	8
	MAT	1469	The risk of abduction from the maternity unit	8
	BOTH	3725	Junior Doctors Strike	6
	MAT	1758	Delivery suite coordinator should be supernumerary at all times.	6
	MAT	3400	Screening for GBS at 36 weeks gestation in women with a history of GBS (group B beta-haemolytic streptococcus) infection	6
	NEO	1975	BAPM staffing guidelines - Staff shortages on the Neonatal unit	6
	MAT	3782	Maintenance of maternity equipment	6
	MAT	2459	Transportation and supply of Entonox (Nitrous oxide 50% and oxygen 50%) by Community Midwives for use at Homebirths	4

At the end of Q1 24/25,

0 risks **under review.**

1 risks **awaiting approval**
MAT 4003 Inability to provide ultrasound scanning within 24 hours (SBL 3 requirement) - 10

0 risk **approved**

3 risks **closed**
NEO 1978 Access to a Neonatal dietician (merged with NEO 1977)
MAT 3616 Risk of non-compliance with CNST Yr. 5
MAT 2581 Sustainability of Maternity Services

Exceptions

The Risk register has been added to the respective Maternity and Child Health Patient Safety Group agendas and progress is being made to support with overdue risk actions and progress risks through to tolerated risk status as a team in live time. There are 6 risks scoring 6 or less which are under review to establish if can be tolerated.

4. Ockenden 2 progress update

Q3 Update		Local Actions			N/A	Trust Corp Action	National/ regional Action
		Red	Amber	Green			
EA1	Workforce planning and sustainability	0	1	7			3
EA2	Safe staffing	0	0	9			1
EA3	Escalation and accountability	0	0	5			
EA4	Clinical governance-leadership	0	1	5		1	
EA5	Clinical governance – incident investigation and complaints	0	0	7			
EA6	Learning from maternal deaths	0	0	2			1
EA7	Multidisciplinary training	0	1	6			
EA8	Complex antenatal care	0	0	4			1
EA9	Preterm birth	0	0	4			
EA10	Labour and birth	0	1	3	2		
EA11	Obstetric anaesthesia	0	0	7			1
EA12	Postnatal care	0	0	4			
EA13	Bereavement care	0	0	4			
EA14	Neonatal care	0	0	5			3
EA15	Supporting families	0	0	3			
	Total	0	4	75	2	1	10

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

Q1 24/25 has seen some progress against the actions and 4 remain outstanding.

The MIAA Ockenden 2 audit has been completed and the result was *substantial assurance given*.

Exceptions - 4 actions remain, all are in progress. All action leads have been asked to provide regular updates on their actions.

5. Maternity Incentive Scheme Year 6

The maternity incentive scheme (MIS) applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

MIS Yr.6 was published on the 2nd April 2024 and we are working closely with the LMNS for shared oversight and quality assurance. Leads appointed and work against Safety Actions continues.

No exceptions

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q4 23/24

	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU	TARGET
Jan-March 2024	557	33 (5.92%)	32 (5.74%)	7 (21.8%)	**4.5%**

In Q4, the total number of term admissions to the NNU was 5.92% of total term live births. This is a decrease from Q3.

Unexpected term admissions to the NNU accounted for 5.74% of total term live births. This is a decrease from Q3.

There is still work to be done with 7 (21.8%) of total admissions being potentially avoidable.

Findings from audit

- Term admissions to the NNU are on a downward trajectory
- Counselling around benefits and risks of earlier IOL/ELCS and steroid use was good
- ELCS are on the increase and steroid uptake for early ELCS declining
- Babies born via ELCS 37 -38+6 having not had steroids are more likely to go to the NNU for additional support
- Thermoregulation of the newborn has improved.

Recommendations

- Improve access to colostrum harvesting antenatal advice
- Facilitate use of hospital notes for all babies
- Improve maternity ward SBAR tools
- Improve the neonatal resuscitation documentation paperwork
- Identify any correlation between neonatal birth centile and admission
- Observe compliance of NEWTT 2 tool (Newborn Early Warning Track and Trigger) and Warm Care Bundle sticker
- Develop guideline to support the use of the NEWTT 2 tool

No exceptions

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

	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
	Q2 23-24			Q3 23-24			Q4 23-24			Q1 24 -25		
Total births	183	234	205	211	221	197	199	194	213	204	223	181
Total Stillbirths	0	2	2	1	1	0	1	1	0	1	0	0
Stillbirths adjusted for MTOP	0	2	2	1	0	0	1	1	0	1	0	0
Total late fetal loss 22 – 23+6	0	0	0	0	0	0	0	0	0	0	0	0
Total Neonatal Deaths	0	1	1	0	0	1	1	1	0	0	1	0
Early neonatal deaths (0-7 days)	0	1	1	0	0	1	1	1	0	0	1	0
Neonatal deaths adjusted for MTOP	0	0	1	0	0	1	0	1	0	0	0	0
Total Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0

7.1 Stillbirths

2024	Type of stillbirth	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
April	Antenatal	36	Black Caribbean	2	35	36.5	No	No	18.2	Yes	Await
May	-	-	-	-	-	-	-	-	-	-	-
June	-	-	-	-	-	-	-	-	-	-	-

There was 1 stillbirth in Q1 24/25. There were no immediate care or service delivery issues identified which likely affected the outcome.

Incidental findings:

- the use of the placental growth factor (PIGF) based testing to help diagnose pre-eclampsia in women who present with gestational hypertension was not used. WWL current guidance for initiating the PIGF pathway is for BP>140/90 and/or ≥ 1 proteinuria and/or unresolved symptoms. Utilising this guidance, a PIGF test should have been undertaken as there was evidence of protein in the patient’s urine sample.

Await PMRT.

7.2 Neonatal Deaths

There was 1 Neonatal death in Q1 24/25 at 17+2 weeks gestation. Under care of pre-term birth clinic. No care issues affecting outcome. A neonatal death at this gestation would not be eligible for PMRT, LMNS or MBRRACE data.

2024	Type of NND	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
April	-	-	-	-	-	-	-	-	-	-	-
May	Early	17+2	White British	9	33	36	No	No	-	No	NA
June	-	-	-	-	-	-	-	-	-	-	-

Themes

Low numbers make thematic analysis difficult. However all data is logged to allow analysis over time. We continue to monitor ethnic origin and social deprivation index for all mortalities. Black Caribbean origin and Decile 2 (low socio-economic group) were noted for the stillbirth in Q1.

There is currently no enhanced maternity service for those women living in Decile 2 or those women of black or ethnic origin who speak English. WWL maternity services are currently reviewing the enhanced team model to optimise the support given to vulnerable women in the Borough.

Raised BMI and maternal age ≥33 years is noted in both stillbirth and neonatal death data in Q1 24/25.

7.3 PMRT and MIS Year 6 compliance

In Q1 24/25, 0 cases were finalised at PMRT.

Case (date of death)	Standard 1 Notify all deaths within 7 working days	Standard 2 Seek parents' views of care: For at least 95% of all the deaths of babies	Standard 3a 95% of reviews to be started in 2 months of death	Standard 3b Minimum of 60% MDT reviews to be completed/published within 6 months
06/04/24	Met (1 day)	Met	Met	Due 06/10/24
14/02/24	Met (2 days)	Met	Met	Due 14/08/24
07/02/24	Not eligible			
17/01/24	Met (3 days)	Met	Met	Due 17/07/24
21/01/24	Notification only	-	-	-
27/12/23	Not eligible			

No exceptions

8. Saving Babies Lives (SBL)

Element	RAG	Compliancy/ Improvement Plan
Element 1- reducing smoking in pregnancy		CO @ booking 96 % for Q4 - meets SBL parameter of 95%. CO @ 36 weeks is 75%. Does not meet SBL parameter of 95% - ongoing issue with E3 some data was not collected due to question disappearing from Pre Delivery section where CO is recorded. Addressed and data needs to be re calculated. Quit date data needs improvement currently @45% minimum target is 50%. Under discussion with GM Smokefree group to set the quit date at the second visit to capture more women and allow incentives to be up taken. Regular teaching sessions of CO monitors are undertaken. Audit regularly undertaken. Trends, equity, and equality health status are used in all audits.
Element 2- risk assessment and surveillance for fetal growth restriction		Audit completed monthly. Number of babies detected in antenatal period is 43% - SBL parameter is 50%. Slightly below stretch target all Datix and gap grow audit completed, with no clear identified issues of care. All SFH and scan plotted correctly. Scan accuracy is also investigated; no issues identified within any category. Face to face training for SFH measurement and plotting, grow 2.0 digital plotting. Number of babies born <3rd centile and >37+6 weeks is 35% - SBL parameter is <70%. Babies born >3rd centile and <39 weeks is 26%. SBL parameter is <30% all below stretch target parameters.
Element 3- Raising awareness of reduced fetal movements.		Audit shows Dawes Redman CTG 100% within SBL parameter of 80%. Next working day scan is 36 % which is below minimum of 80%. Moving forward improvement in documentation and next working day scan slot availability will improve percentages. Number of inductions where the reason is only RFM is 7% above the stretch target of < 3 %. Small numbers of RFM inductions and then one in the category can make the percentages massively above the necessary targets. New facility in Triage commenced 14.03.2024. Two morning sessions now in place by midwife sonographer. Two MUPS currently in training complete in September 2024.
Element 4- Effective fetal monitoring during labour		Number of audited records that had a risk assessment completed at onset of labour is 91%- SBL parameter is 90%. Maternal and fetal wellbeing hourly review is 88% - SBL parameter is 90%. Sample is a small cross section, and some did not receive a fresh eye within the second stage. Fresh eyes review within time frame, CTG categorisation and escalation is 84%. SBL parameter is 90%.
Element 5- Preterm Births.		All optimisation/ SBL parameters are being met except one 5.20 Livebirths born < 34+0 weeks who receive steroids antenatally is 50%- SBL parameter is >60%. Data is small sample of women in category, if one or two don't receive both doses because of precipitate labour and other factors percentages can fluctuate massively. Quick access preterm birth box utilised on delivery suite. Preterm birth clinic started in March 2024, dedicated access to consultant and TV scanning. Trends are identified in audit and highlighted issues are addressed.
Element 6 – Diabetes in Pregnancy.		One stop clinic template implemented within SBL parameters, CGM is 100% above stretch target of 95%. HbA1C is @ 89%, measurement just below stretch target of 90%. All other parameters met.
SBL training Elements 1-6.		91% doctors and midwives compliant with element modules. 8.5% non-compliant all contacted via e mail and face to face to address any ongoing issues with access, time allocation or learning challenges. Midwives 91.5 % compliant, doctors 86% compliant. Grow 2.0 training commenced, completed -139 members of staff trained by Q1 end. 75% compliant. Above stretch targets in all categories.

9. GMEC LMNS Ambition

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

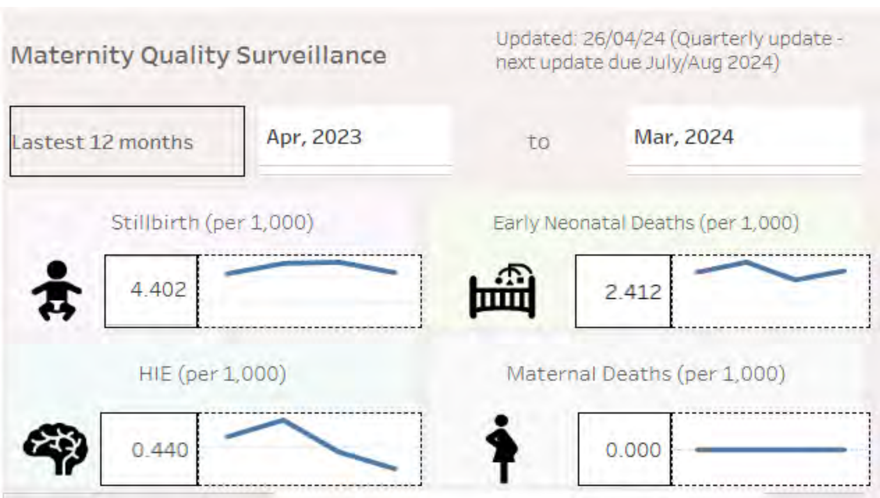
• Reduction in still births to a rate of 3.5 per 1000 registerable births in 2024/25

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

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

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

WWL measures its progress against the GMEC LMNS ambition. Over this rolling 12 period stillbirth data has started a steady decline. Data for the rate of HIE is incredibly positive and it is vital that we continue to monitor, learn and improve to sustain this figure.



10. Mandatory Training Compliance Midwifery

	Number attended	Percentage of staff	Rolling percent
BLS	43	26.5%	90%
NLS	43	26.5%	90%
PROMPT	44	27%	94%
Fetal Physiology	48	30%	97%

In Sept 2023 the structure of mandatory training updated. Midwives are allocated 4 maternity training sessions per year, consisting of PROMPT, Full day Fetal Physiology, Maternity Safety day and Specialist Services update, ensuring all elements of CNST and Core Competencies Framework 2 included. All midwifery training is >90% compliance for Q1 24/25. From September 2024 a 5th day will be introduced to maternity training schedule to allow 1 full day for SBL training.

Community PROMPT commenced in June 2024 with one midwife from each community team attending each month.

No exceptions

10.1 Mandatory Training Compliance Other Specialities

	PROMPT		Fetal Physiology	
	Number attended	Rolling percentage	Number attended	Rolling percentage
Consultant Obstetrician	2	100%	5	85%
Obstetric Registrar	2	75%	3	83%
Anaesthetist	5	77%		

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

Exceptions
There has been a decline in compliance for obstetric Fetal Physiology training.
x2 obstetricians are allocated to training in July 24.

Feedback from staff following PROMPT training high-lights not enough obstetricians present per session. The Practice Education team will work with the roster master to ensure an even spread on training dates.

11. Workforce / Safe staffing

At the end of Q1 24/25 there are 9.9 WTE midwifery vacancies.

WWL Maternity services are out to recruitment for 8.32 Band 5 WTE and 1.58 Band 6 WTE.

There are 3.64 WTE nursing vacancies on the neonatal unit. Recruitment for 0.94 WTE Band 7 post is planned for Q2 24/25.
There are 0.97 WTE HCA vacancies and WWL are out to recruitment.

11.1 Maternity Red Flags events including supernumerary shift co-ordinator

In Q1 24/25 there were 14 validated red flag events. In June, only 1 red flag was reported which reflects a reduction in sickness levels, the uptake of bank shifts and reduced activity and acuity.
The contributing factors for the red flags in April and May are related to short-term sickness and high levels of acuity. The key theme identified is delays in induction of labour being commenced, safety was maintained and all appropriate monitoring was undertaken.

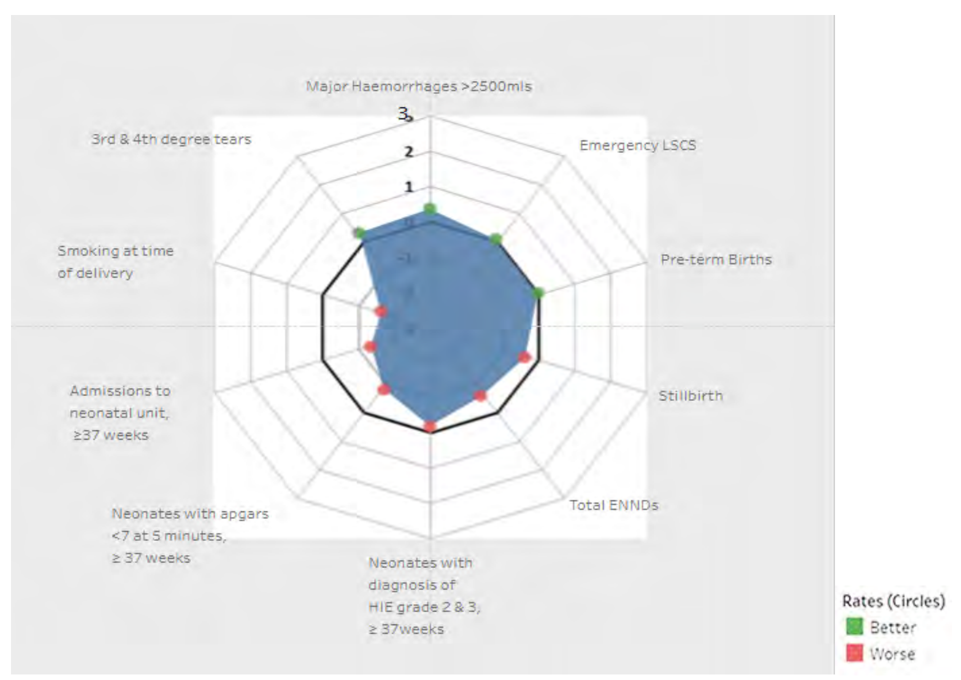
1 red flag was reported due to the shift coordinator not remaining supernumerary; this was due to a reduction in medical staffing and 2 emergency scenarios occurring simultaneously; appropriate escalation was followed.

From analysis of the red flag events appropriate escalation was followed, safety was maintained, no harm was caused.

11.2 Maternity Unit Diverts

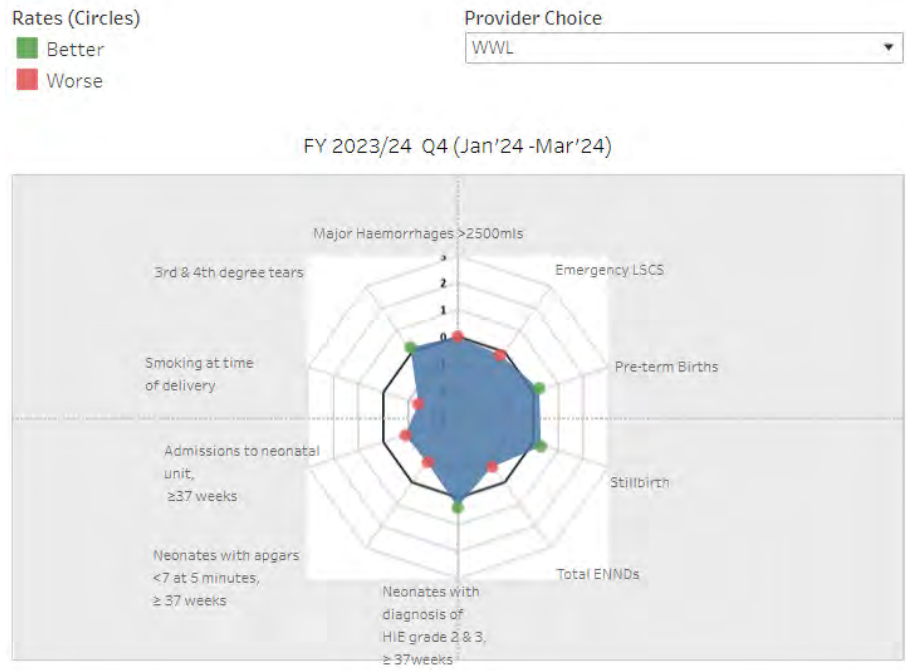
In Q1 24/25 there were 2 Diverts, one in April and one in May. Both were due to obstetric doctor short term sickness. 5 women were affected by the Divert and letters of apology were sent. There was no harm caused.

12. WWL data as compared to GMEC - rolling 12 months (Apr 23 – Mar 24)



Between April 23 and March 2024, WWL performed better than GMEC average for rates of major obstetric haemorrhage >2500mls, 3rd and 4th degree tears, emergency LSCS and pre-term births.

12.1 WWL Data compared to GMEC average – Q4 23/24 (latest data available) Source Tableau



In Q4 23/24, WWL has performed better than the GMEC average in rates of 3rd/4th degree tears, stillbirth, pre-term births and neonates diagnosed with HIE 2 and 3 at term.

In Q4 23/24, WWL has performed worse than the GMEC average in term admissions to NNU, early neonatal death, neonates with Apgars <7 at 5 at term, term admissions to the NNU and major haemorrhages >2.5 litres.

*Note that current recommendations are that Trusts do not benchmark the rate of Emergency Caesarean Sections as it was recognised by Ockenden that the pressure for normality may compromise patient safety.

While we remain outside the GMEC average for some parameters in the rolling 12 month period above, we are making progress and consistently improving rates of smoking at the time of delivery, stillbirth, neonatal death, term admissions to the NNU, 3rd and 4th degree tears and HIE 2 and 3 at term.

There were 2 neonatal deaths in this period. As per the last report both were 20 weeks gestation, below the age of viability, and will not be eligible for PMRT or included in MBRRACE neonatal death statistics. Immediate review is carried out on all deaths and there were no care or service delivery issues identified.

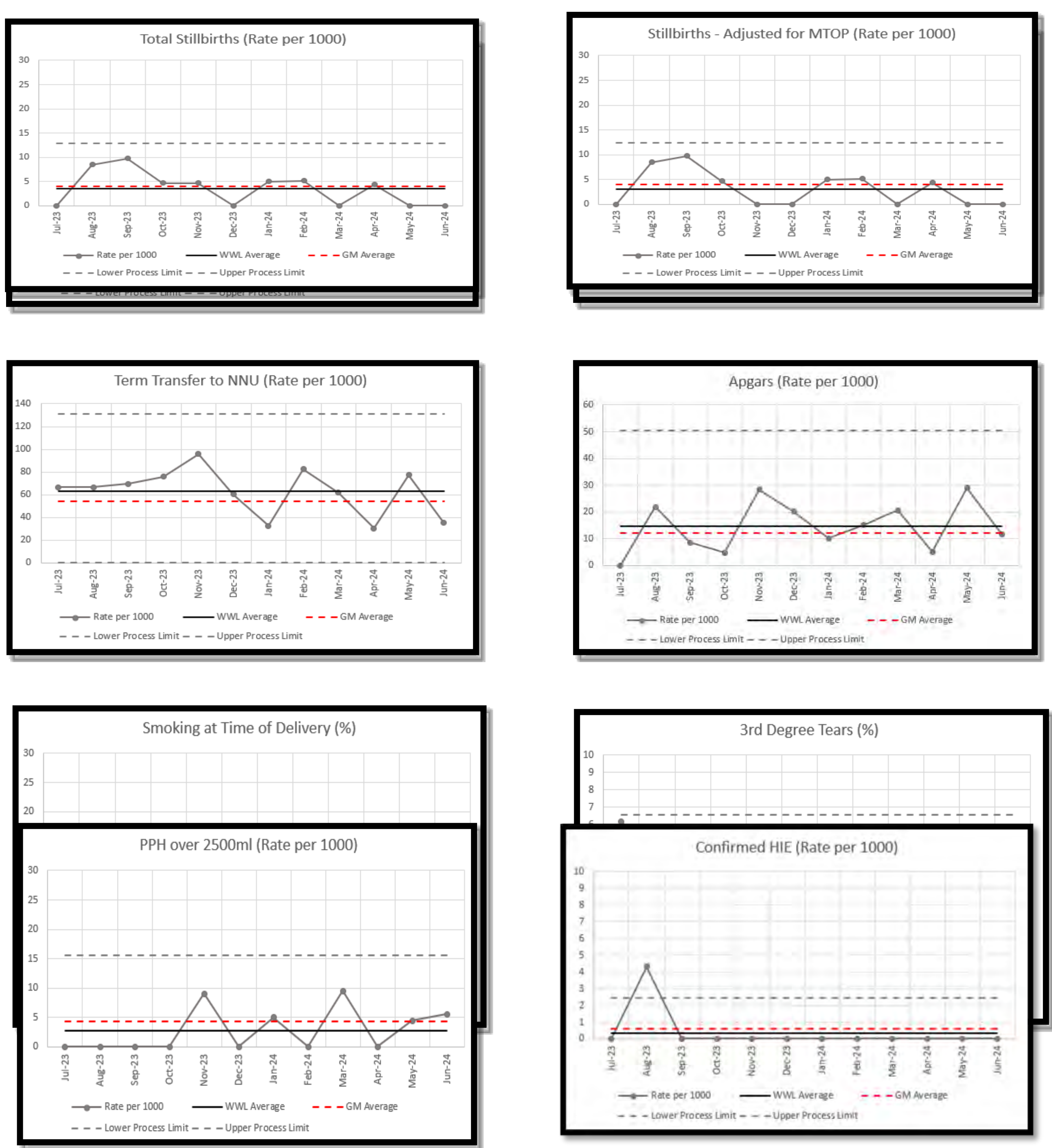
While we celebrate our own success, even making a splash in the Wigan Post, with a downward trend in smoking at the time of delivery, there is still work to be done to reach the national ambition set by NHS England of <6%.

12.2 SPC charts Q1 24/25

The SPC charts below are a more up to date and useful tool to review our own progress and position against GMEC average over time. The charts below give assurance of continued improvement and QI work continues in all areas and themes and trends monitored.

In the last 12 months the only parameters outside GMEC are for term admissions to the NNU and Apgars <7 at 5 minutes.

Themed analysis is underway to identify areas for improvement in relation to Apgars <7 at 5 minutes. ATAIN reviews are undertaken weekly with an overarching action plan to drive improvement work and a downward trend in the number of admissions is noted.



12.3 Outlier assurance data Q1 24/25

Outlier assurance was provided to the LMNS in May 24 for stillbirth data. WWL triggered against the England and GMEC average 3 times within a 6 month period.

Analysis of the stillbirth data between Nov 23 and May 24 showed that,

- WWL total stillbirth data is in line with the GMEC average over time.

- WWL data is below GMEC average when data adjusted for MTOP over time.

- 66% (2 out of 3) of stillbirths were to white British mothers.
- 100% (3 out of 3) of stillbirths were to mothers who live in areas of high social deprivation.
- 33% (1 out of 3) of stillbirths were due to anomaly (MTOP).
- 0% (3 out of 3) of women who had a stillbirth smoked cigarettes.
- 66% (2 out of 3) of women who had a stillbirth had a BMI ≥30.
- 66% (2 out of 3) of women who had a stillbirth were aged >30 years of age at booking.
- 33% (1 out of 3) of women who had a stillbirth had diabetes (gestational).

- 100% (3 out of 3) of initial stillbirth reviews did not find learning that affected the outcome.
- 33% (1 out of 3) of initial stillbirth reviews found important but incidental learning.

Learning - any proteinuria indicates need to offer PIGF test (pre-eclampsia).
- GMEC guideline is overdue an update

Summary

MIS Yr. 6 criteria was published on the 2nd April 2024 and WWL maternity services are working closely with the LMNS for shared oversight and quality assurance. All Safety Actions have been reviewed, leads appointed and work continues.

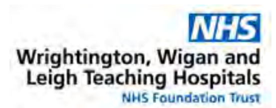
Q1 24/25 SPC charts give assurance of continued improvement with QI work continuing in all areas and themes and trends monitored. For the first time, smoking rates at the time of delivery are in line with GMEC averages and now our focus turns to achieving the national ambition of <6%. ATAIN QI work has resulted in a sustained downward trend in term admissions to the NNU with the foot remaining firmly on the pedal as the improvement drive expands to support Transitional Care. An MDT working group to review PPH of more than 1.5 litres is ready to commence with a view to identifying areas for improvement.

Outlier assurance data was provided to the LMNS in May 24 for stillbirth rates triggering 3 times against England and GMEC averages, however analysis of the data over time shows that WWL are in line or below GMEC averages. No points of concern identified. Incidental learning has been shared.

Active midwifery and nursing recruitment through Q1 should bring significant improvements in vacancies in Q2/Q3 24/25.

The Score Survey to explore team culture has been undertaken and results are pending. Once received, analysis of the data will take place to inform an improvement action plan as required.

Maternity Perinatal Quality Surveillance Dashboard 2024



CQC Maternity Rating – Last assessed 2023

OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
Good	Requires Improvement	Good	Good	Good	Good

		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Cardiotocograph (CTG) training and competency assessment	Midwives	10 (98.7 % compliant)	14 (98% compliant)	8 (96.3 % compliant)	5 (97 % compliant)	19 (97 % compliant)	12 (95.2% compliant)
	Consultants	1 (90% compliant)	1 (83% compliant)	2 (92.8% compliant)	2 (85.7% compliant)	0 (78 % compliant)	1 (84% compliant)
	Registrars	1 (86% compliant)	2 (100% compliant)	1 (88% compliant)	1 (90% compliant)	1 (100 % compliant)	1 (83% compliant)
Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)	Midwives	0 (0%) (85% compliant) PROMPT cancelled due to doctors strike	14 (8.9%) (87% compliant)	21 (13%) (82% compliant)	11 (6.7%) (86.5% compliant)	13 (7.8%) (95% compliant)	17 (10.8%) (89% compliant)
	MSW	0 (0%) (86% compliant) PROMPT cancelled due to doctors strike	4 (11%) (89% compliant)	4 (11%) (89% compliant)	3 (8.6%) (94% compliant)	4 (10.8%) (94% compliant)	3 (8.8%) (94% compliant)
	Obstetric Consultants	0 (0%) (69% compliant) PROMPT cancelled due to doctors strike	1 (7.7%) (61.5% compliant)	2 (18%) (77% compliant)	1 (7.7%) (84% compliant)	1 (7.7%) (100% compliant)	0 (100% compliant)
	Obstetrics Registrars	0 (0%) (92% compliant) (1 now on LTS) PROMPT cancelled due to doctors strike	1 (7%) (86% compliant) (1 now on LTS)	2 (17%) (67% compliant) (1 now on LTS)	1 (7%) (84.6% compliant) (1 now on LTS)	0 (79% compliant)	1 (7%) (84.6% compliant) (1 now on LTS)
	Anaesthetists	0 (0%) (88% compliant) PROMPT cancelled due to doctors strike	3 (15%) (90% compliant)	2 (15%) (80% compliant)	0 (15%) (88% compliant)	2 (6.8%) (94% compliant)	1 (3%) (77% compliant)
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)		60	60	60	60	60	60
1:1 care in labour		100%	100%	100%	99%	100%	100%
Maternity Red Flags reported (>3)		0	3	5	5	8	1

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Diverts: Number of occasions unit unable to accept admissions(>1)	0	0	0	1	1	0
Supernumeray Shift Co-ordinator	100%	100%	100%	98%	100%	100%
The number of incidents logged graded as moderate or above (>5)	0	1	1	2	1	0
All cases eligible for referral to MNSI.	0	0	0	0	0	0
Number of Datix submitted when shift co-ordinator not supernumerary*	0	0	0	1	0	0
Healthcare Safety Investigation Branch (HSIB)/NHS Resolution (NHSR)/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0
Progress in achievement of CNST 10	Progress with standards OnTrack	Progress with standards OnTrack	Awaiting the publication of CNST Year 6 (standards from Year 5 maintained)	Publication of CNST Year 6 (Review of standards underway)	Progress with standards On Track	Publication of CNST Year 6 Standards Review of all standards underway
Number of StEIS Reportable Incidents**	0	0 (1 NN)	0	0	0	1
Number of Stillbirths	1	1	0	1	0	0
Number of Early Neonatal Deaths ***	1	1	0	0	0	0
Number of Maternal Deaths	0	0	0	0	0	0

Maternity Perinatal Quality Surveillance Dashboard June 2024

CQC Maternity Rating – Last assessed 2023

OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
Good	Requires Improvement	Good	Good	Good	Good

May - Exception report

Stillbirths	StEIS Reportable Incidents	Maternity Red Flags reported
• There was 0 stillbirth in June 2024	1 Never Event Retained Vaginal Swab identified 12 days postnatally Process followed. Possible human factors involvement PSII commissioned at LfPSE Immediate Learning - the use of whiteboards to support with swab counts	• 1 validated Red Flag was reported on Birthrateplus app • Delayed or cancelled time critical activity • Safety maintained at all times and no harm caused
Early Neonatal Deaths before 7 days (over 20 weeks)	**1:1 care in labour**	**All cases eligible for referral to MNSI**
• There were no Early Neonatal Deaths in June	• 99% as one woman had a BBA and did not receive 1:1 care in labour	• There were no cases eligible for referral to MNSI. There have been no cases referrred to MNSI in 2024

Cardiotocograph (CTG) training	Practical Obstetric Multi-Professional Training (PROMPT)
Overall compliance for fetal physiology in June is 98.2% Consultants = 11/13 (84%) Registrars = 10/12 (83%) Midwives = 161/165 (95.2%) The 4 Doctors who are non complaint have been added to the July training	Midwives 17 attended (10.8%) Rolling % 89% MSW 3 attended (8.8%) rolling 94% Obstetric Consultants 0 attended (0%) rolling % 100% Obstetric registrars 1 attended (7%) rolling % 84.6% (1 now on LTS) Anaesthetists 1 attended (3%) rolling % 77%

Feedback

Service User Voice Feedback	Staff Feedback from Frontline Champions & Walkabouts (Bi-Monthly)
Feedback from Patient I felt extremely well looked after. I was overwhelmed and exhausted after my labour ending in an emergency c-section but the staff were so supportive helping me with breastfeeding and pain management. I never felt judged for not knowing what to do and everything was always explained clearly to me and my choices were always respected. I honestly can't thank every member of staff for their help and support during such a vulnerable, life-changing time. Thank you!	Formal Walkabout The next Formal Walk around is scheduled for the 9th July 2024

Agenda item: [21]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	M3 2425 Integrated Performance Report
Presented to:	Board of Directors
On:	7 August 2024
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 M3 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?

Executive Team Meeting: 25.7.24.

Recommendation(s)

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

Report

Please see the enclosed M3 IPR report.

Board of Directors IPR M3 2425.pdf

M3 24/25 Integrated Performance Report

Board of Directors

7 August 2024

Contents

- Integrated Performance Report Summary
- Integrated Performance Report Overview
- Holistic commentary
- Quality & Safety Overview
- Quality & Safety Commentary
- Quality & Safety Insight Report
- People Overview
- People Commentary
- People Insight Report
- Performance Overview
- Performance Commentary
- Performance insight report
- Finance Overview
- Finance Commentary
- Finance Insight Report
- Change Log

Trust Matrix : M3 June 24

VARIATION / ASSURANCE	Target is consistently met	Inconsistent performance compared to target	Target consistently failing
Improving Special Cause Variation	HSMR Rolling 12 months	Elective Recovery Plan - Inpatient activity performance ERF Income Agency Expenditure (£'000s) Better Payment Practice Code (BPPC)	SHMI Rolling 12 Months Appraisal Rate card adherence (Medical) A&E waiting times - patients seen within 4 hours No Right to Reside Patients (excluding Discharges) Total patients waiting over 65 weeks Elective Theatre Utilisation - Capped touchtime Escalation
No significant change	2-hour urgent community response	Never Events Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI Investigation How many incidents triggered a Patient Safety Review Category 3 and 4 Pressure Ulcers causing harm Moderate and Above Falls causing harm Methicillin-Susceptible Staphylococcus Aureus (MSSA) WVL Clostridium Difficile (CDT) Patient Experience (FFT) - Patients who would recommend the service Mandatory training compliance Sickness - %age time lost Time to hire Non-elective Length of Stay, RAEI Virtual ward patients Cancer 62 day performance Total patients waiting over 52 weeks Cancer faster diagnosis (FDS) standard performance Elective Recovery Plan - Day case activity performance Surplus /Deficit (£'000s) Adjusted Financial Performance (£'000s) Agency % of Total Pay Capital Expenditure (£'000s) Cost Improvement Programme (CIP) (£'000s)	Complaints Responses % Turnover Rate Vacancy rate Ambulance handovers 60+ minutes delay Critical Care Delayed step down Percentage of patients waiting less than 6 weeks for diagnostic tests % of new outpatient attendances or with procedure completed
Concerning Special Cause Variation	Cash (£'000s)	Methicillin-Resistant Staphylococcus Aureus (MRSA)	12-hour performance in Eds G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI

Trust Matrix : M3 June 24

ASSURANCE (columns) / **VARIATION** (rows)

VARIATION	Target is consistently met: Q&S	People	Perf.	Finance	Inconsistent performance compared to target: Q&S	People	Perf.	Finance	Target consistently failing: Q&S	People	Perf.	Finance
Improving Special Cause Variation	2						17	3, 4, 10	1	2, 3	3, 8, 10, 15	6
No significant change			18		3, 4, 5, 6, 7, 9, 10, 12	1, 6, 7	5, 7, 9, 11, 13, 16	1, 2, 5, 7, 9	11	4, 5	1, 6, 12, 14	
Concerning Special Cause Variation				8	8						2, 4	

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 (£'000s)
2. Adjusted Financial Performance (£'000s)
3. ERF Income
4. Agency % of Total Pay
5. Agency Expenditure (£'000s)
6. Escalation
7. Capital Expenditure (£'000s)
8. Cash (£'000s)
9. Cost Improvement Programme (CIP) (£'000s)
10. Better Payment Practice Code (BPPC)

Trust Holistic Narrative : M3 June 24

Good progress continues to be made with the SHMI work and there are no new alerting areas. Although there was a further increase in the numbers of complaints, there is improvement work being undertaken including the complaints workshop held in the Division of Medicine.

Staff sickness absence rate remains an area of concern and focus on long term sickness continues. There are >140 staff across the Trust absent from work more that 4 weeks. The Cashflow position remains a concern and is closely managed. Significant focus remains on delivery of the CIP programme including maximising ERF opportunities.

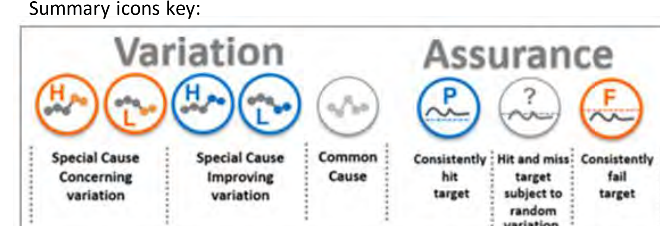
There has been further improvement in the ED 4-hour standard having met the performance in the revised trajectory. However, the number of patients spending 12 hours or more in the department remains too high. Bed occupancy and the 'No Criteria To Reside' numbers remain problematic. The diagnostic performance is improving except for non-obstetric ultrasound and further actions are being taken to address this. There remains continued focus on eliminating 65-week RTT waits and there are specific actions for the challenged specialties, in particular gynaecology.

Elective activity was on plan, but day case activity only achieved 91.3% of planned activity largely driven by under-performance in Orthopaedics (recovery plan in draft). The Leigh site surgical hub accreditation visit took place on 10th July, with an outcome expected on 5th August – accreditation would support the Trust mutual aid strategy.

Quality & Safety Overview: M3 June 24

#	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	SHMI Rolling 12 Months	Mar 24	105.99	100			110.04	108.24	111.85
2	HSMR Rolling 12 months	Mar 24	91.09	100			94.43	0.00	96.91
3	Never Events	Jun 24	1	0			0	0	2
4	Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI Investigation	Jun 24	3	4			4	0	12
5	How many incidents triggered a Patient Safety Review	Jun 24	27	33			34	0	56
6	Category 3 and 4 Pressure Ulcers causing harm	Jun 24	0	0			0	0	2
7	Moderate and Above Falls causing harm	Jun 24	1	1			1	0	5
8	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Jun 24	1	0			0	0	0
9	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Jun 24	1	0			1	0	6
10	WWL Clostridium Difficile (CDT)	Jun 24	2	5			3	0	15
11	Complaints Responses	Jun 24	67.2%	90%			63.3%	37.9%	88.7%
11	Patient Experience (FFT) - Patients who would recommend the service	Jun 24	89.8%	86.7%			86.9%	79.5%	94.3%

Summary icons key:



Quality & Safety Narrative: M3 June 24

Incidents

In month 3 (June 2024), 3 incidents triggered a Patient Safety Incident Investigation (PSII) as per our Patient Safety Incident Response Plan (PSIRP). One of these incidents related to a Never Event as defined by the NHS England Framework. This related to a retained swab in maternity that was identified within the community. On initial investigation of the procedure that this relates to, no issues appears within the local safety process and further investigation is taking place. Other PSIIs declared related to an incident of least restrictive practice and a possible missed ruptured AAA. Both incidents are being investigated and the least restrictive practice incident will be reviewed by the task and finish group established to review improvements.

Complaints

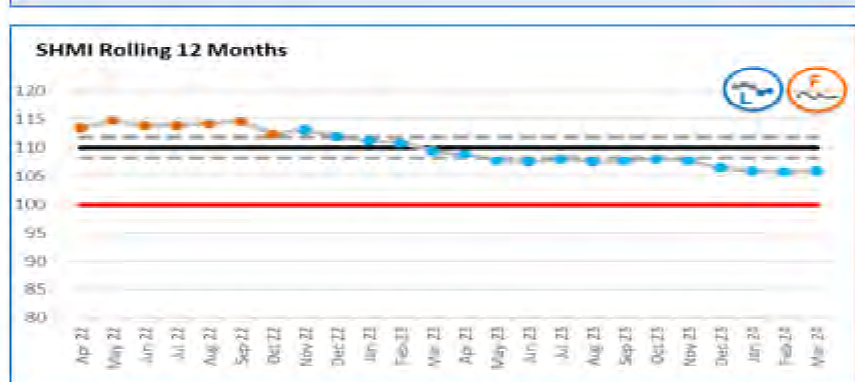
There was another increase in the numbers of complaints received in M3, June 2023. There was an increase in the compliance figures this month and improvement work is ongoing. The Division of Medicine hosted a complaints workshop where staff from all Divisions volunteered to work on complaints and attempt to deescalate/complete the investigations on the day in the Trust Boardroom. This allowed for a number of de-escalations and a number of complaints being closed and quality checked.
Top 3 types of complaints remain Values and behaviours, communication and admissions & discharges. Complaints training continues to support the addressing of these issues.

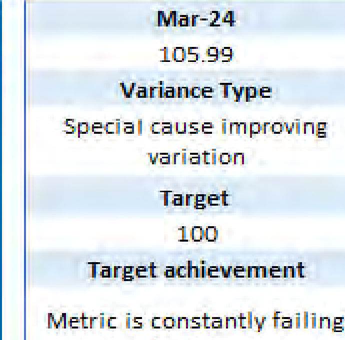
SHMI

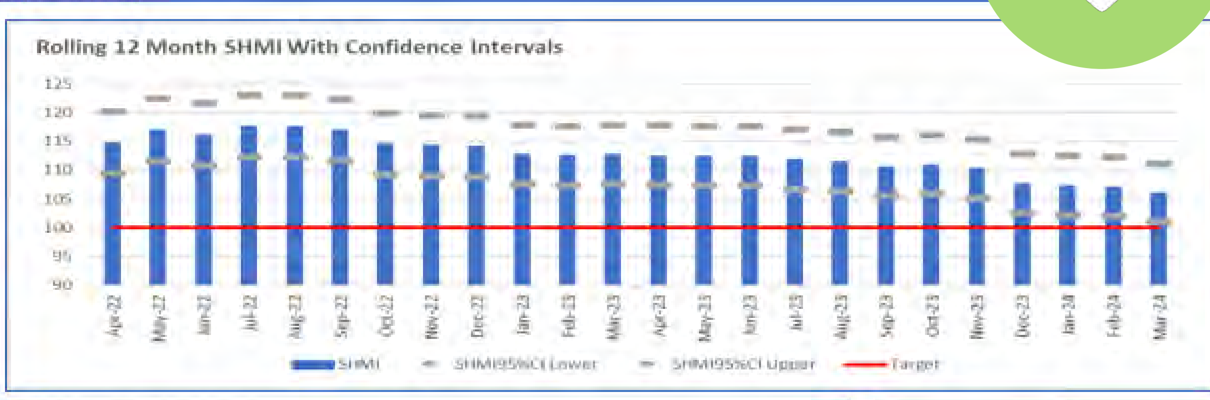
Our in hospital and out of hospital SHMI continues to get better and has now reduced to 105.99 which is one of the lowest we have seen. Monthly and quarterly mortality review groups are still in place, reviewing any alerting areas, however, there are no new alerting areas. Mortality reviews continue weekly and any areas of concern are escalated for further review.

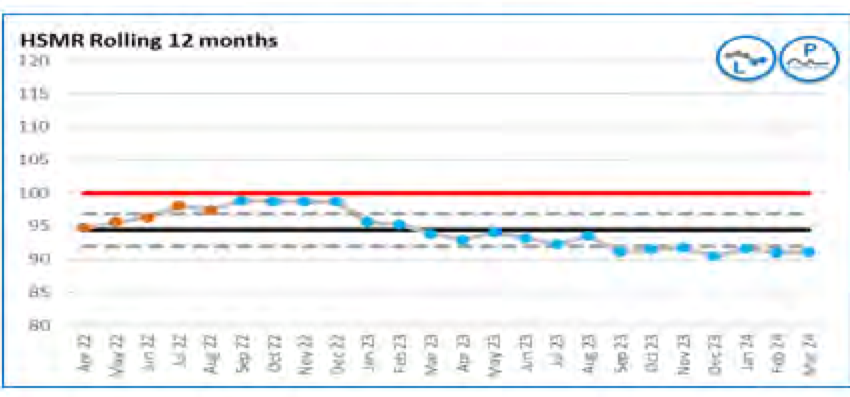
Quality & Safety Insight Report: M3 June 24

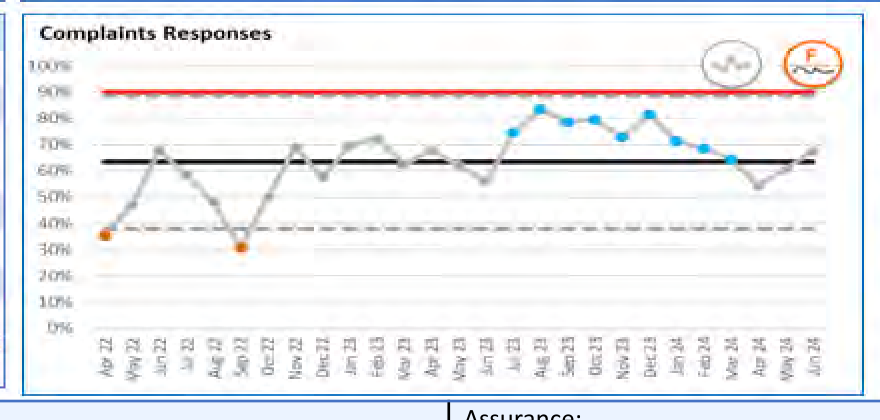
Focus : Quality & Safety

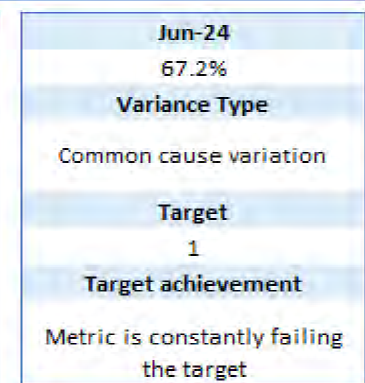












Summary:	Actions:	Assurance:
SHMI and HSMR Monthly and quarterly mortality review groups continue to review any areas of SHMI that are alerting and seek assurances that these are being managed appropriately **Complaints responses** Complaints compliance is under weekly review and monitor progress of 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** Continue to support Divisions in quality checking of complaints, as well as planning for future workshops Work on 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. HSMR continues to fall **Complaints responses** Although complaint compliance has dropped in recent months, intensive work is underway to support the timely investigation

Our People Overview : M3 June 24

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Mandatory training compliance	Jun 24	95.4%	95%		?	94.9%	93.9%	95.8%
2	Appraisal	Jun 24	81.8%	90%	H	F	79.3%	77.5%	81.0%
3	Rate card adherence (Medical)	Jun 24	71.4%	80%	H	F	52.8%	34.8%	70.7%
4	% Turnover Rate	Jun 24	9.0%	8.5%		F	9.0%	8.7%	9.2%
5	Vacancy rate	Jun 24	7.1%	5%		F	6.1%	5.0%	7.2%
6	Sickness - %age time lost	Jun 24	5.1%	5%		?	5.2%	4.6%	5.8%
7	Time to hire	Jun 24	56.9	65		?	57.7	46.9	68.5

Summary icons key:

Variation
- Special Cause Concerning variation
- Special Cause Improving variation
- Common Cause

Assurance
- Consistently hit target
- Hit and miss target subject to random variation
- Consistently fail target

Our People Narrative : M3 June 24

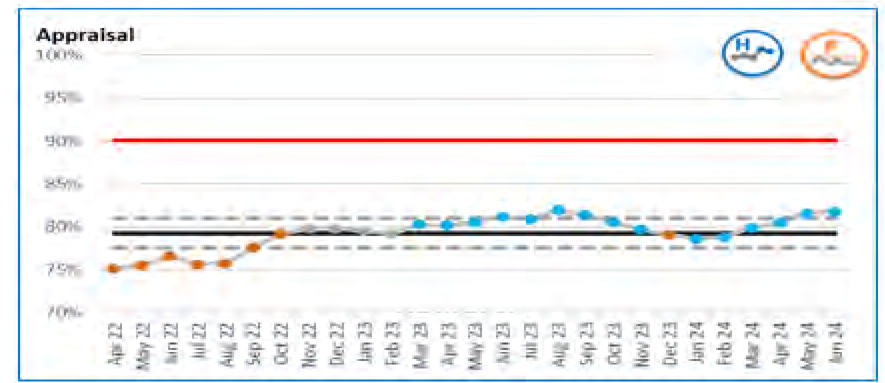
Sickness absence rate decreased in June 2024 to 5.1% (in-month) from 5.3% in May. This remains a common cause variation. Long term sickness cases remain high across the Trust with >140 staff absent from work more that 4 weeks based on ESR data (6 weeks lapse). Stress/Anxiety/Depression remains the greatest proportion of absence and continues to be an area of focus for the Trust in understanding the support our staff require to enable them to stay well and in work. As part of the Trust's EDI Strategy Group a workstream has been established to support improved experience of our disabled workforce, and looking particularly at the implementation of the Health Passport to ensure staff with long term health conditions are supported with reasonable adjustments to support them to remain well and in work.

Turnover is now above the Trust target of 8.5% at 9% remaining consistent with the average from October 2023. With the impetus of our new stretch target of 8.5% and implementation of the WWL People & Culture Strategy will provide actions that support the retention of workforce in WWL. Further strategic work as part of the EDI agenda will also provide a platform to improve retention and reduce turnover rates.

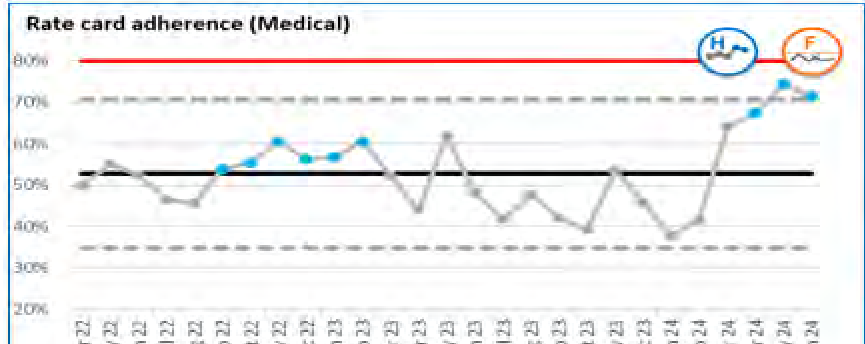
Vacancies have increased in June to 7.1% from 6.6% which is a further decrease from the 5% target. Some of these are attributed to vacancy approval process in line with financial stability plans causing some additional delays. Linked to turnover our EDI workstreams including civility and respect and inclusive recruitment will assist in reducing our vacancy rate and decrease turnover once benefits are realised from schemes of work. E&F division are under specific pressure due to ongoing vacancies.

Time to hire has decreased by almost 2 days from May to 57 days, which is well within the target of 65 days and is consistently hitting target since February 2024. Noting the links to our vacancy rate and turnover, scrutiny continues to be applied to achieve financial sustainability. Time to Hire remains a primary concern of the Establishment Control Group which continues to meet weekly to support the timely and efficient push through of vacancies that are approved.

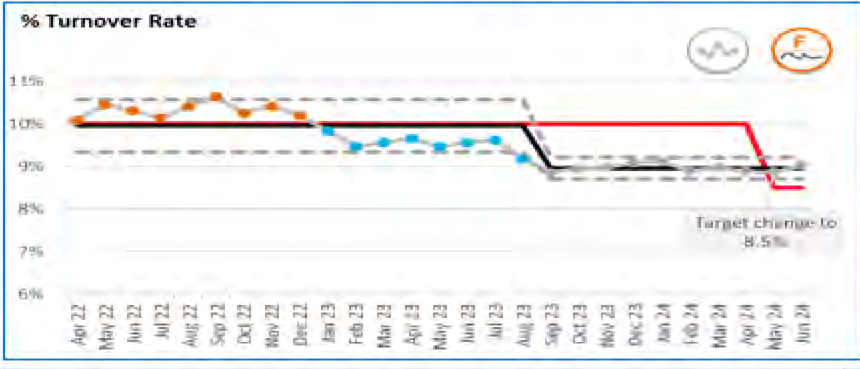
Our People Insight Report : M3 June 24



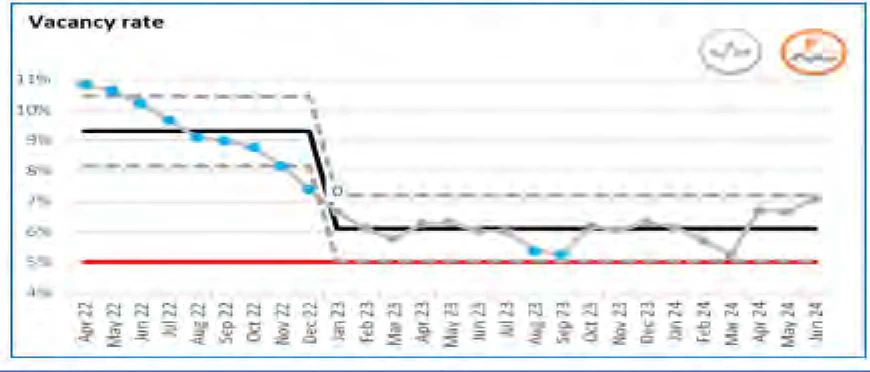
Jun-24
81.80%
Variance Type
Special cause improving variation
Target
90%
Target achievement
Metric is constantly failing the target



Jun-24
71.40%
Variance Type
Improving special cause variation
Target
80%
Target achievement
Metric is constantly failing the target



Jun-24
9.00%
Variance Type
Common cause variation
Target
9%
Target achievement
Metric failing the revised target



Jun-24
7.1%
Variance Type
Common cause variation
Target
5.0%
Target achievement
Metric is constantly failing the target

Summary:

1. Appraisal continues to report an increase. As reported in Apr IPR the newly agreed, more flexible approach, to completing appraisals will support line managers with capacity to ensure appraisals can be completed in a timely manner. This will not affect the way compliance is monitored. Focussed improvement plan for Medics (Lead Employer) Significant improvement in compliance figures. Rank 8th in GM compared to original ranking 25th in Jan 2024
2. Whilst the Trust continues to fail to meet the target on rate card adherence, added scrutiny has had a positive impact. This will continue.
3. Turnover has remained static with % at previous months level. We remain focused on driving towards our new stretch target. E&F challenged with high turnover currently.
4. The vacancy rate has increased this month. Vacancy approval delays due to additional scrutiny. High vacancies contributed via turnover in E&F.

Actions:

1. Detailed compliance information shared with Divisions. Discussion at Divisional Assurance Meetings. Monthly escalation report via Wider Leadership Team to be established. Compliance is likely to reduce in M4 due to large intake of medics (Lead Employer), improvement plan will remain in place to continue focussed work to maintain compliance levels
2. Weekly medical establishment control meetings are in place. Liaison (Medical Bank provider) attend monthly and support review. Systematically working through each rate card breach to review lessons learnt.
3. Immediate action is to undertake a detailed piece of work to understand reasons for leaving in a more in-depth way.
4. Linked to EDI & retention strategy as part of turnover actions. Developments around values-based recruitment also being considered.

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.
3. The Trust benchmarks well when compared with other similar organisations.
4. The EDI strategy group provides oversight of EDI strategic agenda and actions which includes key themes linked to inclusive recruitment and retention.

Our Performance Overview : M3 June 24

#	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Ambulance handovers 60+ minutes delay	Jun 24	133	0			239	39	438
2	12-hour performance in EDs	Jun 24	15.7%	10%			15.6%	12.7%	18.6%
3	A&E waiting times : patients seen within 4 hours	Jun 24	74.0%	74%			69.1%	65.5%	72.7%
4	G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI	Jun 24	100.0%	96%			99.1%	97.4%	100.9%
5	Non-elective Length of Stay, RAEI	Jun 24	3.93	4.68			4.08	3.55	4.61
6	Critical Care Delayed step down	Jun 24	18	0			16	3	30
7	Virtual ward patients	Jun 24	74.6%	80%			87.8%	65.7%	109.8%
8	No Right to Reside Patients (excluding Discharges)	Jun 24	112	50			134	117	152
9	Cancer 62 day performance	May 24	74.9%	75%			78.9%	69.0%	88.8%
10	Total patients waiting over 65 weeks	Jun 24	418	270			894	308	1480
11	Total patients waiting over 52 weeks	Jun 24	2408	2619			3681	1225	6138
12	Percentage of patients waiting less than 6 weeks for diagnostic tests	Jun 24	76.3%	95%			73.6%	65.3%	82.0%
13	Cancer faster diagnosis (FDS) standard performance	May 24	81.4%	77%			78.6%	70.3%	86.8%
14	% of new outpatient attendances or with procedure completed	Jun 24	45.6%	46%			43.8%	41.8%	45.9%
15	Elective Theatre Utilisation - Capped touchtime	Jun 24	83.7%	85%			79.6%	74.7%	84.6%
16	Elective Recovery Plan : Day case activity performance	Jun 24	91.3%	100%			99.4%	84.2%	114.6%
17	Elective Recovery Plan : Inpatient activity performance	Jun 24	100.6%	100%			91.4%	63.9%	119.0%
18	2-hour urgent community response	May 24	86.2%	70%			83.5%	72.2%	94.8%

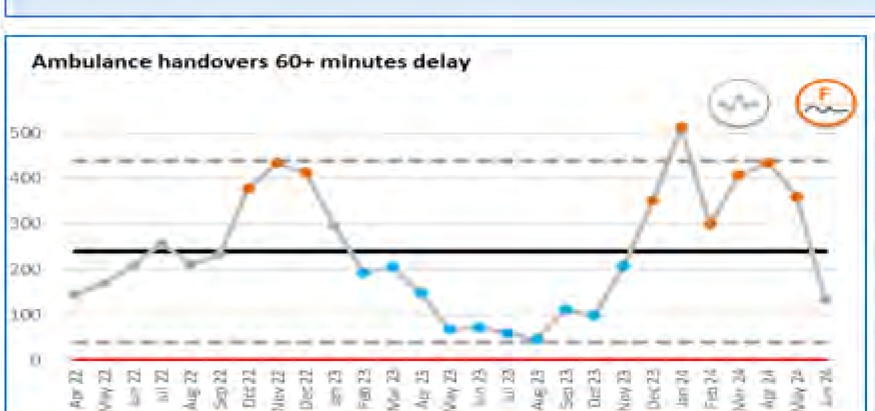
Summary icons key:

Our Performance Narrative : M3 June 24

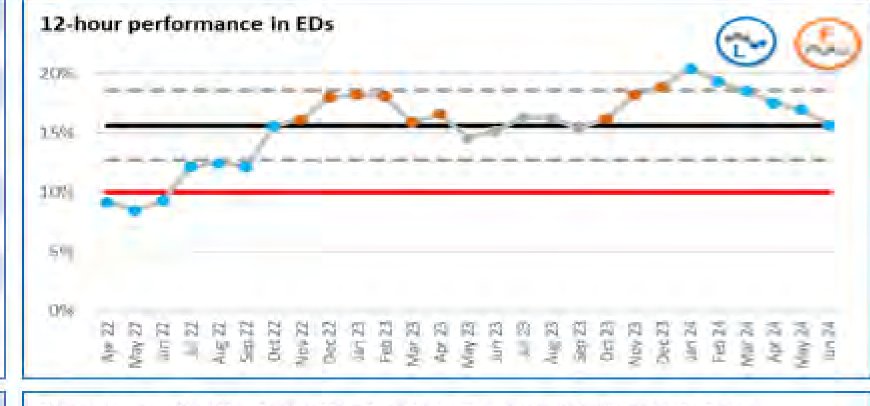
- 4-hour performance in June continued to improve, achieving exactly 74% in line with our revised trajectory (74%) .
- 12 hour waits reduced by over 3% in month but still remain a significant pressure and a key focus for improvement.
- Ambulance handover improved significantly in month but remains above target - WWL performed best in GM on a number of occasions throughout June - this is being managed at Exec level via detailed action plan.
- G&A bed occupancy remains 100% - despite this, corridor care was de-escalated throughout June and into July. The Escalation Area, AAA has also been de-escalated and has now been removed from ED capacity plans.
- The number of patients waiting beyond 52 weeks is lower than plan, which is positive. However, more patients are waiting beyond 65 weeks than planned – this is driven by Gynaecology and Endocrinology. Endocrinology is now on target to eliminate 65 week waits by the end of September. Gynae remains a risk specialty due to increased demand, capacity challenges and inability to access mutual aid. Insourcing options are being explored with a view to progressing at pace.
- Cancer services continued to exceed the 28-day faster diagnosis standard. 62-day performance in May was 74.9%, just below the target of 75%. Pressure areas are colorectal and gynae
- Elective theatre utilisation improved again but is still below target of 85% - the improvement is driven by increased utilisation on the Leigh site. The Leigh site surgical hub accreditation visit took place on 10th July, with an outcome expected on 5th August – accreditation would support the Trust mutual aid strategy. Elective activity was on plan, but day case activity only achieved 91.3% of planned activity - this was due to an under-performance within Trauma and Orthopaedics - an initial recovery plan has been presented to the Executive Team and is being revised following feedback.

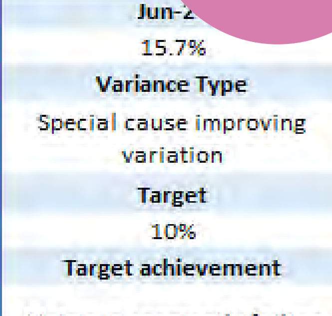
Our Performance Insight Report : M3 June 24

Focus : Performance

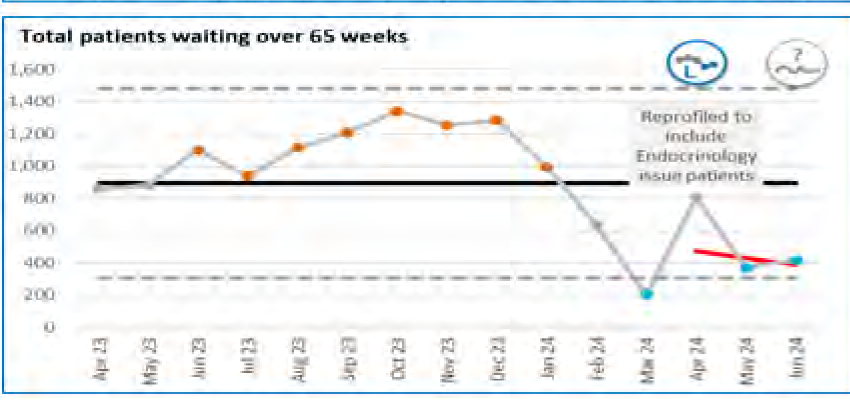


Jun-24
133
Variance Type
Common cause variation
Target
0
Target achievement
Metric is constantly failing the target

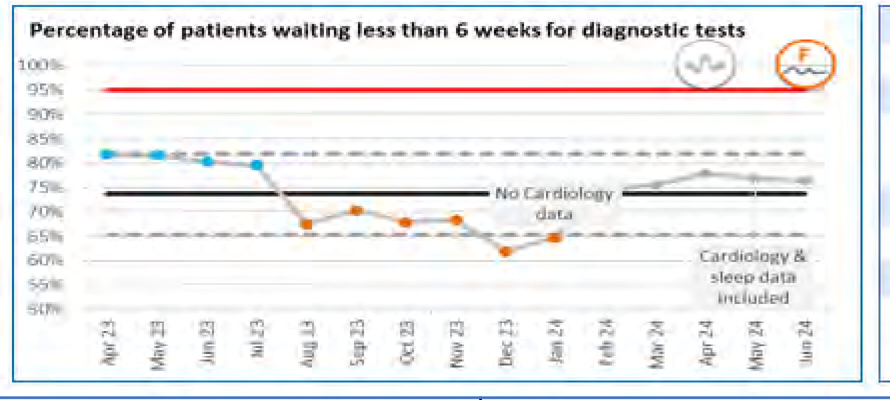


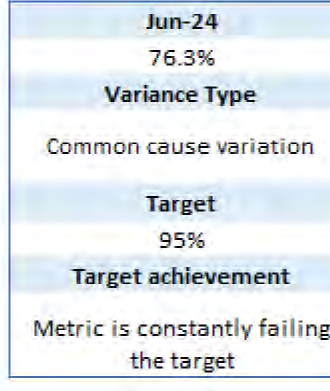


Jun-24
15.7%
Variance Type
Special cause improving variation
Target
10%
Target achievement
Metric is constantly failing the target



Jun-24
419
Variance Type
Improving special cause varitation
Target
270
Target achievement
Hit and miss target, subject to random variation





Jun-24
76.3%
Variance Type
Common cause variation
Target
95%
Target achievement
Metric is constantly failing the target

Summary:

1. A&E 4-hour performance improved and meets planned trajectory but remains below target of 78%
2. 12-hour performance in June was 15.7%
3. Slight deterioration in performance this month in patients waiting over 65 weeks and failing trajectory – gynae remains a risk to achievement of 65-week clearance, plans in place to mitigate as much as possible
4. The percentage of patients waiting less than 6 weeks for diagnostic tests dipped slightly in June, driven by capacity issues in non-obstetric ultrasound. All other modalities are on track to achieve 95%, and a recovery plan is now in place for NOUS

Actions:

1. Back to Basics, Ambulance Turnaround project and focus on daily breaches
2. Progressing revised acute medical offer via Discharge and Flow Programme
3. Medinet contract in progress for gynae insourcing - current plan to go live 17th August
4. NOUS LPV now agreed to support delivery - insourcing support is also under consideration

Assurance:

1. Improving position, month on month – June performance currently at 74%
2. Exec led weekly scrutiny with identification of specific cohorts and development of clinically led plans to address the long waiters
3. Micromanagement of waiting lists, gynae insourcing
4. NOUS recovery plan in place, supported by LPV

Our Finance Performance Overview : M3 June 24

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Surplus /Deficit (£'000s)	Jun 24	-1255	-752			-1079	-7692	5535
2	Adjusted Financial Performance (£'000s)	Jun 24	-1253	-736			-658	-5581	4264
3	ERF Income	Jun 24	9307	9868			8756	7354	10159
4	Agency Expenditure (£'000s)	Jun 24	623	689			928	475	1381
5	Agency % of Total Pay	Jun 24	2.0%	3.2%			2.6%	1.7%	3.5%
6	Escalation	Jun 24	476	0			766	564	969
7	Capital Expenditure (£'000s)	Jun 24	1548	1112			2112	-3136	7360
8	Cash (£'000s)	Jun 24	13957	16263			29437	18443	40431
9	Cost Improvement Programme (CIP) (£'000s)	Jun 24	2044	2275			2086	-478	4649
10	Better Payment Practice Code (BPPC)	Jun 24	93.2%	95.0%			92.3%	85.2%	99.5%

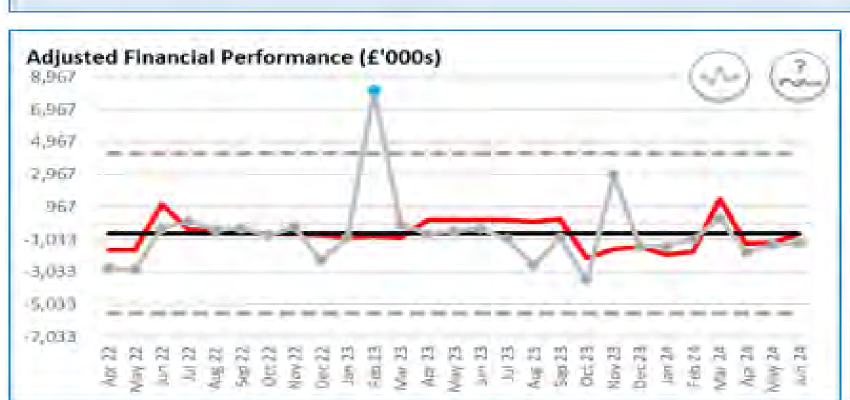
Summary icons key:

Our Finance Performance Narrative : M3 June 24

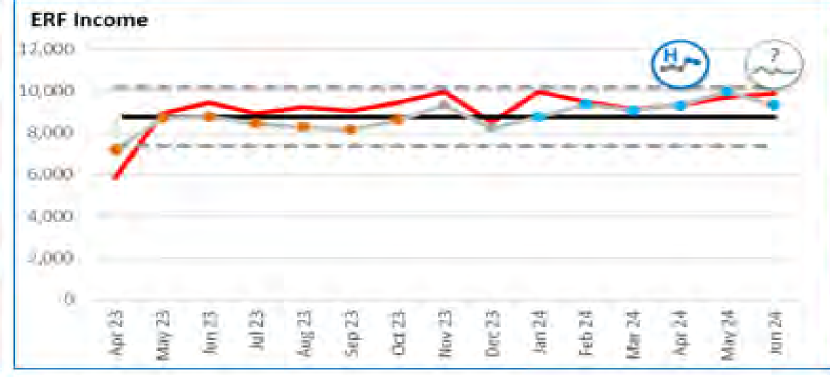
Description	Performance Target	Performance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Red	The Trust is reporting an actual deficit of £1.3m for month 3 (June) which is £0.5m adverse to plan. Year to date, the Trust is reporting an actual deficit of £4.4m which is £1.2m adverse to plan. The key drivers for the adverse variance are CIP slippage of £0.2m for June and £0.7m year to date. Industrial action costs were £0.3m. This deficit 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 £0.6m behind plan in month and £0.6m year to date. This activity shortfall needs to be recovered by the end of the financial year to achieve the 2024/25 plan.
Agency	To remain within the agency ceiling set by NHSE.	Amber	Agency expenditure is £0.6m in month 3, which is comparable to previous months and aligned to plan. This is £0.3m 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	At month 3, the reported escalation spend is £0.6m in month, which is a reduction on the prior month.
Capital expenditure	Achieve capital plan for 2024/25.	Green	Month 3 actual capital expenditure is £1.5m, which is £0.4m above plan due to the phasing of expenditure.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber	The Trust has a closing cash balance of £14.0m at the end of June 2024 which is £2.3m below plan.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red	In month 3, the Trust has delivered £2.0m CIP against the plan of £2.3m, therefore there is a shortfall of £0.2m in June and £0.7m year to date. As at month 3 there is an unidentified gap of £4.4m in year and £4.1m recurrently. Work is ongoing with the Divisions to close the gap.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Red	BPPC performance to end of June is 93.8% by volume and 94.8% by value, which is a slight deterioration to previous months by volume, improvement by value.

Our Finance Performance Insight Report : M3 June 24

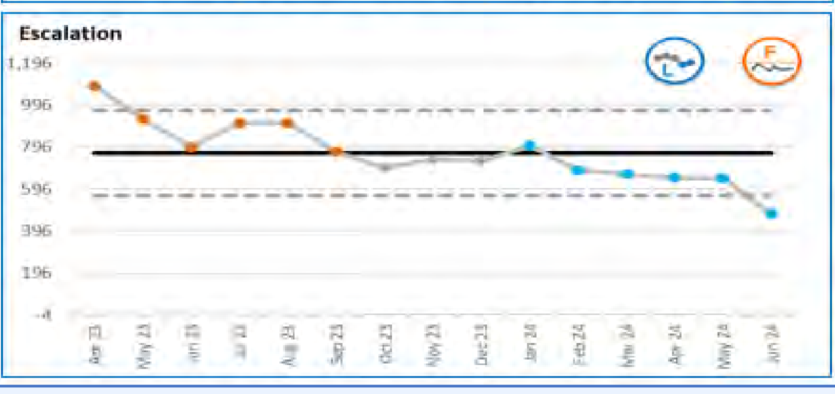
Focus : Finance



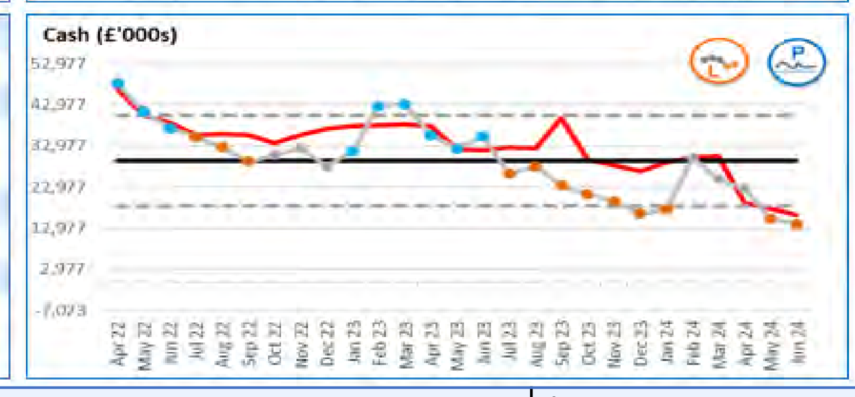
Jun-24
-1253
Variance Type
Common cause variation
Target
-736
Target achievement
Inconsistent performance compared to target



Jun-24
9307
Variance Type
Special cause improving variation
Target
9868
Target achievement
Inconsistent performance compared to target



Jun-24
476
Variance Type
Special cause improving variation
Target
0
Target achievement
Metric is constantly failing the target



Jun-24
13957
Variance Type
Special cause concerning variation
Target
16263
Target achievement
It is possible to meet the target

Summary:

1. The Trust is reporting an actual deficit of £1.3m for month 3 (June) which is £0.5m adverse to plan. Year to date, the Trust is reporting an actual deficit of £4.4m which is £1.2m adverse to plan. The key drivers for the adverse variance are CIP slippage of £0.2m for June and £0.7m year to date. Industrial action costs were £0.3m. This deficit needs to be recovered by the end of the financial year to achieve the 2024/25 plan.
2. ERF is £0.6m adverse to plan for month 3 (June) and £0.6m year to date. This is mainly due to reduced Trauma &Orthopaedics activity within the Specialist Services division.
3. Escalation costs for June were £0.5m, and £1.8m year to date. This is showing special cause improvement as expenditure has been on a downward trend since January 2024.
4. Cash is showing concerning special cause variation due to the downward trend. The cash balance at the end of June is £14.0m.

Actions:

1. This financial year is year one of the three-year financial sustainability plan. Continued focus on delivery of financial position, with grip and control measures continuing from 2023/24.
2. Specialist Services division have been tasked with completing a recovery plan to recover the ERF position in full for review at the executive team on the 11th August 2024.
3. The discharge and flow transformation board have approved plans to further redesign patient pathways to improve patient experience and reduce costs further this year.
4. Cash management strategy in place with detailed cash forecasting. Current run rate forecasts indicate cash support required from November. Confirmation awaited around mitigations from GM ICB and revenue deficit support funding.

Assurance:

1. Monthly divisional assurance meetings for all clinical divisions, Finance Improvement Group (FIG) and Finance and Performance Committee. Monthly provider oversight meeting with GM ICB (Ext.).
2. ERF is being monitored at the Elective Recovery programme board each month and the recovery plan for Specialist Services is going to the executive team on the 11th August 2024. Activity will also be monitored at the monthly divisional assurance meetings.
3. Monthly reviews of the de-escalation program of work at the discharge and flow program board, in addition to monthly divisional assurance meetings with the clinical divisions.
4. Cash Management Group, Finance and Performance Committee. GM Capital and Cash Group (Ext.)

Change log

Ref	Metric	Change	Date	Requested by:
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

Thank you

Agenda item: [22]

Title of report:	Trust finance report for June 2024 (month 3)
Presented to:	Board of Directors
On:	7th August 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 3 (June 2024). The formatting has been updated as part of a reporting refresh and any feedback is welcome.

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 13 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?

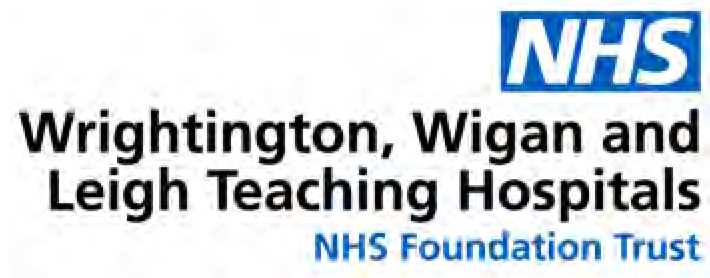
The finance report was reviewed by ETM on 25th July 2024 and by Finance and Performance Committee on 30th July 2024.

Wider implications

There are no wider implications of this report.

Recommendation(s)

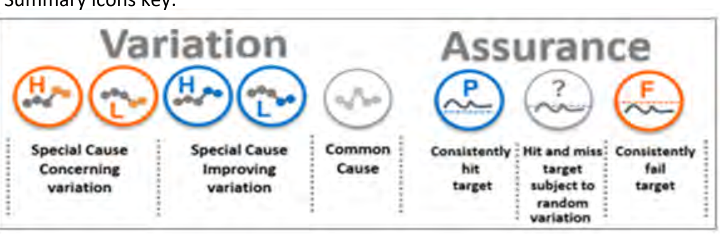
The Board of Directors are asked to note the contents of this report.



Trust Finance Report

Month 3 – June 2024

Summary icons key:



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Key Messages

For June 2024, we are reporting a deficit of £4.4m year to date, which is £1.2m below plan year to date. The month 3 position was a deficit of £1.3m, which was £0.5m adverse to plan, therefore month 3 was a deterioration on month 2. The planned deficit for the full year is £14.2m, with 2024/25 being the first year of the three-year financial sustainability plan.

Month 3 has been challenging. The underperformance in month of £0.5m is related to industrial action expenditure of £0.3m, CIP slippage of £0.2m and ERF underperformance of £0.6m. This has been offset by a non-recurrent benefit of £0.5m associated with recalculating the 2023/24 ERF underperformance. Year to date, CIP slippage is £0.7m against plan which will need to be recovered in year.

Elective activity is £0.6m behind plan in month. Surgery is £0.2m favourable to the internal plan and Specialist Services and Medicine are adverse by £0.8m and £0.1m respectively. Specialist Services underperformance is predominantly due to lost theatre sessions in Trauma & Orthopaedics, and the division have been asked to complete a recovery plan to mitigate the underperformance and fully recover and achieve their plan.

Workforce and pay costs remain static and above plan. other than the costs incurred for supporting the period of junior doctors' industrial action £0.3m. Escalation costs were £0.5m in June, which is a reduction of £0.2m on the prior month. This benefit is being offset with temporary staffing costs across multiple areas.

The Trust cash balance is declining, with external support likely within quarter 3. This may be mitigated if NHSE deficit support is agreed with the GM system based on the plan resubmission.

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Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Red		The Trust is reporting an actual deficit of £1.3m for month 3 (June) which is £0.5m adverse to plan. Year to date, the Trust is reporting an actual deficit of £4.4m which is £1.2m adverse to plan. The key drivers for the adverse variance are CIP slippage of £0.2m for June and £0.7m year to date. Industrial action costs were £0.3m. This deficit 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 £0.6m behind plan in month and £0.6m year to date. This activity shortfall needs to be recovered by the end of the financial year to achieve the 2024/25 plan.
Agency	To remain within the agency ceiling set by NHSE.	Amber		Agency expenditure is £0.6m in month 3, which is comparable to previous months and aligned to plan. This is £0.3m 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		At month 3, the reported escalation spend is £0.6m in month, which is a reduction on the prior month.
Capital expenditure	Achieve capital plan for 2024/25.	Green		Month 3 actual capital expenditure is £1.5m, which is £0.4m above plan due to the phasing of expenditure.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		The Trust has a closing cash balance of £14.0m at the end of June 2024 which is £2.3m below plan.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red		In month 3, the Trust has delivered £2.0m CIP against the plan of £2.3m, therefore there is a shortfall of £0.2m in June and £0.7m year to date. As at month 3 there is an unidentified gap of £4.4m in year and £4.1m recurrently. Work is ongoing with the Divisions to close the gap.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Red		BPPC performance to end of June is 93.8% by volume and 94.8% by value, which is a slight deterioration to previous months by volume, improvement by value.

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Financial Performance

Headlines

- In month 3 (June 2024) we reported an actual deficit of £1.3m, an adverse variance of £0.5m to the planned deficit of £0.8m.
- Year to date, the actual deficit is £4.4m which is £1.2m adverse to the planned deficit of £3.2m.
- A forecast deficit of £14.2m has been reported to NHSE, based on delivery of the plan in full. NHSE have advised to exclude the impact of industrial action within the forecast.
- The plan reflects the resubmission made to NHSE on 12th June 2024 with a full year planned deficit of £14.2m.

Income

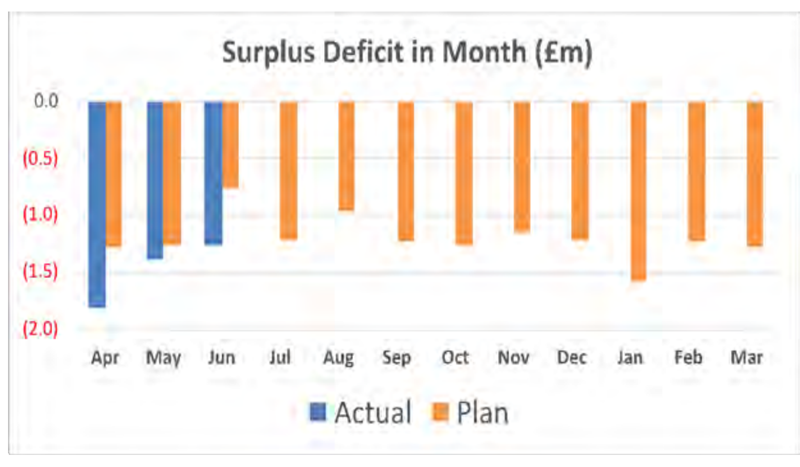
- Income is £0.1m favourable to plan in month 3.
- ERF underperformance of £0.6m is offset by a non-recurrent benefit of £0.5m associated with the recalculation of ERF underperformance for 2023/24.

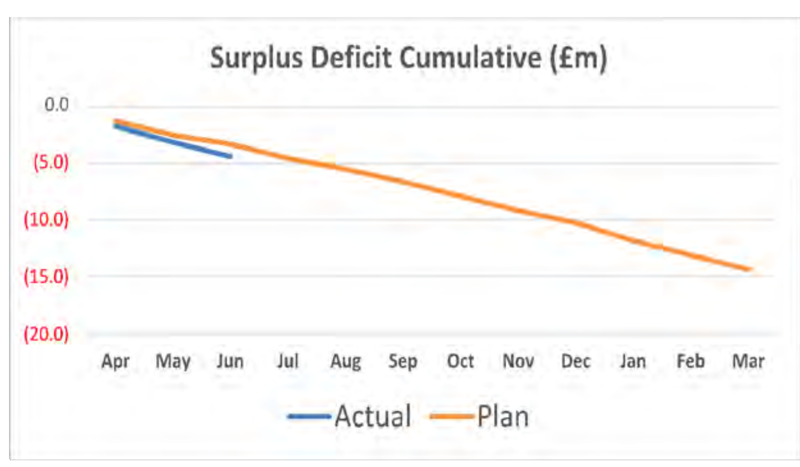
Pay

- Pay expenditure is £31.1m in month 3 which is £0.4m adverse to plan. CIP overperformance £0.2m offset with industrial action backfill costs of £0.3m.

Non pay

- Non pay expenditure is £11.6m in month 3, which is £0.3m adverse to plan. CIP shortfall of £0.3m.





Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	43,498	43,381	117	129,814	129,588	226	521,102
Pay	(31,083)	(30,731)	(352)	(92,984)	(92,160)	(825)	(369,989)
Non Pay	(11,629)	(11,351)	(278)	(35,458)	(34,530)	(927)	(140,768)
Financing / Technical	(2,040)	(2,050)	10	(5,835)	(6,181)	346	(24,725)
Surplus / Deficit	(1,255)	(752)	(503)	(4,463)	(3,283)	(1,180)	(14,380)
Adjusted Financial Performance *	(1,253)	(736)	(517)	(4,438)	(3,235)	(1,203)	(14,187)

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

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Key Metrics

CIP

- £2.0m transacted in month, adverse to plan £0.2m. Year to date CIP is £0.7m adverse to plan.

Temporary expenditure

- Bank expenditure £2.3m in month, £6.8m year to date.
- Agency expenditure is £0.6m in month, and £2.2m year to date. This is below the agency ceiling at 2.0% of total pay bill (ceiling 3.2%).

Cash

- £14.0m cash balance at the end of June, decrease of £1.3m on last month.
- £2.3m below plan.

Capital

- Total capital spend of £1.5m in month, £0.4m behind the plan of £1.1m.
- CDEL expenditure £0.2m; PDC expenditure £1.3m.

Escalation

- Expenditure of £0.5m in month 3, £1.8m year to date.

Key Metrics	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
CIP	2,044	2,275	(231)	6,077	6,825	(748)	27,300
Bank expenditure	2,292	2,207	(85)	6,754	6,621	(133)	26,833
Agency expenditure	623	689	66	2,232	2,975	743	11,840
Cash balance	13,957	16,263	(2,306)	13,957	16,263	(2,306)	7,415
Capital expenditure: CDEL	202	217	15	809	824	15	9,287
Capital expenditure: Leases	0	0	0	168	168	0	2,655
Capital expenditure: PDC	1,346	895	(451)	2,860	2,409	(451)	8,210
Total capital expenditure	**1,548**	**1,112**	**(436)**	**3,837**	**3,401**	**(436)**	**20,152**
Escalation expenditure	476			1,774			

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Income

Division	In Month (£000)			Year to Date (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	(25)	188	(213)	348	563	(215)
Surgery	544	231	312	1,209	694	515
Specialist Services	493	1,135	(642)	2,497	3,119	(622)
Community Services	576	570	6	1,690	1,710	(20)
Non Divisional Income	40,756	40,226	530	120,871	120,322	549
Finance	16	11	5	48	33	15
IM&T	10	7	3	19	22	(2)
Dir of Strat & Planning	195	224	(29)	499	672	(174)
Chief Operating Officer	0	0	0	0	0	0
Human Resources	25	1	24	76	3	73
Medical Director	119	54	65	244	149	96
Estates & Facilities	436	459	(24)	1,314	1,378	(64)
Nurse Director	136	29	107	335	191	144
Trust Executive	0	13	(13)	(0)	38	(38)
GTEC	202	250	(48)	648	750	(103)
Corporate	16	(18)	34	17	(55)	72
Reserves	0	0	0	0	0	0
Total	**43,498**	**43,381**	**117**	**129,814**	**129,588**	**226**

Headline

- Income is £0.1m favourable in month and £0.2m favourable YTD.

Specialist Services

- £0.6m adverse due to £0.8m underperformance on ERF offset by £0.1m over performance on Private Patients.

Medicine

- £0.2m adverse due to under performance on ERF income includes backdated correction to remove CDC income recorded elsewhere.

Surgery

- £0.3m favourable due to ERF over performance.

Non-Divisional Income

- £0.5m favourable in month. The Trust has reviewed the month 12 freeze data and reduced the contract provisions for 2023/24 ERF underperformance £0.5m and drugs challenges by £0.2m. This is offset with under performance on CDC activity of £0.2m.

Nurse Director

- £0.1m favourable due to Education income.

Medical Director

- £0.1m favourable due to prior year medical examiners funding.

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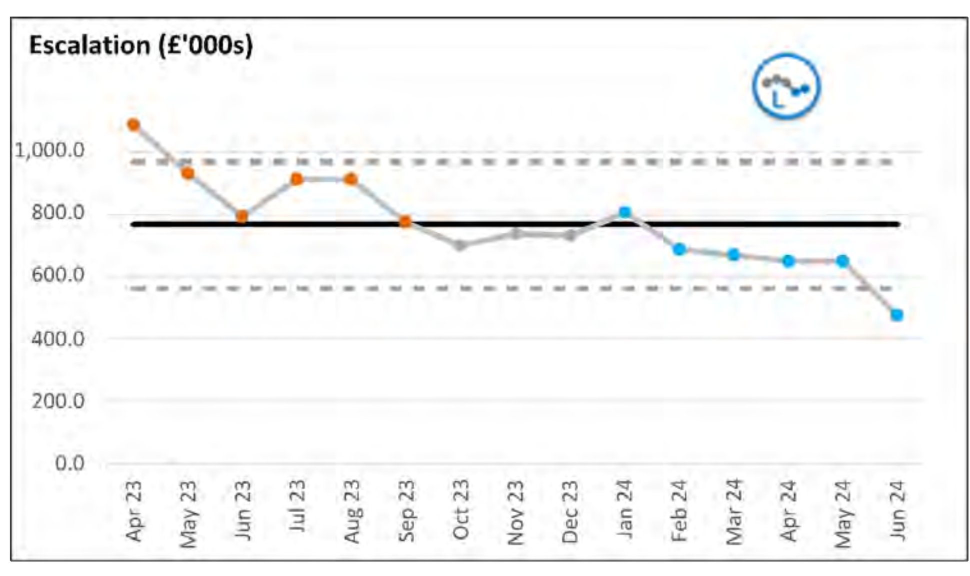
Escalation – Medicine Division

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)	YTD total (£000)	Full year Forecast (£000)
	Escalation Costs – Division of Medicine Q4 2023/2024				2024-25 Escalation Costs				
A&E Rota Issues	208	169	156	3,248	128	128	103	359	1,285
New ED Shifts				0	0	19	0	19	19
Paeds rota issues	78	78	78	1,014	67	67	67	201	803
Acute Rota Issues	51	51	51	809	51	51	51	152	428
Acute Outliers	26	26	26	517	26	26	26	79	315
AAA	5	0	0	129	79	77	68	224	532
Discharge Lounge	52	49	46	157	53	46	18	117	469
Corridor	203	159	164	1,748	92	48	28	169	345
Waiting room	31	31	31	374	31	31	31	93	372
1:1 Enhanced Care	149	122	113	1,724	123	154	84	361	1,444
Total	**803**	**685**	**666**	**9,721**	**650**	**647**	**476**	**1,774**	**6,012**
Winter Business Cases	92	114	124	570	140	140	148	428	1,751
Grand Total	**895**	**799**	**790**	**10,291**	**790**	**787**	**624**	**2,202**	**7,763**



Headlines

- June saw a sustained period of de-escalation in the hospital, with reported escalation costs reducing by £170k compared the previous months.
- A&E rota issues continue to show cost reductions, with an improvement of £25k relative to April and May.
- Additional shifts reported in ED for May have now been stood down following a review of ED staffing by the division.
- Acute care remains static from a cost perspective for the first quarter of the year.
- De-escalation of the hospital has supported costs reductions in the discharge lounge of £28k this month, and corridor costs of £20k this month. 1:1 enhanced care costs have reduced this month by £70k.
- During June, the division have worked up plans to further safely de-escalate the hospital site that have been approved by the discharge and flow programme board.
- This work stream has reduced the escalation cost estimate by a further £1.6m by the year end.

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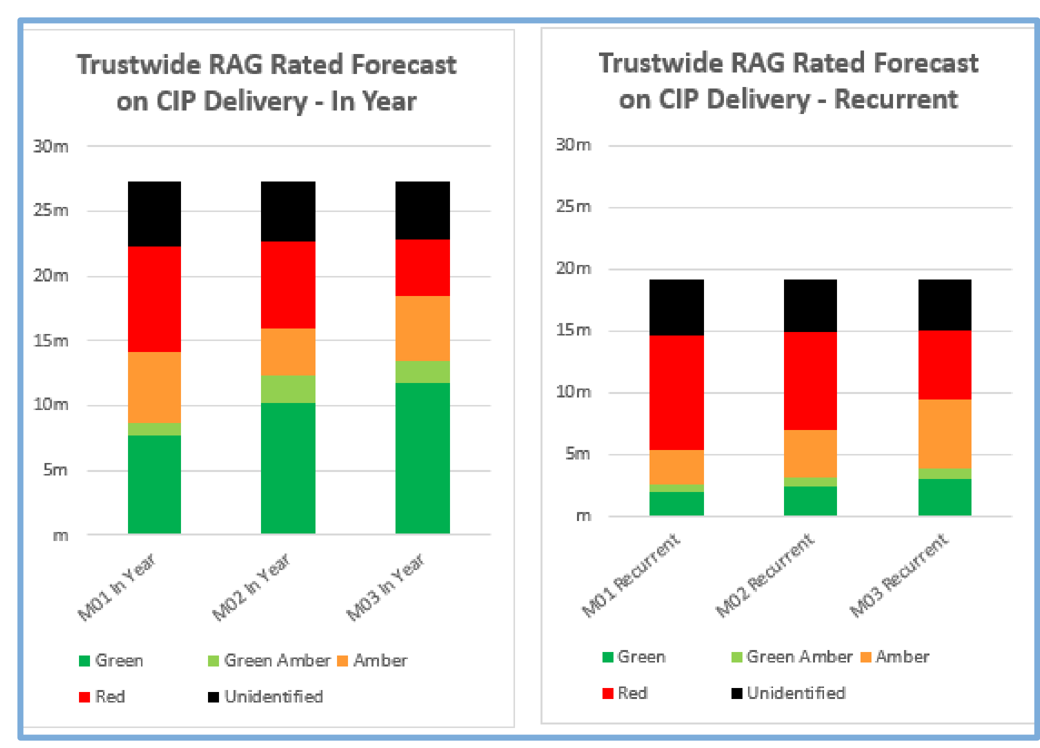
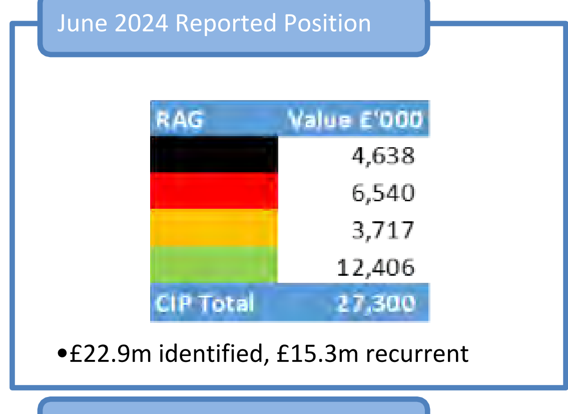
Trust wide CIP Delivery 2024/25

2024/25 CIP Plans

- The CIP Tracker currently includes schemes totalling £22.9m – 16% are categorised as High Risk.
- The total value unidentified is £4.4m. This is an improvement of £0.2m on the Month 2 reported position but is still 16% below the target.



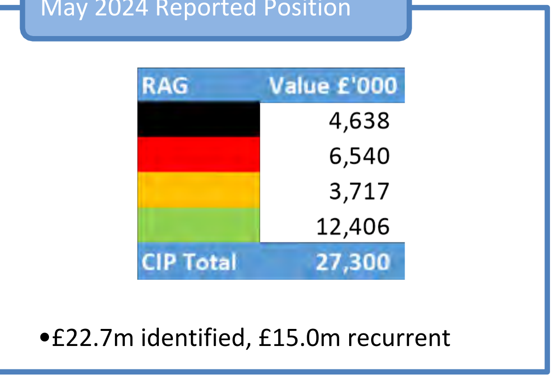
June 2024 Reported Position



RAG	Value £'000
	4,638
	6,540
	3,717
	12,406
CIP Total	27,300

- £22.9m identified, £15.3m recurrent

May 2024 Reported Position



RAG	Value £'000
	4,638
	6,540
	3,717
	12,406
CIP Total	27,300

- £22.7m identified, £15.0m recurrent

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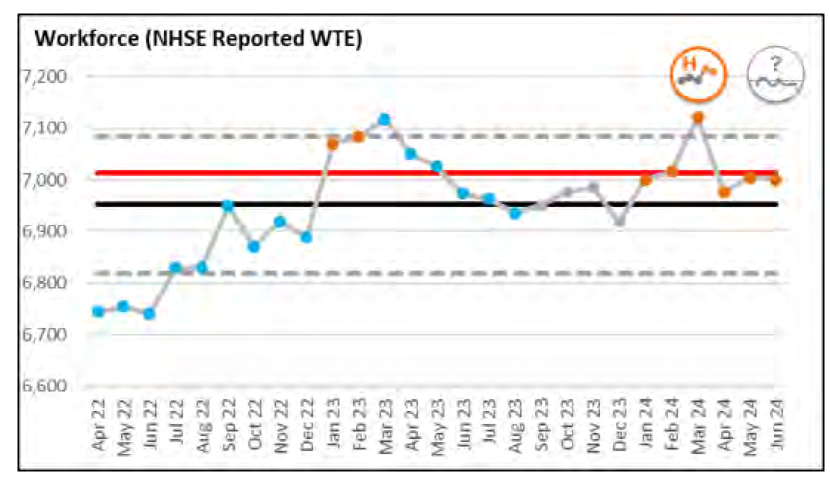
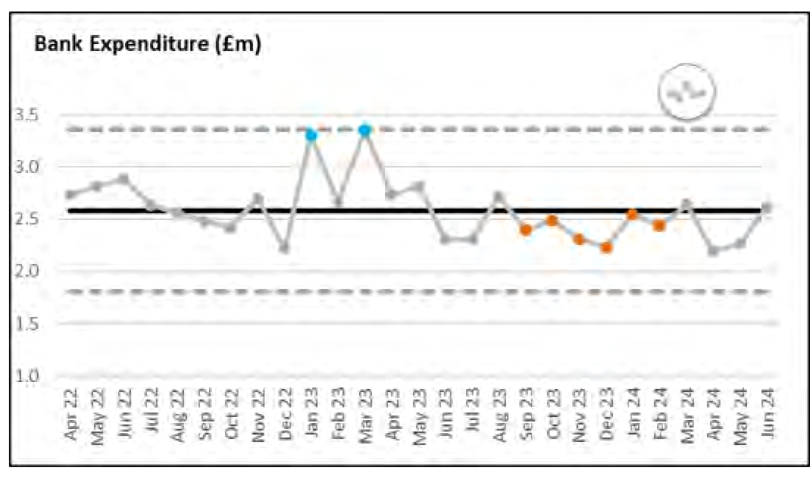
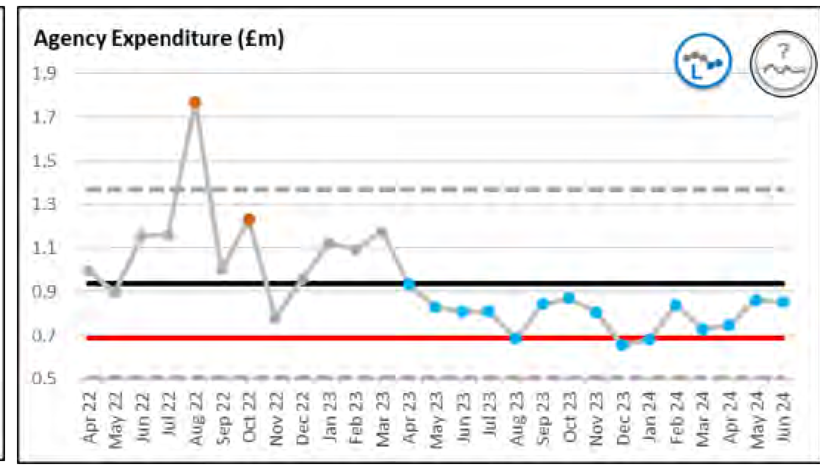
Workforce







Pay expenditure

- The in-month pay expenditure is £31.1m which is £0.4m adverse to plan.
- Medicine is showing an overspend on pay £0.4m mainly due to costs of covering the industrial action and back fill of vacant medical posts.
- Surgery is also showing an overspend of £0.4m 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 Trust has updated its WTE reporting methodology to align with NHSE guidance (contracted substantive WTE and worked bank and agency WTE).
- The overall number of WTE has largely remained static with a slight decrease in June to 7,001 WTE. There have been minor movements between the divisions over the period in line with day-to-day operations. Contracted WTE has decreased slightly in June, due to routine turnover.

Bank expenditure

- The trend is showing common cause variation within bank staffing expenditure, and over more recent months special cause improving variation in costs. During June bank costs were £2.3m across the trust, a slight increase from May.
- 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, filling rota gaps, and providing 1:1 enhanced care.

Agency expenditure

- The trend is showing special cause variation that is improving, as agency pay costs have decreased over the last year.
- Agency spend in June is £0.6m, which has decreased since May.
- The division of Medicine utilises the most agency staffing across to back fill vacant medical posts.

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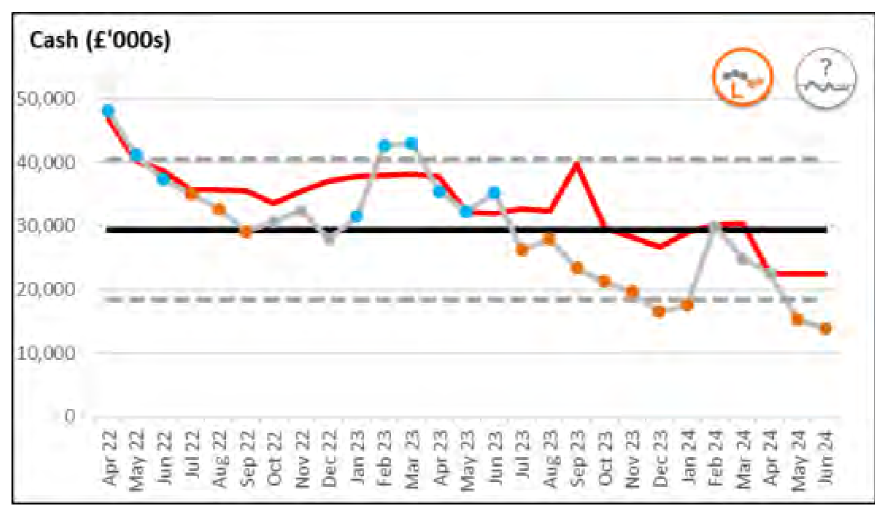
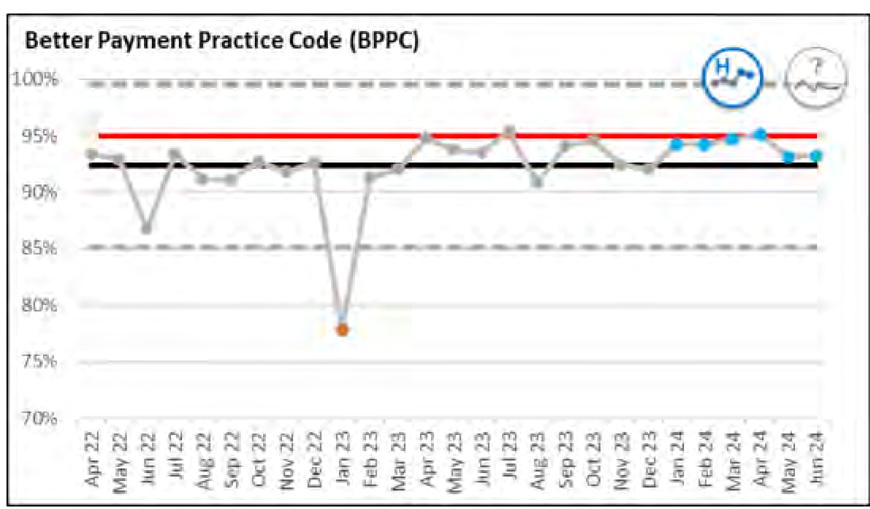
Cash and BPPC





Current cash position

- Closing cash at the end of June was £14.0m, a decrease of £1.3m from May.
- The closing cash balance is £2.3m below the plan of £16.3m, largely due to delay in payment of SLA income now expected in July, the variance to the revenue plan and other timing differences in payment of invoices.

Cash forecast

- There has been an improvement in the cash run rate forecast this month due to support from GM ICB. This relates to advance payment of the ERF activity growth assumed within the NHSE service developments and additions to the contract file. £3.1m is planned in July and £0.8m monthly from August. This has delayed the requirement for revenue cash support from September of Q2 to November of Q3.
- 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)

- 93.8% by volume, whilst worse than May it is equivalent to the 2023/24 outturn.
- An action plan is in place to improve performance against the target of 95.0%. Improvements in processes are having some impact on performance and until this is fully complete the BPPC performance will continue to fluctuate.

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Capital

Scheme	In Month (£000) Actual	In Month (£000) Plan	In Month (£000) Var	Year to date (£000) Actual	Year to date (£000) Plan	Year to date (£000) Var	Full Year (£000) Plan
Operational capital (CDEL)	202	217	15	809	825	16	9,287
Lease expenditure (IFRS16)	0	0	0	168	168	0	2,655
Sub total internally funded	**202**	**217**	**15**	**977**	**993**	**16**	**11,942**
National funding (PDC)							
Theatre 11, Wrightington	192	205	13	765	778	13	1,325
Endoscopy	1,155	690	(465)	2,096	1,631	(465)	6,885
Sub total national funding	**1,346**	**895**	**(451)**	**2,861**	**2,409**	**(452)**	**8,210**
Total capital programme	**1,548**	**1,112**	**(436)**	**3,838**	**3,402**	**(436)**	**20,152**

Capital plan 2024/25

- Total capital plan for the financial year of £20.2m broken down as:
  - Internal operational CDEL £9.3m.
  - Lease expenditure £2.7m.
  - PDC £8.2m.
- CDEL plan of £9.3m includes £0.7m over commitment to be managed during the financial year. Mitigations have been identified.

Internal CDEL

- On plan year to date and in the month.
- Profiling of plan updated in month 2 following request from NSHE.

PDC funded schemes

- £0.5m above plan in month and year to date. This relates to the Endoscopy scheme and is associated with phasing of expenditure which is forecast to be recovered within year.

Lease Expenditure

- Lease expenditure £0.0m in month in line with plan and on plan year to date, £0.2m.
- 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.

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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.	The GM ICS position is behind plan at month 2 which could lead to further mandated intervention from NHSE. This is described as an investigation and rapid intervention process ('I&I').
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. • Impact of industrial action, with NHSE indicating that there will be no additional funding within 2024/25. • Delivery of the activity plan to meet the planned levels of income. • Management of other potential cost pressures in year. At present, we are forecasting to deliver our deficit plan of £14.2m for 2024/25.	Further work is ongoing within the transformation programmes as well as the ICB and the locality to address escalation, and to identify further opportunities for CIP with a view to recover the deficit seen in June.
Cash	The cash balance is declining, and external support may be required within quarter 3. There has been an improvement in the cash run rate forecast this month due support from GM ICB. This relates to advance payment of the ERF activity growth assumed within the NHSE service developments and additions to the contract file. £3.1m is planned in July and £0.8m monthly from August. This has delayed the requirement for revenue cash support from September of Q2 to November of Q3.	Awaiting confirmation on NHSE deficit support. Cash management strategy including daily cash forecasting Proactive relationship with lead commissioner Cash applications to NHSE made in advance of need.

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

Forward look

We are supporting GMICB with the introduction of a system led vacancy scrutiny panel with a view to further enhancing grip and control. This is a specified condition for providers who are seeking cash support from NHSE.

NHSE have indicated that there will be particular focus on run rates and workforce plans in the coming months for systems who are not delivering their financial plan.

Work has commenced on a recovery plan to support the delivery of elective activity plan, focusing on Trauma and Orthopaedics. This will be presented to the executive team on the 11th August 2024.

The finance team are finalising the contract documentation with the GMICB for 2024/25. There are no technical issues and sign off is anticipated during July.

CIP remains a significant risk. Enhanced executive support is being directed to the most challenged divisions with a view to unblocking issues and accelerating the recurrent CIP program delivery. An action plan will be developed following the check and challenge meetings.

Agenda Item: 23

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Assurance Framework (BAF)
Presented to:	The Board
On:	7 August 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 10 July 2024. There have been no changes to the risk scores for the three existing risks since the last Board meeting in June 2024. No new risks have been escalated or removed from the BAF.

2.3 **People:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives in preparation for the People Committee Meeting on 13 August 2024. Following a review of the risks at the People Committee Meeting in June, the following risk has seen a reduction in scoring: Risk PR4 Workforce Sustainability. The current risk score for this risk has been reduced from a 10 to an 8. This is on the basis that the Trust has seen the continued low reporting of Trust turnover, low vacancy rates and sickness absence rates that report on, or just above target on a consistent basis. All other risks have remained the same.

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 30 July 2024. There have been no changes to the risk scores for the six existing risks since the last Board meeting in June 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 7 August 2024. The current risk score for Risk PR 14: Partnership working - CCG changes has been reduced from a 12 to 9. There has been some improved stability in partnership working in Wigan, driven in part by the collaboration around Newton Europe and the UEC programme. All other risks have remained the same.

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 June 2024.

The title for Risk PR6 *Internationally Educated Nurses* has been updated to *Workforce EDI* to align with Objective 10: We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.

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 June 2024.

6. Review Date

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

Board assurance framework

2024/25

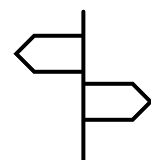
The content of this report was last reviewed as follows:

Board of Directors	June 2024
Quality and Safety Committee:	July 2024
Finance and Performance Committee:	July 2024
People Committee:	June 2024
Executive Team:	July 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

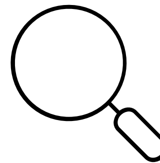
Definition based on guidance jointly provided by NHS Providers and Baker Tilly

How the Board Assurance Framework fits in

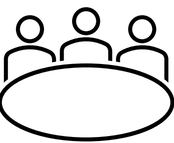


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

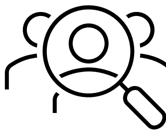
Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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



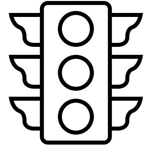
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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

Likelihood ↑ / **Impact →**	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Critical 5**
Almost certain 5	5 Moderate	10 High	15 Significant	20 Significant	25 Significant
Likely 4	4 Moderate	8 High	12 High	16 Significant	20 Significant
Possible 3	3 Low	6 Moderate	9 High	12 High	15 Significant
Unlikely 2	2 Low	4 Moderate	6 Moderate	8 High	10 High
Rare 1	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

DIRECTOR LEADS

CEO:	Chief Executive	DCA:	Director of Corporate Affairs
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

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

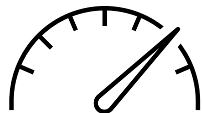
We will…
- Enable better access to care by having the right people, in the right place, in the right number at the right time
- Ensure we improve experience at work by actively listening to our people, and turning understanding into positive action
- Have an inclusive and representative workforce that 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.

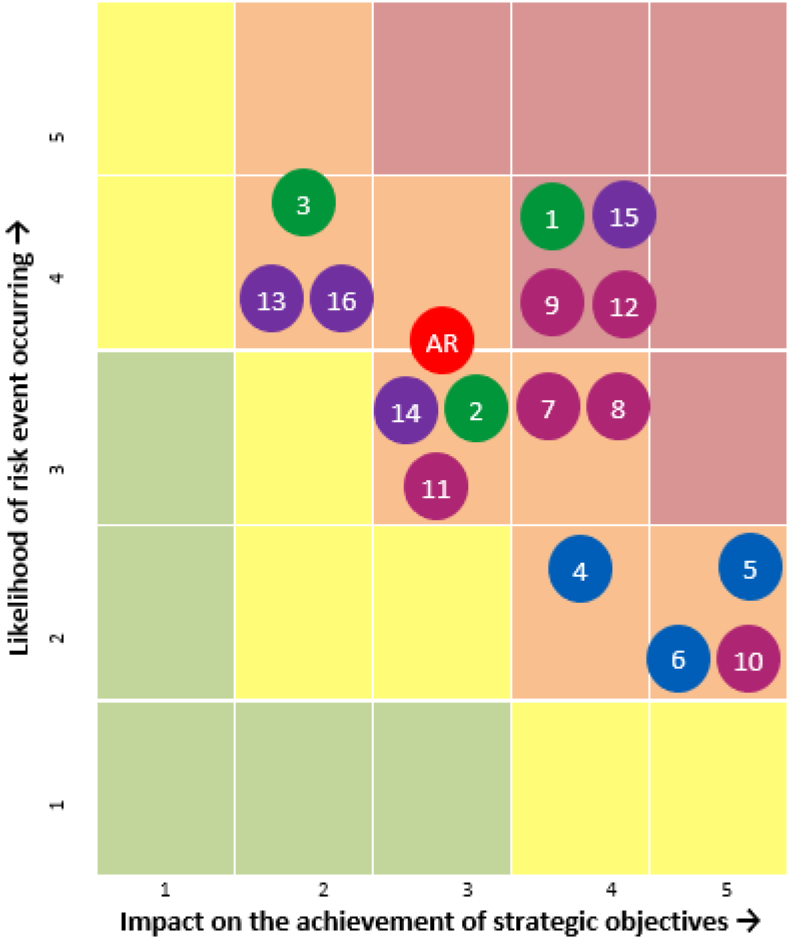


Risk management

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

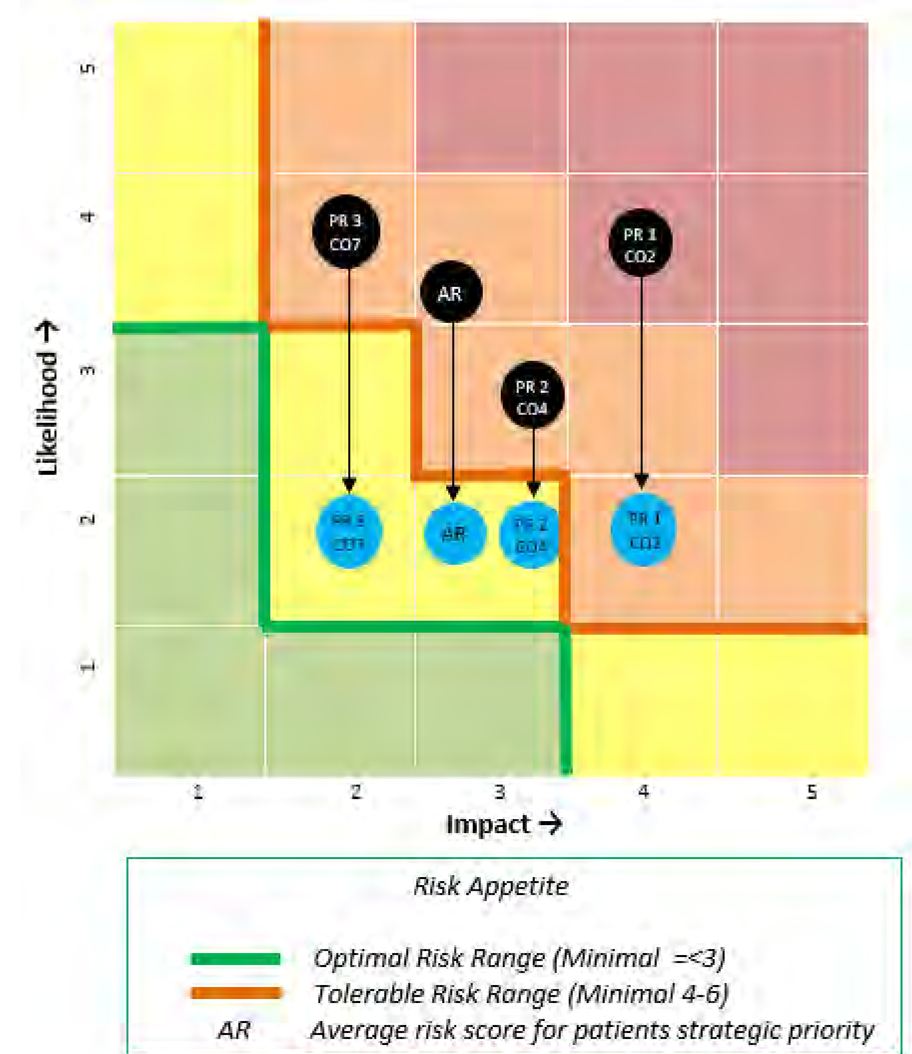
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

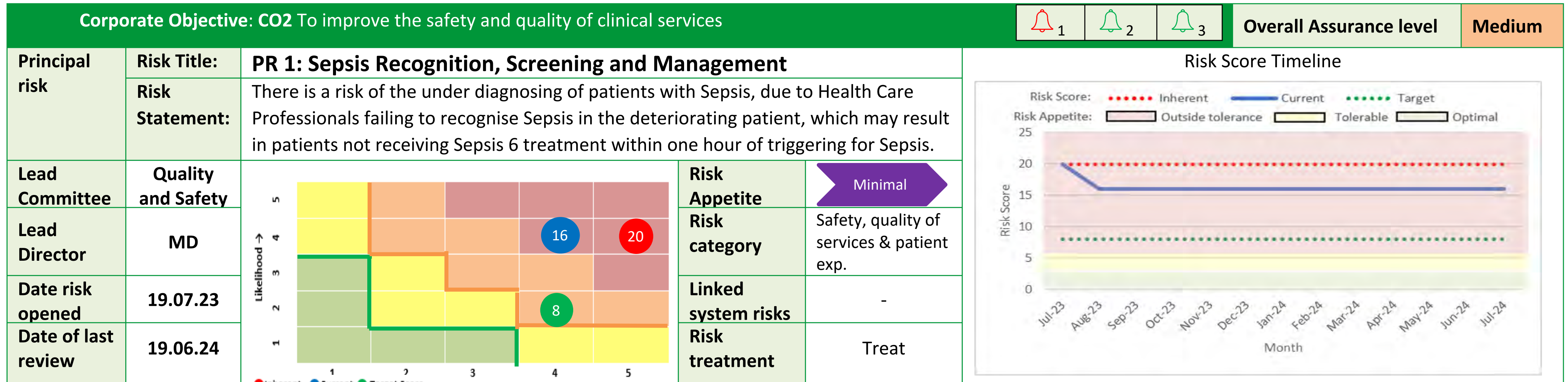
Monitoring: Quality and Safety Committee

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.

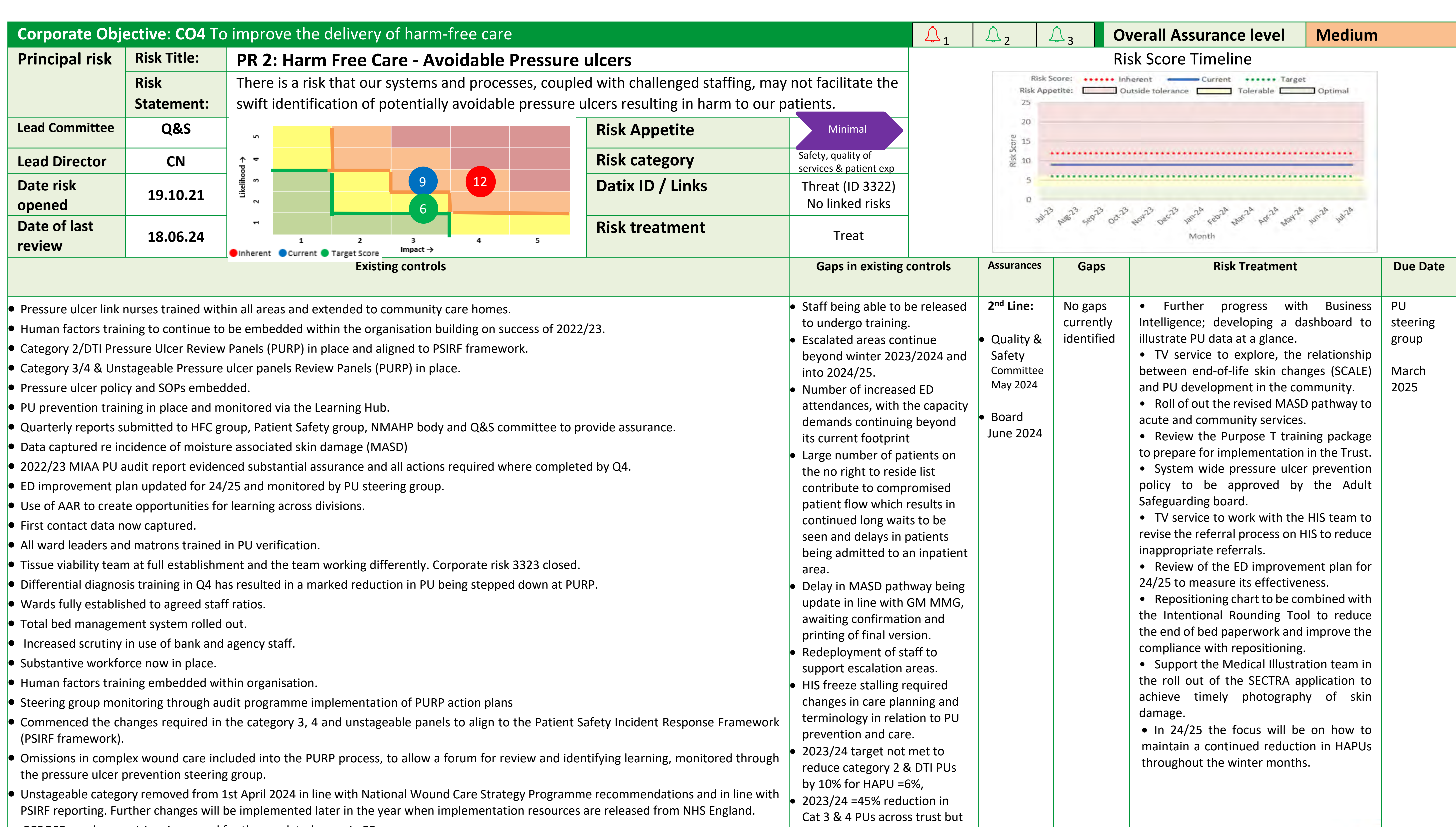
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:





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 Score Timeline		
	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	19.06.24		Risk treatment: Treat			

Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date By Whom
Threat: **(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 May 2024 • Board June 2024 • ECC Red Flag Sepsis Audit • AQ Audit	• None currently identified.	1. Sepsis E-Learning review to incorporate the new NICE Guidance and new policy information 2. Community SOP for Adults	September 2024 Sepsis Lead September 2024 Sepsis Lead

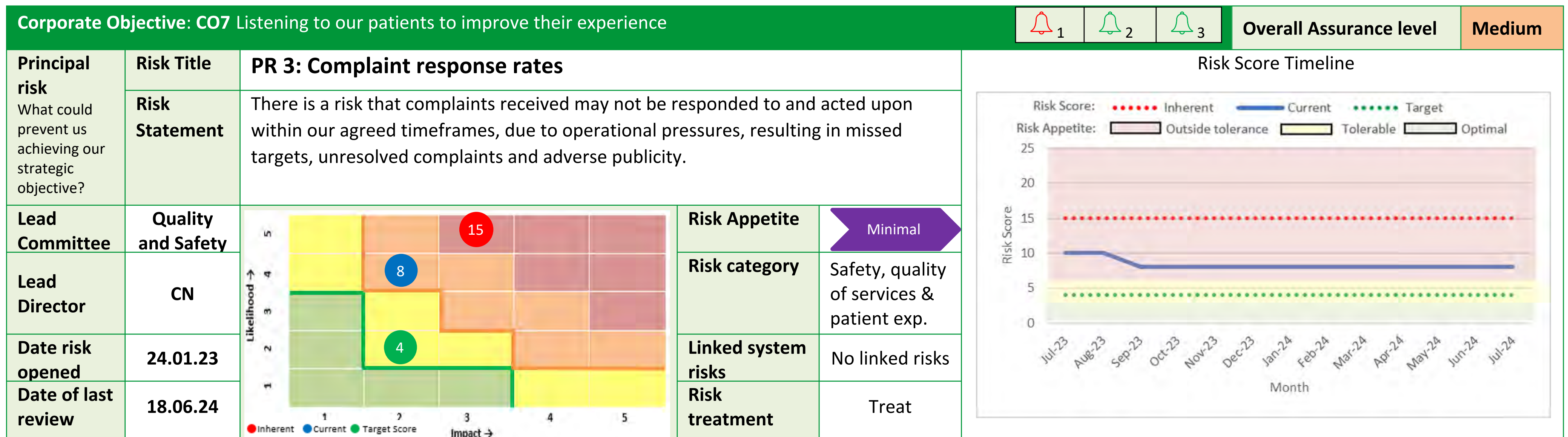


Corporate Objective: CO4 To improve the delivery of harm-free care | 1 | 2 | 3 | **Overall Assurance level** | **Medium**

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	18.06.24	

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

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 May 2024 • Board June 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 Score Timeline
	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	**18.06.24**	**Risk treatment**	Treat

Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 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 May 2024 • Board June 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.	September 2024 CN

People

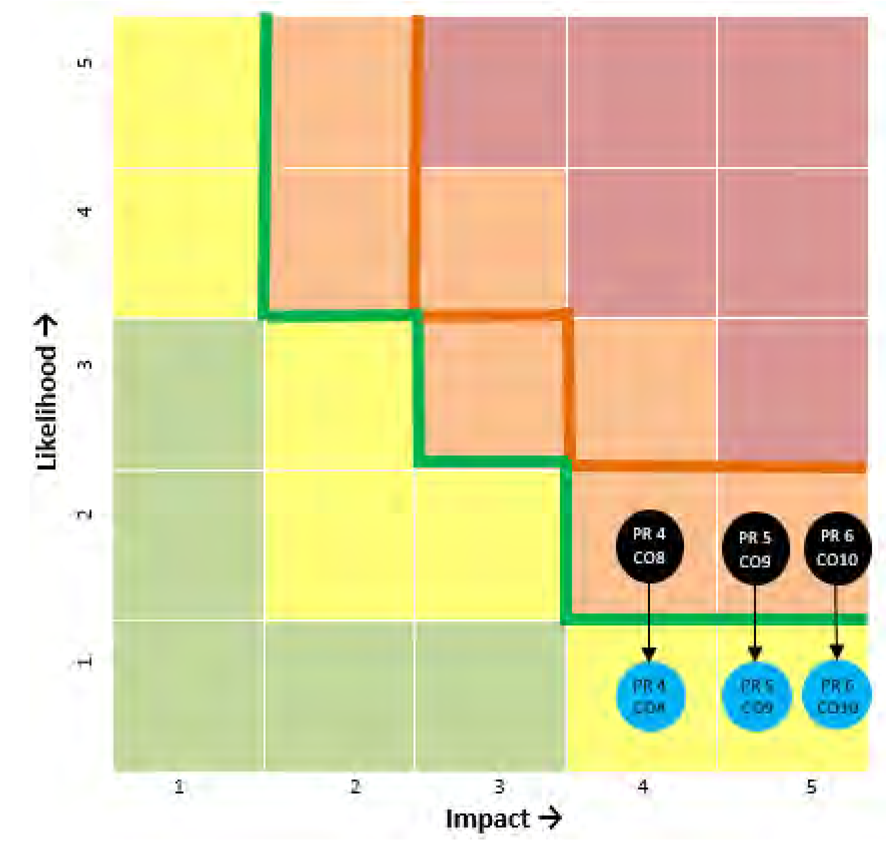
To ensure wellbeing and motivation at work and to minimise workplace stress.

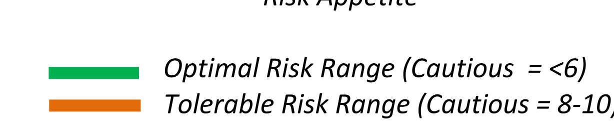
Monitoring: People Committee

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

Ref.	Purpose of the objective	Scope and focus of objective	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:



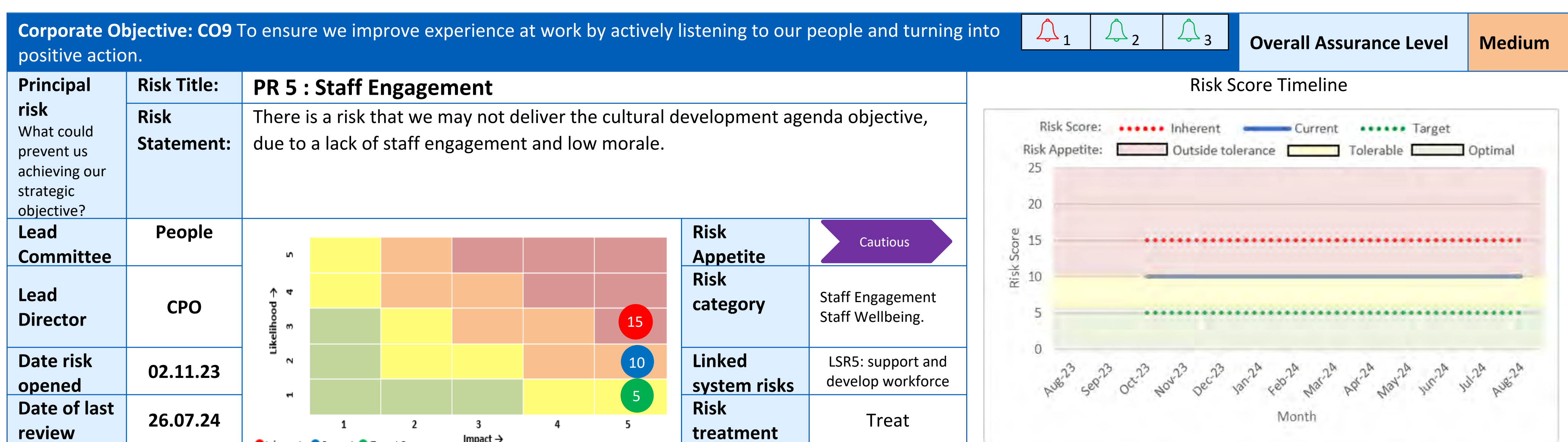


Corporate Objective: CO8 To enable better access to the right people, in the right place, in the right number, at the right time	1	2	3	**Overall Assurance Level**	**Medium**

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

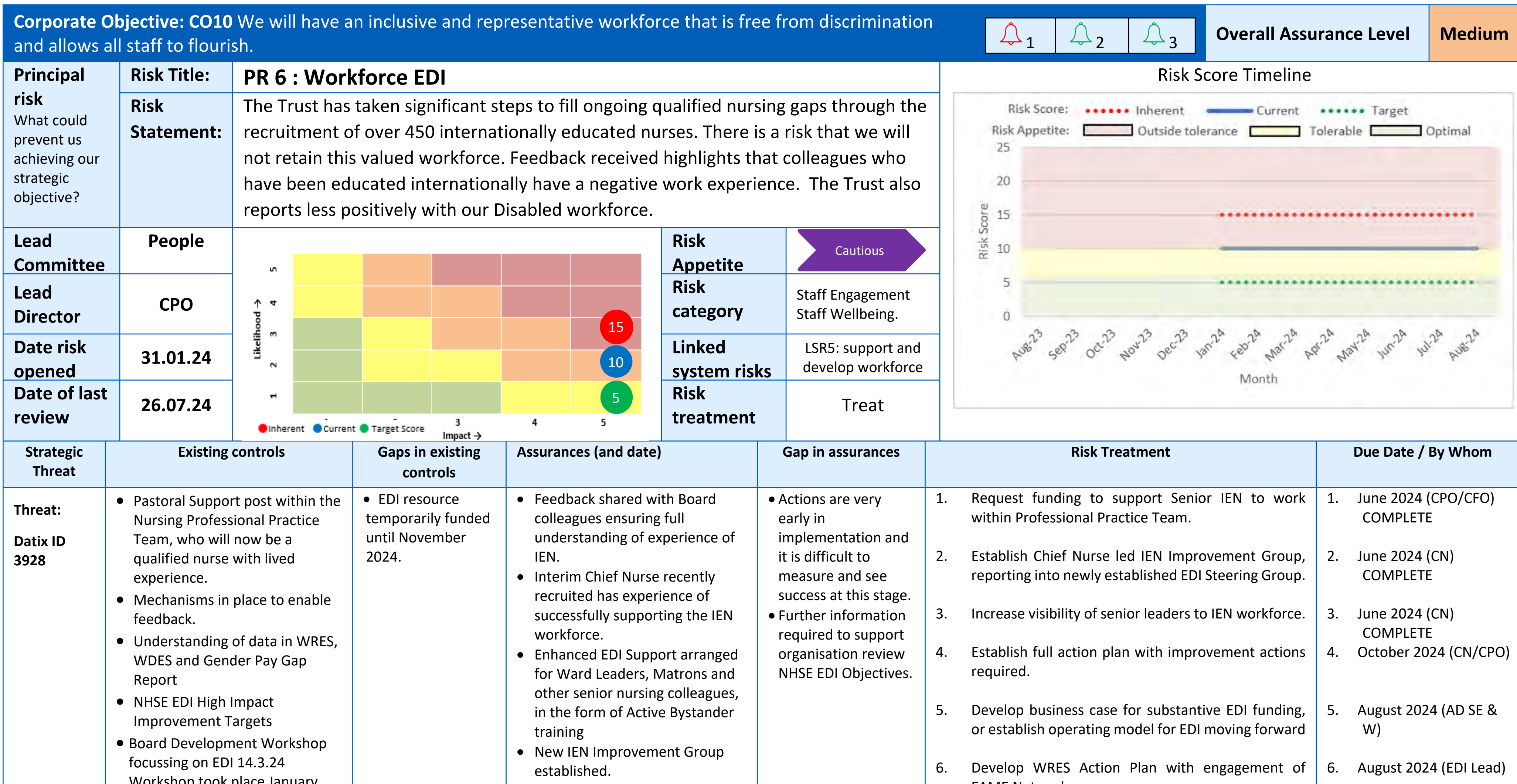


Corporate Objective: CO9 To ensure we improve experience at work by actively listening to our people and turning into positive action.

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

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	
Lead Director	CPO	
Date risk opened	31.01.24	
Date of last review	26.07.24	

Risk Appetite	Cautious
Risk category	Staff Engagement Staff Wellbeing.
Linked system risks	LSR5: support and develop workforce
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

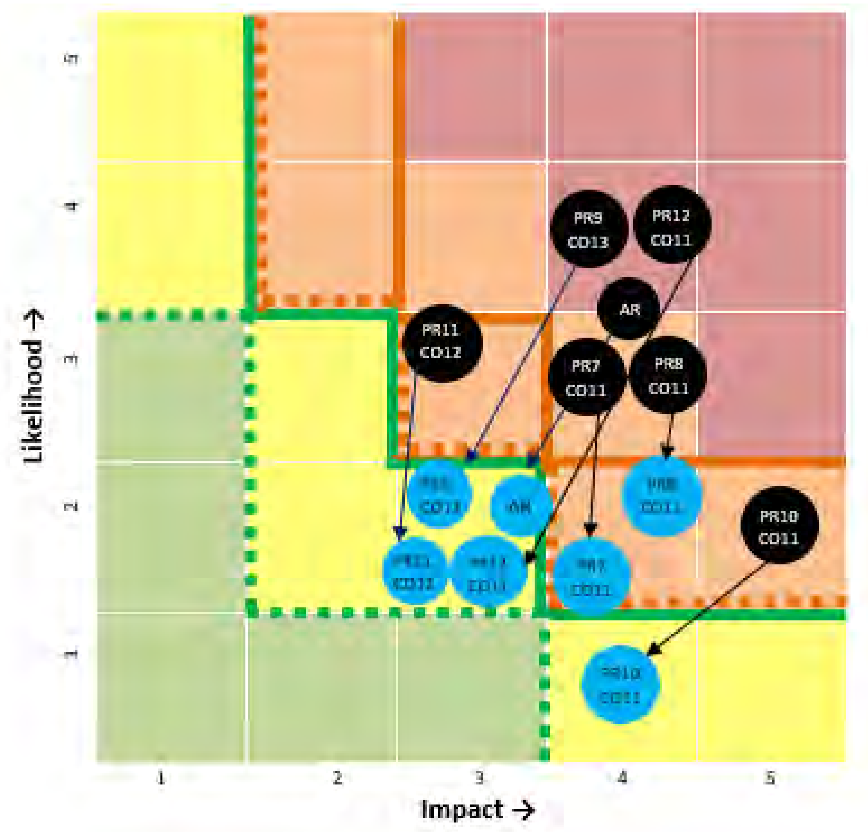
Our ambition is to consistently deliver efficient, effective and equitable patient care

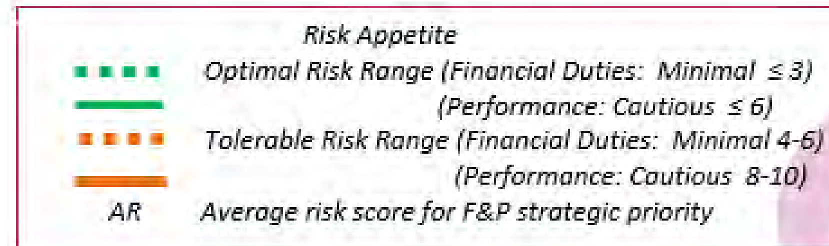
Monitoring: Finance and Performance Committee

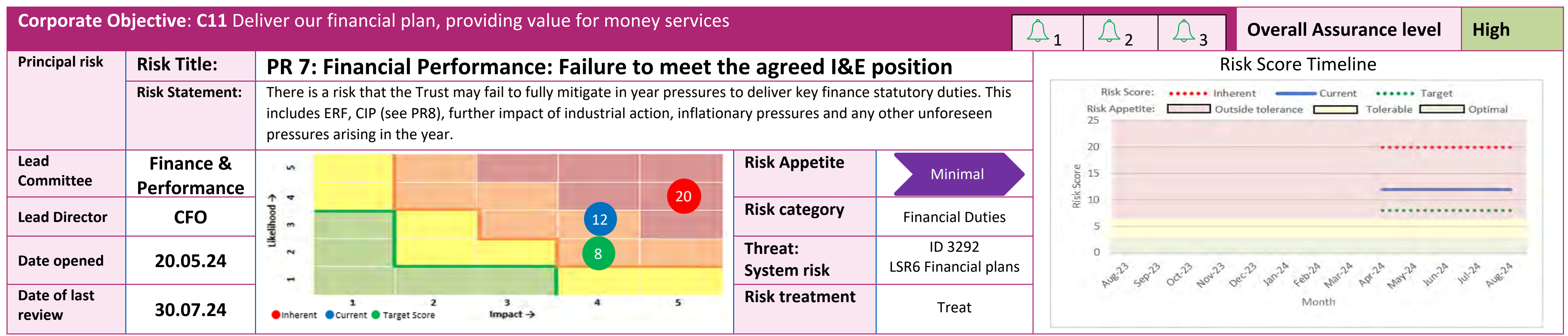
The following objectives are aligned to the **performance** strategic priority:

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:







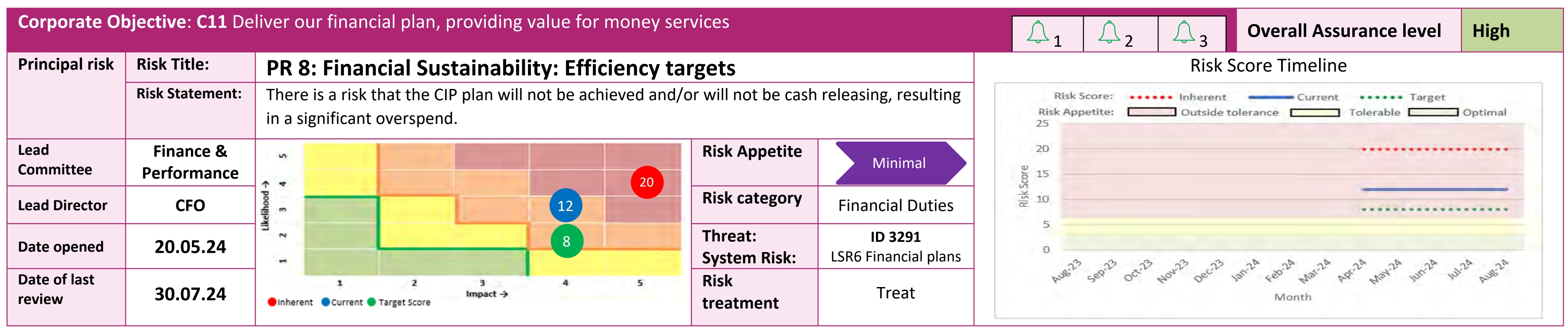
Corporate Objective: C11 Deliver our financial plan, providing value for money services

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	
Lead Director	CFO	
Date opened	20.05.24	
Date of last review	30.07.24	

Risk Appetite	Minimal
Risk category	Financial Duties
Threat: System risk	ID 3292 LSR6 Financial plans
Risk treatment	Treat

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) • Continued engagement with Newton Europe with an aim to sign contract on 9 Aug 2024 to start the programme in Sep 2024 (Ext)	• 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 23024.25 to ensure the 3 year trajectory for recovery is achievable • Pay awards not yet confirmed and could lead to further industrial action with no confirmed financial arrangements agreed (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 July 24. **External:** Monthly Provider Oversight Meeting with GM ICB (Ext) July 24	• 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



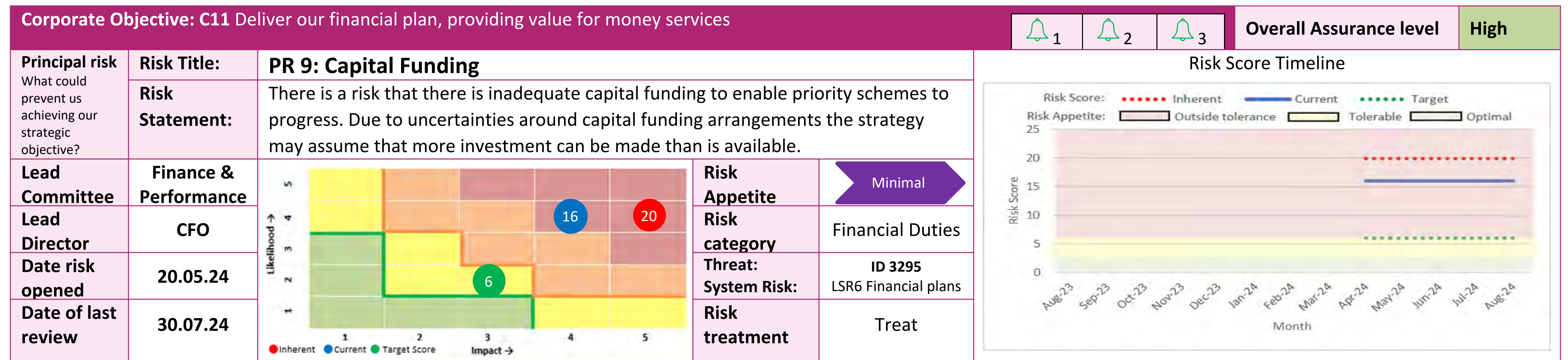
Corporate Objective: C11 Deliver our financial plan, providing value for money services

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	30.07.24	Risk treatment	Treat

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)	• Limited mechanisms to facilitate delivery of system wide savings. • GM Sustainability plan not yet finalised	**1st Line:** Monthly Divisional Assurance meetings for applicable divisions and monthly finance improvement group (FIG) **2nd Line:** Finance & Performance Committee July 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

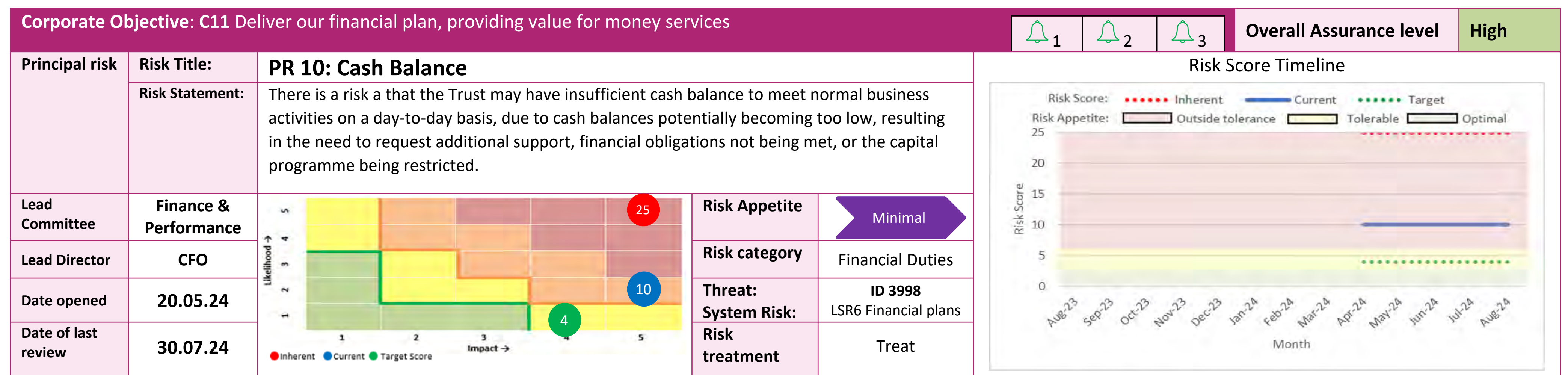


Corporate Objective: C11 Deliver our financial plan, providing value for money services | 1 | 2 | 3 | **Overall Assurance level** | **High**

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	30.07.24	**Risk treatment**	Treat

Strategic Opportunity / Threat Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• 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)	• 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. Infrastructure plan not yet finalised	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - July 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		Risk Appetite	Minimal
Lead Director	CFO		Risk category	Financial Duties
Date opened	20.05.24		Threat: System Risk:	**ID 3998** LSR6 Financial plans
Date of last review	30.07.24		Risk treatment	Treat

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 July 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

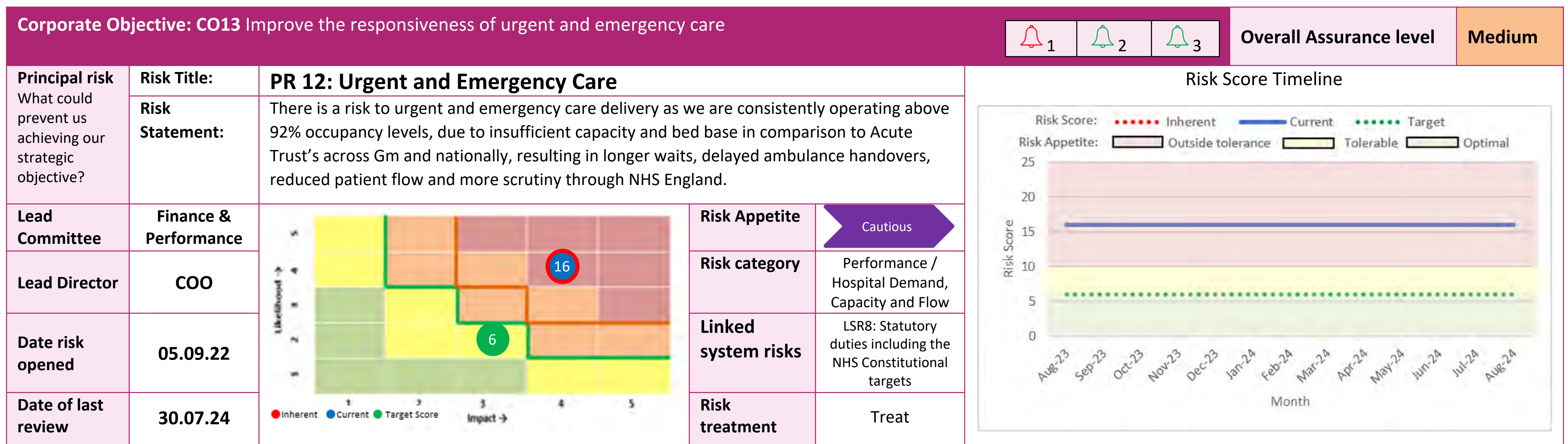
Corporate Objective: CO12 To minimise harm to patients through delivery of our elective recovery plan	1 2 3	Overall Assurance level	Medium

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	**30.07.24**	**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)** Linked risks on corporate risk register: **3572** Industrial action **3718** Elective Recovery	• 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 – May 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.	August 2024 August 2024 August 2024



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	30.07.24	**Risk treatment**	Treat

Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(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 • WWL's Multi agency Discharge Event (MADE) took place 11th to 17th March. • 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. • Working on an action plan in anticipation of CQC report.	• 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. • IMC bed capacity reduced in Nov 2023 and is continuing to impact on pathway 2 discharges.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – July 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

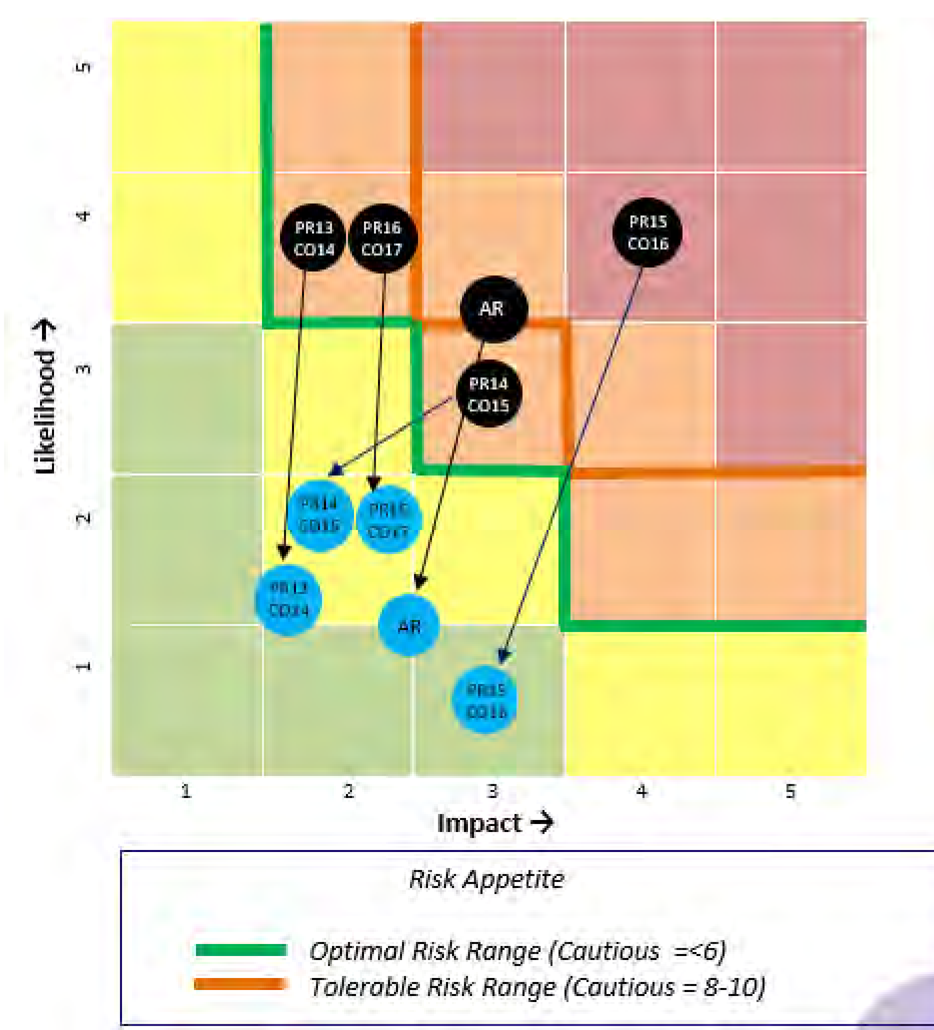
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

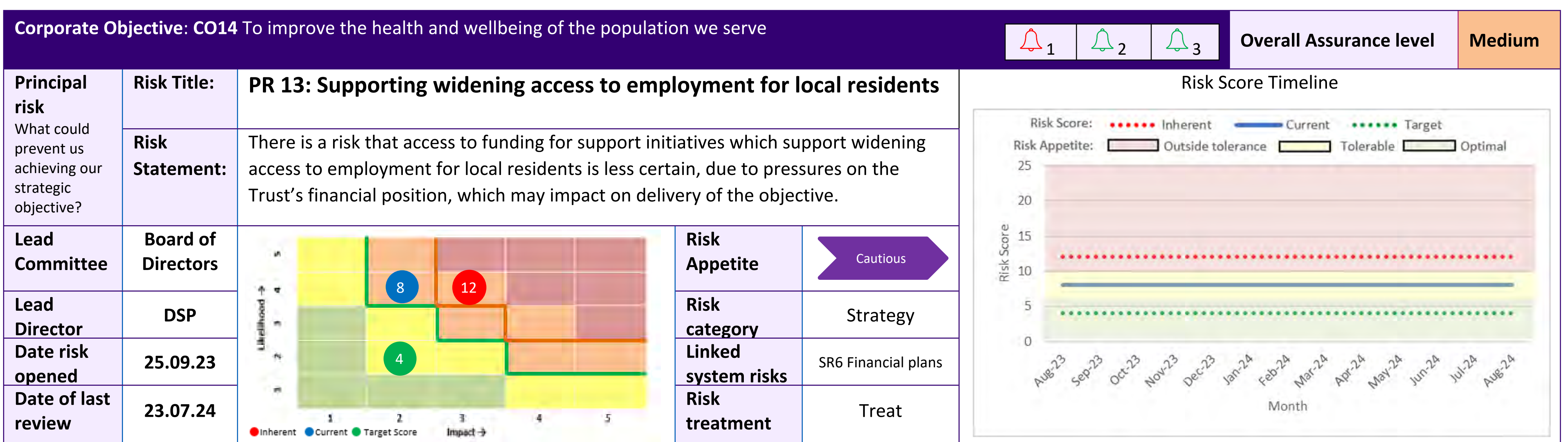
Monitoring: Board of Directors

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:



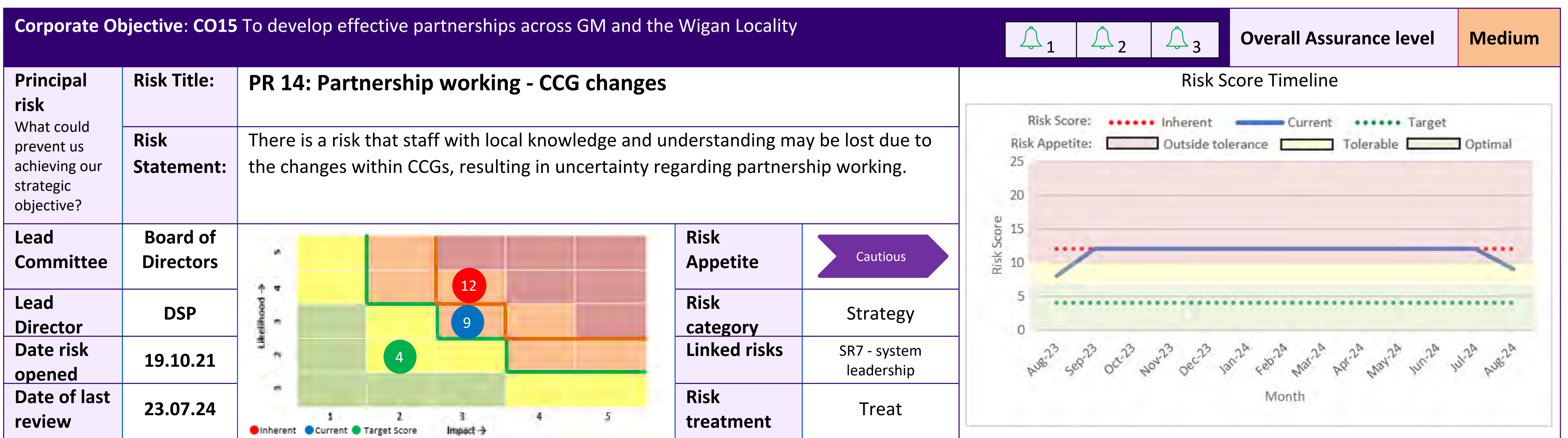


Corporate Objective: CO14 To improve the health and wellbeing of the population we serve

1	2	3	Overall Assurance level	Medium

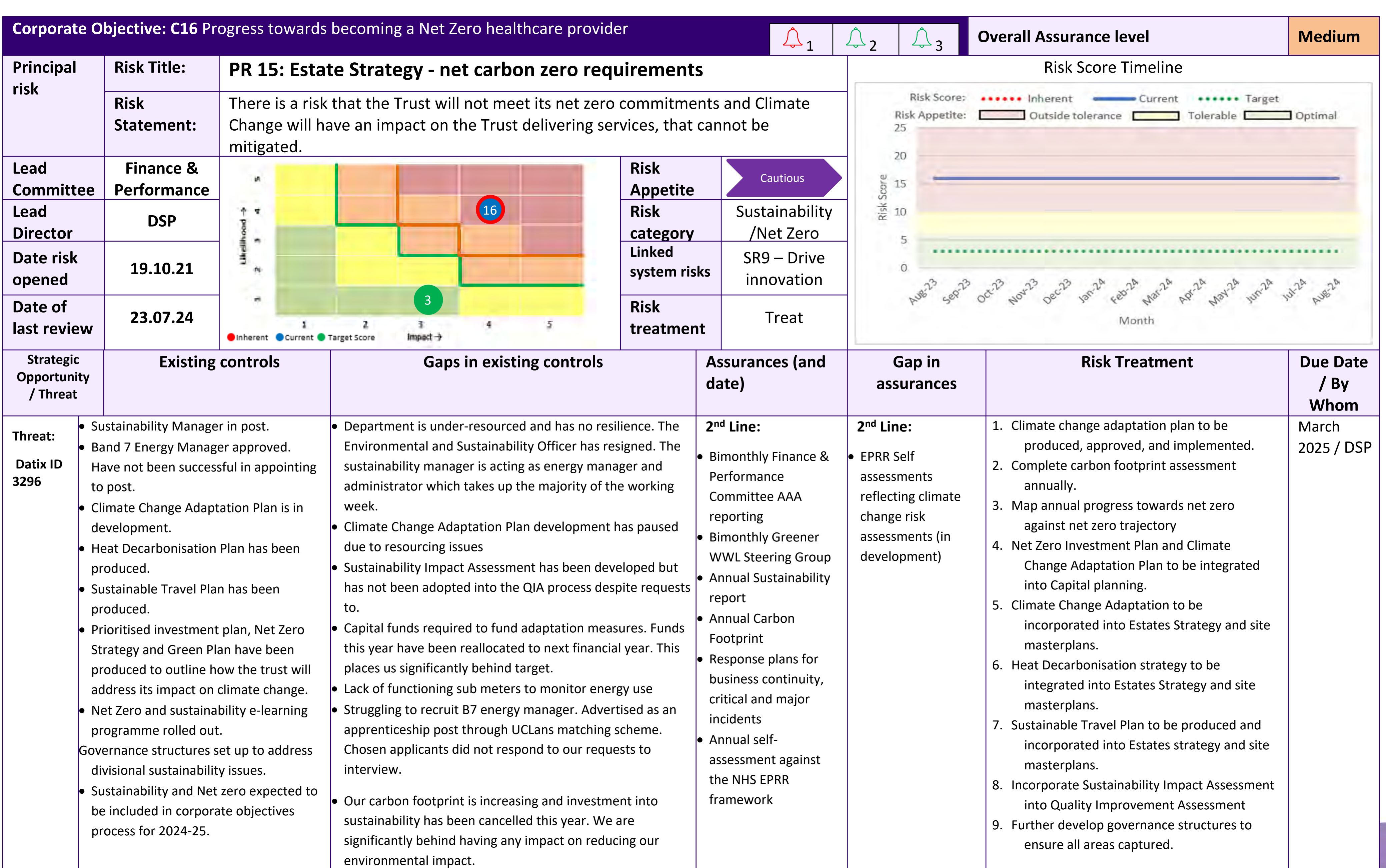
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 13: Supporting widening access to employment for local residents**	
	Risk Statement:	There is a risk that access to funding for support initiatives which support widening access to employment for local residents 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	**23.07.24**	**Risk treatment**	Treat

Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 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 Score Timeline	
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.				
Lead Committee	**Board of Directors**		**Risk Appetite**	Cautious		
Lead Director	**DSP**		**Risk category**	Strategy		
Date risk opened	**19.10.21**		**Linked risks**	SR7 - system leadership		
Date of last review	**23.07.24**		**Risk treatment**	Treat		

Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3300**	• Locality meeting structures in place to support lasting corporate knowledge. • 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	**23.07.24**	**Risk treatment**	Treat

Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 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 Score Timeline				
	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	**23.07.24**		**Risk treatment**	Treat			

Risk matrix: Likelihood → (1–5) / Impact → (1–5); Inherent 12, Current 8, Target Score 4. Legend: Inherent, Current, Target Score.

Risk Score Timeline: Risk Score: Inherent, Current, Target. Risk Appetite: Outside tolerance, Tolerable, Optimal. Risk Score axis 0–25; Month axis Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24.

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 14 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 – June 2024	• None currently identified.	The key actions for increasing University employed research Principal Investigators. Current status: Target – 14. 4 clinical academics in place, therefore 10 appointments required in final 2 years to achieve target of April 2026 for UHA application. ✓ 4 substantive EHU clinicians with Honorary Consultant status in WWL ✓ 2 (in progress) substantive EHU Clinical Academics offered Honorary Clinical Contracts with WWL ✓ 1 (in progress) agreement to appoint EHU Clinical Academic in Infectious Diseases. If the 3 in progress are confirmed within 2024/25, there remains 7 to achieve in final year 2025/26.	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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

PEOPLE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

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

(a) Approval and oversight of the implementation of the WWL People & Culture Strategy and Equality, Diversity and Inclusion Strategy;

(b) Approval of prioritised annual people corporate objectives;

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

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

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

3. SCOPE OF RESPONSIBILITIES

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

(b) To ensure that WWL has thorough and robust implementation plans in response to the NHS Staff Survey, in line with the NHS People Promise;

(c) To monitor the implementation and relevance of the WWL Equality Diversity and Inclusion Strategy, and to provide assurance of improvements and compliance against key statutory and NHS specific workforce equality, diversity and inclusion requirements;

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

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

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

(g) To ensure strategic alignment of the WWL People & Culture Strategy with the NHS Long Term Workforce Plan, Greater Manchester People and Culture Strategy, NHS People Plan, HR / OD Futures report and other NHSE/I mandated standards;

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

(i) To encourage innovation and the development of new clinical and non-clinical roles to meet the needs of our patients and innovation in service delivery models;

(j) To ensure that the strategies it monitors and the workstream which it oversees make use of digital and sustainable solutions to support efficiency, in line with WWL's Digital Strategy and Green Plan;

(k) To monitor delivery progress of national and mandated standards falling within its remit;

4. MEMBERSHIP

4.1. The membership of the Committee shall consist of:

(a) Non-Executive Director Chair;

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

(c) Chief People Officer;

(d) Chief Nurse;

(e) Medical Director;

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

4.3. The Committee will be deemed quorate to the extent that two Non-Executive Directors and two Executive Directors, one being the Chief People Officer or their nominated deputy,

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

5. SECRETARY

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

6. ATTENDANCE

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

(a) Deputy Chief People Officer;

(b) Staff Side Chair

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

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

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

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

7. FREQUENCY OF MEETINGS

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

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

8. MINUTES AND REPORTING

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

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

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

(a) Local Negotiating Committee;

(b) Educational Governance Group;

(c) Partnership Council;

(d) Equality Diversity and Inclusion Strategy Group

9. PERFORMANCE EVALUATION

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

10. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

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

2.2. Its key duties are as follows:

Finance

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

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

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

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

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

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

(g) Monitoring delivery of the Cost Improvement Programme;

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

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

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

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

Performance

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

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

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

(o) To consider investment or divestment in services;

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

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

(r) To monitor delivery against the green plan;

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

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

Risk

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

Business cases

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

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

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

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

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

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

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

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Chief Finance Officer;

(c) Chief Operating Officer; and

(d) Director of Strategy and Planning.

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

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

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

4. SECRETARY

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

5. ATTENDANCE

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

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

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

6. FREQUENCY OF MEETINGS

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

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

7. MINUTES AND REPORTING

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

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

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

7.4. The following groups shall report to the Committee:

(a) Financial Improvement Group

~~(a)~~(b) Digital Strategy Oversight Group;

~~(b)~~(c) Global Training Education Steering Group;

~~(c)~~(d) Greener WWL Steering Group

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

2.1 The Committee will enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate assurance and governance structures, processes and controls are in place throughout the Trust to:

(a) Promote safety, equality and excellence in patient care;

(b) Identify, prioritise and manage risk arising from the provision of any clinical service provided and contributed to by WWL;

(c) Ensure effective and efficient use of resources through evidence-based clinical practice;

(d) Protect the health and safety of Trust employees, patients and visitors;

(e) Ensure compliance with legal, regulatory and other obligations.

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

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

3. QUALITY STRATEGY ROLE

3.1 To review and recommend to the Board the Quality Strategy of the Trust, and to monitor progress against the strategy and other improvement plans that may impact on clinical quality.

3.2 To ensure there are robust systems for monitoring clinical quality performance indicators within Divisions and to receive reports on clinical quality performance measures.

3.3 Review and monitor the process and outcomes of Quality Impact Assessments relating to significant service changes and transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

3.4 In response to requests from Board, or where appropriate as decided by the Committee, monitor the implementation of improvement plans in respect of quality of care, particularly in relation to incidents (including never events), survey outcomes (such as safety culture elements of the NHS staff survey), outcomes of clinical audits, issues raised through complaints or concerns and similar issues.

4. COMPLIANCE AND REGULATION ROLE

4.1 To receive and consider the necessary action in response to external reports, reviews, investigations or strategies (from the Care Quality Commission, NHS England , HM Coroner, Parliamentary and Health Service Ombudsman and other NHS bodies such as Royal Colleges).

4.2 To monitor the Trust's responses to relevant external assessment reports (including reports from the Care Quality Commission) and associated implementation plans.

5. CLINICAL GOVERNANCE AND RISK MANAGEMENT ROLE

5.1 To review assurance reports mandated to be received by the Board that may impact on clinical quality, for example, mortality reports, maternity compliance against NHS Resolution safety standards.

5.2 Through divisional governance reports from the divisional triumvirate teams, monitor and obtain assurance regarding the effectiveness of processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

5.3 To received regular reports on the ASPIRE clinical quality accreditation and, to ensure effectiveness and that actions arising from them are addressed in a timely and appropriate mannerby the appropriate divisional governance group.

5.4 To receive regular reports from the following groups to gain assurances of the completion of improvement plans to arising from areas of concern: Mortality, Medicines Management, Infection Prevention and Control, Safeguarding Effectiveness, Occupational Safety and Health.

5.5 To review the Board Assurance Framework (Patients) and corporate risks escalated by the Risk Management Group in accordance with the Trust's risk management strategy to seek assurances regarding mitigating action.

6. SAFETY CULTURE ROLE

6.1 To review the themes, trends and monitor improvements related to incident management (including incidents involving staff and patients), inquests and litigation.

6.2 To gain assurance that appropriate feedback mechanisms are in place for those reporting incidents and that a culture of openness and transparency in respect to incident reporting is encouraged and supporting the speaking up agenda.

6.3 To ensure that where necessary, action plans to address incident related themes, trends and/or required improvements, are developed and monitored.

6.4 To ensure that the NHS England Just Culture guide is implemented by all staff across the Trust.

6.5 To receive assurances on the implementation of the Patient Safety Incident Response Framework and monitor it's effectiveness

7. PATIENT EXPERIENCE ROLE

7.1 To consider reports from the Patient Experience and Engagement Group and other sources of feedback (such as Healthwatch) on all formal and informal patient feedback, both positive and negative, and to consider further action in respect of matters of concern.

7.2 To gain assurance that actions arising from national patient surveys and reviews that may impact on clinical quality are addressed in a timely and appropriate manner under the management oversight of the Patient Experience Group.

7.3 To review the themes, trends and monitor improvements relating to complaints and concerns.

7.4 To ensure that where necessary, action plans to address complaint themes and trends are developed and monitored.

8. CLINICAL AUDIT AND EFFECTIVENESS ROLE

8.1 To ensure there is a comprehensive clinical audit programme in place to support and apply evidence-based practice, implement clinical standards and guidelines, and drive quality improvement.

8.2 To ensure that care is based on evidence of best practice/national guidance and recommendations from national audits and external bodies such as the National Confidential Enquiry into Patient Outcomes and Death are responded to.

9. MEMBERSHIP

9.1 The membership of the Committee shall consist of:

(a) Four Non-Executive Directors, one of whom shall be Chair;
(b) Chief Nurse or his/her nominated deputy;
(c) Medical Director or his/her nominated deputy;

9.2 Deputies shall only be nominated to attend in exceptional circumstances and with the prior approval of the Chair;

9.3 A representative of the Council of Governors shall be entitled to attend to observe meetings.

9.4 The Committee will be deemed quorate to the extent that two Non-Executive Directors and one Executive Director are present, provided that a deputy has been nominated to attend on behalf of the other Executive Director member.

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

10. SECRETARY

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

11. ATTENDANCE

11.1 The following participants are expected to attend meetings of the Quality and Safety Committee:

(a) Associate Director of Governance and Patient Safety
(b) One clinical representative from each clinical division, being **either**:
  (i) Divisional Nurse Director **or**
  (ii) Divisional Medical Director

In addition, subject matter experts relevant to agenda items may be invited by the Chair to attend for their agenda item(s) only.

11.2 For the purposes of this document, the clinical divisions shall comprise:

(a) Community Services

(b) Medicine

(c) Midwifery and Neonates

(d) Specialist Services

(e) Surgery

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

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

12. FREQUENCY OF MEETINGS

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

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

13 MINUTES AND REPORTING

13.1 Formal minutes shall be taken of all Committee meetings.

13.2 Once approved by the Committee, the minutes should be presented to the Board of Directors for information.

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

13.4 Divisional triumvirate teams will report to the Committee via divisional governance reports.

13.5 The following sub-groups shall report to the Quality and Safety Committee:

(a) Clinical Audit and Effectiveness Group

(b) Equality Diversity and Inclusion Steering Group (Patients)

(c) Infection Prevention and Control Group

(d) Medicines Management Strategy Group

(e) Mortality Group

(f) Occupational Safety and Health Group

(g) Patient Experience and Engagement Group

(h) Patient Safety Group

(i) Safeguarding Effectiveness Group

(j) Any other standing group or ad hoc task and finish group established to oversee governance in any of the areas falling within the Committee’s purview, at the Committee’s request.

14. PERFORMANCE EVALUATION

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

15. REVIEW

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