Board of Directors - Public Meeting

Wed 04 December 2024, 14:20 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

17. Declarations of Interest

Information *Mark Jones*

Verbal item

17.1. Register of directors' interests

Information *Mark Jones*

17.1 Directors DoIs - Dec 2024.pdf (3 pages)

18. Minutes of the previous meeting

Approval *Mark Jones*

18. Minutes_Board of Directors - Public Meetings _021024.pdf (7 pages)

19. Action Log

Discussion *Mark Jones*

19. Public Board Action Log 2024.pdf (1 pages)

20. Staff Story

Information

21. Chair's report and stakeholder update

Information *Mark Jones*

22. Chief Executive's report

Information *Mary Fleming*

22. CEO Board Report_December 2024_Public.pdf (8 pages)

23. Board performance and Finance report: Learnings and Future plans

Discussion *All*

24. Committee chairs' reports

Information *Non Executive Directors*

24.1. Quality and Safety

Information *Francine Thorpe*

24.1. AAA.QS.Nov.24.pdf (2 pages)

24.2. Finance and Performance

Information *Julie Gill*

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

24.3. Audit Committee

Information

24.3 AAA - Audit Committee - 25 Nov 2024.pdf (2 pages)

24.4. People Committee

Information *Lynne Lobley*

24.4. AAA People - 8 Oct 2024.pdf (2 pages)

24.5. Research

Information *Clare Austin*

Verbal report due to close proximity of the meeting

25. WRES and WDES

Discussion *Juliette Tait*

25. Board Meeting WRES and WDES Report 2024 December2024 final.pdf (32 pages)

26. Integrated performance report

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

26. Board of Directors IPR M7 2425.pdf (3 pages)
26a. Board of Directors_IPR_M7_2425.pdf (19 pages)

27. Finance report

Information *Tabitha Gardner*

27. Board Cover Sheet - Trust Finance Report October 2024.pdf (2 pages)
27a. Trust Finance Report 24-25 October Month 7 Board.pdf (18 pages)

28. Financial plan deficit funding adjustment

Approval *Tabitha Gardner*

28. Board paper - Financial plan deficit funding adjustment.pdf (5 pages)

29. Multi Storey Car Park

Approval *Tabitha Gardner*

29. Trust Board - Multi Storey Car Park – Full Business Case Update - 04.12.24.pdf (10 pages)

30. Maternity reports

Information *Kevin Parker-Evans*

30.1. Q2 Perinatal Quality Surveillance report

30.1. Perinatal Quality Surveillance Q2 24-25 Jul-Sep 24 (For Board).pdf (32 pages)

30.2. SCORE culture survey

30.2. SCORE Culture Survey Paper for Trust Board December 2024.pdf (5 pages)

31. University Teaching Hospitals update

Information *Sanjay Arya*

31. University Hospital Status Progress Report Nov 24 Final.pdf (5 pages)

32. Board Assurance Framework

Information *Nina Guymer*

32. BAF Report Board December 2024.pdf (30 pages)

33. Reflections on equality, diversity and inclusion

Discussion *Mark Jones*

Consent Agenda

34. Standing Financial Instructions

Endorsement

34. SFI annual review Board.pdf (4 pages)
34a. SFIs 24-25 Nov 2024.pdf (65 pages)

35. Maternity Dashboards and Achieving National ambition reduction in Stillbirths report

Information

35. Maternity Dashboard Report October 24 - Consent agenda.pdf (10 pages)
35b.Optimisation Dashboard - Oct 24 - Consent agenda.pdf (1 pages)
35a. Maternity Dashboard - Oct 2024 - Consent agenda.pdf (3 pages)
35c. Perinatal Exception Report - Oct 24 - Consent agenda.pdf (1 pages)
35d. Perinatal Dashboard - Oct 24 - Consent agenda.pdf (2 pages)

36. Date, time and venue of the next meeting

Information

05 February 2025, 1.15pm, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Directors' declarations of interest
Presented to:	Board of Directors
On:	04 December 2024
Purpose:	Information
Prepared by:	Deputy Company Secretary E: nina.guymer@wwl.nhs.uk

NON-EXECUTIVE DIRECTORS	
Name	**Declared interests**
AUSTIN, Claire	Employed by Edge Hill University as Pro-Vice-Chancellor and Dean of the Faculty of Health and Social Care and medicine Son works for Azets Audit Services Limited as a Trainee Auditor
BRADLEY, Rhona	Trustee, Addiction Dependency Solutions charity Governor, Learning Training Employment (LTE) Group Non-Executive Director, Home Group Housing Association Spouse is The Rt Hon Lord Bradley of Withington
GILL, Julie	Nil declaration
HOLDEN, Simon	Chairman of Governors, Pear Tree Academy School Director, Simon Holden Associates Limited
JONES, Mark	Nil declaration
LOBLEY, Lynne	Nil declaration
MOORE, Mary	Director and shareholder, Scenario Health Ltd (CRN: 13066776) Non-Executive Director, Stockport NHS Foundation Trust
WILKINSON, Mark	Cheshire East Place Director, NHS Cheshire and Merseyside Non-Executive Director and Vice Chair, Bolton At Home Ltd Non-Executive Director, Mastercall Healthcare

	Governor, Edge Hill University Director, Fairway Consulting Services Ltd Wife employed by Lancashire County Council public health department Son works for Mersey and West Lancs NHS FT
THORPE, Francine	Independent Chair, Salford Safeguarding Adults Board

EXECUTIVE DIRECTORS	
Name	**Declared interests**
ARYA, Sanjay	Clinical private practice, Beaumont Hospital and WWL. Undergraduate Clinical Lead in Cardiology, Edge Hill University. Contracted to act as Principle Investigator for Triage Heart Failure Study Medtronic Company (in association with Manchester Foundation Trust). Honorary position on the Advisory Panel at Bolton University Medical School. Director and Chair of the Hospital Doctors' Forum, British International Doctors' Association (CRN: 01396082) Director, Highbank Grange (Bolton) Residents Association Limited (CRN: 04300183) Spouse is General Practitioner in Bolton
BRENNAN, Sarah	Nil declaration
TAIT, Juliette	Nil declaration
FLEMING, Mary	Nil declaration
GARDNER, Tabitha	Governor, Aspiring Learners Academy Trust Spouse is director of Manchester University NHS FT
HOWARD, Paul	Director and shareholder, PDH Advisory Limited (CRN: 09800579) Independent Person for Bolton Council Tutor and examiner for the Chartered Governance Institute UK and Ireland Spouse works for North West Ambulance Service NHS Trust and is shareholder of PDH Advisory Limited (CRN: 09800579)

MILLER, Anne-Marie	Spouse is director of Railway Children charity and Railway Children Trading Company Limited Spouse acted as a Fundraising Consultant for WWL on one project in 2023/24
MUNDON, Richard	Nil declaration
PARKER-EVANS, Kevin	Spouse is Head of Safeguarding and Designated Adult safeguarding nurse for NHS Greater Manchester (Stockport Locality)

Board of Directors - Public Meetings

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

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Attendees

Board members

Mark Jones (Chair), Sanjay Arya (Medical Director), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Sarah Brennan (Chief Operating Officer), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Ian Haythornthwaite (Non-Executive Director), Simon Holden (Non-Executive Director), Paul Howard (Director of Corporate Affairs), Lynne Lobley (Non-Executive Director), Mary Moore (Non-Executive Director), Richard Mundon (Director of Strategy and Planning), Kevin Parker-Evans (Chief Nurse), Juliette Tait (Chief People Officer), Francine Thorpe (Non-Executive Director), Mark Wilkinson (Non-Executive Director)

Absent: Anne-Marie Miller (Director of Communications and Stakeholder Engagement)

In attendance

Aydin Djemal (Development Non-Executive Director), Hameeda Khan-Davey (Development Non-Executive Director)

Meeting minutes

14. Declarations of Interest

Information

Mark Jones

No declarations of interest were raised.

14.1. Register of directors' interests

The register was noted.

14.1 Private Board - Directors DoIs - Sep 2024.pdf

15. Minutes of the previous meeting

Approval

Mark Jones

The Board **APPROVED** the minutes of its previous meeting.

15. Minutes_Board of Directors - Public Meeting_070824.pdf

16. Action Log

Discussion

Mark Jones

The action log update was noted and it was agreed that action 126/24 could be closed.

16. Public Board Action Log - Aug 2024.pdf

17. Research Story

Information

Video

A video was displayed for the committee providing the positive story of a WWL patient and her involvement in a research trial.

18. Chair's report

Information

Mark Jones

The Chair reported positively upon a recent meeting of local leaders, organised by Wigan Council, to launch 'Progress with Unity', its plan for the next decade to create fair opportunities for all children, families, residents and businesses and make all of the borough's towns and neighbourhoods flourish for those who live and work in them. He went on to describe the focus on health inequalities, deprivation, community care and the prevention agenda, not just at this meeting but at the Healthy Wigan Partnership meeting held in September 2024.

He had also met with Lisa Nandy MP who had joined WWL to open its new endoscopy unit and with Josh Simons MP in the Makerfield constituency.

He briefly described the differences in governance structures between NHS and council organisations and appreciated that although this can present a challenge, the teams in Wigan are committed to working together to tackle its unique issues as a locality. Further, WWL will be moving forwards with several collaborative initiatives with Bolton NHS FT to build resilience in to their services. All board members now have objectives set which focus around system working, in support of this current approach.

He went on to emphasise the importance of the governor role in holding non-executive directors to account for the Board's performance and reported back on the revised format for governor workshops, which now see non-executive assurance committee chairs speak to smaller groups of governors to discuss key themes from their committees. This is intended to strengthen their ability to hold non-executives to account.

He highlighted the importance of non-executive directors being able to triangulate externally as they do internally and to support this, will soon visit the Mornington Row Family Hub in Hindley to learn about the support that this clinic provides for its communities and speak to the GPs there.

He noted the importance of governors also engaging with communities and that GP Gen Wong would be attending their next meeting to share learnings from his West Leigh community project.

19. Chief Executive's report

Information

Mary Fleming

The Chief Executive summarised her report, which had been shared in advance of the meeting.

The Board received and noted the update.

19. CEO Board Report Oct 2024_Final.pdf

20. Committee chairs' reports

Information

Non Executive Directors

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

20.1. Quality and Safety

Information

Francine Thorpe

Mrs F Thorpe highlighted that the issues in the patient safety report of late have not concerned matters which the committee has been unaware are problematic and that as Chair, she feels adequately sighted on all matters of concern.

The Chair asked whether the Trust has adequate flu jabs for staff, which the Chief Nurse advised that it does.

20.1. AAAQSsept24.pdf

20.2. Finance and Performance

Information

Julie Gill

The Chair asked the Chief Executive to set out progress with the recovery plan for the specialist services division. She advised that herself and some members of the executive team had met with a group of clinicians within the division for a listening event, to get a better understanding of what the issues are which are inhibiting the increase in activity within the division. They came up with their own ideas around how problems can be tackled which will be put in to action and she noted that the GIRFT (getting it right first time) team have also agreed to assist WWL, in light of its position as a Core20PLUS5 trust. The position will be monitored by the Finance and Performance Committee moving forwards.

20.2. AAA F&P - Sept 2024.pdf

20.3. Audit Committee

Information

Ian Haythornthwaite

No queries were raised.

20.4. People Committee

Information

Lynne Lobley

Mrs L Lobley highlighted a recent themes which has been discussed within each divisional deep dive, around the workforce profile, specifically, the aging workforce.

Mrs F Thorpe asked whether all doctors need to recomplete mandatory training when they join a new organisation. It was clarified that doctors have a training passport which should transfer to the new organisation from the lead employer.

In response to this and a follow up query from the Chief Executive, she clarified that many do come over to WWL being non-compliant but that this is fed back to the lead employer and that the process is being refined to prevent this from continuing.

Lady R Bradley asked what the current position is in respect of nurse industrial action.

The Chief Nurse advised that it is likely that there will be more industrial action but there is a lack of clarity on when and if this will happen.

20.4. AAA People - Aug 2024.pdf

20.5. Research

Information

Clare Austin

The Chair asked about the number of jointly appointed clinicians and asked whether WWL are now behind where they thought they would be and how far.

The Medical Director noted that the posts are aligned to vacancies and that 6% of the total substantive consultant posts must be joint, 13 are therefore required and currently WWL have 6 appointed. He felt that the 2026 target was attainable although the Board did appreciate the difficulty with this.

The University Hospital Association is now considering whether the appointment must be a medical grade consultant since WWL had raised that, given the focus on alternative workforce models now, these posts could actually be filled in other ways. The current position is that this is not possible and it was noted that the denominator used is the total number of medical consultants and so there would be difficulty in measuring the percentage requirement should this be widened.

20.5. AAA - Research - Sep 2024.pdf

21. Integrated performance report

Information

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

The Chief Operating Officer presented the report which had been shared in advance of the meeting. She noted how the metrics reported in the matrix highlight the areas which the trust need to focus on to improve services, particularly within urgent care.

The Medical Director wished to highlight that the SHMI score has continued to reduce each month and that HSMR has been below 100 for two years. The Chief Nurse added that the complaints response score continues to increase.

The Chief People Officer noted in respect of the sickness score that the long term sickness has reduced but that short term has increases and expressed concern around burn out caused by pressures, although WWL are in the lowest three trusts in GM in terms of that score.

The Chief Operating Officer acknowledged that the 72.9% A&E performance does not meet the national target.

Mrs F Thorpe expressed concern around the 62 day cancer performance. She noted that the impact on this for patients must be significant from a physical and mental health perspective. She asked whether the number of days over the target is reported, which was confirmed.

Mrs L Lobley asked how the Trust is maintaining its relationship with the ambulance service.

The Chief Operating Officer advised that there have been many changes in management personnel at the North West Ambulance Service recently but that now a new team is in place, the organisations have met to make introductions and are looking to hold monthly meetings to support their working together and ensure the safety of patients through ambulance handovers. WWL have suggested to them that if they are able to support with patient transport at the end of the care journey, patients will be able to be discharged faster and then WWL can take handovers more effectively.

The Board received and noted the update.

21a. M5 2425 Integrated Performance Report.pdf
21. Board of Directors M5 2425 IPR.pdf

22. Maternity reports

Kevin Parker-Evans

The Chief Nurse presented the following reports which had been shared in advance of the meeting, highlighting triangulation with what had been reported with what is going on when himself and other board members have visited the maternity ward:

- Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (MIS)
- Local Maternity and Neonatal System saving babies lives quarterly report
- MIS 4: Neonatal Workforce Compliance

The Board received and noted the action plans and the update, concurring with his observation.

23. Partnerships report

Information

Richard Mundon

The Director of Strategy and Planning presented the report which had been shared in advance of the meeting.

The Chief People Officer added that she had attended a borough wide meeting earlier in the week around education and training, with a meeting upcoming with Edge Hill University.

The Board received and noted the update, commenting on how the content of the report had in the main been positive.

23. Trust Board - Partnerships Report October 2024 FINAL.pdf

24. Finance report

Information

Tabitha Gardner

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

Mrs F Thorpe asked whether the in month deficit being £0.4m adverse to plan could be due to the cost of non-pay items increasing or due to wastage.

The Chief Finance Officer advised that it is likely to be a mix of the two.

The Board received and noted the update.

24. Board Cover Sheet - Trust Finance Report August 2024.pdf
24a. Trust Finance Report 24-25 August Month 5 Board.pdf

25. Complaints annual report

Information

Kevin Parker-Evans

The Chief Nurse presented the report with thanks to his team for compiling it.

Mrs L Lobley noted that most complaints are around clinical treatment and asked whether these come through in any specific area.

The Chief Nurse highlighted the emergency department and waiting list waits as areas which tend to generate more complaints but noted that more work will be done to identify more themes and trends to identify areas and services which may need additional support.

In response to a query from Prof C Austin he clarified that the complaints score for this month is a blip, caused by the significant increase in activity in A&E.

The Chair asked how communication will be improved and noted the errors which are sometimes apparent in hospital communications, such as text messages which are received by patients about appointments which have already taken place.

The Chief Nurse advised that there is some work going to improve communications around discharge planning, he went on to explain that the 'nurse in charge' hotline has now been set up, allowing all patients to contact the 'nurse in charge' at any time. He added that there is an opportunity to utilise volunteers in a more effective way through deploying them to go on to wards and talk to patients and check in on whether they have had key information passed to them and had the support that they need. He acknowledged the need to make sure that patients are asked what the best way for the Trust to communicate with them is before their care begins.

The Chair appreciated the progress made here.

The Board received and noted the update.

25.PRD annual report June 2024 new format.pdf

26. Board Assurance Framework

Information

Paul Howard

The Director of Strategy highlighted in respect of the partnerships objectives, that the Board should closely monitor PR16 around the university teaching hospital status risk score which may need to increase in the coming month but more positively, that the score for PR14 is likely to be able to reduce, given the significant progress with partnership working, most of which had been discussed or noted in the reports for the meeting.

The Board received and noted the update.

26.BAF Report Board October 2024.pdf

27. Freedom to Speak Up Guardian's report

Information

Selina Morgan

The Freedom to Speak Up (FTSU) Guardian joined the meeting to present the report.

The Chief People Officer thanked the Freedom to Speak Up Guardian for attending.

The need to try and encourage staff to feel comfortable to report to their line manager was noted. The Medical Director asked what the rationale is for staff contacting the Guardian instead of a line manager, where they are happy to provide their name and not raise issues anonymously.

The Board discussed the need to work on the message to staff that the guardian service is just one route through which concerns can be raised but that these can also be raised with a manager. It was felt that staff often do not understand that the guardian's role is to facilitate resolution of issues in the same way that a manager would but in circumstances where staff are not comfortable to raise issues with their own manager.

Mrs F Thorpe observed that the FTSU service was introduced after an enquiry at the Mid Staffordshire NHS FT, where staff had been unable to raise safety related concerns but observed that there are very few safety related concerns raised through this report.

The Board received and noted the update.

27. FTSU Quarterly report for Board 17.09.24 v0.3.pdf

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

Discussion

Mark Jones

The Board considered how their discussions had given consideration to ED&I factors as well as health inequalities, noting the Chair's introduction and how this had emphasised the importance of weaving this in to its day to day business. The Board felt like this has been well embedded at WWL.

The Chair noted that the meeting would be Mr I Haythornthwaite's last as WWL's Chair of Audit Committee. He thanked him for his contribution over the previous six years and wished him well in the future on behalf of the Trust.

29. Consent Agenda

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

30. Risk Management Framework

Ratification

That the framework be **RAFTIFIED**.

29.Board FS Risk Management Framework.pdf
29a. Risk Management Framework for Board Ratification.pdf

31. Revalidation report

That the report be noted and compliance with the Medical Profession (Responsible Officers) Regulations 2012 **AGREED**.

30.Appraisal Revalidation Annual Submission_Trust Board.pdf

32. Guardian of Safe Working Hours

Information

That the report be noted.

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

33. EPRR core standards

That the report, including the self assessment and areas of non-compliance, be noted.

32. EPRR Statement of Compliance 2024-2025 - WWL.pdf

32a. 240816 NHS Core Standards for EPRR 2024 WWL Self Assesment v1.pdf
32. 241002 - Report on NHS EPRR Core Standards 2024.pdf

34. Maternity dashboards and achieving national ambition reduction in still births

That the dashboard and report be noted.

35. Audit Committee terms of reference

That the terms of reference be **APPROVED**.

36. Date, time and venue of the next meeting

Information

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

Action log: November 2024

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
			NONE DUE			

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	04/12/2024
Item purpose:	Information
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy and corporate objectives

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

Included within the report are references to financial matters, including a description of the steps being taken to mitigate financial challenges.

Legal implications

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

People implications

There are no people risks associated with this report.

Equality, diversity and inclusion implications

There are no specific equality, diversity and inclusion implications within the report, but the report provides an overview of the strategic direction of the organisation and the challenges faced, which may ultimately have EDI implications.

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

This report was reviewed by the Executive Team at its meeting on 28 November 2024.

Recommendation(s)

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

Introduction

Over the past few months, we have had the pleasure of receiving some very special and influential guests across our three main hospital sites and we have seen some great examples of working differently and in partnership to improve services and outcomes for our patients.

Whilst it is important for us to celebrate and spotlight this, such celebration must be balanced against providing real context of the environment that WWL is operating within – it is challenging, and we are responding to by making changes that are both safe and sustainable to ensure we continuously improve the services we provide.

Improving access to services: Clinical Diagnostics Centre

Being able to access services at times of need is essential for the health of our local population, we have some of the highest areas of deprivation in the country within our borough, coupled with a disproportionately elderly population – all of which can challenge the delivery of services, which is why our Clinical Diagnostics Centre (CDC) is an excellent new asset to Wigan.

In November I was delighted to welcome Andy Burnham, Greater Manchester (GM) Mayor and Co-Chair of the GM Integrated Care Board (ICB) to officially open our CDC at Leigh Infirmary. So far over 65,000 additional tests have been provided to patients across the borough and weekly activity has ramped up to 1,600 tests each week. Having brand-new, state of the art CT and MRI scanning equipment at Leigh Infirmary means we are now able to offer both diagnostic procedures for the first time at the site – something that had previously only been able to be delivered at Royal Albert Edward Infirmary and Wrightington Hospital. With increased access to diagnostics and additional capacity, waiting times will be reduced and there is the potential to offer flexible appointments so that they can be more convenient for our patients.

The CDC is a shining example of how WWL is investing in our journey to outstanding and contributing to Wigan Council's 'Progress with Unity' strategy both of which aims to level up and address health inequalities across the Wigan Borough, as well as creating fair opportunities for every resident, something we are very much invested in here at WWL. The diagnostic part of healthcare is crucial. We know that the earlier patients receive diagnostics, the earlier they can have peace of mind or the quicker they can receive the treatment they need.

Improving outcomes and addressing health inequalities: Respiratory project

Another great example of how we are working differently to improve outcomes and address health inequalities for our patients is a respiratory project led by our Deputy Medical Director, Dr Abdul Ashish. Dr Ashish is spearheading this pilot in conjunction with primary care colleagues within primary care networks (PCN), Dr Vallabh, Clinical Director at the SWAN PCN and Dr Oliveira, Respiratory Consultant. The pilot looks at integrated ways of working and has reviewed and developed a new pathway for patients to be proactively contacted and to receive their care in the community rather than in a hospital setting.

The results have been incredible, incorporating prevention and health promotion and consultant care in a community clinic. We have seen lung cancers being detected earlier, significantly reduced 'do not attend' rates for appointments, and it truly is a real 'one stop shop' for patients where their treatment has been reviewed and optimised. Patient feedback has been fantastic, with those who left the clinic feeling better equipped to manage their condition, and that the team

worked well together at a location that was convenient for them. The new integrated team have said there is no added workload but obvious benefits for patients and the clinic runs more efficiently with less duplication. Due to its success, we are considering running the pilot across other specialities.

Blue plaque for Professor Sir John Charnley

Wrightington Hospital was also the recipient of some very special guests from Wigan Council in November. The Mayor of Wigan Borough, local Councillors and other esteemed colleagues from Wigan Council's Culture and Heritage Team visited the hospital to award WWL with its very first blue plaque, to commemorate Professor Sir John Charnley and his pioneering work in orthopaedics.

We were also pleased to welcome members of the Charnley family as well as trustees of the John Charnley Trust and Wrightington Hospital staff past and present. The blue plaque is proudly displayed at the entrance of The Centre for Hip Surgery, which is just a few metres away from the brand-new state-of the art Theatre 11 which opened in November; a real reflection of the historical significance of the site where pioneering work will continue to transform lives.

Photo credit: Wigan Council

Financial position

WWL is currently experiencing financial challenges with a £3.1m deficit which is £2.9m worse than plan.

We are delivering lower than expected elective activity however many of our Surgical specialities are over delivering on plan through the use of our elective hub sites. We are currently facing underperformance in our recurrent Cost Improvement Programme (CIP). This is being mitigated through non-recurrent CIP measures; however, these measures unfortunately are not impacting our financial position to the same extent. Costs have increased in relation to both pay and non-pay and despite our increased grip and control our normalised pay is stubbornly static.

To improve our financial outlook, we have already implemented several actions. These include aligning nursing bank rates with other GM providers, enhancing non-medical vacancy controls, and introducing stricter controls on specific non-pay spending categories. These measures are expected to show promising results however, further action is required to achieve our plan as the current forecast suggests that, in a mid-case scenario, it will be challenging to meet our in-year plan.

These measures have had an impact, Surgical specialities exceeding their elective activity plan, non-recurrent CIP is over delivery and the normalised pay bill has been stabilised, however further steps are needed to address the challenges we now face. As a Board, we will be discussing a number of further potential controls, alongside enhanced managerial oversight, to ensure focused delivery. We will be considering additional measures across all areas – including non-pay, performance, service reviews, workforce, and business case developments – and we will always ensure that any proposals are subject to rigorous quality impact assessment.

As an organisation, we have a very clear three-year financial sustainability plan which has been agreed by the board; rooted in a desire to safely reduce costs and improve efficiency each year. We continue to engage with our colleagues to seek out those smaller, local changes that collectively make big difference – this year we have so far delivered £5.3m of recurrent financial savings against a full-year target of £11.1m, and we are working to deliver a total cost improvement £27.3m in total by the end of the financial year. We recognise the importance of delivering recurrent cost savings – removing the costs completely rather than simply avoiding them for one year – and there is a renewed focus across the organisation to identify opportunities to take non-recurrent savings that have been identified and to make them recurrent.

Part of our three-year financial sustainability plan is to safely reduce our pay bill. To do this we have strengthened our executive-led vacancy panel and introduced greater controls on our workforce establishments. We are also prioritising resources that benefit the delivery of safe and quality care, such as aligning nursing bank rates of pay with other GM providers and incorporating enhanced non-medical vacancy controls.

At the very heart of encouraging excellence, sharing best practice and investing in people and services is ensuring that our patients get the right treatment, at the right time and in the right place and that we improve outcomes for our patients. With this in mind, we have a key role in reducing long waits for elective procedures as we have two dedicated Surgical Elective Hubs and we have utilised them to receive a significant number of patients via mutual aid requests; far surpassing any other trust in GM. That said, we are currently not meeting our elective recovery plan for trauma and

orthopaedics, and this is impacting on our overall position, despite other surgical specialties delivering in excess of their planned activity.

We are working hand in hand with our specialist services and surgical divisions to maximise theatre capacity and to take steps to recover our plan, whilst recognising that this will be challenging given that we are heading into a busy winter period where elective bed capacity may be impacted by the need to care for patients who are admitted via our urgent and emergency care pathways. Following a listening event with Orthopaedic Consultant colleagues, Chief Executive and Executive Directors on the Wrightington Hospital site, a detailed action plan has been developed to support increasing activity within our trauma and orthopaedics service and this is regularly reviewed by the Executive Team, alongside key performance indicators relating to finance, performance and workforce. Plans are also being developed to utilise the theatre capacity on the Wrightington Hospital site for other surgical procedures, so that theatre utilisation can be maximised, patients can be seen as swiftly as possible and additional income can be generated.

The Wigan context

There is plenty of evidence to show a poor demographic unemployment and a disproportionate elderly population brings challenges of its own and the Wigan Borough is one which has particular challenges. With 330,000 residents, Wigan is a very large borough which also has a disproportionate number of aging people. 20% of our population is aged over 65 and there is a direct correlation between age and health need. For example, we know that those aged over 75 are the most frequent attenders at A&E.

Wigan also has high levels of deprivation, with 29% of our residents (c.100,000 people) living in the bottom quintile of deprived areas in the country and around 20% of children living in poverty. 40% of those who attend A&E are from the most deprived areas. WWL has the lowest general and acute bed base of all provider organisations in Greater Manchester, with 4.9 beds available per 1,000 population.

Taking action and identifying learning

As a Board, we are constantly reviewing progress in the above areas with much of the detailed scrutiny and challenge taking place through Divisional Assurance meetings and then via our sub-board committees mainly Finance and Performance Committee, People Committee, Quality and Safety Committee. We also continue to consider areas of interest identified through the GM ICB Provider Oversight Meetings with a particular focus on:

1. **What has happened?**
   Reviewing our forecast outturn position and comparing it with our plan

2. **Why has it has happened?**
   Analysing causes and steps taken to mitigate both risk and impact

3. **What happens next?**
   Refining our plans and identifying lessons to learn for the future

At the same time as focusing on delivering our financial position for the current financial year, planning for 2025/26 is also underway and our initial planning returns have already been submitted to GM. We will ensure that lessons learnt this year are built them into our planning for next year and beyond, and we are working on closer alignment between physical and workforce capacity to make sure we optimise our activity plans. It is therefore intended that our 2025/26 plans will be more integrated, particularly in relation to workforce models and quality outcomes.

Winter

Our winter operational planning is well underway, and plans are already being implemented. Winter is always a challenging period for health and social care systems, and we have already seen demand for services increasing, resulting in an increased pressures on hospitals, community services and primary care.

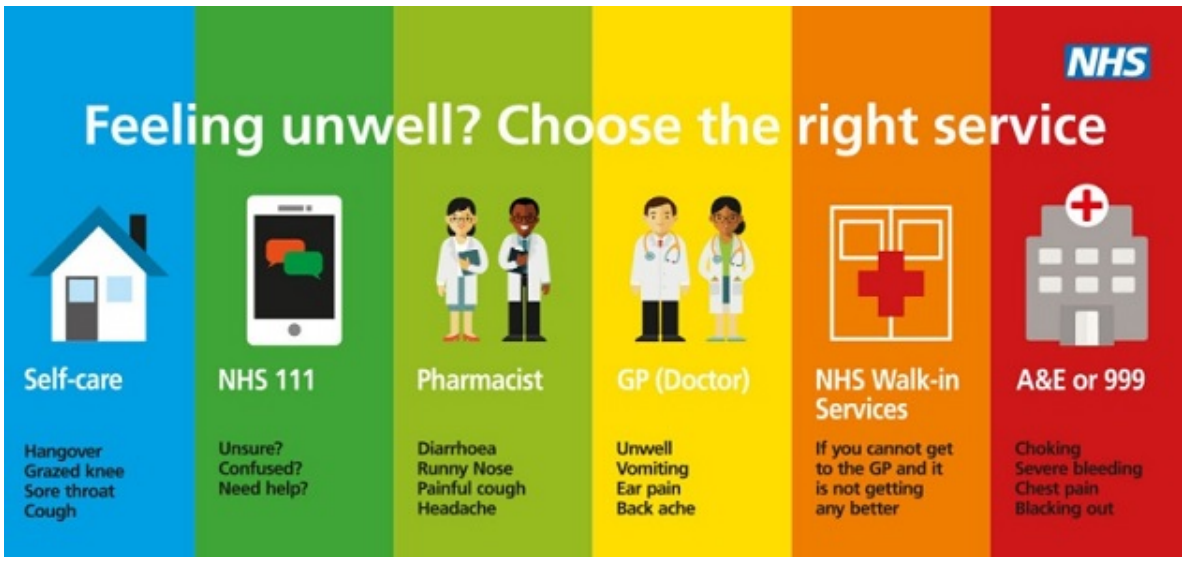
Our Resilience Team is leading on our seasonal preparedness plan which sets out the actions and measures that have been put in place to manage the increase in pressures, including supporting safe and effective patient flow, risk mitigation, concise escalation and de-escalation processes, as well as staff health and wellbeing considerations. We know that winter will be a challenging period for our teams, and I want to take this opportunity to thank them for all that they do.

Thank you

I would like to end this report by acknowledging our local community for their support during pressured times, particularly in identifying and using the full range of services available. As a reminder:

- In an emergency, always dial 999 or attend A&E.
- If it is not an emergency but you think you need medical help right now, contact NHS 111. You can get help from NHS 111 by calling 111 from your phone, visiting 111.nhs.uk online or by accessing the service via the NHS app. (111 online is for people aged 5 and over – please call 111 if you need help for a child under 5).

NHS 111 can direct you to the best place to get help if you cannot contact your GP during the day or when your GP is closed. You can get an emergency supply of regularly prescribed medicine from 111 online and 111 online can also help with dental problems.


NHS
Feeling unwell? Choose the right service
Self-care
Hangover
Grazed knee
Sore throat
Cough
NHS 111
Unsure?
Confused?
Need help?
Pharmacist
Diarrhoea
Runny Nose
Painful cough
Headache
GP (Doctor)
Unwell
Vomiting
Ear pain
Back ache
NHS Walk-in Services
If you cannot get to the GP and it is not getting any better
A&E or 999
Choking
Severe bleeding
Chest pain
Blacking out

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	20th November 2024
Chair:	Francine Thorpe

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

ALERT

- Feedback from the Escalation Assurance Group outlined the following:
  - Limited assurance that agreed escalation plans are being followed
  - No reliable data to evidence that de-escalation is being recorded when the emergency department full capacity status has been called
  - Risks associated with staff redeployment from other areas leading to potential patient harm
  - Potential risk around delays in recognition and escalation of the patients that may be deteriorating during times of sustained pressure
    The group has been established to regularly review and monitor incidents and risk using a range of data to secure improvement
- The Sepsis report highlighted improvement in the Advancing Quality metrics; however fluctuating performance was reported against 3 of the 4 measures. Actions are being progressed to secure sustained improvement.
- A report on an independent culture survey undertaken within maternity and neonatal services was received highlighting a number of themes for consideration. An action plan to address these is being developed and will be shared at the next meeting
- A Deep Dive from the Deteriorating Patient Group identified 6 key areas for improvement based on analysis of incidents and other data. Improvement programmes for each area have been identified. The committee asked that measures to track progress were included in the next report.

ASSURE

- The Estates and Facilities Deep Dive highlighted:
  - Sustained performance on the Patient-Led Assessments of the Care Environment (PLACE) with WWL being ranked joint 1st nationally against all Acute Trusts
  - Good progress in delivering the capital works programme for theatres
  - Significant improvements in the security team's approach to the managememt of violent and aggressive patients through least restrictive practice training and links with the safeguarding team
  - Compliance with national accreditation audits

- The Q2 Perinatal Quality Surveillance Report provided assurance on a range of quality and safety indicators which included:
  - Progress against Ockenden actions
  - No barriers to completing actions against the CNST maternity incentive scheme
  - Full compliance around mandatory training
  - Positive benchmarking against Greater Manchester and East Cheshire Maternity Network measures in all but 1 area
- The Biannual Mortality Report highlighted that the Trust is within the expected range for Summary Hospital-level Mortality (SHMI) and Hospital Standardised Mortality Indicator (HSMI). Assurance was received in terms of the scrutiny and oversight provided through the monthly mortality group to consider comparative data for all clinical conditions.
- The Sepsis Report highlighted a consistent upward trend in the timely administration of IV antibiotics; it is anticipated that the 95% target wll be achieved by year-end.
- The establishment of the Escalation Assurance Group was noted to be a positive response to ensuring that the Committee has a good level of oversight in relation to quality and safety metrics for patients presenting on emergency care pathways. Progress is being made in developing a dashboard aligned to incident reporting which enables triangulation, scrutiny and supports improvement planning.
- A Safe Medical Staffing Report was received that provided assurance that medical staffing for resident doctors within Acute Medicine and SDEC is consistent Royal College recommendations. It was agreed that further work should be undertaken to consider integrating this data with Safe Nursing Staffing information to provide a more hoilsitic overview.
- The Aspire Accreditation Report provided asurance that good progress ie being made to achieve corporate objective CO6. Plans are being developed to amend the accrediation programme for 25/26 to include a broader range of services and develop a more supportive peer review aproach

ADVISE

- The committee heard feedback from a family articulating their emotional distress at the loss of patient property with significant sentimental value. An update was received in relation to improvement work around this area, including the introduction of Patient Property bags.
- A report on progress in achieving corporate objective 'To enhance patient care through digital transforamtion' (CO1) highlighted slow progress in engaging with care homes. The committee approved the recommendations outlined within the report from the Care Home Board. They included working with an alternative care home provider and to integrate this work into the Better Lives admission avoidance workstream.
- The Committee's reflections on Equality Diversity and Inclusion included:
  - Lived experience information received through family story
  - Maternity reports including ethnicity and inequalities data
  - Work on Martha's rule being undertaken

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the Board Assurance Framework were reviewed; no risks have yet been identified to the acheivement of objectives CO1 and CO3. In light of the slow progress with CO1 members of the committee requested further consideration of any risks associated with these objectives be brought back to the next meeting.
- The Estates and Facilities Divsional risks were presented as part of their Deep Dive

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	26 November 2024
Chair:	Julie Gill

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

ALERT

- The general level of risk in finance and performance is increasing – the committee reviewed the six principal risks noted on the board assurance framework and increased the risk associated with financial performance (PR7: There is a risk that the trust may fail to fully mitigate in-year pressures to deliver key finance statutory duties.) from the current score of 12 (Impact 4 x Likelihood 3) to a new score of 16 (Impact 3 x Likelihood 4).
- The committee also considered two other principal risks on the board assurance framework (PR11: Elective services and PR12: Urgent and emergency care) and, whilst deciding that the risk scores do not currently need to be increased, nonetheless wish to alert the board to the increasing level of challenge and the fact that the risk scores may be increased at the next review.
- Significant challenges around the urgent and emergency care pathway were noted, with 4-hour performance deteriorating to 69.8%, higher levels of acuity amongst patients presenting at the Emergency Department and a reduced number of discharges impacting on patient flow through the department as well as on ambulance handover times. Note was also made of the fact that, whilst the number of patients with no criteria to reside had improved, there was still some way to go in achieving the target of 55 such patients.
- The committee wishes to alert the board to the fact that the revenue position for month 7 has triggered the red line ICB metric due to the variance to our forecast trajectory. This will be covered under the finance report at today's meeting. The committee received an update on the work that is being progressed, with a particular focus on mitigating actions to seek to deliver the agreed 2024/25 plan.

ASSURE

- The committee received three reports on the realisation of stated benefits within business cases that had previously been approved.
- A number of performance-related reports were received, and the committee was particularly pleased to note the focused work around digital and data performance. The committee noted in particular that there had been 100% uptime for critical systems during the

monitored period and that refreshes of the data platform had been undertaken on time 100% of the time in September 2024 and 96% of the time in October 2024.

- The committee was pleased to note the improved cash position following receipt of non-recurrent deficit funding from Greater Manchester Integrated Care Board, which means that cash support is no longer required. Whilst this has alleviated immediate cash concerns, the current run rate indicates that support may still be required in Q1 2025/26 and this remains subject to regular review and scrutiny by the committee. Given that the is no forecast requirement for cash support in-year, the score for principal risk 10 ('There is a risk that the trust may have insufficient cash balance to meet normal business activities on a day-to-day basis') was reduced from the current score of 10 (Impact 5 x Likelihood 2) to 5 (Impact 5 x Likelihood 1).

ADVISE

- The committee considered a business case for the proposed multi-storey car park development on the Freckleton Street site and recommended this to the board for approval.
- The committee received benefits realisation reports on SHO and clinical fellows following investment earlier on the year that made savings in locum costs and on Home First, which the committee noted would need to complement the work on Better Lives.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- As noted above, the score for principal risk 7 was increased from 12 to 16. The score for principal risk 10 was reduced from 10 to 5.
- As noted above, the committee was alert to the general level of risk associated with both finance and performance. Whilst scores are currently unchanged, there may be a requirement to increase scores at the next review.

Committee report

Report from:	Audit Committee
Date of meeting:	25 November 2024
Chair:	Simon Holden

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 update provided around the Multi Story Car Park (off balance sheet) transaction and the external auditors informal opinion that there are no concerns with the process and plan put forward. It accepted however that a formal opinion on the matter would not be given until the work has been completed. ▪ It noted the assurance provided by the freedom to speak up report only requested a more streamlined reporting format for FTSU moving forwards through an annual report, focussed more on process. ▪ The losses and special payments report was received. ▪ A high assurance internal audit on key financial controls audit was received. ▪ The internal audit plan is on track – and significant progress made with WWL's overall position ▪ High assurance was noted on general ledger, accounts payable and receivable and general financial management. ▪ The counter fraud report was noted and the plan on track. ▪ The annual review and update of standing financial instructions was reviewed and agreed for board approval. ▪ The independent review of the Charity's annual report and accounts had been received from Voisey & Co LLP, the committee therefore endorsed them for approval of the Charitable Trust Committee.
ADVISE
▪ A moderate assurance audit on employee relations was received with further assurance to be provided at next meeting by Chief People Officer around retention of documentation. ▪ The committee approved the draft responses for audit planning on management enquiries for those charged with governance.

- The committee noted several matters where it had reflected upon equality diversity and inclusion (ED&I) considerations along with health inequalities:
  - Fraud – challenging in relation to IVF being withheld from patients with certain criminal convictions, on the basis that healthcare should be accessible to all.
  - Losses and special payments – seeking further assurance around actions in place to prevent loss of patient accessibility aids.
  - Noting how other assurance committees consider this, through their minutes.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Following the annual review of the risk register and management process, the committee noted four new risks escalated to the corporate risk register, scoring 15 or above:
  - 4056: Sterile services decontamination air handling unit
  - 3912: Endocrinology patient waiting list
  - 3942: Sleep follow up waiting list
  - 4049: Insufficient medical resus cover at Leigh Infirmary

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	8 October 2024
Chair:	Lynne Lobley

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

ALERT
▪ Local compliance for mandatory training in clinical areas remains to be an issue. The Committee noted the ongoing work to support Divisions in mandatory training completion and that this is managed via the Divisional Assurance Meetings. The Committee welcomed the national work which is moving forward at pace in reviewing the mandatory compliance arrangements. ▪ The Committee noted hard to fill roles in Ophthalmology and Anaesthetics, and again a high proportion of staff approaching retirement, particularly in Theatres. ▪ The Workforce Race Equality Standard (WRES) highlighted that employees from a black, Asian and minority ethnic background had a worse experience in white staff when specifically looking at bullying and harassment. The report also highlighted that white applicants were more likely to be appointed than black, Asian and minority ethnic applicants following shortlisting. ▪ The Workforce Disability Equality Standard (WDES) highlighted a declining score for WWL staff who have a disability being able to access reasonable adjustments. The committee also noted to the low declaration rate for staff who have a disability. ▪ The staff story presented to the Committee was in relation to Freedom To Speak Up, and the Committee acknowledged the need to support our senior leaders in routes to speak up as this may feel difficult.
ASSURE
▪ The Committee were pleased to note the ongoing collaboration with Bolton Foundation Trust in relation to Human Resources. ▪ Similarly there was assurance provided regarding the strengthened relationships with Wigan Education and Skills Partnership (WESP) ▪ Mandatory training compliance overall was above the Trust target. ▪ Whilst the staff story presented to the Committee in relation to Freedom to Speak Up was something which the Trust needs to take significant learning from, the Committee felt that to have this level of exposure to people's stories around speaking up demonstrated a growing level of maturity with the ability to hear such stories in a way that enables growth and learning. ▪ The People Dashboard was continuing to go from strength to strength with the Committee being presented with key workforce data that enables a level of assurance in relation to workforce performance across the organisation. ▪ The Trust has continued to perform well in relation to the WRES data reporting that

black, Asian and minority ethnic staff do not experience disproportionality in relation to disciplinary action. ▪ The WRES report highlighted that 14% of our workforce is from a black, Asian and minority ethnic background which provides us with a level of diversity above that of the population we currently serve. ▪ The Trust has adopted a new way of sending out the quarterly staff survey which has resulted in a much improved response rate.
ADVISE
▪ The Leadership Strategy was presented which is starting to take shape. ▪ A high level workforce plan was presented.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ BAF to be updated ahead of next Board meeting

Title of report:	WRES & WDES Annual Reports 2024
Presented to:	Board of Directors
On:	4th December 2024
Presented by:	Chief People Officer
Prepared by:	Head of Staff Experience, EDI Lead (Workforce) and Assistant HR Business Partner
Contact details:	Angelique.hartwig@wwl.nhs.uk / Sarah.Berry@wwl.nhs.uk

Executive summary

The purpose of this report is to present the latest Trust Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results, highlight the areas of focus and to share the WRES and WDES action plans that aim to improve staff experience of our people from Black, Asian or minority ethnic background and those who are disabled and living with long term health condition.

The report sets out priority areas for action based on the analysis of the 2024 WRES and WDES results. The areas of focus will be the WRES indicators and WDES metrics that have not improved from the previous year and show the Trust WRES and WDES results to be worse than the NHS Trust benchmark.

WRES 2024

This year's WRES metrics show some areas of improvement and some areas of continued concern, highlighting key priorities for us to improve the experience for our colleagues from Black, Asian and Minority Ethnic groups. Key findings include:

Areas of improvement

- Black and Minority Ethnic staff are more likely to access non mandatory and CPD training
- Black and Minority Ethnic staff are less likely to be the subject of a formal disciplinary process

Areas of focus

- Black and Minority Ethnic staff are over 3 times more likely to experience being subjected to discrimination by their manager or colleague

- Black and Minority Ethnic staff are more likely to experience bullying and harassment at work than from a colleague compared to white staff
- Black and Minority Ethnic staff are 2.4 times less likely to be appointed after shortlisting than white staff
- Within agenda for change clinical roles, there is a disparity between representations from band 5 – 6 roles, and a very low representation at more senior roles band 8a and above, indicating a barrier to career progression.
- Black and Minority Ethnic staff are less likely than white staff to say that the Trust provides equal opportunities for career progression and promotion

WDES 2024

This year's WDES metrics suggest that our position against some indicators has improved whilst others have deteriorated since 2023. People who are disabled or have long-term health conditions still have a less positive work experience across all People Promises compared to other staff and remain a key focus for our effort to eliminate inequalities and create an inclusive workplace culture. Key findings include:

Areas of improvement

- Slight decrease in likelihood of disabled staff entering formal capability process for performance management but still 2.9 time more likely

Areas of focus -WDES

- Disabled staff are more likely to experience bullying, harassment and abuse in the workplace from all sources
- Disabled staff more likely to experience bullying, harassment and abuse from their manager
- Third disabled staff have reported not receiving adequate adjustments to enable them to do their work
- Disabled staff feel less valued than non-disabled staff
- Disabled staff report greater pressure to come to work compared to their non-disabled colleagues
- Disabled staff are less likely than non-disabled staff to say that the Trust provides equal opportunity for career progression and promotion

The WRES and WDES actions to address the areas of focus are included in Appendix 4. This year, our priority remains on creating conditions for inclusive, compassionate workplace culture for all staff, by developing our leaders in becoming consciously inclusive, making our policies and processes more person-centred and creating more inclusive career development opportunities.

The high-level actions have been shared with the EDI Strategy Group chaired by the CEO and will be progressed through the relevant EDI workstreams to give assurance that improvements in staff experience for those with protected characteristics will be made over the next 12 months. The WRES and WDES report has been received by ETM and the EDI Strategy Group to support the implementation of the action plans. The report has also been received by People Committee to support the proposed action plans. The draft WRES and WDES reports and action plans have been published on our Trust Website on 31st October and will be updated upon ratification by the Board.

Link to strategy

Trust Strategy 2030 People Strategy
EDI Strategy
Corporate People Objective 2024 – "We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish"

Risks associated with this report and proposed mitigations

Unsatisfactory progress regarding the WRES and WDES would be a risk to the Trust's reputation; both as an aspiring Outstanding NHS provider and as an employer of choice.

Financial implications

NHS WRES Team have indicated that, when black and minority ethnic and staff living with disabilities report greater engagement, there is a correlation with improved patient care, reduced turnover, less sickness absence and improved financial performance. Creating conditions for fair treatment will also prevent the risk of employment tribunal claims which are associated with significant financial impact for the organisation.

Legal implications

The Trust has legal obligations under the Public Sector Equality Duty to eliminate unlawful discrimination, advance equality of opportunities, and foster good relations between people with protected characteristics and those who do not. The Trust is also required to demonstrate improvements against nationally mandated EDI reporting frameworks, including WRES and WDES. There are increased risks of employment tribunal claims concerning the areas of disparity highlighted within the WDES & WRES.

People implications

The people issues which arise from the WDES & WRES are wide ranging and at the heart of this issue is fairness and equality of opportunity for Black and Minority Ethnic and disabled staff within the organisation.

Wider implications

There is a wide body of research evidence within the NHS which makes it clear that the experiences of black and minority ethnic and staff living with a disability and long-term health condition acts as a good barometer for the experience of our patients; the more positive the experience of our staff with protected characteristics, the more positive the experience of our patients.

Recommendation(s)

The Board is asked to ratify the WRES and WDES report and proposed action plans to improve our staff's experience at WWL.

Mandatory Equality, Diversity and Inclusion (EDI) reporting

1 Background

The Workforce Race Equality Standard and Workforce Disability Standard are a mandated requirement through the NHS Contract. The WRES was mandated in 2016 and WDES in 2019. Organisations are expected to report and publish their WRES and WDES data on an annual basis, illustrating organisational progress against nine (WRES) indicators and ten (WDES) indicators relating to workforce race and disability equality. This report allows the Trust to understand where the data indicates the areas of greatest challenge and where we are performing well.

2 Workforce Race Equality Standard (WRES)

The aim of WRES is to improve the experience of Black, and Minority Ethnic staff in the workplace. This includes employment, promotion and training opportunities.

The WRES comprises nine indicators against which we are required to assess performance:

- Four indicators cover the comparison of White and Black and Minority Ethnic staff metrics held within the Electronic Staff Record (ESR).
- Four indicators cover the comparison of White and Black, Asian, and minority ethnic staff responses within the National Staff Survey results for 2023.
- One indicator covers an assessment of whether our Board ethnicity is representative of the Trust's whole workforce

Appendix 1 includes the summary of the Trust's WRES scores 2024 which relates to data from 1st April 2023 – 31st March 2024. Appendix 5 includes the full WRES submission data.

Key Findings from the WRES 2024

WRES Data from WWL HR systems

- Trust workforce is 7373 as of 31st March 2024. Black and Minority Ethnic representation was 14.7% compared with 5% Black and Minority Ethnic for the Wigan Borough. A high level of staff have self-reported their ethnicity with 98.2% declared data.
- White staff were 2.41 more likely to be appointed from shortlisting compared with Black and Minority Ethnic applicants. There has been little change compared to last year's figure of 2.3. For this WRES indicator the Trust is performing worse than last year's NHS Trust benchmark.[1]
- The relative likelihood of Black and Minority Ethnic staff entering the disciplinary process compared to White staff is 0.65. This has improved significantly since the previous year where Black and Minority Ethnic staff were twice as likely to enter the disciplinary process compared to White staff. For this indicator, the Trust is performing better than last year's NHS benchmark.

[1] National NHS WRES and WDES benchmarking data for 2024 has not been published yet; only NHS National Staff Survey benchmarking data is available

- The relative likelihood of White staff accessing non mandatory training and CPD compared to Black and Minority Ethnic staff was 0.86. This is the first year the Trust has been able to report on this indicator following the roll out of a new learning system. For this indicator, the Trust is performing better than last year's NHS benchmark.

WRES Data from NHS Staff Survey - Bullying, Discrimination and Equal Opportunities

- White staff experience lower levels of bullying, harassment and abuse from the Public/Service Users at 19.03% compared to 22.29% for Black and Minority Ethnic staff. Compared to the previous year's figures there has been an improvement for both staff groups. For this indicator, the Trust is performing better than the NHS benchmark.
- Black and Minority Ethnic staff experience higher levels of bullying, harassment and abuse from other staff at 28.13% compared to 19.20% for white staff. Compared to the previous year's figures there has been a slight improvement for white staff and comparable for Black and Minority Ethnic staff with a 0.86% increase. For this indicator, the Trust is performing better than the NHS benchmark.
- Black and Minority Ethnic staff report significantly higher levels of discrimination at work from Manager/Team Leader or other Colleagues at 20.68% compared to 6.14% for white staff. Compared to the previous year's survey results this is an improving position for Black and Minority Ethnic staff (24.00%) and is comparable for white Staff (6.50%). For this indicator, the Trust is performing worse than the NHS benchmark.
- There has been an improvement in the number of Black and Minority Ethnic staff reporting that the Trust provides equal opportunities for careers progression or promotion, from 38.98% in 2022 to 46.48% in 2023. However, this is still below the figure reported in the 2021 staff survey of 50.00%. The number of White staff reporting that the Trust provides equal opportunities for careers progression or promotion was 57.58% and this has remained static over the last three years. For this indicator, the Trust is performing worse than the NHS benchmark.

3 Workforce Disability Equality Standard (WDES)

The aim of the Workforce Disability Equality Standard (WDES) is to improve the experience of staff living with a disability and long-term condition in the workplace. This includes employment, promotion and training opportunities.

The WDES comprises of ten metrics against which the Trust is required to assess its performance;

- Three metrics cover the comparison of Disabled and non-disabled staff metrics held within the Electronic Staff Record (ESR).
- Six metrics cover the comparison of staff with and staff without disabilities responses within the NHS National Staff Survey results for 2023.
- One metric covers an assessment of whether our Board is representative of the overall staff within WWL.

Appendix 2 includes the summary of the Trust's WDES scores 2024 which relates to data from 1st April 2023 – 31st March 2024. Appendix 6 includes the full WDES submission data.

3.1 Key Findings from the WDES 2024

WDES Data from HR Systems

- Non-disabled staff are 1.47 times more likely of being appointed from shortlisting compared to disabled staff. This has increased compared to last year's figure of 1.09.
- None of the 14 Trust Board members have declared living with a disability and/or a long-term condition on ESR.
- The likelihood of disabled staff entering the formal capability process for performance management is 2.9 times more likely than non-disabled staff. This figure is calculated based on a two-year rolling average and is an improvement compared to the previous year's figures of 5.1. This metrics requires further analysis as the numbers involved are small.

WDES Data from NHS Staff Survey

- The percentages of disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public, and also from colleagues in the last 12 months is 23.27% and this is higher than 18.3% of non-disabled staff. For this indicator, the Trust is performing better than the NHS benchmark.
- The percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months is 15.94% and this is higher than for non-disabled staff experiencing bullying and harassment from managers (6.57%). For this indicator, the Trust is performing worse than the NHS benchmark.
- The percentage of staff believing that the Trust provides equal opportunities for career progression or promotion was lower for disabled (48.71%) staff than non-disabled staff (58.55%), this is comparable to the previous year's figures for Disabled Staff (49.03%) and non-disabled Staff (57.84%). For this indicator, the Trust is performing worse than the NHS benchmark.
- The percentage of staff saying that they have felt pressure from their manager to come to work, was higher for disabled (29.38%) staff than non-disabled staff (17.05%). Compared to last year the figure has deteriorated for disabled staff (26.50%). For this indicator, the Trust is performing worse than the NHS benchmark.
- The percentage of staff saying that they are satisfied with the extent to which their organisation values their work is lower for disabled staff (35.31%) compared to non-disabled staff (47.10%). This is an improvement on previous years' figures for disabled staff (32.40%) and non-disabled staff (45.11%). For this indicator, the Trust is performing worse than the NHS benchmark.
- There has been a deterioration in the percentage of disabled staff that say their employer has made adequate adjustment(s) to enable them to carry out their work (66.49% this year and 68.48% last year). For this indicator, the Trust is performing worse than the NHS benchmark.

4 Progress on WRES and WDES action plans 2023-2024

Last year, the WRES and WDES action plans were aligned with the NHS England 6 High Impact Actions and focused on improving the EDI governance structure for our Trust and establishing EDI workstreams to drive improvements of the EDI agenda. In early 2024, a renewed EDI plan was created, combining strategic objectives and key actions from national EDI frameworks to guide our EDI agenda going forwards In April 2024, the Trust relaunched its Equality, Diversity and Inclusion Strategy Group chaired by Mary Fleming, CEO, and associated EDI workstreams. Senior Responsible Officers (SRO) have been assigned to the EDI workstreams and this will help to ensure that the WRES and WDES actions are implemented across WWL. They report into the EDI strategy Group which provides regular progress reports and assurance reports to the People Committee.

The Board can take assurance that work has been undertaken to improve our WRES and WDES data and make EDI as the core business of the organisation, including:

1. Development and launch of new WWL Trust values underpinning everything we do to create a positive work culture
2. Commenced journey to gain bronze status of the Northwest Anti-Racist Framework
3. Anti-Racism communication campaign including launch of WWL Anti-Racist Organisation Statement and anti-racism interactive sessions led by CEO and Chief People Officer at All Staff Team Brief and Leaders' Forum
4. Roll-out of Active Bystander Training for clinical nursing leaders
5. Acceptance onto the National NHSE Chief Nursing Officer 90 Global Challenge programme, leading to the recruitment of a Global Majority Practice Development Nurse and 4 Global Majority Nurse Fellows to provide focussed support for internationally educated colleagues
6. Self-assessment against the NHS England Civility and Respect Framework and development of culture change action plan
7. Disability Confident Employer self-assessment completed and due to be revalidated by November 2024
8. Refresh of current health passport and adjustments guidance underway to support our staff in staying well at work
9. Divisional People Promise plans include at least one EDI objective
10. Acceptance onto the NHS Confederation Diversity in Healthcare Partners Programme.

5 Understanding what matters to our people – Developing our WRES and WDES actions for 2024

To develop this year's WRES and WDES action plans, seven focus groups were delivered by the EDI lead during July and August in collaboration with the WWL staff networks as well as two interactive Anti-Racism sessions led by the Chief People Officer on the All-Staff Team Brief and Leaders' Forum. The purpose of the engagement sessions was to gain insights from staff with lived experience what key barriers they face at work and what actions would make the biggest difference to their experience at WWL and help us to address the main areas of focus of the WRES indicators and WDES metrics. All themes from different engagement sessions have been summarized in Appendix 3.

There were some common themes that emerged from the focus groups which are shared amongst staff from different protected characteristics, including:

- Need for leadership education on how to be inclusive and support staff from different backgrounds and lived experience
- Promoting kindness and respect between colleagues
- Policies and processes should be more person-centred and compassionate
- Staff are reluctant to speak up and need to feel supported by the organisation
- Negative experiences at work impact on health and wellbeing and ability to work
- Need for inclusive career development pathways and recruitment processes

We asked staff what actions would have the biggest impact on their experience at WWL. They shared the following:

- Supporting each other as one team
- Confidence in challenging unprofessional behaviour in a respectful way
- Creating accountability for inappropriate behaviour
- Demonstrating curiosity and developing awareness through education and learning from each other's experiences
- Creating inclusive recruitment practices

There was a shared understanding that WWL does not yet have an effective open culture where all staff can raise concerns without fear of retribution or a fear of a breach of their confidentially, although it was acknowledged that the Freedom to Speak Up Guardian has provided a safe route for people to share their concerns. The focus groups were consistent in suggesting the need to ensure that managers receive the necessary training and support to enable them to promote a culture of inclusion in their area of influence. And whilst training is important, it was also acknowledged that managers and leaders needed to be held to account for role-modelling our values and actively looking for ways to improve staff experience.

Staff shared that they wanted to see the Trust implement evidence-based interventions that are known to improve the WRES and WDES results. Staff were given the assurance that the Trust has strengthened its EDI Governance by establishing an EDI strategy group and workstreams.

WRES and WDES action plans 2024

This year's WRES and WDES action plans aim to improve our continued areas of focus, particularly around creating an inclusive culture free from bullying and harassment and working towards more inclusive policies and processes which allow for all staff to feel they belong and have equally positive experience at work and opportunities to develop or progress in our organisation.

In line with what staff have told us would make the biggest difference to them, we plan on focusing on empowering staff to speak up and challenge unprofessional behavior in a respectful way and providing education and shared learning for our leaders to role model compassionate and inclusive leadership. We will also continue to prioritize improving inclusive recruitment processes and career development opportunities. The draft WRES and WDES action plans can be found in Appendix 4.

7. Conclusion

The Board is asked to ratify the WRES and WDES report and proposed action plans to improve our staff's experience at WWL, noting review at the meeting of the Executive Team and EDI Strategy Group and finally People Committee. Upon ratification, the final version of the reports and action plans will be uploaded on our Trust website.

Appendix 1

Appendix 1 includes a summary of the Trust's WRES scores for 2024 and trends over time. This relates to data from 1st April 2023 – 31st March 2024. The data collection is extensive and is drawn from a range of sources including the Electronic Staff Record (ESR), the Trust`s recruitment system TRAC, HR data and a number of National staff survey indicators.

WRES indicator			WRES Reporting Year			
			2021	2022	2023	2024
1	Percentage of BME staff		8%	11.1%	14%	14.7%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		No data	1.47	2.3	2.41
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.34	2.19	2	0.65
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		No data	No data	No data	0.86
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	21.90%	19.90%	24.51%	22.29%
		White	24.40%	25.00%	21.67%	19.03%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	31.39%	28.42%	27.27%	28.13%
		White	24.94%	24.02%	21.78%	19.20%
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion **	BME	45.65%	50%	38.98%	46.48%
		White	56.67%	57.43%	57.97%	57.58%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	11.76%	20.94%	24.00%	20.68%
		White	6.91%	6.68%	6.50%	6.14%
9	BME board membership		7.1%	12%	13.3%	6.3%

Appendix 2

Appendix 2 includes the Trust`s WDES scores for 2024 and trends over time. This relates to data from 1st April 2023 – 31st March 2024. The data collection is extensive and is drawn from a range of sources including the Electronic Staff Record (ESR), the Trust`s recruitment system TRAC and a number of National staff survey indicators.

WDES indicator			WDES Reporting Year			
			2021	2022	2023	2024
1	Percentage of disabled staff		2.63%	3.1%	3.75%	4.2%
2	Relative likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants		No data	1.70	1.09	1.47
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance		2.4	2.02	5.1	2.9
4a	Harassment, bullying or abuse from patients, service users, their relatives or other members of the public.	Disabled	30.73%	33.41%	28.25%	23.27%
		Not Disabled	22.38%	22.27%	20.08%	18.31%
4b	Harassment, bullying or abuse from managers.	Disabled	20.94%	20.32%	16.11%	15.94%
		Not Disabled	11.53%	9.20%	9.47%	6.57%
4c	Harassment, bullying or abuse from other colleagues.	Disabled	25.06%	27.59%	25.67%	24.36%
		Not Disabled	16.67%	17.52%	15.48%	14.60%

4d	**Percentage of staff who reported harassment, bullying or abuse the last time it happened.**	Disabled	42.25%	44.50%	45.4%	50.00%
		Not Disabled	45.77%	44.32%	46.6%	50.20%
5	**Percentage of disabled staff compared to non-disabled staff believing their trust provides equal opportunities for career progression or promotion.**	Disabled	50.00%	50.79%	49.03%	48.71%
		Not Disabled	57.21%	57.93%	57.84%	58.55%
6	**Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**	Disabled	33.21%	32.21%	26.5%	29.38%
		Not Disabled	21.98%	17.06%	19%	17.05%
7	**Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**	Disabled	34.56%	32.95%	32.4%	35.31%
		Not Disabled	48.33%	46.02%	45.1%	47.10%
8	**Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.**		No data	No data	68.48%	66.49%
9a	**The staff engagement score for disabled staff from the NHS Staff Survey, compared to non-disabled staff.**	Disabled	6.70	6.47	6.46	6.44
		Not Disabled	7.15	7.11	7.03	7.08
9b	**Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard?**		Yes	Yes	Yes	Yes
10	**Percentage of the board's membership who have declared a disability.**		0%	0%	0%	0%

Appendix 3 – Staff feedback on anti-racism and inclusion (themes)

Focus groups on WDES

- Hesitation to disclose disabilities due to stigma attached
- People do not see benefit in disclosing if no further support/no action is taken
- Return to Work documents and conversations are not always person-centred
- No differentiation between disability/LTH/other sickness when managing absence
- Disability and long-term health conditions do not feature enough in Attendance Management Policy,
- Attendance management policy and implementation not compassionate
- Tendency for managers to use triggers for monitoring; at managers' discretion and inconsistent across the Trust
- People not feeling supported with adjustments and left to find their own solutions

Focus groups on WRES

Assumptions being made about colleagues based on their race or nationality
Experience of being denied career development opportunities
Incivilities and exclusion behaviour
Lack of support when witnessing racial behaviour by patients
Hesitation to challenge racism because of perception that nothing will be done and/or they will be victimised
Fear of being seen as disruptor or losing job when challenging racism
Big impact of incivilities on health and wellbeing
Training need for managers to support staff and create inclusive practices in the team

All Staff Team Brief August 2024

What action for change would make the biggest difference to our people?

- Education and shared learning
- Being an active bystander
- Empower staff to feel confident in challenging unprofessional behaviour
- Creating accountability for inappropriate behaviour

How can we do this together as one team?

- Raising awareness of people's unique stories, cultures and beliefs
- Acting as active bystander
- Supporting each other as one team
- Listen and learn from each other with curiosity

Leaders' Forum Sept 2024: What have you done in your teams to promote inclusion?

Building curiosity and shared learning experiences

- Sharing active bystander learning
- Support time to be involved in EDI activities
- Sharing lived experience
- Celebration boards for cultural days
- Learn together about EDI
- Celebrate uniqueness in the team
- Be curious about others' lived experience

Provide opportunities for involvement and equal access

- Involve team in decision making
- Equal access to training
- Supporting staff who have had negative experiences

Cultivating civility and respect

- Endorsing anti-racist messages
- Role model kindness
- Challenge unprofessional behaviour
- Treat each other with respect
- Open honest conversation about any issues

Leaders' Forum Sept 2024: What would help you in being a more confident anti-racist leader?

Supporting inclusive recruitment

- Inclusive recruitment training
- Transparent procedures for recruitment and promotions
- Include EDI questions in recruitment process
- Diversify interview panels

Challenging unprofessional behaviour

- Training on challenging racist behaviour
- Active bystander training
- Understanding what is respectful to say or not to say

Developing cultural awareness

- Recognising and addressing bias
- More learning opportunities to understand different cultures and experiences
- Sharing more examples and data of lived experience
- Improved EDI mandatory training
- Joining staff networks to learn

Appendix 4 – Draft WRES and WDES Action Plans 2024

Workforce Race Equality Standard (WRES) Action Plan – 2024-25

WWL recognises the need to make significant improvements to improve the working experience of our staff with Black, Asian and Minority Ethnic colleagues and are committed to progressing an action plan which drives forward cultural improvements that will support improvements across all indicators. WWL will elevate the voice of Black, Asian and Minority Ethnic colleagues by measuring progress in a variety of ways but with absolute involvement of our FAME Staff Network. This plan is supported by the organisation's implementation of the NHS England EDI Improvement Plan, and the six high impact actions contained within that.

Ref	Improvement Themes / Areas of Focus	Action	Lead Workstream	Completion Date	Success Criteria
1	**NW Anti-Racist Framework**	• Gain Bronze status of the NW Anti-Racist Organisation Framework	Anti-Racism and Civility and Respect	January 2025	• Bronze status accreditation evidencing improvements regarding culture and decreasing health inequalities
2	**Discrimination at work (WRES Indicator 8) and Bullying and harassment (Indicator 6)**	• Implement Civility and Respect Response Framework to support internal routes and processes related to civility, respect, bullying, harassment and dignity at work • Develop and implement leadership strategy to empower our leaders to become confidently inclusive • Continue to roll out Active Bystander Training for clinical leaders • Continue to roll out Anti-Racism communications campaign • Develop a supportive and compassionate programme of work to support and enhance the experience of our internationally educated nurse colleagues.	Anti-Racism and Civility and Respect Supporting internationally educated colleagues	March 2025	• Reduce the levels of reported discrimination, bullying and harassment across the Trust • Improved support for staff having experienced incivility, bullying or discrimination • Decrease in formal grievances • Higher staff engagement and morale

					• Improve the retention rate of Global Majority staff after their 3 year contract is complete.
3	**Inclusive Recruitment and career opportunities (WRES Indicator 2 and 7)**	• Implementing inclusive recruitment processes for all roles including acting up, secondments and developmental opportunities • Review and roll-out of inclusive recruitment training and guidance for managers and panels • Increase the diversity of interview panels • Promote career development opportunities (internal and external) • Encourage managers to hold career development conversations with staff	Inclusive Recruitment	March 2025	• Increase relative likelihood of ethnic minority staff being appointed from shortlisting across all posts. • Improvement in ethnic minorities stating the Trust provides equal opportunities • Year on year improvement in ethnic minority representation at Band 8+

Workforce Disability Equality Standard (WDES) Action Plan 2024-2025

WWL recognises the need to make significant progress to improve the working experience of our staff with Disabilities and Long-Term Health Conditions and are committed to progressing an action plan which drives forward cultural change that will support improvements across all indicators. WWL will elevate the voice of disabled colleagues by measuring progress in a variety of ways but with absolute involvement of our Disabled and Long-Term Health Conditions Staff Network. This plan is supported by the organisation's implementation of the NHS England EDI Improvement Plan, and the six high impact actions contained within that.

Ref	Improvement Themes / Areas of Focus	Action	Lead Workstream	Completion Date	Success Criteria
1	**Disability Confident Employer**	• Undertake actions to achieve Disability Confident Leader status • Improve disability declaration rates through targeted comms campaign	Disability Confident	August 2025	• Working towards Disability Confident Leader – August 2025 • Increase in disability declaration rate by August 2025
2	**Bullying and harassment (from line managers and colleagues) (WDES Indicator 4b and 4c)**	• Implement Civility and Respect Response Framework to support internal routes and processes related to civility, respect, bullying, harassment and dignity at work • Develop and implement leadership strategy to empower our leaders to become confidently inclusive	Anti-Racism and Civility and Respect	March 2025	• Reduce in reported levels of bullying, harassment and discrimination across the Trust • Improved support for staff having experienced incivility, bullying or discrimination • Decrease in formal grievances • Higher staff engagement and morale scores
3	**Health adjustments and supporting wellbeing at work (Metrics 6,8,9a)**	• Refresh of health passport and adjustments guidance for managers and staff • Design and roll out training and support for managers and leaders in supporting staff health and wellbeing • Review of attendance management policy and guidance • Communication campaign to raise awareness and promote health passports and guidance	Disability Confident	April 2025	• Increase the % of staff receiving a reasonable adjustment • Strengthened reasonable adjustment guidance and support for staff and managers. • Leaders' confidence in supporting their staff's wellbeing • Person-centred attendance management and adjustments policies

4	**Inclusive Recruitment and career opportunities (WDES Metric 2)**	• Implementing inclusive recruitment processes for all roles including acting up, secondments and developmental opportunities • Review and roll-out of inclusive recruitment training and guidance for managers and panels • Increase the diversity of interview panels • Promote career development opportunities (internal and external) • Encourage managers to hold career development conversations with staff	Inclusive Recruitment	May 2025	• Increase relative likelihood of staff living with a disability and long-term condition being appointed from shortlisting across all posts. • Improve access to career progression, training and development opportunities for staff with disabilities • Reduction in health inequalities through equal access to employment

Appendix 5 – WRES Submission 2024

Collection name: **Workforce Race Equality Standard (WRES) Data Collection**

For: **Wrightington, Wigan and Leigh NHS Foundation Trust (RRF)**, FY2023/24

Submitted: **Thu, May 30, 2024, 9:20 AM** by **Sarah Berry (sarah.berry@wwl.nhs.uk)**

Status: **Completed**

Welcome to the WRES 2024 Data collection

Please exclude all NHS held bank worker data from your submission. Bank workers are defined as workers who in your organisation work solely on a zero hour/'bank only' contract.

Guidance and additional information can be viewed here: Guidance (Link:)and Additional Information (Link:)

- Our information governance notice can be viewed here: Information Governance Notice (Link:)
- Web form technical support queries and queries about your account and password should be sent to: ips.servicedesk@england.nhs.uk (Link:)
- Requests for additional users to access the web form should be sent to: england.wres@nhs.net (Link:)
- Any queries about how to populate this data collection should be sent to: england.wres@nhs.net (Link:)

Indicator 1a - Non-Clinical Workforce

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Under Band 1				3 *	0 *	0 *	
Band 1				7 *	0 *	0 *	
Band 2				596 *	18 *	7 *	
Band 3				485 *	20 *	6 *	
Band 4				393 *	18 *	3 *	
Band 5				170 *	8 *	3 *	
Band 6				106 *	3 *	0 *	
Band 7				81 *	4 *	0 *	
Band 8A				46 *	4 *	1 *	
Band 8B				46 *	5 *	2 *	
Band 8C				22 *	0 *	1 *	

Indicator 1b - Clinical Workforce

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Under Band 1				1 *	0 *	0 *	
Band 1				21 *	1 *	0 *	
Band 2				726 *	31 *	5 *	
Band 3				703 *	38 *	9 *	
Band 4				219 *	11 *	3 *	

Band 5				627 *	467 *	20 *		
Band 6				941 *	72 *	15 *		
Band 7				595 *	21 *	10 *		
Band 8A				161 *	13 *	2 *		
Band 8B				15 *	2 *	0 *		
Band 8C				11 *	0 *	0 *		
Band 8D				4 *	1 *	0 *		
Band 9				0 *	0 *	0 *		
VSM				0 *	0 *	0 *		

Indicator 1 - Medical and Dental Consultants

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Medical & Dental Consultants				84 *	148 *	18 *	
Of which Senior Medical Manager				0 *	3 *	0 *	
Non-consultant career grade				20 *	98 *	11 *	
Trainee Grades				41 *	81 *	9 *	
Other				7 *	16 *	7 *	

Number of staff in Workforce

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
				6159	1082	132	

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts.

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Number of Shortlisted Applicants				4409 *	1880 *	209 *	
Number Appointed from Shortlisting				950 *	168 *	67 *	
Relative likelihood of appointment from shortlisting	%	%	%	21.55 %	8.94 %	32.06 %	
Relative likelihood of White staff being appointed from shortlisting compared to BME staff				2.41			

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note: This indicator will be based on year-end data.

	Last Year			This Year			
	White	BME	Ethnicity Unknown / Null	White	BME	Ethnicity Unknown / Null	Comments
Number of staff in workforce				6159	1082	132	
Number of staff entering the formal disciplinary process				35 *	4 *	0 *	
Likelihood of staff entering the formal disciplinary process	%	%	%	0.57 %	0.37 %	0 %	
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff					0.65		

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

	Last Year			This Year			
	White	BME	Ethnicity Unknown / Null	White	BME	Ethnicity Unknown / Null	Comments
Number of staff in workforce				6159	1082	132	
Number of staff accessing non-mandatory training and CPD				2489 *	510 *	40 *	
Likelihood of staff accessing non-mandatory training and CPD	%	%	%	40.41 %	47.13 %	30.3 %	
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff				0.86			

Indicator 9 - Percentage difference between the organisations' Board voting membership and its overall workforce.

Note: Only voting members of the Board should be included when considering this indicator.

Note: Only voting members of the Board should be included when considering this indicator.

	Last Year			This Year			
	White	BME	Ethnicity Unknown / Null	White	BME	Ethnicity Unknown / Null	Comments
Total Board members				15 *	1 *	0 *	
of which: Voting Board members				13 *	1 *	0 *	
Non-voting Board members				2	0	0	
Exec Board members				8 *	1 *	0 *	
Non-exec Board members				7	0	0	
Number of staff in workforce				6159	1082	132	
Total Board Members - % by Ethnicity				93.8	6.3	0	

	%	%	%	%	%	%	
Voting Board Members - % by Ethnicity	%	%	%	92.9 %	7.1 %	0 %	
Non-voting Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %	
Executive Board Members - % by Ethnicity	%	%	%	88.9 %	11.1 %	0 %	
Non-executive Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %	
Overall Workforce - % by Ethnicity	%	%	%	83.5 %	14.7 %	1.8 %	
Difference (Total board - Overall workforce)	%	%	%	10.2 %	-8.3 %	-1.8 %	

Appendix 6 – WDES Submission 2024

Workforce Disability Equality Standard – Data Collection Framework

Introduction

This data is being collected as part of the 2024 data collection for the Workforce Disability Equality Standard (WDES). The aim of WDES is to improve the working and career experiences of Disabled staff in the NHS. The WDES is mandated through the NHS Standard Contract and has been approved as a data collection by NHS England Data Alliance Partnership Board. It has also been subject to a data protection impact assessment.

The requirement to submit WDES data is outlined in clause 13.8 of the NHS Standard Contract 2022/23 Service Conditions, which state "The Provider (if it is an NHS trust or an NHS Foundation Trust) must implement and comply with the National Workforce Disability Equality Standard and submit an annual report to the Co-ordinating Commissioner on its compliance".

The Data Collection Framework (DCF) should be used to submit data for the WDES metrics (note the information on the tab for metrics 4 to 9a for NHS trusts). The survey tab contains a series of qualitative questions and should also be completed.

Guidance on how to complete the DCF has been produced and is available on NHS Futures via this link (Link:).

Navigation and Completion

Each section of the DCF can be accessed using the links near the top of the page. Please note:

- White boxes will collect the data. The grey boxes will be automatically filled when all the required information has been entered.
- Items marked with a red asterisk * are compulsory.
- Entries and changes are not saved automatically. At the foot of each section is a button labelled "Save as draft": this should be used as often as possible.
- Once all sections are complete, the "Submit" button can be pressed at the foot of any section.
- Each page may be saved as a PDF or printed using the standard process for your browser. (For example, in Chrome, pressing the three dots at the top-right of the screen brings up several options including Print.)
- Once the data has been submitted, an option will be given allowing a PDF version of the submission to be produced. You are strongly advised to do this and retain it for your records, and to aid in the completion of your 2023 Action Plan.
- Do not use the Back button on your browser: this will return you to the Open Collections screen, and any unsaved data will be lost.

Bank and Agency staff

Trusts should NOT include Band staff in the 2023 return, but do include Agency staff if they were also included in the 2022 return. Please use the Notes sections to indicate whether Agency staff have been included or not.

Deadlines

NHS trusts should submit their data between **1 May 2024** and by **close of business on 31 May 2024**.

The metrics data in this submission should be used to create a SMART action plan, in collaboration with Disabled staff. The action plan should be approved by the trust's Board, and published with the metrics data on the trust's website by 31/10/24. For comparison and benchmarking information on WDES metrics, see the Model Health System (Link:), the NHS Staff Survey (Link:) and the WDES 2021 report (Link:).

Queries

- Our Guidance can be viewed here: Guidance (Link:)
- Our information governance notice can be viewed here: data collection notice (Link:)
- Web form technical support queries and queries about your account and password should be sent to: ips.servicedesk@england.nhs.uk (Link:)
- Requests for additional users to access the web form should be sent to: england.wdes-datahelpdesk@nhs.net (Link:)
- Any queries about how to populate this data collection should be sent to: england.wdes-datahelpdesk@nhs.net (Link:)

Metric 1 - non-clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	%	0 *	%	0 *	%	0
Band 1	2 *	28.6 %	4 *	57.1 %	1 *	14.3 %	7
Band 2	31 *	5 %	480 *	77.3 %	110 *	17.7 %	621
Band 3	33 *	6.5 %	381 *	74.6 %	97 *	19 %	511
Band 4	9 *	2.2 %	325 *	78.5 %	80 *	19.3 %	414
Band 5	11 *	6.1 %	149 *	82.3 %	21 *	11.6 %	181
Band 6	5 *	4.6 %	90 *	82.6 %	14 *	12.8 %	109
Band 7	7 *	8.2 %	63 *	74.1 %	15 *	17.6 %	85
Band 8a	3 *	5.9 %	41 *	80.4 %	7 *	13.7 %	51
Band 8b	2 *	3.8 %	46 *	88.5 %	4 *	7.7 %	52
Band 8c	1 *	4.3 %	19 *	82.6 %	3 *	13 %	23
Band 8d	0 *	0 %	11 *	91.7 %	1 *	8.3 %	12
Band 9	0 *	0 %	7 *	70 %	3 *	30 %	10
VSM	0 *	0 %	8 *	100 %	0 *	0 %	8
Other e.g. Agency and/or any other groups, please specify	1 *	25 %	3 *	75 %	0 *	0 %	4

Notes

Total non-clinical

Non-clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	75	4.8 %	1190	76.6 %	288	18.5 %	1553
AfC Bands 5, 6 and 7	23	6.1 %	302	80.5 %	50	13.3 %	375
AfC Bands 8a and 8b	5	4.9 %	87	84.5 %	11	10.7 %	103
AfC Bands 8c, 8d, 9 and VSM	1	1.9 %	45	84.9 %	7	13.2 %	53
	105	5 %	1627	77.9 %	356	17 %	2088

Metric 1 - clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	%	0 *	%	0 *	%	0
Band 1	1 *	4.5 %	14 *	63.6 %	7 *	31.8 %	22
Band 2	39 *	5.1 %	611 *	80.2 %	112 *	14.7 %	762
Band 3	24 *	3.2 %	594 *	79.2 %	132 *	17.6 %	750
Band 4	6 *	2.6 %	161 *	69.1 %	66 *	28.3 %	233
Band 5	43 *	3.9 %	925 *	83 %	146 *	13.1 %	1114
Band 6	53 *	5.2 %	812 *	79 %	163 *	15.9 %	1028
Band 7	19 *	3 %	486 *	77.6 %	121 *	19.3 %	626
Band 8a	7 *	4 %	134 *	76.1 %	35 *	19.9 %	176
Band 8b	2 *	11.8 %	12 *	70.6 %	3 *	17.6 %	17
Band 8c	0 *	0 %	10 *	90.9 %	1 *	9.1 %	11
Band 8d	1 *	20 %	3 *	60 %	1 *	20 %	5
Band 9	0 *	%	0 *	%	0 *	%	0
VSM	0 *	%	0 *	%	0 *	%	0
Other e.g. Agency and/or any other groups, please specify	0 *	0 %	1 *	100 %	0 *	0 %	1

Notes

Medical & Dental Staff, Consultants	3 *	1.2 %	168 *	67.2 %	79 *	31.6 %	250
Medical & Dental Staff, Non-Consultants career grade	1 *	0.6 %	130 *	81.8 %	28 *	17.6 %	159
Medical & Dental Staff, trainee grades	3 *	2.3 %	94 *	71.8 %	34 *	26 %	131
Total clinical	195	4.1 %	3763	79.3 %	787	16.6 %	4745
Total medical & dental	7	1.3 %	392	72.6 %	141	26.1 %	540
Total clinical & non-clinical	307	4.2 %	5782	78.4 %	1284	17.4 %	7373

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	70	4 %	1380	78.1 %	317	17.9 %	1767
AfC Bands 5, 6 and 7	115	4.2 %	2223	80.3 %	430	15.5 %	2768
AfC Bands 8a and 8b	9	4.7 %	146	75.6 %	38	19.7 %	193
AfC Bands 8c, 8d, 9 and VSM	1	6.3 %	13	81.3 %	2	12.5 %	16

Metric 2

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Note:
i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the Survey section to ensure comparability between organisations.

	Disabled	Non-disabled	Disability Unknown
Number of shortlisted applicants	438 *	5805 *	255 *

Metric 3

Metric 3 - Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Notes:

i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii. This metric applies to capability on the grounds of performance and not ill health.

iii. If a member of staff enters the capability process for reasons of **both** performance **and** ill health, they should not be included in the count of "ill health only" cases.

iv. For clarification: the data required is the numbers of staff **entering** the capability process from 1 April 2022 to 31 March 2024, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	307	5782	1284
Average number of staff entering the formal capability process for any reason	1 *	6.5 *	3 *
Of these, how many are on the grounds of ill health only?	0 *	0 *	0 *
Likelihood of staff entering the formal capability process			

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff	2.9

Metric 4 - 9a

Metric 4 to 9a

Please note that you are not required to submit data for WDES Metrics 4 to 9a. These metrics relate to the NHS Staff Survey and the WDES Implementation Team will access this data directly.

However, you should include data for these metrics when discussing, producing and publishing your organisation's WDES annual report. The annual report, which should be developed in partnership with the organisation's Disabled staff network and ratified by the Board, must contain data for all 10 metrics along with an action plan that sets out the actions the organisation will deliver over the coming 12 months.

Metric 9b

Metric 9 - Staff Engagement

b) Has your organisation taken action to facilitate the voices of Disabled staff to be heard?

If no, please provide an explanation for your answer.

* ○ Yes
* ○ No

Please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.

Regular disability & long term conditions staff network events planned throughout the year *

Notes

Metric 10

Metric 10 - Board voting membership

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The data for this metric should be a snapshot as of 31st March 2023.

	Disabled	Non-disabled	Disability Unknown	Total
Total Board members	0 *	15 *	1 *	16
How many are voting members?	0 *	13 *	1 *	14
Number of non-voting members	0	2	0	2
How many are Exec Board members?	0 *	9 *	0 *	9
Number of non-exec members	0	6	1	7
Number of staff in overall workforce (from Metric 1)	307	5782	1284	7373
Total Board members - % by Disability	0 %	93.75 %	6.25 %	
Voting Board members - % by Disability	0 %	92.86 %	7.14 %	
Non-Voting Board Member - % by Disability	0 %	100 %	0 %	
Executive Board Member - % by Disability	0 %	100 %	0 %	
Non-Executive Board Member - % by Disability	0 %	85.71 %	14.29 %	
Overall workforce - % by Disability	4.16 %	78.42 %	17.41 %	
Difference % (Total Board - Overall workforce)	-4.16 %	15.33 %	-11.16 %	
Difference % (Voting membership - Overall Workforce)	-4.16 %	14.44 %	-10.27 %	
Difference % (Executive membership - Overall Workforce)	-4.16 %	21.58 %	-17.41 %	

Survey

Survey

Question 1

Name and contact details of the lead(s) compiling this report.

Name *	Email Address *
Sarah Berry	sarah.berry@wwl.nhs.uk
Name	Email Address
Tim Brown	tim.brown@wwl.nhs.uk

Question 2

Name and contact details of the Board lead for the Workforce Disability Equality Standard.

Name *	Job Title *	Email *
Jules Tait	Chief People Officer	juliette.tait@wwl.nhs.uk

Question 3

Name of commissioner, name of commissioning body and email address that the WDES Annual report (containing the WDES metrics report and action plan) will be sent to.

Name of Commissioner	Name of Commissioning Body *	Email *
Rosie Kingham, Equality and Inclusion Service Improvement	ICS Greater Manchester	rosie.kingham@nhs.net

Question 4

Unique URL link or existing web page on which the WDES Annual report will be published.

https://www.wwl.nhs.uk/workforce-disability-equality-standard *

Question 5

Date of Board meeting at which your organisation's WDES Annual report will be discussed and approved. If the date is not known, please provide an approximate date or explain why a date cannot be provided.

October 2024

Question 6

Does your organisation participate in any programmes or initiatives that are focused on disability equality and inclusion?

* (•) Yes
* ( ) No

Please select one or more:

* [ ] Project SEARCH
* [ ] NHS Learning Disability Employment Programme (LDEP) pledge
* [ ] NHS Employers Equality and Inclusion Partners Programme
* [ ] Run or organise Equality and Diversity Conferences with a focus on Disability
* [ ] Leadership programmes (such as Calibre or DRUK Leadership Academy Programme)
* [x] Other – please specify

Disability and Long Term Conditions Staff network.
Disability Confident Level 2
Regular entries in the weekly internal communications email to raise awareness of disability and long term conditions issues such as reasonable adjustments and promoting key disability dates.
Promotion of internal services available to staff such as physiotherapy
Staff were invited to join Service Equality Engagement Events for various services including Learning Disability
Oliver McGowan mandatory training
Autism peer support group
Employment support and psychological interventions our Staff Psychological Support team is providing for colleagues with neurodiversity
Health checks offered by the steps 4 wellness Team

Question 7

Do your staff have access to the ESR self-service portal?

* (•) Yes
* ( ) No

Question 8

Since you published your action plan last year, have any steps been taken within your organisation to improve the declaration rate for disability status?

* ◉ Yes
* ○ No

If yes, please share any examples of interventions that have increased declaration rates at your organisation.

* ☐ Promotion of ESR self-service to encourage staff to update details
* ☑ Other internal communication activities (e.g. staff emails, intranet pages, internal events, poster campaign)
* ☐ Survey of staff to understand views
* ☐ Consultation exercise / workshops
* ☐ Raising visibility of senior Disabled Staff
* ☐ Include an ESR "How to" guide in induction pack or on intranet
* ☑ Other - please specify

*

Communications about declaration rate at staff induction.
Letter sent from Chief People Officer to encourage them to declare their disability status.

Question 9

What level of Disability Confident accreditation does your organisation currently hold?

* ○ None
* ○ Level 1 - Committed
* ◉ Level 2 - Employer
* ○ Level 3 - Leader

☐ Are you a Mindful Employer (https://www.mindfulemployer.dpt.nhs.uk/ (Link:))?

☐ Are you a current or previous participant in the NHS Employers Partners programme?

☐ Are you a member of the Business Disability Forum?

☐ Have you signed the Disability Employment Charter (https://www.disabilityemploymentcharter.org/ (Link:))?

Are you working towards obtaining a higher level of accreditation?

* ◉ Yes
* ○ No

Question 10

Do you encourage Disabled people to apply for jobs by offering an interview to any applicant who declares they have a disability and meets the minimum criteria?

* ◉ Yes
* ○ No

Please add any examples of interventions that have impacted positively on the recruitment of Disabled staff in the last 12 months.

* ☐ Review job descriptions identify and remove barriers to Disabled applicants
* ☐ Review of the implementation of the commitment to interview an applicant who declares they have a disability and meets the minimum criteria
* ☑ Disabled people on interview panels
* ☐ Disabled people advising a review of recruitment processes, policies and procedures
* ☐ Develop external communications to encourage Disabled applicants
* ☐ Refresh of website to encourage Disabled applicants
* ☐ Actions to support Disabled applicants through the application and interview process (e.g. providing questions in advance)
* ☐ Targeted recruitment campaigns
* ☑ Accept applications in alternative formats
* ☐ Other - Please specify

Question 11

Has your organisation compared any of the following other datasets you hold to the WDES Metric 4 (Harassment, Bullying or Abuse)?

◉ Yes
○ No

* ☑ Grievance data
* ☑ Disciplinary data
* ☑ Exit interviews or surveys
* ☐ Data held by Staffside representatives
* ☑ Data held by Freedom to speak up guardians
* ☑ Data held by Health and Wellbeing leads
* ☐ Other

Please explain what you have done along with any insights you have learnt. *

Data reviewed as part of the EDS but can be difficult when trying to triangulate data with small sample sizes
Quarterly ER reviews looking at the learnings from specific employee relations cases
Fair experience reports reviewed at People Committee looking at trends and learnings / ER Deep Dive report discussed at Partnership

Question 12

Please add any actions taken since your action plan was published last year to reduce harassment, bullying or abuse in relation to Disabled staff.

* [x] Dignity at Work Campaign
* [x] Disability Awareness campaigns
* [ ] Harassment and Bullying policy revision
* [x] Champions/ ambassadors/advisors
* [x] Peer support scheme
* [x] NHS Civility and Respect toolkit
* [x] Working with Disabled Staff Networks
* [ ] Other

Please explain what you have done along with any insights you have learnt. *

EDI Champions who have received training on hidden disabilities
Disability awareness campaigns (e.g. dyslexia awareness)
Listening events chaired by the Chief People Officer
Health passport for staff to use in conversations for reasonable adjustments
Newly recruited Freedom to Speak up Guardian and communications on this

Question 13

Does your organisation provide any targeted career development opportunities for Disabled staff?

* ( ) Yes
* (•) No
* ( ) Not at present but planned in the next 12 months

Have you run or participated in any of the following leadership development programmes in the last two years?

- [ ] Calibre
- [ ] Disability Rights UK (DRUK) Leadership Academy
- [ ] From any other provider (please give details).

Question 14

Does your action plan from last year set out any targeted actions to reduce presenteeism i.e. feeling pressured to come to work when not feeling well?

* ( ) Yes
* (•) No
* ( ) Not at present but planned in the next 12 months

Question 15

Does your action plan from last year set out any targeted actions to increase the workplace satisfaction of Disabled staff?

* (•) Yes
* ( ) No
* ( ) Not at present but planned in the next 12 months

If yes, or planned, please select relevant examples. Please feel free to expand in the free text box.

* [x] Working with Disability networks/groups
* [ ] Health and wellbeing days or events
* [ ] Line manager disability awareness training
* [ ] All staff disability awareness training
* [ ] Implementing changes following staff surveys
* [ ] Other – please specify

Question 16

Does your organisation have a reasonable adjustments policy?

* (•) Yes
* ( ) No
* ( ) Not at present but planned in the next 12 months

Has it been reviewed in the last 12 months? *

(•) Yes
( ) No

Question 17

Evidence shows workplace adjustments are more effective when costs are met from central budgets. Are costs for workplace adjustments in your organisation met through centralised or local budgets?

* ( ) Centralised budgets
* (•) Local budgets
* ( ) Both

Question 18

Have you undertaken any actions in the last 12 months to improve the reasonable adjustments process?

* (•) Yes
* ( ) No
* ( ) Not at present but planned in the next 12 months

If yes, or planned, please select relevant examples. Please feel free to expand in the free text box.

* [ ] Training for managers
* [ ] Guidance and support provision
* [x] Internal communications
* [ ] Reasonable/workplace adjustment policy revision
* [ ] Sharing best practice examples through induction/intranet/training
* [ ] Disability/Workplace adjustments passport
* [x] Other - please specify

*

Internal communication and promotion of the health passport.
We are looking to become a disability confident leader and as part of this reasonable adjustments will be looked at.

Question 19

Please list any actions contained in your action plan from last year that have not been completed.

*

The action plan has not been able to progress as planned due to the implementation of the EDI Strategy Group being delayed

Question 20

Are there plans for your Trust to merge with another trust in the next 12 months?

* ( ) Yes
* (•) No

Question 21

When did the Board most recently review progress in delivering the action plan from last year?

* ( ) In the last 3 months
* (•) Between 3 and 6 months
* ( ) Between 6 months and 1 year
* ( ) More than 1 year

Question 22

Do Health and Wellbeing conversations take place with all staff which include opportunity to discuss disability?

* (•) Yes
* ( ) No

Please provide brief details *

Included in the appraisal discussions

Question 23

Have you taken specific actions to support staff with "Long COVID"?

* (•) Yes
* ( ) No

Please provide brief details *

4 weekly absence reviews for staff on long term sick, signposting to support services such as GP referring to long covid clinic (previously we were able to refer internally) , occupational health, peer support groups. Supported return to work phased return and reasonable adjustments.

Question 24

Have you introduced or revised a flexible working policy for Disabled staff in the last 12 months?

* ( ) Yes
* (•) No

Question 25

Would you recommend any courses, training providers, etc. that have had positive benefits for Disabled staff in your organisation?

Oliver McGowan Training. NHS Employers - supporting disabled staff.

Question 26

Do you have a Disability Leave policy?

* Yes
* No

Please provide brief details *

Not a stand alone policy but there is a section included in the special leave policy

Question 27

Does your organisation have a workplace/disability/health/empowerment passport system?

* Yes
* No

Which version do you use? *

- NHS Employers
- Royal College of Nursing
- D&A (Disability and Ability)
- Other organisation (please give details)
- Self-created (please give details)

Question 28

What actions have you undertaken in the last 12 months to increase the retention of your Disabled staff?

None specially for disabled staff

Question 29

Do you have any further comments?

Title of report:	M7 2425 Integrated Performance Report
Presented to:	Board of Directors
On:	4.12.24
Item purpose:	Information
Presented by:	Director of Strategy & Planning
Prepared by:	Principal Data Analyst, Data Analytics and Assurance
Contact details:	BIPerformanceReport@wwl.nhs.uk

Executive summary

The latest month, for M7 October 24 update of the Trust's Integrated Performance Report (IPR) is presented to the Board of Directors.

Additional insight reports can be added to the IPR by contacting the DAA team.

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 21.11.24.

Recommendation(s)

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

Report

Please see the enclosed M7 IPR report for approval prior to being included as part of the Board of Directors papers.

Board of Directors_IPR_M7_24

Appendices

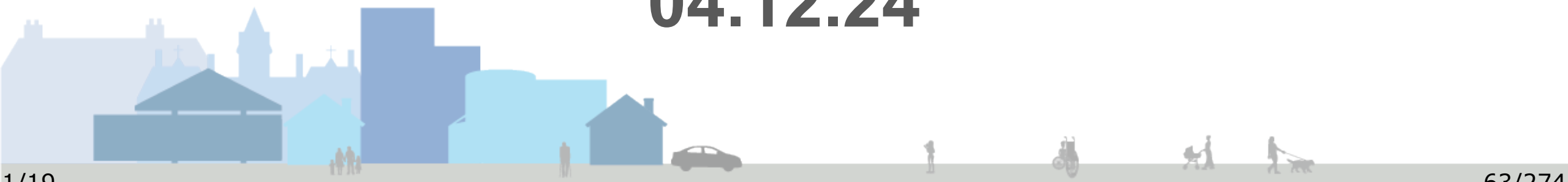
None.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

M7 24/25 Integrated Performance Report

Board of Directors Meeting

04.12.24



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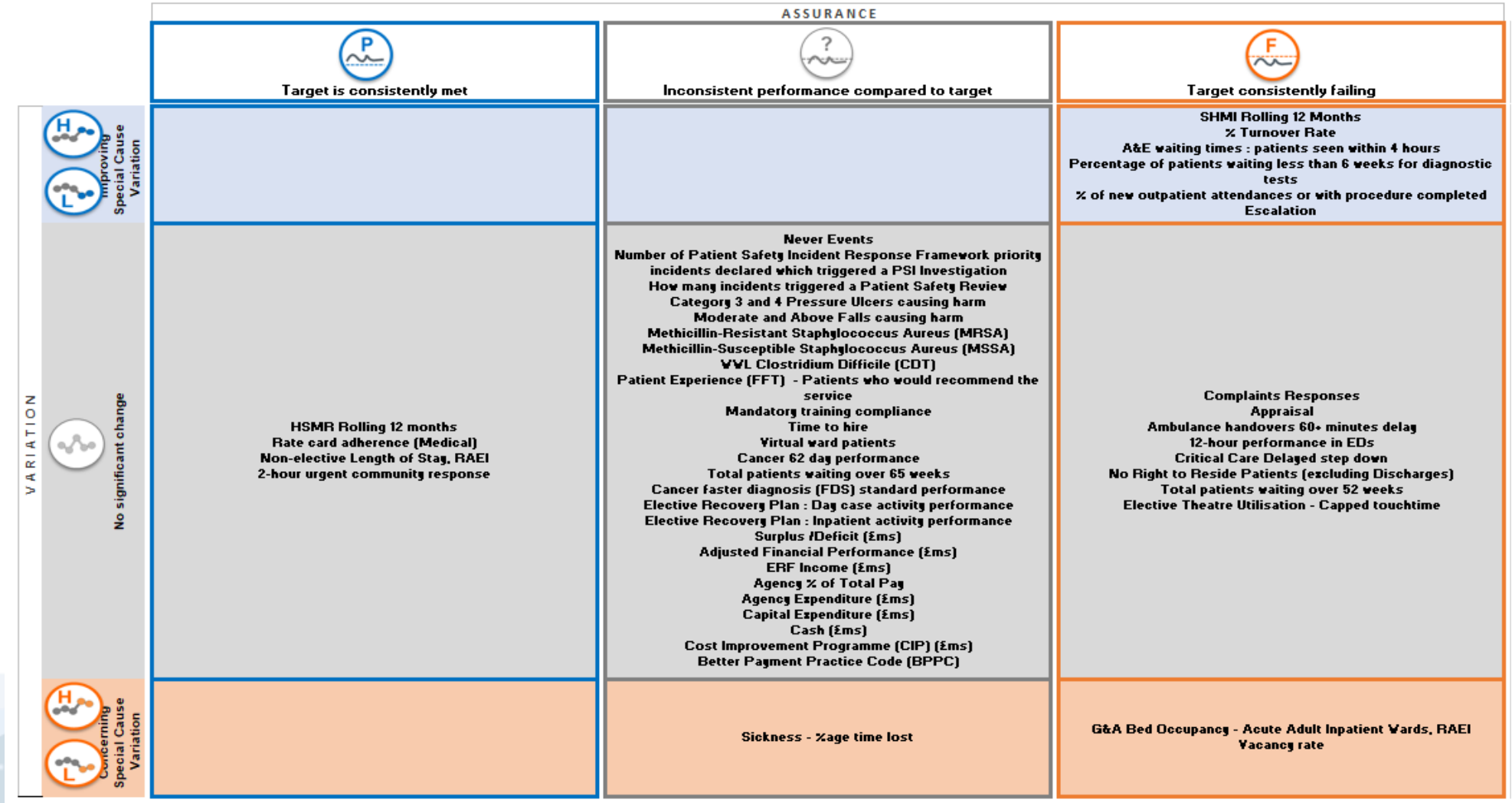
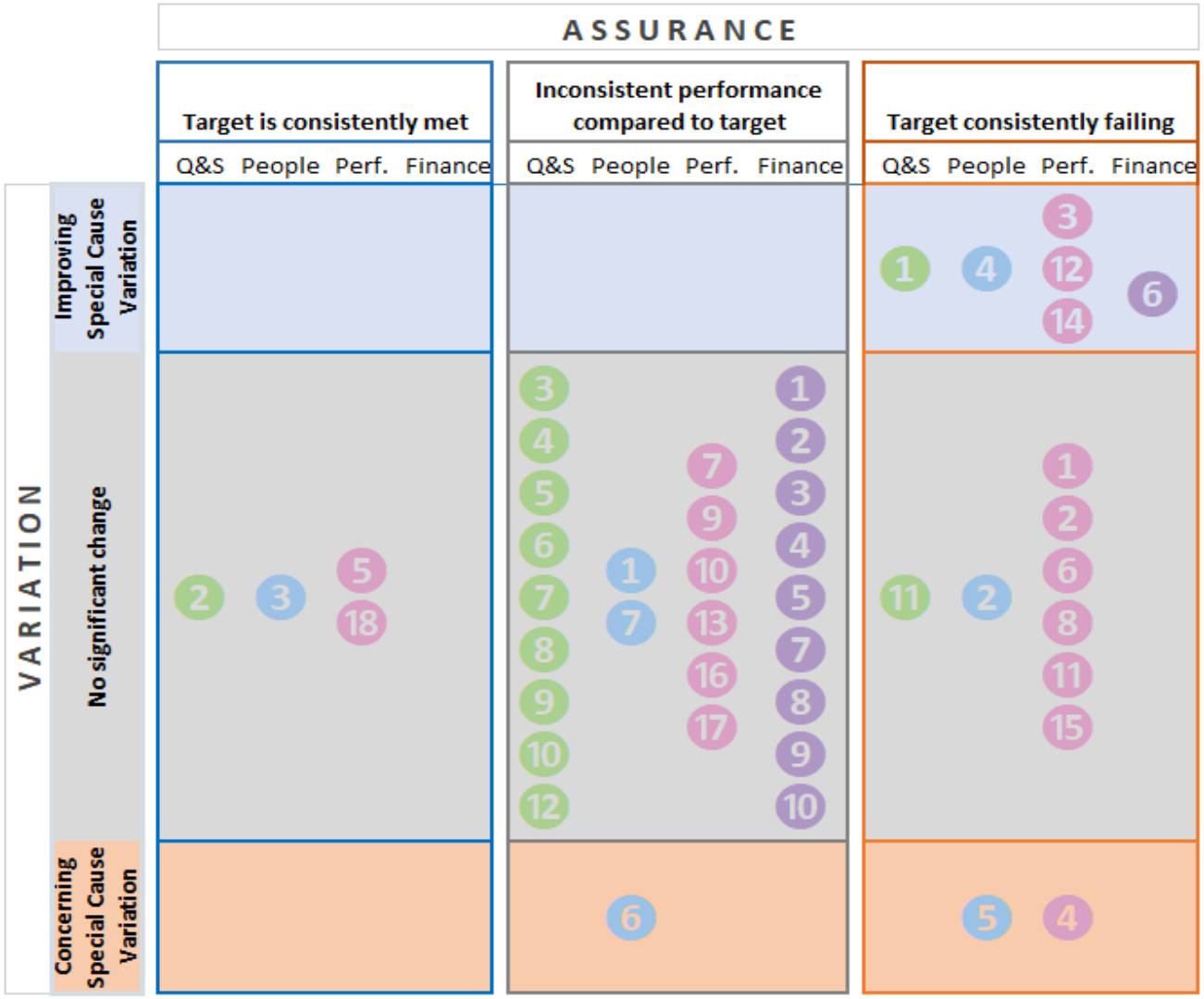
Trust Matrix : M7 October 24



Trust Matrix : M7 October 24



Quality & Safety KPIs

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

People KPIs

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

Performance KPIs

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

Finance KPIs

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

Trust Holistic Narrative : M7 October 24

The Summary Hospital-level Mortality Indicator (SHMI) continues to show improvement, at 103.78, remaining within expected levels. Hospital Standardised Mortality Ratio (HSMR) remains strong at 92.16, below the 100 national benchmark. There was 1 Never Event in month 7, a thematic review has been commissioned to review this and any other similar incidents. In line with our Patient Safety Incident Response Framework, safety actions have already been identified following the rapid reviews and learning is being implemented. Complaints response remains below the target response rate; review panels are due to commence mid-November to seek assurances on timeframes for completion for the most overdue complaints.

With regard to our workforce, sickness absence rate increased to 6% (in-month) which is the highest since January 23; stress/anxiety/depression remain the greatest proportion of absence. Actions remain ongoing regarding improving reasonable adjustments, along with the establishment of a Sickness Absence Task and Finish Group to review where opportunities may exist to further support. Vacancy rate remains above target but reduced again this month following further commencements in post of domestically trained nurses, midwives and Health Visitors aligned to newly qualified staff. A recruitment event was held during October for unregistered nursing vacancies, outcomes from this should support reduced vacancies once new recruits are in place. Whilst turnover rate has been consistently failing the revised target of 8.5%, the data for October 24 shows improvement at 8.6% (target 8.5%), actions remain in place to support retention, with analysis of hot spot areas, where more targeted support can be directed.

Pressure has increased in Urgent Emergency Care (UEC) due to a period of lower patient discharges and sustained attendances. The 4-hour national standard for A&E has improved recently, but remains below the 76% target, at 69.8%. 12-hour performance and ambulance handovers with 60+ minutes delay remain above target. Patients were cared for on the A&E corridor for most days during October 24 (27 days out of 31). Reported escalation costs were £0.5m. The occupancy levels for General & Acute (G&A) inpatient wards at RAEI remains at 100%. The internal discharge and flow programme is now being supported by the Better Lives Transformation programme and ECIST colleagues. The Better Lives initiative is targeted at reducing the numbers of patients who are managed within the Emergency Department and aims to reduce the demand. Working alongside this demand management are the improvement projects related to discharge process and length of stay. These will improve flow out of ED for patients being admitted and thereby reduce congestion and time in the department.

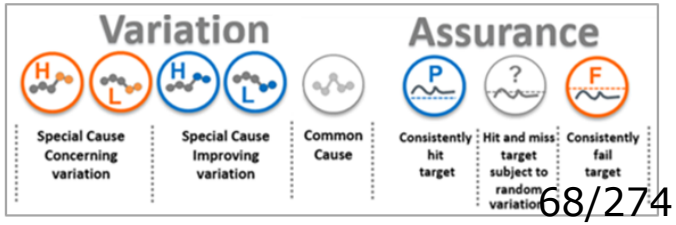
The trust has failed the target of 0 patients waiting over 65 weeks for elective treatment, with 145 patients waiting at the end of October. The position is expected to improve through the month, and the trust remains on plan to have 0 capacity breaches by the end of December, with the caveat of any potential delays in receiving Mutual Aid patients from other GM providers. Cancer faster diagnosis standard remains above target, and 62-day cancer performance has achieved target for the past 2 months. The theatre metric has been aligned to the national metric of Elective Theatre Utilisation Capped Touchtime, current performance is 81.7%, below the 85% target. We are engaging with operational colleagues on the best way to present this metric for future reports to ensure that we incorporate unused or uncapped sessions appropriately to reflect delivery compared to planned levels. Inpatient elective recovery activity is overperforming at 116.1%. This positive position remains driven by surgical specialties, with the Orthopaedics position below plan; an Executive led recovery plan is in place with updates provided to Executive Team Meeting (ETM). Overall, the elective activity is £0.2m behind plan in month, and £1.5m year to date; this activity shortfall needs to be recovered by the end of the financial year to achieve the 24/25 plan. Alongside CIP remaining behind plan, at £0.3m year to date, this is driving external scrutiny with internal actions aiming to provide assurance.

For Surplus / deficit the Trust is reporting an actual deficit for year to date of £3.2m which is £2.8m adverse to plan.

Quality & Safety Overview: M7 October 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	SHMI Rolling 12 Months	Jun 24	103.78	100	L	F	105.24	104.03	106.45
2	HSMR Rolling 12 months	Jul 24	92.15	100		P	91.15	89.01	93.30
3	Never Events	Oct 24	1	0		?	0	0	2
4	Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI Investigation	Oct 24	2	4		?	3	0	9
5	How many incidents triggered a Patient Safety Review	Oct 24	19	33		?	31	0	52
6	Category 3 and 4 Pressure Ulcers causing harm	Oct 24	0	0		?	0	0	2
7	Moderate and Above Falls causing harm	Oct 24	3	1		?	2	0	5
8	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Oct 24	0	0		?	0	0	0
9	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Oct 24	1	0		?	1	0	6
10	WWL Clostridium Difficile (CDT)	Oct 24	12	5		?	6	0	18
11	Complaints Responses	Oct 24	59.5%	90%		F	63.8%	38.6%	89.1%
11	Patient Experience (FFT) - Patients who would recommend the service	Oct 24	85.5%	86.7%		?	87.1%	80.0%	94.2%

Summary icons key:



Quality & Safety Narrative: M7 October 24

SHMI / HSMR

There has been no change to our in hospital and out of hospital SHMI as more recent data has not been yet released. Currently our metric is 103.78 which is well within the 'funnel plot' for expected range. As a comparison to GM Peers, SHMI values range from 94.09 to 115.83, with WWL having a proportionately lower bed base. HSMR remains strong for WWL at 92.15, with GM comparisons ranging from 85.86 to 113.81.

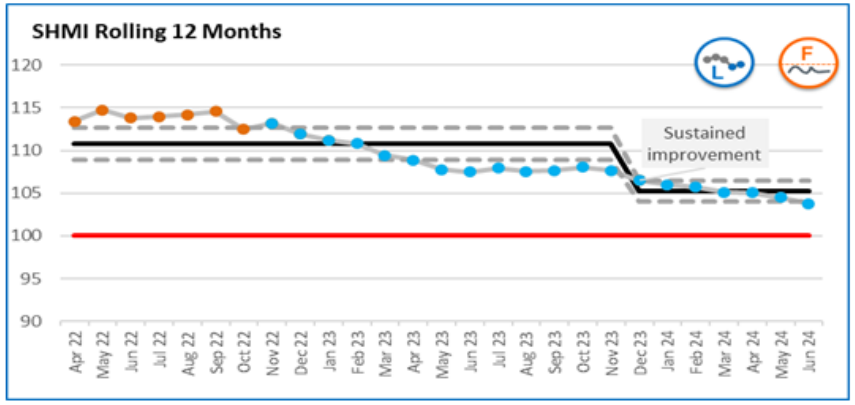
Incidents

In month 7 (October 2024), 2 incidents triggered a Patient Safety Incident Investigation (PSII) as per our Patient Safety Incident Response Plan (PSIRP). These related to delay in diagnosis and suboptimal care of a deteriorating patient, thus relating to 2 of the PSIRF priorities. One incident related to a patient who had pain relief injection in the wrong area. This has been defined as a Never Event and a thematic review has been commissioned to review this and any other similar incidents. The second incident related to a failure to escalate a deteriorating patient within the Emergency Department. In line with our PSIRF process, safety actions have been already identified following the rapid reviews into these incidents and learning is being implemented. Any further learning identified from the PSII reports will also be implemented.

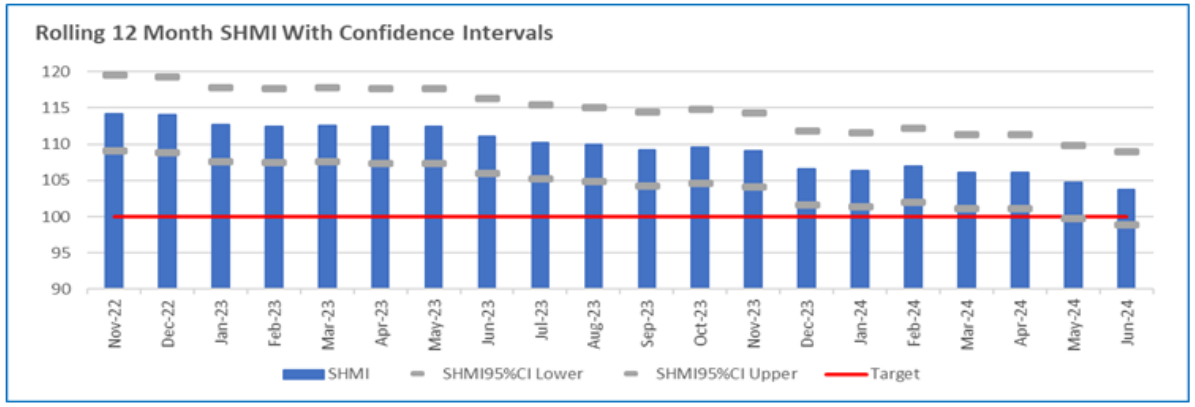
Complaints

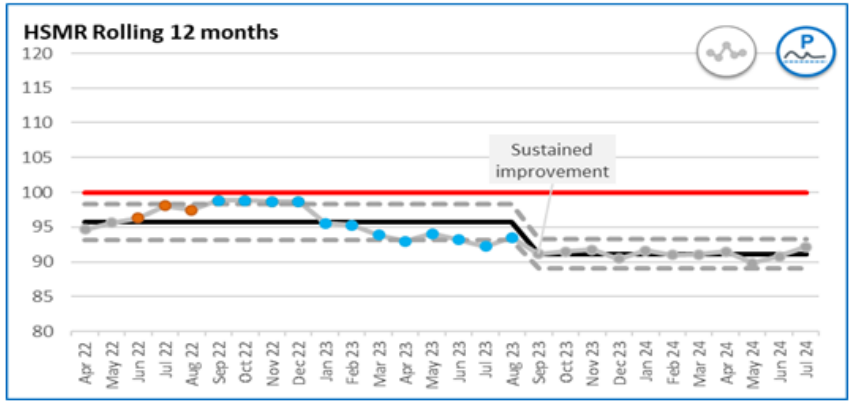
There was a reduction in the Trust response rate within M7. Complaints review panels have now been set up to commence mid-November with Divisions to review the most overdue complaints and seek assurances on timeframes for completion.

Quality & Safety Insight Report: M7 October 24

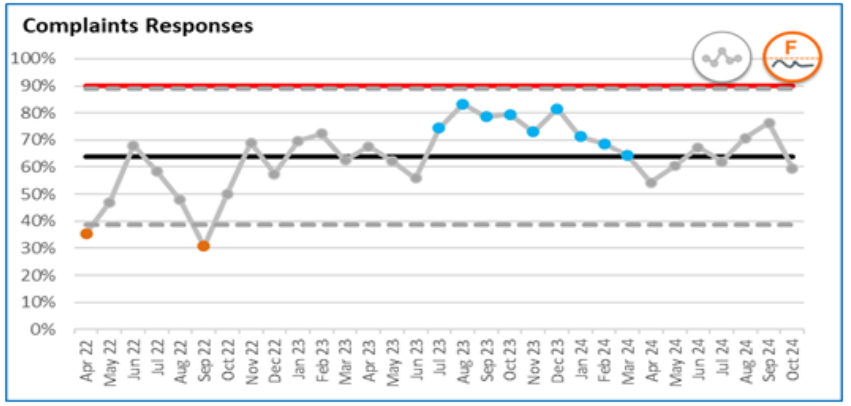


Jun-24
103.78
Variance Type
Special cause improving variation
Target
100
Target achievement
Metric is constantly failing the target





Jul-24
92.15
Variance Type
Special cause improving variation
Target
100
Target achievement
Metric is constantly achieving the target



Oct-24
59.5%
Variance Type
Common cause variation
Target
90%
Target achievement
Metric is constantly failing the target

Summary:	Actions:	Assurance:
SHMI and HSMR Monthly and quarterly mortality review groups continue to review any areas of SHMI that are alerting and seek assurances that these are being managed appropriately. **Complaints responses** Complaints compliance is under weekly review and monitor progress of overdue complaints. Additional support has been provided from the central team to investigate and quality check complaints	**SHMI/HSMR** Continue Sepsis improvement plans to ensure that patients are appropriately managed Work with system partners to ensure appropriate discharge placements for patients **Complaints responses** Continue to support Divisions in quality checking of complaints. Establishment of complaints performance panels to seek assurances on completion of open complaints	**SHMI/HSMR** SHMI is currently within national expected range 'funnel plot' and has been so for many months. Both SHMI and HSMR are continuing to fall and are similar to other similar sized GM Trusts **Complaints responses** Complaints performance has reduced in M7 and will be reviewed

Our People Overview : M7 October 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Mandatory training compliance	Oct 24	94.9%	95%		?	95.0%	94.1%	95.9%
2	Appraisal	Oct 24	82.9%	90%		F	81.9%	80.7%	83.1%
3	Rate card adherence (Medical)	Oct 24	97.6%	80%		P	95.4%	88.7%	102.1%
4	% Turnover Rate	Oct 24	8.6%	8.5%	L	F	8.9%	8.6%	9.2%
5	Vacancy rate	Oct 24	6.4%	5%	H	F	6.3%	5.2%	7.3%
6	Sickness - %age time lost	Oct 24	6.0%	5%	H	?	5.3%	4.6%	6.0%
7	Time to hire	Oct 24	59.6	65		?	58.0	49.2	66.8

Summary icons key:

Our People Narrative : M7 October 24

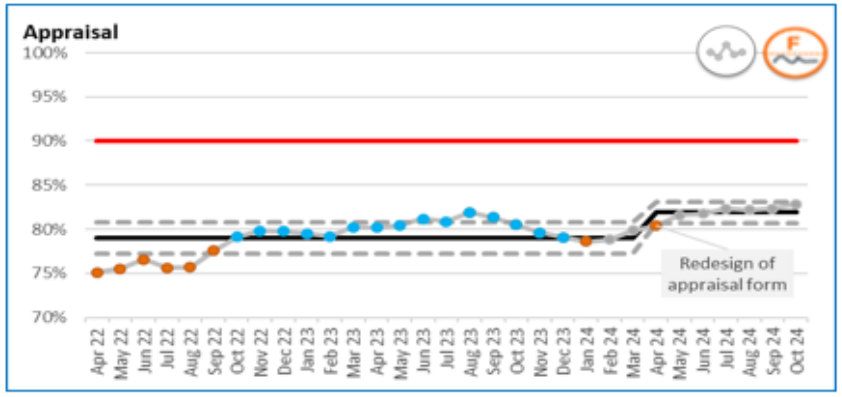
Appraisal - Following the change to enable appraisals to be undertaken all year round, rather than in a defined short appraisal 'window', the appraisal completion rate remains relatively static, and therefore represents a common cause variation. The appraisal completion target of 90% continues not to be achieved. Appraisal completion data continues to be shared with leaders and is reported through a number of meetings via a Workforce Metrics Dashboard. Completion of appraisals is likely to remain a challenge over winter months with anticipated increased sickness absence levels and escalations. Services will continue to be supported to develop plans to ensure appraisals are completed.

Turnover - Whilst turnover rate has been consistently failing the revised target of 8.5%, the data for October 24 continues to represent a special cause improving variation and turnover has generally reduced month on month since June 24. By way of a comparison, turnover in October 22 was at 10.3% and at 8.9% in October 23. This confirms that whilst not currently meeting the revised target, the retention of staff has improved. The main recorded reasons for leaving remain relocation, retirement, further education/training and work/life balance. Actions remain in place to support retention, with analysis of hot spot areas, where more targeted support can be directed.

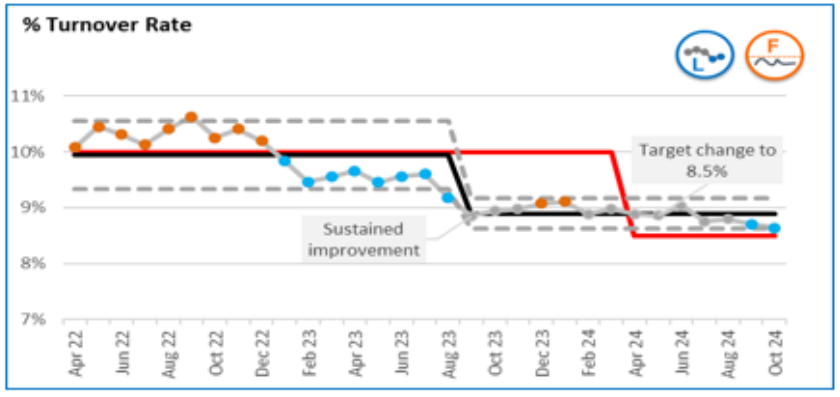
Vacancy - Rate reduced from 6.6% in September 24 to 6.4% in October 24, although is a special cause concerning variation as it remains consistently above the 5% target. A reduction in vacancies in month is linked to further commencements in post of domestically trained nurses, midwives and Health Visitors aligned to newly qualified staff. Stringent Executive Director owned governance processes for vacancy approval remain in place, and analysis needs to be undertaken to understand the impact of deferred or rejected vacancies against the vacancy target/plan. A recruitment event was held in October for unregistered nursing vacancies (B2 and B3), and outcomes from this should support reduced vacancies once new recruits take up their posts.

Sickness - Sickness absence continues to increase in a special cause concerning variation with the absence rate in October at 6%. The sickness absence rate has not been at 6% since December 22/January 23. As part of work across GM to understand and reduce absence levels, Senior HR leads recently participated in a peer review session with Manchester Foundation Trust. This provided assurance that there were no distinct differences in terms of the way absence management is approached. Increases to both short and long term sickness are evident in October, with anxiety/stress/depression accounting for 28% of sickness. Absence related to cough/colds/flu increased in October and accounted for 9% of absence. Actions remain ongoing regarding improving reasonable adjustments process, along with the establishment of a Sickness Absence Task & Finish Group to review where opportunities may exist to further support a reduction in absence levels. Revision of the Sickness Absence Policy is due to commence shortly.

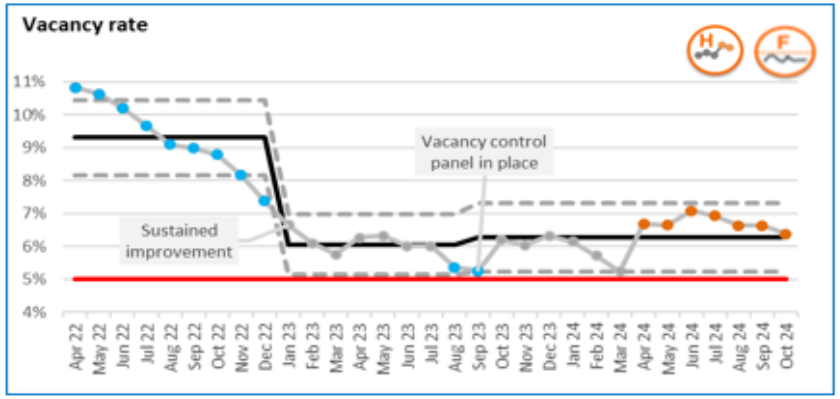
Our People Insight Report : M7 October 24



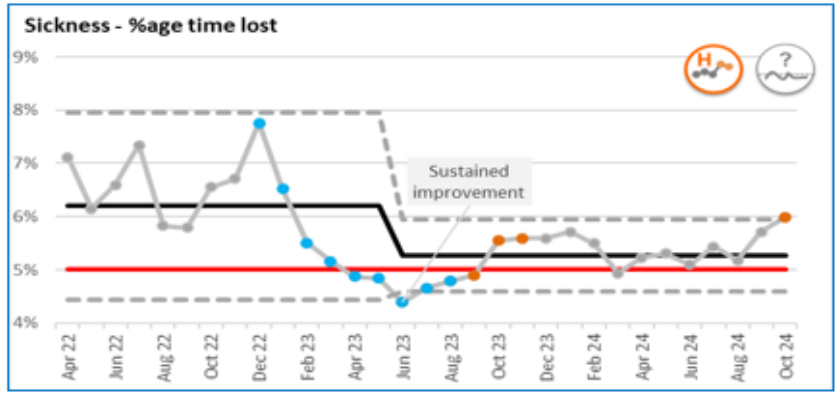
Oct-24
82.9%
Variance Type
Common cause variation
Target
90%
Target achievement
Metric is constantly failing the target



Oct-24
8.6%
Variance Type
Special cause improving variation
Target
8.5%
Target achievement
Metric is constantly failing the target



Oct-24
6.4%
Variance Type
Concerning special cause variation
Target
5%
Target achievement
Metric is constantly failing the target



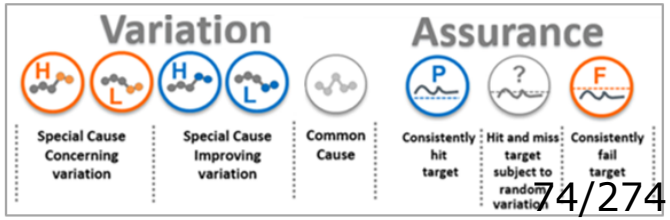
Oct-24
6.0%
Variance Type
Concerning special cause variation
Target
5%
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
1. At 82.9% appraisal completion rate remains below the target of 90%, with no significant improvement 2. Turnover continues to be on a positively decreasing trajectory progressing towards new 8.5% target 3. Vacancy rate continues to be a challenge and consistently fails against target of 5% 4. Sickness a has been on an increasing trajectory since Aug 2024 – contributing factors aligned with long term sickness are absences associated with mental health and MSK issues. Short term sickness contributory factors are increased absence due to infections such as colds and flu	1. Monthly detailed compliance information continues to be shared with Divisions and reviewed at Divisional Assurance Meetings, with divisions developing plans to improve completion rates. Appraisal data is also accessible for leaders via Learning Hub dashboard. 2. Continue to improve data and intelligence from leavers. Improve accuracy of data collection with regards to reasons for leaving recorded. Development of behavioural framework to underpin WWL values 3. Targeted recruitment activity through Recruitment open days. Analysis of data to determine the impact of robust vacancy governance processes on vacancy target 4. Maintain support to divisions in support of increased absence and identify support/adjustments to aid early return to work. Review of Sickness Absence Policy to commence, along with Sickness Absence Task & Finish Group to identify new approaches to reduce absence levels	1. Oversight via Divisional Assurance Meetings and escalation to ETM for areas of concern. 2. Oversight and analysis of turnover rates through Workforce Metrics reports via Divisional Assurance Meetings, Wider Leadership Team Meeting and People Committee 3. Oversight via internal executive led panel around vacancy control and Finance Improvement Group 4. Oversight also via Divisional Assurance Meetings, Wider Leadership Team Meeting and People Committee, along with insight from HR Business Partners, and within HR leadership sessions

Our Performance Overview : M7 October 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Ambulance handovers 60+ minutes delay	Oct 24	349	0		F	239	33	445
2	12-hour performance in EDs	Oct 24	17.4%	10%		F	17.0%	14.5%	19.6%
3	A&E waiting times : patients seen within 4 hours	Oct 24	69.8%	76%	H	F	69.4%	65.9%	72.9%
4	G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI	Oct 24	100.0%	96%	H	F	99.8%	99.3%	100.4%
5	Non-elective Length of Stay, RAEI	Oct 24	3.86	4.68		P	4.04	3.47	4.62
6	Critical Care Delayed step down	Oct 24	19	0		F	18	1	34
7	Virtual Ward Occupancy	Oct 24	77.2%	80%		?	70.5%	45.9%	95.0%
8	No Right to Reside Patients (excluding Discharges)	Oct 24	120	50		F	120	106	133
9	Cancer 62 day performance	Sep 24	82.0%	70%		?	78.0%	66.4%	89.6%
10	Total patients waiting over 65 weeks	Oct 24	145	0		?	390	-46	826
11	Total patients waiting over 52 weeks	Oct 24	2162	1190		F	2303	1859	2746
12	Percentage of patients waiting less than 6 weeks for diagnostic tests	Oct 24	81.5%	95%	H	F	77.8%	74.8%	80.8%
13	Cancer faster diagnosis (FDS) standard performance	Sep 24	81.3%	77%		?	80.9%	74.8%	87.1%
14	% of new outpatient attendances or with procedure completed	Oct 24	45.7%	46%	H	F	44.2%	42.5%	45.9%
15	Elective Theatre Utilisation - Capped touchtime	Oct 24	81.7%	85%		F	81.6%	79.6%	83.6%
16	Elective Recovery Plan : Day case activity performance	Oct 24	93.6%	100%		?	96.5%	87.3%	105.8%
17	Elective Recovery Plan : Inpatient activity performance	Oct 24	116.1%	100%		?	108.6%	85.2%	132.1%
18	2-hour urgent community response	Oct 24	78.5%	70%		P	83.7%	73.2%	94.2%

Summary icons key:



Our Performance Narrative : M7 October 24

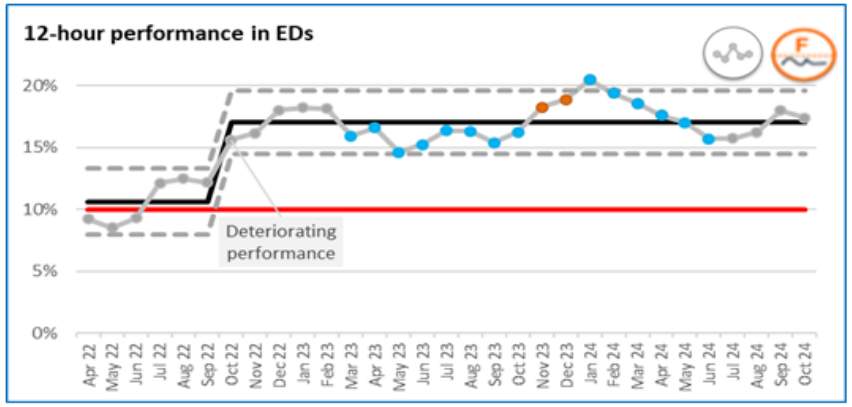
The performance against the 4-hour national standard in A&E, for October 2024 remains challenging at 69% against a target of 76%. Pressure has increased in the department due to a period of lower patient discharges and sustained attendances. The internal discharge and flow programme is now being supported by the Better Lives Transformation programme and ECIST colleagues. Discharging patients into Social Care pathways is a significant issue resulting in many patients being held in an Acute bed without a medical need. The Trust will be working with Local Authority colleagues to improve in our joint approach to improving this position.

12-hour performance continues to be a concern. The Better Lives initiative is targeted at reducing the numbers of patients who are managed within the Emergency Department. This will reduce the demand. Working alongside this demand management are the improvement projects related to discharge process and length of stay. These will improve flow out of ED for patients being admitted and thereby congestion and time in the department. Ambulance handover delays beyond 60 minutes remained very high again due to congestion in the Emergency Department. The G&A bed occupancy for Acute Adult Inpatient Wards at RAEI remained 100% throughout the month

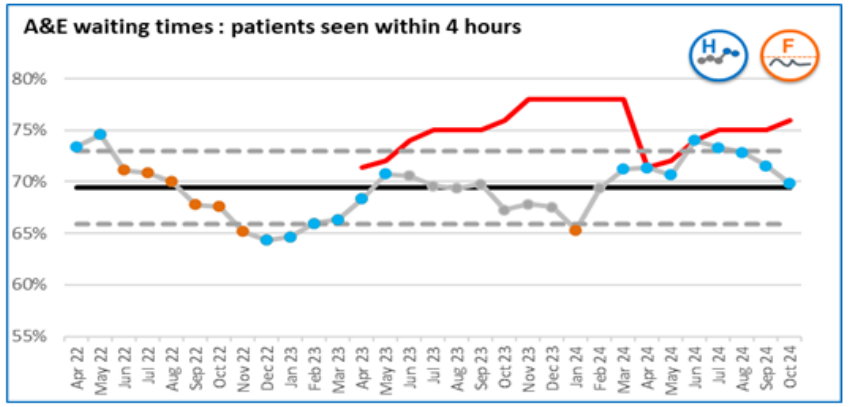
Although the Trust is currently reporting 26 78 week breaches the number has reduced from last month. The vast majority of these are in gynaecology [21/26] and are as a result of the issues found from using an insourced company; there is an escalation meeting with the company on the 18/11/2024 and capacity is available to ensure these are cleared before the end of December. Of the remaining breaches, 3 are in within Orthopaedics and are classed as complex due to the necessary requirement of bespoke specialist equipment.
At this moment within the month there are 88 patients still outstanding that will be classed as breaches by the end of the month. Of these,10 are complex cases, 23 are patient choice and 55 are due to capacity. The majority of the breaches remain within Gynae [57]. Of these, 53 are capacity breaches - again resulting in issues with the insourcing provider. The WWL consultants have agreed to take over the pathways for these patients and through additional capacity we will ensure that all of these breaches are cleared by the end of December.
Vascular have the second highest number of breaches with 8 however these are all patient choice.
The position is likely to improve through the course of the month and the Trust remains on plan to have 0 capacity breaches by the end of December. The only caveat to this is that, as a result of our waiting list/time performance, we have offered to accept Mutual Aid patients [in Orthopaedics, Urology and ENT] from other GM providers; although some patients have come across already, there is a delay in receiving the others which may have an impact in our month end positions. This ‘risk’ has been recognised centrally.

The % of new outpatients with procedures is currently at 45.7% against a target of 46% showing a variance of 0.3% away from plan. Focus continues across the outpatient activity to deliver against the target. There is no significant concern that the target will deteriorate further, and actions are being taken to improve the position through detailed work around clinic templates and case mix.

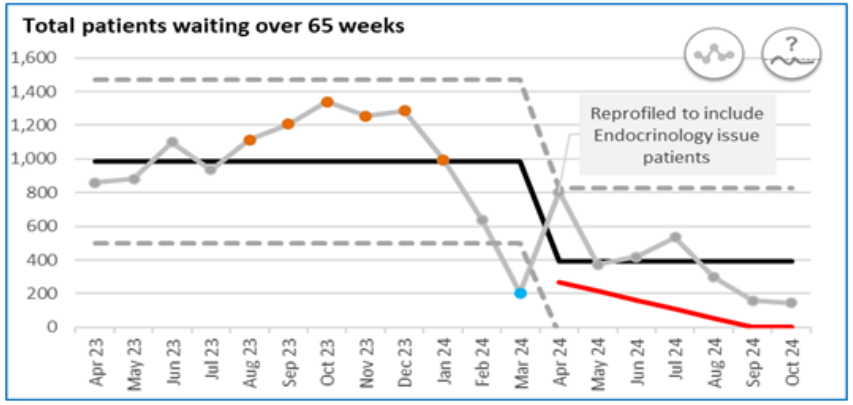
Our Performance Insight Report : M7 October 24



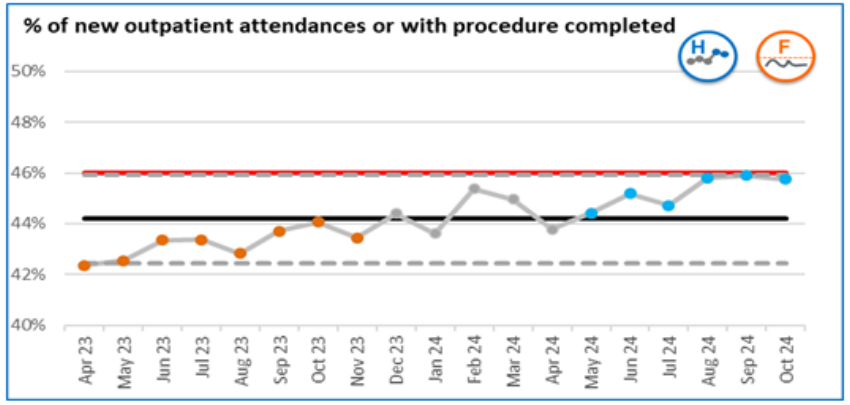
Oct-24
17.4%
Variance Type
Inconsistent performance compared to target
Target
10%
Target achievement
Metric is constantly failing the target



Oct-24
69.8%
Variance Type
Improving special cause variation point
Target
76%
Target achievement
Metric is constantly failing the target



Oct-24
145
Variance Type
Inconsistent performance compared to target
Target
0
Target achievement
Inconsistent performance compared to target



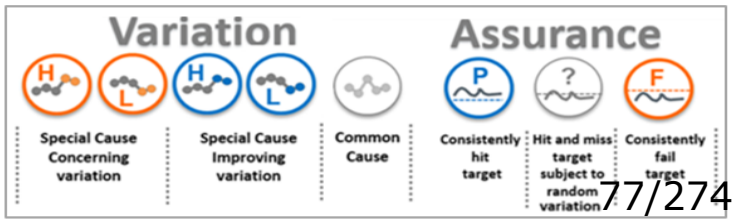
Oct-24
45.7%
Variance Type
Improving special cause variation point
Target
46%
Target achievement
Metric is constantly failing the target

Summary:	Actions:	Assurance:
1. 12-hour performance in ED improved marginally in month . 2. Further improvement in the performance 3. There was a further reduction in patients waiting beyond 65 weeks, the vast majority of patients beyond 65 weeks were either patient choice or clinical complex, with a small number of capacity issues within gynae due to issues with the Medinet service. 4. The target was 0.3% away from plan	1. The Trust will be working with the Local Authority colleagues to improve in our joint approach to improving the position. 2. The internal discharge and flow programme is now being supported by the Better Lives Transformation programme and ECIST colleagues. 3. Concerns with Medinet captured thoroughly and escalated promptly and are being managed a exec level. No further patients are being sent to Medinet currently, and divisional team are finalising a plan for alternative capacity to clear 65 week waits by Dec 24 4. Continued focus on the utilisation of all outpatient capacity through the maximising outpatient transformation	1. Decision to not proceed with second ward closure for estates works 2. Opportunity for 24/7 SDEC pilot presented due to pressures and was introduced at pace and successfully. 3. Divisional team are finalising a plan for alternative capacity to clear 65 week waits by Dec 24 4. It is important to note that due to delays in capture of activity, this metric is likely to change.

Our Finance Performance Overview : M7 October 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Surplus /Deficit (£ms)	Oct 24	-0.53	-0.13			-0.90	-7.68	5.88
2	Adjusted Financial Performance (£ms)	Oct 24	-0.52	-0.12			-0.33	-5.65	4.98
3	ERF Income (£ms)	Oct 24	10.64	10.88			9.81	7.73	11.88
4	Agency Expenditure (£ms)	Oct 24	0.88	0.66			0.92	0.47	1.38
5	Agency % of Total Pay	Oct 24	2.2%	3.2%			2.6%	1.6%	3.6%
6	Escalation (£ms)	Oct 24	0.51	0	L	F	0.61	0.48	0.74
7	Capital Expenditure (£ms)	Oct 24	1.88	2.23			1.46	0.61	2.30
8	Cash (£ms)	Oct 24	18.66	10.80			15.62	1.09	30.14
9	Cost Improvement Programme (CIP) (£ms)	Oct 24	2.53	2.28			2.24	1.70	2.78
10	Better Payment Practice Code (BPPC)	Oct 24	96.0%	95%			93.8%	90.0%	97.7%

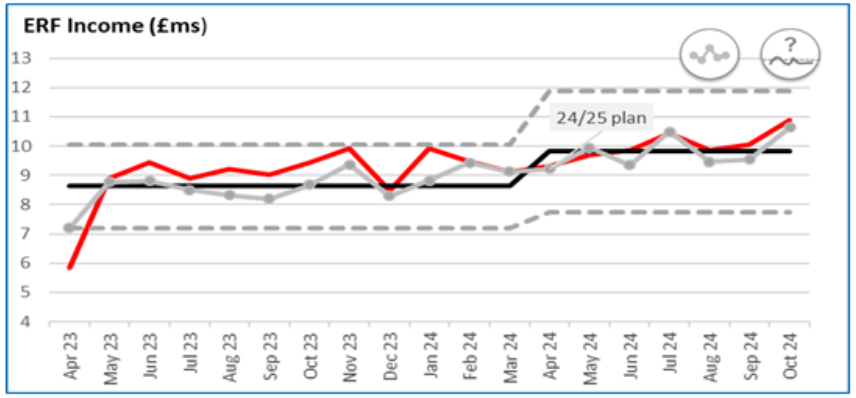
Summary icons key:



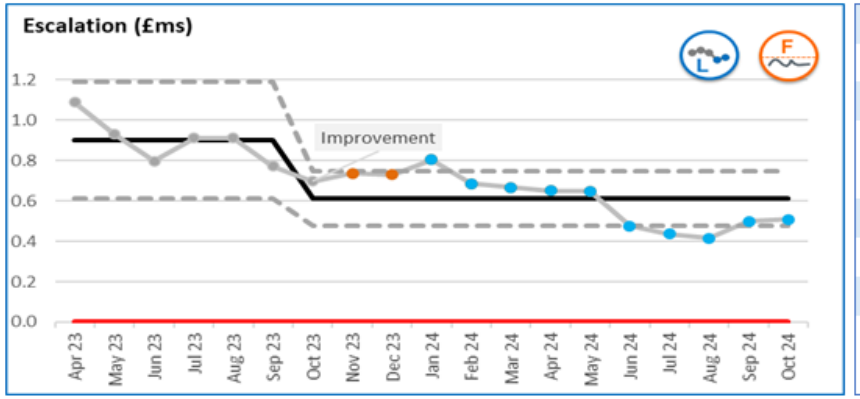
Our Finance Performance Narrative : M7 October 24

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 £0.5m for month 7 (October) which is £0.4m adverse to plan. Year to date, the Trust is reporting an actual deficit of £3.2m which is £2.8m adverse to plan. The plan and the actual position have been adjusted in month 6 for the 24/25 pay award (£14.5m YTD, £24.9m full year). The forecast provided to NHSE is to deliver the full year plan of £0.8m deficit.
	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 £0.2m behind plan in month and £1.5m year to date. This activity shortfall needs to be recovered by the end of the financial year to achieve the 2024/25 plan. Advice & Guidance income of £0.5m YTD has been included in the month end position for diverted activity which would reduce the YTD adverse ERF variance to £1.0m.
Agency	To remain within the agency ceiling set by NHSE.	Amber	Agency expenditure is £0.8m in month 7, similar to last month. This is 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	October saw a further increase due to decant costs on Bryn Ward and general corridor escalation in month. Reported escalation costs for October were £0.5m.
Capital expenditure	Achieve capital plan for 2024/25.	Green	Month 7 actual capital expenditure is £1.9m, which is £0.3m below plan due to the phasing of expenditure.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber	There is a closing cash balance of £18.7m for October 2024 which is £7.9m above plan. There was an increase of £11.1m in month due to the receipt of provider deficit funding, education income received in advance and other timing differences in payment of invoices and receipt of income. The current cash run rate forecast indicates there will be sufficient cash balances for the remainder of the financial year. However, revenue cash support is likely to be required in quarter 1 of 2025/26.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red	In month 7, the Trust has delivered £2.5m CIP which was £0.3m favourable to plan. The year to date adverse variance of £0.3m relates to prior month slippage. As of September, the total target is now fully identified. This is an improvement of £0.9m on the month 5 reported position.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Amber	BPPC performance to end of October is 94.0% by volume and 95.5% by value, which is a slight improvement to previous months.

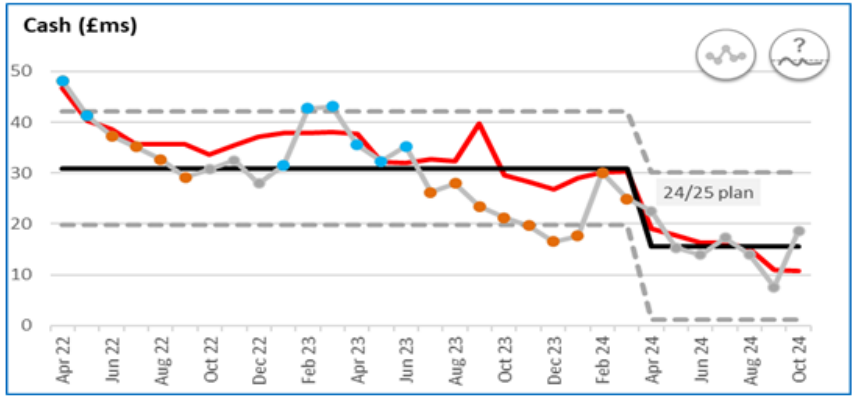
Our Finance Performance Insight Report : M7 October 24



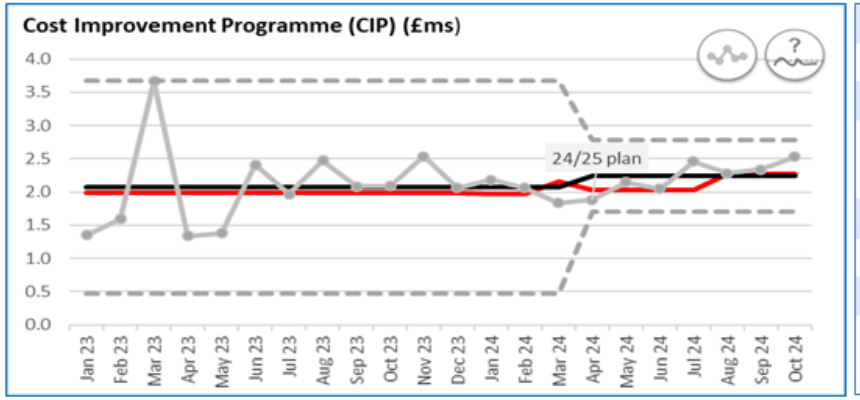
Oct-24
10.64
Variance Type
Inconsistent performance compared to target
Target
10.88
Target achievement
Inconsistent performance compared to target



Oct-24
0.51
Variance Type
Special cause improving variation
Target
0.00
Target achievement
Metric is constantly failing the target



Oct-24
18.66
Variance Type
Inconsistent performance compared to target
Target
10.80
Target achievement
Inconsistent performance compared to target



Oct-24
2.53
Variance Type
Inconsistent performance compared to target
Target
2
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
1. Elective activity is £0.2m behind plan in month and £1.5m year to date. This activity shortfall needs to be recovered by the end of the financial year to achieve the 2024/25 plan. 2. Month 7 saw a further increase due to decant costs on Bryn Ward and general corridor escalation in month. Reported escalation costs for October were £0.5m. 3. There is a closing cash balance of £18.7m for October 2024 which is £7.9m above plan. There was an increase of £11.1m in month due to the receipt of provider deficit funding, pay award funding and education income received in advance. 4. CIP is £0.3m above plan in month. The YTD slippage has reduced to £0.3m due to the overperformance in recent months. The total target is now fully identified. Recurrent CIP delivery is behind plan mitigated in year by non-recurrent CIP, this will impact on the timescale to deliver the Financial Sustainability Plan.	1. Specialist Services underperformance is predominantly due to lost theatre sessions in Trauma & Orthopaedics, and a recovery plan is in place. Further tactical actions will be required to mitigate the forecast variance. Advice and guidance accrued at risk whilst under negotiation with commissioners. 2. The Better Lives programme of work with Newton Europe is underway. Consideration is to be given to permanent recruitment for specific escalation areas. 3. Cash management strategy in place with detailed cash forecasting. Receipt of the non-recurrent deficit funding in month 7 has alleviated the immediate cash concerns . Current run rate forecasts indicate cash support required from Q1 2025/26. 4. Targeted work continues with the divisions to ensure delivery of the red and amber rated recurrent schemes by the end of the financial year.	1. ERF is monitored at the Elective Recovery programme board and the divisional assurance meetings, both held monthly. The recovery plan for Specialist Services is executive led with updates provided to ETM. 2. Medicine Divisional Assurance Meeting, UEC Programme Delivery Group (Ext) 3. Cash Management Group, Finance and Performance Committee 4. Divisional Assurance Meetings, Finance Improvement Group, Finance and Performance Committee

Change log

Ref	Metric	Change	Date	Requested by:
24/25 07	Elective Theatre Utilisation - Capped touchtime	Alignment of the Theatre Utilisation metric with the national metric	12/11/2024	Data Analytics and Assurance
24/25 06	As appropriate	Metrics reviewed and step change added if appropriate.	12/11/2024	Data Analytics and Assurance
24/25 05	All Finance metrics	Finance metrics reported in £ms rather than £'000s to be consistent with the Trust Finance Repor	16/09/2024	Director of Finance
24/25 04	2-hour Urgent Community Response	Reporting deadline moved to latest postion	18/08/2024	Community Division Director of Performance
24/25 03	Elective Recovery Plan - Inpatients & Day Cases Activity	Reported as at working day 1 in line with Finance figures	18/08/2024	Director of Finance
24/25 02	Escalation	Add new metric	16/07/2024	Director of Finance
24/25 01	ERF Income	Add new metric	16/07/2024	Director of Finance

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Thank you

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Trust finance report for October 2024 (month 7)
Presented to:	Board of Directors
On:	4th December 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 7 (October 2024).

Please see slide 3 for key messages and slide 5 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 17 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.

The WWL Way

People implications

There are no direct people implications in this report.

Equality, diversity and inclusion implications

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

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

The finance flash metrics report was reviewed by ETM on 7th November 2024. It was presented to the Finance and Performance Committee on 26th November 2024.

Wider implications

There are no wider implications of this report.

Recommendation(s)

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

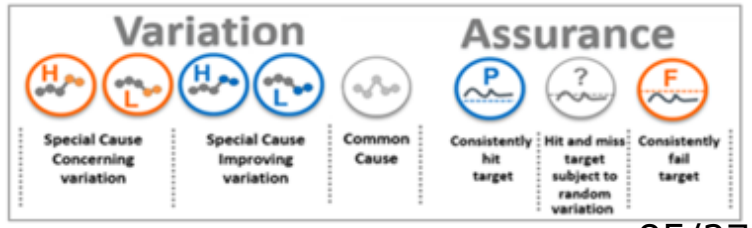
NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Trust Finance Report

Month 7 – October 2024

Contents

Statistical Process Chart (SPC) Key



Key Financial Messages

It has been confirmed that the GM ICS will receive cash backed deficit funding equal to the planned 2024/25 deficit of £175m. The WWL share of the funding allocation is £13.4m for 2024/25, of which £7.6m is within month 7. This allocation is repayable in future years. Our plan for 2024/25 has changed from £14.2m deficit to £0.8m deficit.

For October 2024, the in-month position was a deficit of £0.5m, which was £0.4m adverse to plan. The YTD position is a deficit of £3.1m, which is £2.9m adverse to plan. The revenue position has triggered the red line ICB metric due to the variance to our forecast trajectory. It looks challenging to deliver our agreed plan for this financial year.

Divisional core CIP is above plan in month with £2.5m delivered. The slippage YTD has reduced from £0.5m to £0.3m. The focus needs to remain on the delivery of recurrent savings to support our longer-term financial sustainability.

Divisional ERF performance is £0.2m below plan in month 7 and £1.5m year to date. There is over performance of £0.2m in month (£1.4m YTD) in Surgery, which is offsetting an underperformance of £0.3m in month (£2.6m YTD) in Specialist Services.

The impact of all the pay awards confirmed by the government are included within the month 7 position. This is expected to be net neutral following confirmation of increase to the ICB allocations and assumptions about other sources. The financial impact in full is additional pay expenditure of £24.9m. Divisions have been funded in full for the pay awards based on current establishment.

Total WTE in August was 7,034 WTE, which is an increase of 67 WTE from last month, and the third consecutive month of WTE increases. In month, there are increases within Medicine and Surgery. For September, we are 128 WTE above the workforce plan of 6,906 WTE, which planned for WTE to reduce over the financial year in line with the financial sustainability plan .

Non-recurrent Deficit Funding

Funding allocation

- It has been confirmed that the GM ICS will receive cash backed deficit funding equal to the planned 2024/25 deficit of £175m. i.e. the revised GM plan for 2024/25 is breakeven.
- The WWL share of the funding allocation is £13.4m for 2024/25. The deficit funding has been shared proportionately between providers with a deficit plan.
- The funding has been approved non-recurrently by the Treasury and will be added to contract allocations.
- In line with the business rules, the deficit support funding is repayable as a deduction from allocations in future years.

Revenue plan impact

- The WWL plan improves from a deficit of £14.2m to £0.8m deficit (for the adjusted financial position). The revised technical plan is a £1.0m deficit.
- This was reflected from the month 6 position with a YTD improvement to the plan of £6.5m, changing the YTD plan from £6.6m deficit to £0.1m deficit.
- The plan change reflects the additional income allocation; therefore, there is no risk to delivery. The variance to plan and other underlying risks remain the same.

Cash impact

- WWL will receive the £13.4m as cash within the ICB contract income.
- The cash differs slightly from the revenue plan, with a benefit in month 7.
- The deficit funding delays the requirement for revenue cash support to 2025/26. The cash forecast currently indicates that this would be required in Q1 2025/26 at the current run rate.

	M6 YTD	M7	M8	M9	M10	M11	M12	Total
Current plan (June submission)	(6,581)	(1,245)	(1,138)	(1,196)	(1,557)	(1,203)	(1,266)	(14,187)
Deficit funding	6,464	1,129	1,022	1,080	1,441	1,087	1,149	13,372
Revised plan (Oct)	**(117)**	**(116)**	**(116)**	**(116)**	**(116)**	**(116)**	**(117)**	**(815)**
Memo: Cash profile		7,801	1,165	992	1,353	999	1,061	13,372

Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Red		We are reporting an actual deficit of £0.5m for month 7 (October) which is £0.4m adverse to plan. Year to date, we are reporting an actual deficit of £3.2m which is £2.9m adverse to plan. The plan and the actual position have been adjusted in month 7 for the 2024/25 pay award. The forecast provided to NHSE is to deliver the full year plan of £0.8m deficit, however this requires an improvement on the current run rate of £4.5m between month 8 and 12, which looks increasingly challenging.
	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 £0.2m behind plan in month and £1.5m year to date. This activity shortfall needs to be recovered by the end of the financial year to achieve the 2024/25 plan. Advice & Guidance income of £0.5m YTD has been included for diverted activity which would reduce the YTD adverse ERF variance to £1.0m.
Agency	To remain within the agency ceiling set by NHSE.	Amber		Agency expenditure is £0.8m in month 7, which is similar to last month. This is 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		October saw a further increase due to decant costs on Bryn Ward and general corridor escalation in month. Reported escalation costs for October were £0.5m.
Capital expenditure	Achieve capital plan for 2024/25.	Green		Month 7 actual capital expenditure is £1.9m, which is £0.3m below plan due to the phasing of expenditure. We are forecasting to spend our CDEL envelope in full for 2024/25.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		There is a closing cash balance of £18.7m for October 2024 which is £7.9m above plan. There was an increase of £11.1m in month due to the receipt of provider deficit funding, pay award funding and education income received in advance. The current cash run rate forecast indicates there will be sufficient cash balances for the remainder of the financial year. However, revenue cash support is likely to be required in quarter 1 of 2025/26.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red		In month 7, the Trust has delivered £2.5m CIP which was £0.3m above plan. The YTD slippage has reduced to £0.3m due to the overperformance in recent months. The total target is now fully identified. Recurrent CIP delivery is behind plan mitigated in year by non-recurrent CIP, this will impact on the timescale to deliver the Financial Sustainability Plan.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Amber		BPPC performance to end of October is 94.0% by volume and 95.5% by value, which is a slight improvement to previous months.

Financial Performance

Headlines

- In month 7 (October 2024), we reported an actual deficit of £0.5m, an adverse variance of £0.4m to the planned deficit of £0.1m.
- The plan and YTD actual have been adjusted to include the non-recurrent deficit support funding of £13.4m full year and £7.6m YTD.
- Year to date, the actual deficit is £3.2m which is £2.9m adverse to the planned deficit of £0.3m.
- The YTD actual and plan have been adjusted for the 2024/25 pay awards with no impact bottom line.
- The forecast is to deliver the full year plan of £0.8m deficit. This will require an improvement of £2.2m from the current position.

Income

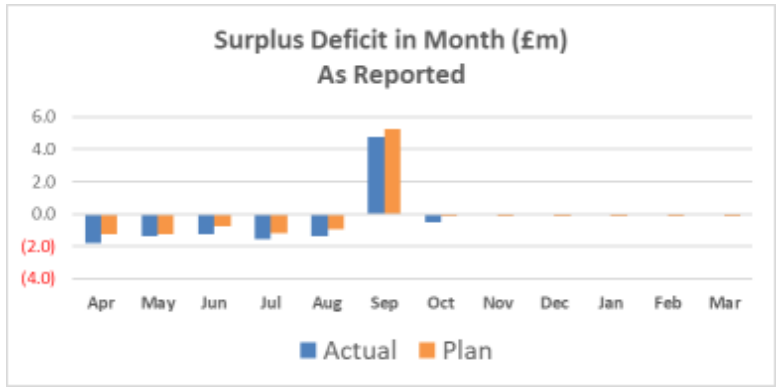
- Income is £0.3m favourable to plan
- The position includes £8.9m of funding associated with the increase in allocation to fund the pay awards.
- ERF underperformance of £0.2m in month, an improvement on last month which was £0.6m adverse in month. YTD the Trust is £1.5m adverse to plan.
- There is £1.1m of non-recurrent deficit funding in month (£7.6m YTD).

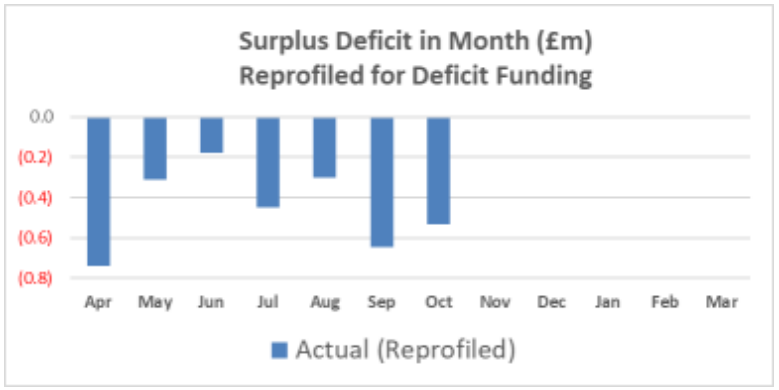
Pay

- Pay expenditure is £40.2m in month 7. This includes the pay award expenditure of £8.9m in month, which is offset by income.
- Temporary staffing is £3.3m in month, with bank expenditure of £2.4m and agency expenditure of £0.9m. Agency has increased on last month by £0.1m.

Non-Pay

- Non pay expenditure is £12.6m in month 7, which is £0.7m adverse to plan.
- There has been upwards creep in non-pay expenditure, particularly in clinical supplies and drugs, creating a pressure in clinical divisions.
- CIP shortfall within non-pay is £0.2m in month and £1.9m YTD.





Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	54,406	54,145	260	322,478	320,190	2,288	550,200
Pay	(40,248)	(40,323)	75	(227,473)	(224,950)	(2,523)	(385,714)
Non Pay	(12,635)	(11,892)	(743)	(84,500)	(81,162)	(3,337)	(140,768)
Financing / Technical	(2,056)	(2,060)	4	(13,666)	(14,423)	757	(24,725)
Surplus / Deficit	(533)	(131)	(403)	(3,161)	(345)	(2,816)	(1,008)
Adjusted Financial Performance *	(516)	(115)	(401)	(3,091)	(233)	(2,859)	(815)

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

Income

Division	In Month (£000)			Year to Date (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	471	397	74	2,602	2,399	203
Surgery	534	236	298	3,294	1,625	1,669
Specialist Services	1,634	1,602	32	8,231	10,611	(2,380)
Community Services	573	584	(12)	3,931	4,004	(73)
Non Divisional Income	49,070	49,353	(283)	295,185	293,701	1,484
Finance	18	11	6	114	80	34
Digital Services	1	7	(6)	44	51	(6)
Dir of Strat & Planning	287	257	30	1,558	1,609	(52)
Chief Operating Officer	0	0	0	0	0	0
Human Resources	22	1	21	179	7	173
Medical Director	96	51	45	672	359	313
Estates & Facilities	388	459	(72)	3,075	3,216	(141)
Nurse Director	113	71	42	843	452	391
Trust Executive	10	9	1	22	63	(41)
GTEC	190	195	(5)	1,415	1,558	(143)
Corporate	999	911	88	1,310	454	856
Reserves	0	0	(0)	0	0	(0)
Total	**54,406**	**54,145**	**260**	**322,478**	**320,190**	**2,288**

Headline

- Income is £0.3m favourable in month and £2.3m favourable YTD.

Medicine

- £0.1m favourable in month due to £0.2m over performance on unbundled drugs and devices, which, offset by £0.1m under performance on ERF income.

Surgery

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

Specialist Services

- On plan in month due to £0.3m underperformance on ERF income offset by £0.3m over performance on unbundled drugs and devices.

Non-Divisional Income

- £0.3m adverse in month. £0.4m adverse due to education income that has been transferred to Divisions and this has been offset by an over performance of £0.1m Advice and Guidance funding that has been included as an estimate pending ICB confirmation.

Estates & Facilities

- £0.1m adverse in month due to under performance on catering income.

Corporate

- £0.1m favourable in month predominantly due to T&O private patient CIP.

Divisional ERF Activity and Income

Activity Plans

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

ERF Performance

- In month 7 the Trust is £0.2m adverse to the internal ERF plan and £1.5m adverse YTD.
- Specialist Services are £0.3m adverse in month and £2.6m adverse YTD predominantly within Trauma & Orthopaedics, this is a result of not utilising all available theatre sessions.
- Surgery have over performed against their plan by £0.2m in month and £1.5m YTD.
- Medicine are £0.1m adverse to plan in month and £0.3m YTD.
- Advice and Guidance income of £0.5m has been included in the month 7 financial position, however it is not included in the above table as it is coded to Non-Divisional income until the split by Division confirmed. This would reduce the YTD ERF adverse variance to £1.0m.

		In Month Activity			In Month (£000)			YTD Activity			YTD (£000)		
Division	POD	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,652	1,838	(186)	1,038	1,148	(110)	10,812	11,991	(1,179)	6,871	7,493	(622)
Medicine	Electives	50	30	20	67	45	22	226	193	33	336	294	41
Medicine	OP Proc New	144	215	(71)	49	72	(23)	902	1,402	(500)	302	469	(167)
Medicine	OP Proc FUP	590	398	192	106	77	29	4,409	2,595	1,814	784	501	282
Medicine	OPA New	2,260	2,482	(222)	553	585	(32)	16,482	16,186	296	3,981	3,818	164
Medicine Total		**4,696**	**4,962**	**(266)**	**1,813**	**1,928**	**(115)**	**32,831**	**32,366**	**465**	**12,275**	**12,576**	**(301)**
Specialist Services	Day Cases	751	849	(98)	1,243	1,352	(109)	4,927	5,412	(485)	7,918	8,582	(664)
Specialist Services	Electives	424	444	(20)	2,936	3,122	(186)	2,539	2,805	(266)	17,802	19,738	(1,936)
Specialist Services	OP Proc New	879	927	(48)	133	148	(15)	6,633	6,046	587	1,025	965	60
Specialist Services	OP Proc FUP	1,339	1,169	170	174	155	19	9,264	7,625	1,639	1,224	1,011	213
Specialist Services	OPA New	3,315	3,549	(234)	661	706	(45)	21,905	23,148	(1,243)	4,327	4,606	(279)
Specialist Services Total		**6,708**	**6,939**	**(231)**	**5,147**	**5,484**	**(337)**	**45,268**	**45,036**	**232**	**32,297**	**34,902**	**(2,605)**
Surgery	Day Cases	929	905	24	1,224	1,151	73	5,999	5,909	90	7,967	7,524	443
Surgery	Electives	230	131	99	569	487	82	1,385	852	533	3,584	3,177	408
Surgery	OP Proc New	1,879	1,841	38	363	380	(17)	12,716	12,004	712	2,564	2,476	88
Surgery	OP Proc FUP	3,545	3,325	220	669	598	71	23,285	21,685	1,600	4,407	3,901	506
Surgery	OPA New	4,471	4,438	33	857	853	4	28,846	28,944	(98)	5,565	5,561	4
Surgery Total		**11,054**	**10,639**	**415**	**3,682**	**3,469**	**213**	**72,231**	**69,395**	**2,836**	**24,087**	**22,639**	**1,448**
Divisional ERF Totals		**22,458**	**22,540**	**(82)**	**10,642**	**10,880**	**(238)**	**150,330**	**146,797**	**3,533**	**68,659**	**70,117**	**(1,458)**

Overperformance

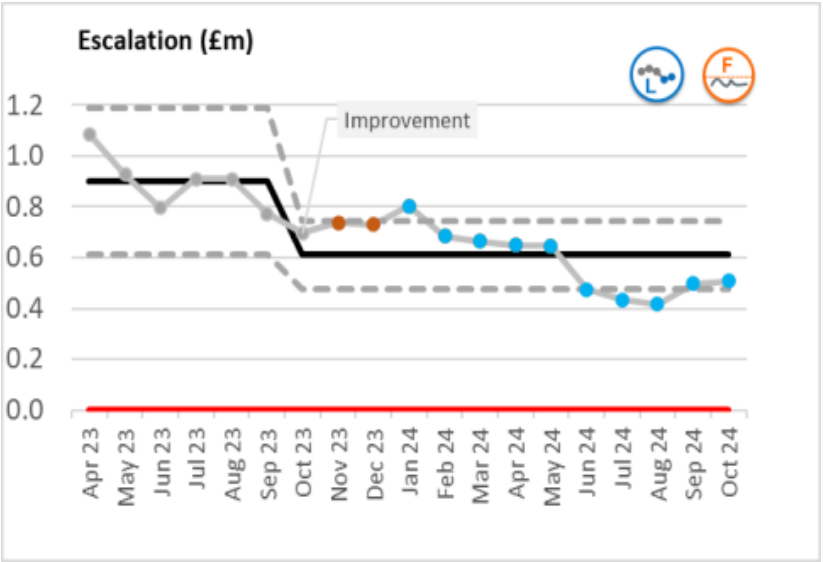
- Surgery £1.5m YTD

Underperformance

- Specialist Services £2.6m YTD
- Medicine £0.3m YTD

Escalation – Medicine Division

Area	2023/24 (£000)	M1 Actual (£000)	M2 Actual (£000)	M3 Actual (£000)	M4 Actual (£000)	M5 Actual (£000)	M6 Actual (£000)	M7 Actual (£000)	YTD total (£000)	2024/25 Forecast (£000)
A&E Rota Issues	3,248	128	128	103	103	103	103	103	668	1,285
New ED Shifts	0	0	19	0	0	0	0	0	19	19
Paeds rota issues	1,014	67	67	67	67	67	67	67	402	803
Acute Rota Issues	809	51	51	51	51	28	21	21	251	374
Acute Outliers	517	26	26	26	26	26	26	26	157	275
AAA	129	79	77	68	0	0	0	7	224	231
Discharge Lounge	157	53	46	18	24	14	26	19	181	303
Corridor	1,748	71	31	15	41	21	78	98	257	925
Waiting room	374	31	31	31	31	31	31	31	186	372
1:1 Enhanced Care	1,724	123	154	84	87	125	79	86	652	1,173
BWN Decant Costs	0						67	51	67	119
Total	**9,721**	**629**	**630**	**463**	**430**	**415**	**498**	**509**	**3,064**	**5,879**
Winter Business Cases	570	140	140	148	148	148	148	148	872	1,760
Grand Total	**10,291**	**769**	**770**	**611**	**578**	**563**	**646**	**657**	**3,936**	**7,639**



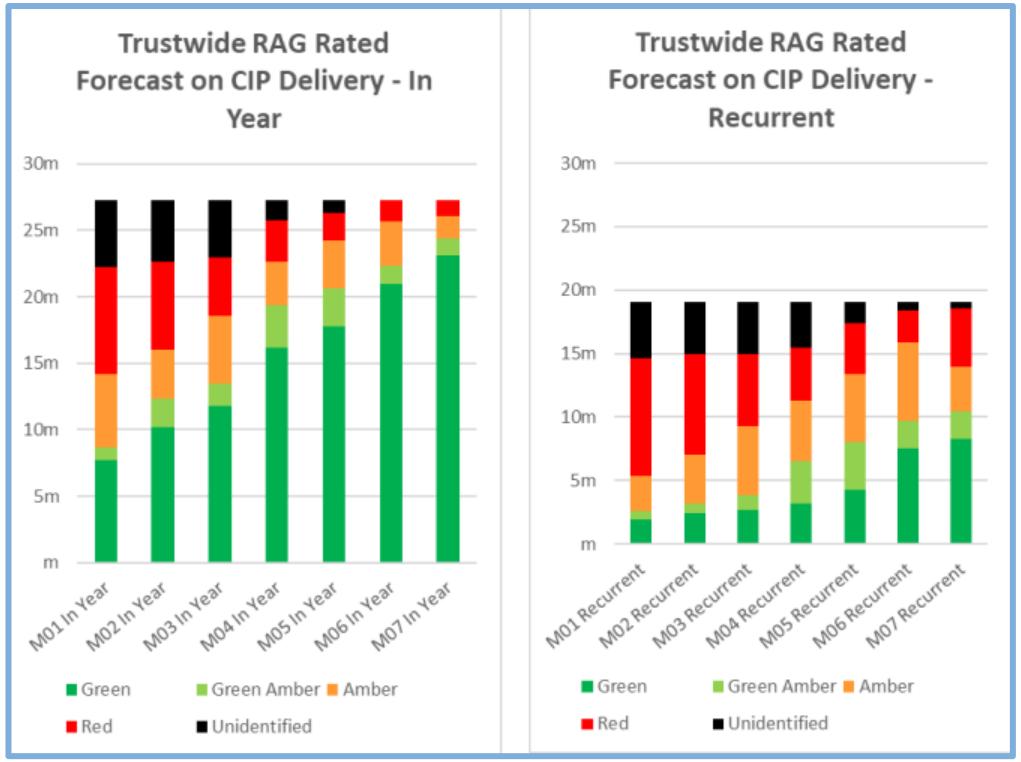
Headlines

- The SPC analysis shows special cause improving variation.
- In month, there was a further £50k due to Bryn Ward north decant costs whilst the copper pipework and electrical works were undertaken on Winstanley Ward.
- Decants costs include opening SDEC and DL overnight for 2 weeks plus an additional 8 beds on the corridor.
- General corridor escalation increased in month by £20k, with beds at 16 for almost half the month.
- 1:1 enhanced care slightly increased across all wards, although in line with forecast.

Trust Wide CIP Delivery 2024/25

2024/25 CIP Plans

The CIP Tracker currently includes schemes totalling £27.3m – 6% are categorised as high risk. The target is fully identified.



October 2024 Reported Position

RAG	Value £'000
-	0
	1,710
	1,507
	24,082
CIP Total	27,300

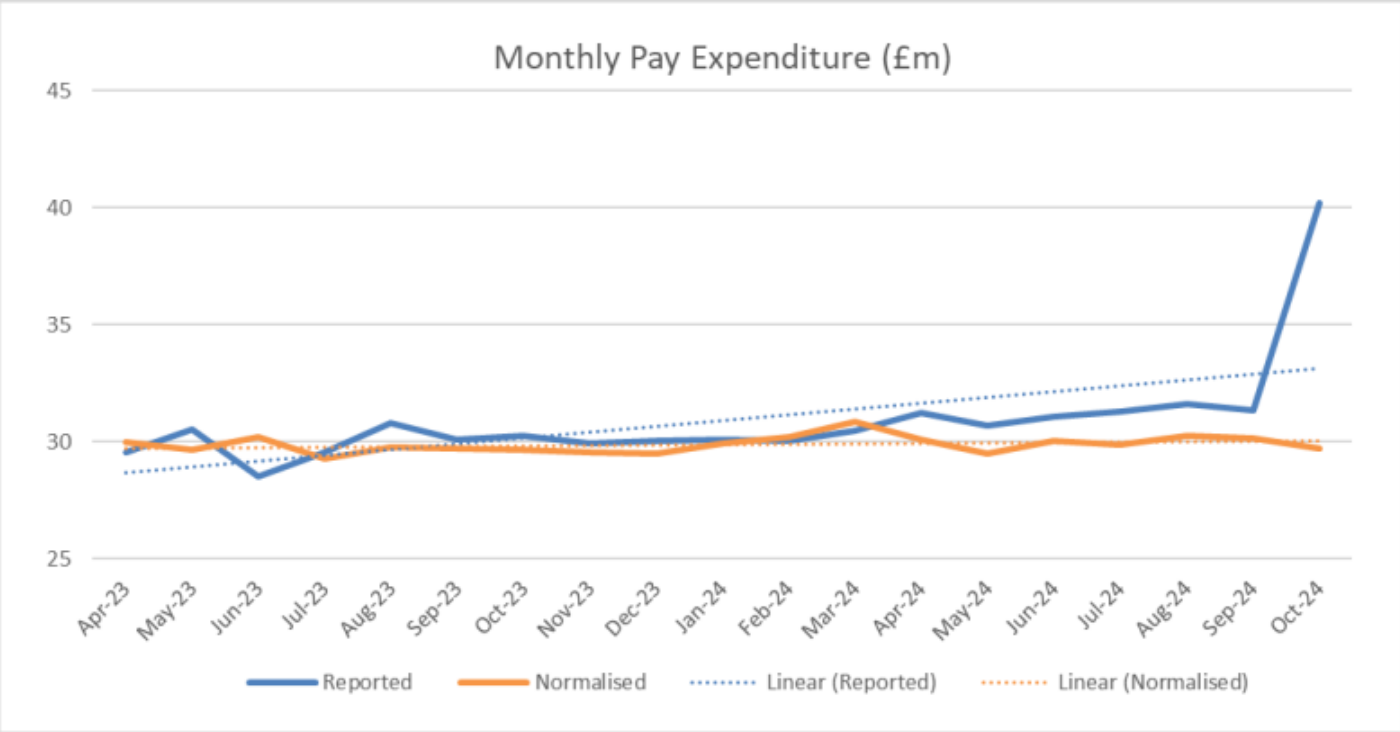
- £27.3m identified, £18.6m recurrent

September 2024 Reported Position

RAG	Value £'000
-	0
	1,596
	3,406
	22,298
CIP Total	27,300

- £27.3m identified, £18.5m recurrent

Normalised Pay Expenditure



Normalised quarterly average

Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	M7 24/25
£29.9m	£29.6m	£29.5m	£30.3m	£29.8m	£30.0m	£29.7m

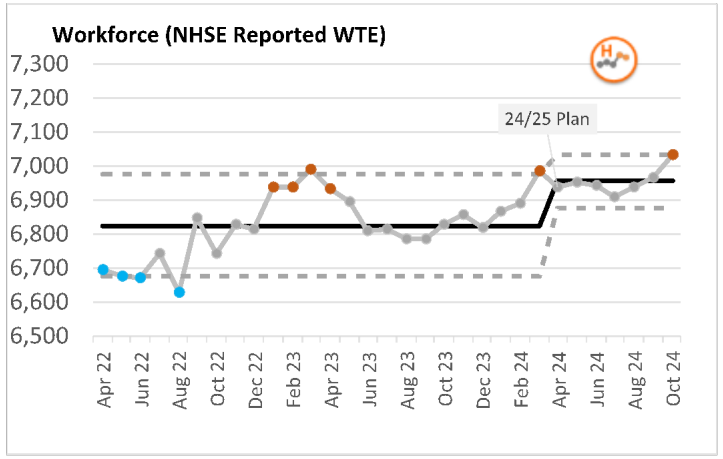
Key Messages

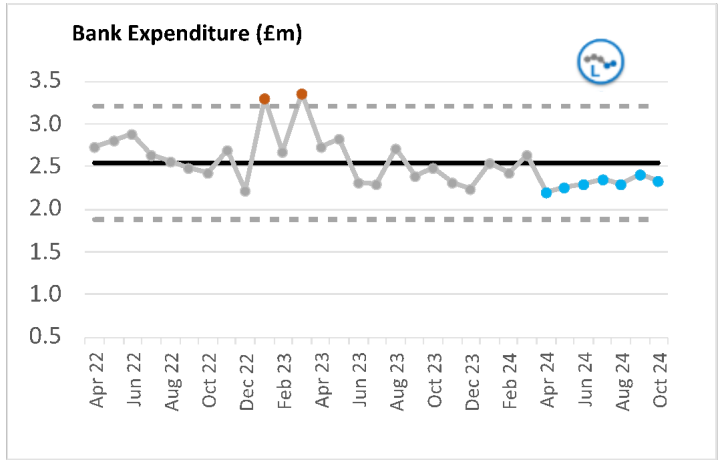
- The increase in the reported pay position is primarily due to pay inflation, investment growth and other non-recurrent items. Month 7 pay expenditure includes the remainder of the pay award agreed for 2024/25 backdated to April 2024.
- When these are normalised, the 'clean' pay position is static between April 2023 and October 2024.
- The month 7 normalised position is £29.7m, which is £0.3m less than the Q2 2024/25 average, but within the normal range of fluctuations.
- There is no material reduction apparent yet from recurrent CIP delivery.

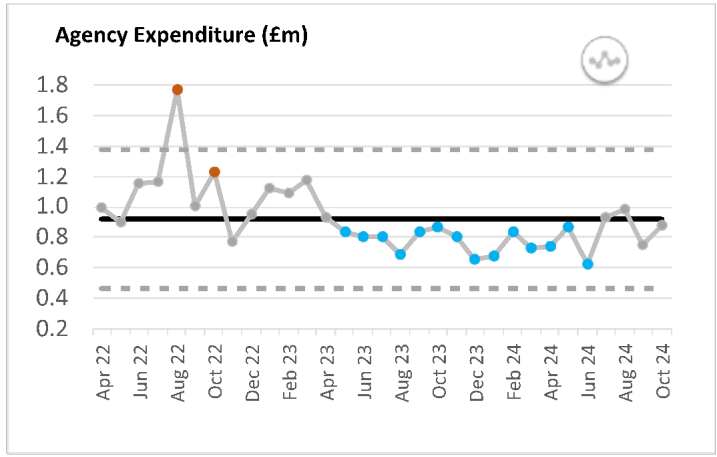
Normalising adjustments

- Industrial action excluded
- Balance sheet support excluded
- Pay awards:
  - 23/24 rephased across year to smooth impact of arrears
  - 24/25 pay awards for AFC and Medical staff excluded, including resident doctors arrears for 23/24
- Investments excluded:
  - CDC
  - Virtual hub
  - Theatre 4, Leigh
  - Home First
  - Theatre 11
- No adjustments made in respect of non-recurrent CIP (non-recurrent vacancies) on the basis that the transaction of non-recurrent vacancies doesn't impact on the run rate.

Workforce







Pay expenditure

- The in-month pay expenditure is £40.2m which is £0.1m favourable to plan in month. This includes arrears and accruals for the full impact of the 2024/25 pay awards.
- Medicine has £0.2m medical and £0.1m nursing overspends but this is offset by other vacancies across the division.
- Surgery is £0.1m adverse due to medical rotas, CIP not delivered offset by vacancies in various specialties.
- Specialist is £0.4m favourable to plan due to vacancies in Theatres and Radiology.

Workforce (WTE)

- The overall number of WTE further increased in October by 67 WTE to 7,034 WTE, which is 128 WTE above the NHSE plan of 6,906 WTE.
- Substantive staffing has increased by 33 WTE with new starters in Medicine (recruitment across wards) and Surgery (HCO, maternity, neonatal, RAEI wards, medical staffing, theatres).
- Bank staffing has increased by 28 WTE. This is within Medicine across ward nursing staff and Surgery (Neonatal, Rainbow, Ward 1:1, Theatres)
- Agency staffing has reduced by 6 WTE. This is mainly within Medicine across Nursing and Pharmacy.

Bank expenditure

- During October bank costs were £2.3m, a slight improvement from last month, therefore the chart is showing special cause improving variation.
- In month 7, Medicine and Surgery are biggest users of bank staffing across nursing staff, followed by medical staff across various specialties.

Agency expenditure

- Agency spend in month is £0.8m, a slight increase from prior month, therefore the trend is showing common cause variation as this is still within the typical process limits.
- Agency spend in month is 2.2% of the total pay spend, which is below the NHSE agency ceiling set at 3.2%
- Medicine continues to have the highest level of agency within the Trust.

Pay Award Summary

Expenditure

- The full impact of the pay reform and pay awards for 2024/25 are **additional pay expenditure of £24.9m**.
- As per NHSE guidance, the full impact is reported within October, including the elements to be paid in November.
- All divisions funded for the pay award based on current establishment.

Income

- Commissioner allocations have been uplifted in line with the revised cost uplift factor (CUF) which has increased to 3.9% (£22.4m).
- The backpay for resident doctors for 2023/24 is being funded directly by NHSE (£1.0m).
- Local CEAs awards ceased (other than legacy awards) (£0.8m).
- There is also an expectation that other incomes are uplifted, including education and training tariffs, R&D and local authority contracts (£0.5m).
- **Total income assumed £24.8m**.

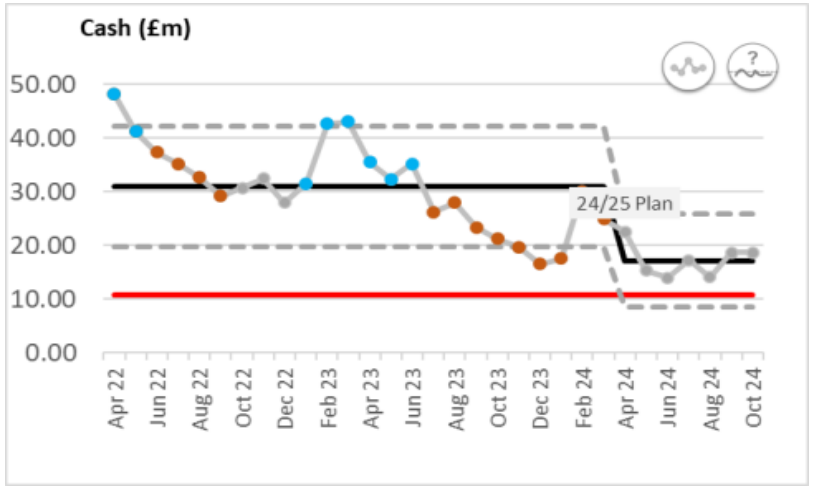
Net Impact

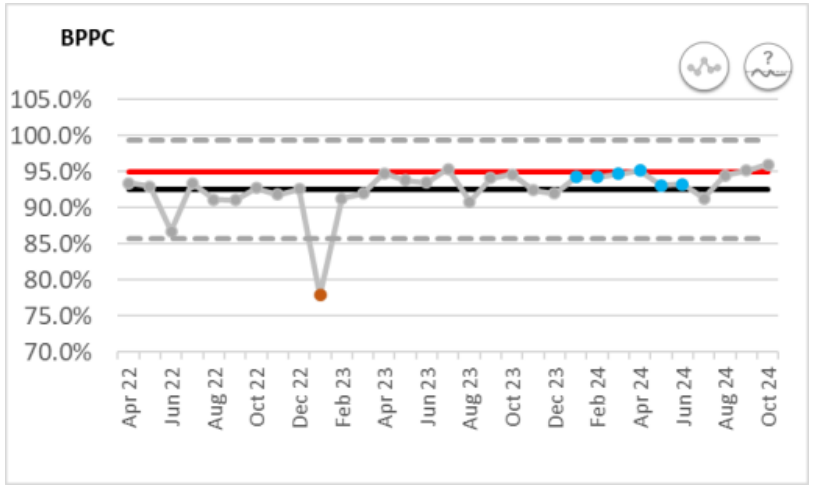
- There is a cost pressure of £0.1m associated with the 2024/25 pay awards and reform, assuming all the income steams above are uplifted.

Pay Awards Announced by the Government

Staff Group	Standalone Pay Award / Reform	2024/25 Pay Award	WWL Annual Impact
Agenda for change (AfC)	N/A	5.5% for all bands, plus new intermediate steps for band 8a to 9	£15.5m
Consultants	4.95% plus removal of pay points effective from Mar 2024 (paid May 24)	6.0%	£4.8m
SAS doctors	6-9% depending on contract (paid Aug 24)	6.0%	£0.7m
Resident (junior) doctors	Average 4.1% effective from Apr 2023	6.0% plus £1,000 consolidated payment (total average 8.0%)	£3.8m
Senior NHS managers	N/A	5.0%	0.1m
Total			**£24.9m**

Cash and BPPC





Current cash position

- Closing cash at the end of October was £18.7m, an increase of £11.1m from September, £7.8m of this increase relates to the receipt of provider deficit funding, £2.7m education income received in advance and other timing differences in the payment of invoices.
- The closing cash balance is £7.9m above the plan of £10.7m largely due to the provider deficit funding, pay award funding, variance to the revenue plan and other timing differences in payment of invoices.

Cash forecast

- Deficit funding support of £13.4m has been confirmed, £7.8m was received in October (7/12ths) with the remainder being phased over the year.
- The pay award will impact cash over Q3 due to the timing of arrears split across October and November, and the payment of employer tax and NI the following month.
- As a result of the deficit support funding the forecast indicates there will be sufficient cash balances for the remainder of the financial year. However, based on the current run rate, revenue cash support is likely to be required in quarter 1 of 2025/26.

Better Payment Practice Code (BPPC)

- In month performance was 96.0% by volume and 95.7% by value, which are both above the target of 95.0%.
- YTD performance 94% by volume which is slightly under target, and 95.5% by value which is above target.

Capital

Scheme	In Month (£000) Actual	Plan	Var	Year to date (£000) Actual	Plan	Var	Full Year (£000) Plan	YTD Actual of Full Year Plan (%)
Operational capital (CDEL)	1,076	1,279	203	4,885	5,450	564	9,287	53%
Lease expenditure (IFRS16)	161	112	(49)	373	1,719	1,346	2,655	14%
Sub total internally funded	**1,237**	**1,391**	**154**	**5,258**	**7,169**	**1,910**	**11,942**	**44%**
National funding (PDC)								
Theatre 11, Wrightington	29	0	(29)	1,325	1,325	0	1,325	100%
Endoscopy	610	718	108	3,592	3,804	212	6,885	52%
RAAC Eradication Programme	4	118	114	11	118	107	711	2%
Nasogastro	0	0	0	0	0	0	267	0%
Sub total national funding	**643**	**836**	**193**	**4,928**	**5,247**	**319**	**9,188**	**54%**
Total capital programme	**1,880**	**2,227**	**347**	**10,186**	**12,416**	**2,229**	**21,130**	**48%**

Capital plan 2024/25

- Total capital plan for the financial year of £21.1m broken down as:
  - Internal operational CDEL £9.3m.
  - Lease expenditure £2.7m.
  - PDC £9.2m.
- Additional PDC support of £1.0m approved by NHSE in year:
  - £0.7m to eradicate Reinforced Autoclaved Aerated Concrete (RAAC)
  - £0.3m Nasogastro endoscopy equipment

Month 7 Headlines

- Capital expenditure is £0.3m below plan in month and £2.2m below plan YTD.
- The YTD underspend is largely due to leases £1.3m and operational CDEL £0.6m.

Operational CDEL

- £0.5m below plan year to date and £0.2m below plan in month.
- There is a variance of £0.5m against Bryn Ward due to the decision to defer this scheme; there is an underspend against plan on Endoscopy £0.1m and Electrical Infrastructure £0.3m offset by overspends against plan on Theatre 12 £0.2m, copper pipework £0.2m.
- Contingency plan in progress.

PDC funded schemes

- £0.2m below plan in month and £0.3m below plan year to date, largely due to phasing of expenditure.
- The Endoscopy scheme has forecast slippage from 2024/25 into 2025/26 and a plan has been agreed to mitigate this across the wider capital programme.
- Theatre 11 scheme complete however there will be some elements of expenditure that have not yet been transacted.

Lease Expenditure

- Lease expenditure is slightly above plan in month and £1.3m below plan year to date.
- OBCs totalling £1.0m have been approved both internally and with the ICB and work is underway to progress these.
- Lease expenditure will continue to trigger ICB red line metrics until expenditure is back on plan.
- Underspend on leases £0.1m offered to the ICB to support system overcommitment on leases.

Full Year Forecast Scenarios

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

Straight line forecast £5.3m deficit	Remove non-recurrent items and phasing adjustments -£1.8m	ERF Forecast +£2.1m	Improvement required to deliver plan +£4.2m	Current forecast £0.8m deficit (as per plan)
•Extrapolated from £3.1m YTD deficit	•Non recurrent items, extrapolated impact -£2.7m: •Prior year income -£1.0m •Industrial action £0.2m •Non pay mitigations -£1.9m •Phasing adjustments £0.9m •Winter expenditure -£0.5m (within plan – phasing adjustment only) •Deficit funding phasing £0.4m •Other H2 adjustments £1.0m	•Specialist Services ERF recovery plan forecast indicates an improvement on run rate of £2.1m, which includes the contribution from theatre 11. Based on this forecast, Specialist Services would underperform by £4.0m to the original plan. •Assumes payment received for Advice and Guidance. •The overall ERF underperformance to plan is £1.3m, with Specialist offset by overperformance in Surgery (assumed to continue).	•CIP improvement on run rate £0.4m (to deliver plan in full and recover YTD slippage). •Other tactical plan improvements £3.8m as outlined in the mid-year review: •Income: Additional ERF requirement •Pay: Vacancy freeze, rate standardisation •Non-pay: Discretionary spend, mitigate inflationary pressures	•As submitted to NHSE •All other pressures to be mitigated within existing plan •Assumes no further industrial action •Excludes 2024/25 pay award currently

Key assumptions to achieve plan

- ERF improvement of £2.1m for T&O between month 8 and 12, including benefit of theatre 11 opening Nov 24
- Deliver CIP plan in full through cash releasing savings
- Other plan improvements of £3.8m required as outlined in the mid-year review
- Monthly run rate improvement of £0.9m required (from £0.4m YTD actual average deficit to £0.5m surplus per month)

High level scenarios for full year forecast

Worst Case	Mid Case	Best Case
£7.1m deficit (£6.3m adverse to plan)	£2.7m deficit (£1.9m adverse to plan)	£0.8m deficit (on plan)

Risk Management and Mitigation

Revenue position

Recurrent CIP delivery: Recurrent CIP is below plan by £5.9m YTD which will impact on delivery of the Financial Sustainability Plan and timescale to return to a break-even position

ERF: The activity and income plan for 2024/25 includes an increase within the second half of the financial year, primarily within T&O. A step change in activity is required to deliver our plan.

Winter: The forecast assumes no unplanned increase in expenditure over winter, due to the Better Lives programme. (£0.5m planned in surgery)

Industrial action: The Royal College of Nursing (RCN) voted to reject the 5.5% pay award for 2024/25. Therefore, there is the risk of further industrial action which could impact the financial position if not mitigated via additional funding.

Non pay pressures: Creep in non-pay expenditure for clinical supplies and drugs, including inflationary pressures, to be managed in year.

Noviniti underwriting: £1.0m of costs have been underwritten to date, following approval at Trust Board to progress the scheme for the multi storey car park at Freckleton Street. This is a risk to the revenue position if financial close is not reached in year.

Annual leave accrual: This was released in full in 2023/24 in line with the Trust's policy. Following the annual accounts audit, a review of this has been requested for 2024/25.

Other

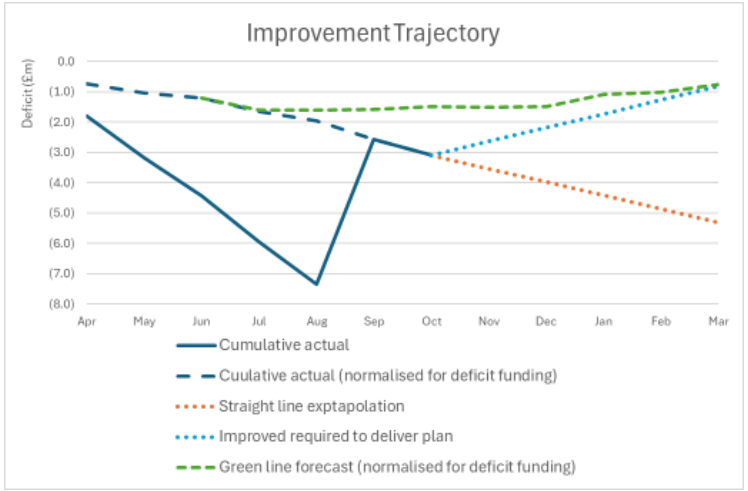
Cash: The cash position at the end of September was the lowest it has been since 2017/18. The non-recurrent deficit funding improved the cash position by £7.8m in October 2024. The revised cash forecast indicates external support would not be needed until Q1 2025/26 at the current run rate.

Capital: There remains an over-commitment at system level for both operational CDEL and lease capital. System wide mitigations are under development with Director of Finance oversight.

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.

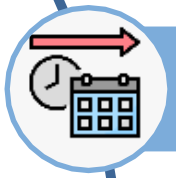
Revenue Position Risk

Based on current run rate there needs to be a **£4.5m improvement** between month 7 and month 12 to deliver the 2024/25 plan; an average of £0.9m per month.



Forward look

Following, the government announcement of the 2024/25 pay awards, the NHS Staff Council has ratified the recommendation of the NHS Pay Review Body (NHS PRB) to add an intermediate pay point in each of pay bands 8a and above; this will be processed in November salaries. The financial impact is currently being assessed across the system, but as a Trust the impact on the bottom line has been cost neutral.



NHSE have indicated that multi-year revenue and capital plans are likely to be required from the planning round for 2025/26. The national view is that 2025/26 will continue to be financially challenged. The ambition is to have a draft financial plan for the GM system by the end of November.

The introduction of the Procurement Act 2023 has been delayed to February 2025. This seeks to reform the UK's public procurement scheme post Brexit and replaces the Public Contracting Regulations 2015. The procurement team continue to work with other GM provides to prepare for the changes.

A mutually agreed resignation scheme (MARS) closes for applications at the end of November.

Theatre 11, which is the newly built additional theatre funding via the Targeted Investment Fund (TIF), is due to open at the Wrightington site in November 2024. This is planned to facilitate an additional 1,200 elective cases per annum. The work on the adjoining theatre 12 has commenced and is due to complete by the end of the financial year. Theatre 12 will facilitate the decommissioning of old theatre stock, in support of the Wrightington site strategy.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Financial plan deficit funding adjustment
Presented to:	Board of Directors
On:	4th December 2024
Item purpose:	Approval
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Heather Shelton, Deputy Director of Operational Finance
Contact details:	T: 0300 707 3736 E: heather.shelton@wwl.nhs.uk

Executive summary

It has been confirmed that the GM ICS will receive cash backed deficit funding equal to the planned 2024/25 deficit of £175m. i.e. the revised GM plan for 2024/25 is breakeven. The WWL share of the funding allocation is £13.4m for 2024/25. The deficit funding has been shared proportionately between providers with a deficit plan.

The funding has been approved non-recurrently by the Treasury and will be added to contract allocations. In line with the business rules, the deficit support funding is repayable as a deduction from allocations in future years.

The WWL plan improves from a deficit of £14.2m to £0.8m deficit (for the adjusted financial position). The revised technical plan is a £1.0m deficit. This will be reflected in the month 6 position with a YTD improvement to the plan of £6.5m, changing the YTD plan from £6.6m deficit to £0.1m deficit. The plan change reflects the additional income allocation; therefore, there is no risk to delivery.

WWL will receive the £13.4m as cash within the ICB contract income. The deficit funding delays the requirement for revenue cash support to 2025/26. The cash forecast currently indicates that this would be required in Q1 2025/26 at the current run rate.

Link to strategy and corporate objectives

There are no direct links to strategy. This links to the corporate objective to deliver our financial plan, providing value for money services.

Risks associated with this report and proposed mitigations

There are no new risks associated with the change to the financial plan as this is income backed and agreed with the ICB. Other risks associated with delivery with the financial plan in year remain unaffected.

Financial implications

This report relates to the financial plans for 2024/25 but has no direct financial implications.

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report. There was no change to the workforce plan for 2024/25 because of the plan resubmission.

Equality, diversity and inclusion implications

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

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

This paper was approved by ETM on 3rd October 2024 and the Finance and Performance Committee on 26th November 2024.

Recommendation(s)

The Board of Directors are asked to approve the adjustment to the revenue plan for 2024/25 for the £13.4m non-recurrent deficit support revenue allocation. The revised revenue plan is technical deficit of £1.0m and an adjusted financial performance (used to measure system performance) deficit of £0.8m.

1.0 Non-recurrent deficit support

In May 2024, NHSE issued updates to the financial framework for 2024/25 which included incentives and consequences associated with financial performance for all systems. Where deficit plans were agreed with systems then systems would receive non-recurrent deficit support equal to the value of the deficit plan. The receipt of the funding would enable all systems to deliver a breakeven position for the year.

The GM ICS plan resubmission on 12 June 2024 was a system deficit of £175m for 2024/25. This plan was accepted by NHSE and therefore the value of the non-recurrent deficit support is also £175m. There has been a national delay in confirmation of the funding, due in part to the election, but NHSE have now confirmed that this will be included with the month 6 ICB allocations.

In line with the business rules, the deficit support funding is repayable as a deduction from allocations in future years. This is in addition to the repayment of prior year deficits which for GM ICS includes the 2023/24 deficit of £180m.

2.0 WWL allocation and revenue plan adjustment

The deficit support funding has been allocated proportionately across GM providers with a deficit plan. As three providers have a surplus plan, the funding does not facilitate all providers reaching a break even plan.

The WWL allocation of the funding is £13.4m. The full allocation for all providers of the £175m is shown in table A below. This is shared between six providers.

Table A: Allocation of the non-recurrent deficit support funding

Provider Plans	Current Plan	Revenue & Cash	New Plan
BOLTON NHS FOUNDATION TRUST	-£10,244	£9,656	**-£588**
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	-£4,266	£4,021	**-£245**
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	£3,606	£0	**£3,606**
PENNINE CARE NHS FOUNDATION TRUST	£50	£0	**£50**
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	-£75,740	£71,391	**-£4,349**
STOCKPORT NHS FOUNDATION TRUST	-£43,779	£41,265	**-£2,514**
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	-£37,454	£35,303	**-£2,151**
THE CHRISTIE NHS FOUNDATION TRUST	£7,006	£0	**£7,006**
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	-£14,187	£13,372	**-£815**
Total	**£175,008**	**£175,008**	**£0**

The additional allocation of £13.4m for WWL will improve the revenue plan for 2024/25 from £14.2m deficit to £0.8m deficit. There is no risk associated with the improvement to the plan as it purely relates to the additional income allocation which will be included within the ICB monthly contract payments from October.

The revised plan for 2024/25 is shown in table B, with the outturn for 2023/24 and current plan for comparison.

Table B: Statement of Comprehensive Income for 2024/25

Statement of Comprehensive Income (SOCI)	2023/24 Full Year Actual £m	2024/25 Resubmitted Plan (June) £m	2024/25 Revised Plan (Oct) £m	Total movement from resubmitted plan to revised plan £m [1]
Operating income from patient care activities	494.6	493.9	508.9	15.0
Other operating income	28.5	25.9	25.6	(0.3)
Employee expenses	(372.8)	(368.5)	(369.9)	(1.4)
Operating expenses excluding employee expenses	(161.6)	(159.6)	(159.6)	
OPERATING SURPLUS / (DEFICIT)	**(11.3)**	**(8.4)**	**5.0**	**13.4**
Finance costs	(4.5)	(6.0)	(6.0)	
SURPLUS / (DEFICIT) FOR THE YEAR	**(15.8)**	**(14.4)**	**(1.0)**	**13.4**
ADJUSTED FINANCIAL PERFORMANCE SURPLUS / (DEFICIT)	**(10.4)**	**(14.2)**	**(0.8)**	**13.4**

[1] Includes the non-recurrent deficit support of £13.4m and other changes which do not impact the bottom line. NHSE allows and encourages adjustments to be made mid year where these are material and do not impact the bottom line or phasing of the plan, typically these adjustments are for pay awards.

The ICB were required to notify NHSE of the plan adjustments on behalf of all providers and these have been reflected in the month 6 provider templates for completion. Therefore, we are not required to resubmit a revised version of the financial planning template directly.

3.0 Cash implications

The non-recurrent deficit support allocation is cash backed, therefore WWL will receive an additional £13.4m cash compared to what was previously forecast. There is an expectation nationally that this allocation will significantly reduce the level of provider revenue support applications being made by providers requiring cash support from NHSE. Any providers requesting borrowing from this point can expect a greater level of scrutiny than has been the case up to now.

The phasing of the cash payments differs slightly from the plan changes, with a benefit in month 7. WWL should receive £7.8m cash in October 2024 with a further £1.0m-£1.4m for each month between November 2024 and March 2025. The full phasing is shown in table C.

Table C: Phasing of the revenue plan adjustment and cash profile

	M6 YTD	M7	M8	M9	M10	M11	M12	Total
Current plan (June submission)	(6,581)	(1,245)	(1,138)	(1,196)	(1,557)	(1,203)	(1,266)	(14,187)
Deficit funding	6,464	1,129	1,022	1,080	1,441	1,087	1,149	13,372
Revised plan (Oct)	**(117)**	**(116)**	**(116)**	**(116)**	**(116)**	**(116)**	**(117)**	**(815)**
Memo: Cash profile		7,801	1,165	992	1,353	999	1,061	13,372

The additional cash means that are not forecasting requiring cash support within the 2024/25 financial year. The revised cash forecast indicates this will be needed in Q1 2025/26 based on the current run rate. It should be noted that cash typically tends to decrease in April-May due to capital expenditure incurred in the final quarter, and therefore this presents a greater risk. The cash forecast will continue to be monitored closely as part of the cash management strategy.

4.0 Recommendation

The Board of Directors are asked to approve the adjustment to the revenue plan for 2024/25 for the £13.4m non-recurrent deficit support revenue allocation. The revised revenue plan is technical deficit of £1.0m and an adjusted financial performance (used to measure system performance) deficit of £0.8m.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Multi Storey Car Park – Full Business Case Update
Presented to:	Trust Board
On:	4th December 2024
Item purpose:	Approval
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Dan Smith, Head of Strategic Projects
Contact details:	dan.smith@wwl.nhs.uk

Executive summary

Following approval of the Full Business Case in July, further progress has been made over the last three months to fully develop the agreed transaction to build a Multi Storey Car Park (MSCP) on the existing Freckleton Street Car Park.

As part of the wider RAEI Car Parking Strategy, additional car park spaces are required to meet the current demand for patients, visitors, and staff.

Due to the constrained availability of capital, the preferred option was to pursue an off-balance sheet funding arrangement with an external partner (Noviniti) to build a multi-storey car park providing 356 patient / visitor parking spaces, 64 staff spaces and 4 resident spaces. The preferred option requires a contribution from CDEL of £450K from the 2024/25 allocation, CDEL funding will be utilised to construct the surface level carpark spaces to be used by staff and residents.

The approved business case financial model assumes that parking income will rise 5% every 5 years however RPI on the car park operator lease is compounded at 2% per annum over the 35-year term, the car park is forecasting to generate a surplus throughout the term.

This paper is intended to update the Board, following approval of the Full Business Case, on progress to date and seek approval to enter into the documentation to achieve financial close of the project

Link to strategy and corporate objectives

The MSCP project links to the RAEI car parking strategy and the wider Estates Strategy

Risks associated with this report and proposed mitigations

See Key Risks in Business case, in particular E2 and S5

Financial implications

The financial model makes a revenue surplus throughout the term of the legal agreement.

The funding model with the external partner is subject to a collar of 2% and cap of 5% for the initial 15-year term and reverts to CPI plus 1% from years 16 onwards. It is unknown how RPI is going to track, the impact RPI increasing to 3% over the term has been modelled within the business case and update paper and is included within the main body of this paper. The risk of RPI sensitivity has been reflected within the risk register.

Subject to the final funding approval, a repayment option will now be included within the funding agreement, allowing the debt to be repaid at year 20. The final terms from the funder have yet to be provided but will be reflected within the legal agreements.

Stage 1 construction costs of £142k have been paid in January 2024
Stage 2 construction costs of £489K have been paid in July 2024
Both stage 1 and 2 costs are recovered upon financial close
£450K of CDEL is required to undertake the works to the surface level parking

Legal implications

Approval to take the project through to financial close.

People implications

We recognise a high number of staff will experience temporary change during the construction phase and key updates will be provided to staff-side and through our key open communications channels e.g. All Staff Team Brief, Leaders' Forum, Executive Vlogs and the intranet.

It is important that the MSCP is positioned as one of a number of key changes and enhancements to our overall car parking masterplan to find a sustainable solution to meet the demands of car park users.

Equality, diversity and inclusion implications

None

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

Executive Team Meeting, F&P Committee

Recommendation(s)

Trust Board is asked to:

1. Note the progress made to date on negotiating the revenue impact, such that the proposal now makes a financial contribution across all years.
2. Progress to Financial Close subject to completion of Stage 2 Legals

Report

1. Context

Additional car park spaces are required as part of the wider RAEI Car Parking Strategy to meet the current demand for patients, visitors and staff and to re-provide car parking lost when additional bed capacity was created during COVID. As a consequence, the essential changes that took place at RAEI in response to the Covid pandemic (the Community Assessment Unit and Bryn Ward), the site has seen a significant reduction in parking capacity, both in standard parking and in disabled bays. Following approval of the Full Business Case in July, further progress has been made over the last three months to take the project towards financial close and allow the construction of the Multi Storey Car Park (MSCP) on the existing Freckleton Street Car Park.

Due to the constrained availability of capital, the preferred option is to pursue an off-balance sheet funding arrangement with an external partner (Noviniti) to build a multi-storey car park providing 356 patient / visitor parking spaces, 64 staff spaces and 4 resident spaces. The preferred option requires a contribution from CDEL of £450K from the 2024/25 allocation, CDEL funding will be utilised to construct the staff and residents surface level carpark spaces.

Table 1 – additional capacity created through the car parking strategy.

Staff Car Parking	Exisiting	Proposed	Net Change		Date of change
RAEI B & C	165	205	40	Planning Application to build 40 new spaces by end March 2025	31/03/2025
RAEI Christopher Home 'A'	0	20	20	Remodeling of existing car park to create 20 short stay staff spaces	31/12/2025
RAEI Miscellaneous	162	162	0	No change	
Freckleton Street	112	64	-48	Reprovision of 64 staff spaces on surface level car park	30/09/2025
Water Street	200	300	100	100 additional spaces off site serviced by shuttle services	31/03/2024
Mesnes Terrace	321	321	0	No change	
SUB TOTAL	**960**	**1072**	**112**	**Net Increase**	

Patient and Visitor Car Parking	Exisiting	Proposed	Net Change		Date of change
RAEI Christopher Home 'A'	69	40	-29	Remodeling of existing car park to create 40 Blue Badge Patient and Visitor Spaces	31/12/2025
Freckleton Street	113	356	243	New MSCP spaces for Patients and Visitors	30/09/2025
SUB TOTAL	**182**	**396**	**214**	**Net Increase**	

The development of the MSCP at Freckleton Street will be a dedicated facility to support visitors and public car parking. This proposal is in line with the Trust's car parking strategy and will ensure that the public and visitors attending the hospital will have good and safe access to park near to the hospital facilities. At this time, visitors attending site regularly cannot gain access to parking and on routinely, patients are late or miss clinic appointments as a direct result of the lack of parking on-site.

The benefits considered of the preferred option include:

- Enhanced facilities for Patients, Visitors and Staff;
- A full turnkey, off-balance sheet solution;
- Self-financing;
- Park Mark Plus accredited Multi Storey Car Park;
- Reduced complaints from patients, visitors and staff relating to car parking availability;
- Potential reduced DNAs for clinical appointments at RAEI due to difficulties with patients trying to park;
- Potential increased efficiency of theatre and day-case units by eliminated car parking delays for patients, visitors, and staff.

A VFM assessment has not been undertaken as the project is off-balance sheet and the funding is from an external source, other than utilising the Trust CDEL of £450K,. However, rigorous analysis of the project costs and value for money has been undertaken as part of external audit discussions Areas of overcharging have been challenged, as this ultimately impacts the starting rental from the car park operator. Work is on-going as areas of value-engineering are pursued.

A sensitivity analysis has been undertaken to assess the impact of RPI should the rate of inflation track above 2%.

2. Approved Option

The full business case detailed 3 options with the preferred solution being to develop with an external partner a MSCP at Freckleton Street for patient and visitor use and to create using Trust CDEL a surface level car park for the use of staff.

Part of the Freckleton Street land will be leased to the external partner for a term of circa 35 years (from practical completion), who would appoint a 3rd party car park operator (CPO) to manage the multi-storey car park for an initial 15 years from practical completion.

The external partner will construct the MSCP and the surface level car park providing circa 356 patient and visitor spaces. The surface level car park will provide 64 staff spaces, plus a further 4 resident spaces. It is estimated the build project will take approximately 11 months from financial close.

The preferred option generates a revenue surplus during the 35-year term assuming the interest remains at 2% compounded over the term. The financial model assumes a daily income of £9.48 per day (excluding VAT) based on each space being utilised 3.25 times per day with an average ticket price of £3.50 including VAT. Based on the current revenue generated from Freckleton Street Car Park and patient numbers we believe this revenue to be achievable.

Since the submission of the full business case, additional work has been undertaken with the capital team and Noviniti to review the project costs. The full business case assumed construction costs, including the cost of the surface level parking of £12.26m, the revised expected costs is anticipated to be approximately £11.3m.

The tender for the CPO was issued by Noviniti with two operators submitting a bid, unfortunately both were outside of the financial model envelope. As such a clarification was issued to all bidders

requesting the impact of an award of an ANPR solution over the remaining WWL carparks. Of the original two operators who submitted a bid, Group Nexus advised of a discount of £80K p.a the other bidders costs increased. Group Nexus has been confirmed as the preferred CPO bidder.

The impact of the reduced construction costs and CPO tender is reflected below within the financial tables. Table 4 sets out the **final** financial position. Over the life of the project a total of £10.048m surplus is generated, with a contribution in every year. The rental charge to Noviniti is £585k per annum, the CPO management fee is £275k (offset by £80k contribution from the full ANPR), and WWL operating costs are assumed to be £40k. The main movements from the original business case is a reduction in the rental through negotiation on the construction costs and fees, but an increase in the CPO costs.

Table 2 – Full business case financial modelling for preferred option - 2% RPI

PWF - 356 Multi-storey with 64 SL staff spaces	Year 1	Year 2	Year 3	Year 4	Year 5	Year 10	Year 15	Year 20	Year 30	Year 35	Yr 1-35 (Total)
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	1,252	1,252	1,252	1,252	1,314	1,379	1,447	1,518	1,672	1,754	51,379
CPO debt (2% compounded)	-611	-623	-636	-648	-661	-730	-806	-890	-1,085	-1,198	-30,547
CPO Management fee	-145	-145	-148	-151	-154	-170	-188	-207	-252	-279	-7,110
WWL op costs (inc rates)	-115	-115	-115	-115	-115	-115	-115	-115	-115	-115	-4,025
Surplus / deficit	381	368	353	337	384	364	338	306	219	163	9,697

Table 3 – Full business case financial modelling adjusted for updated CPO rental and management fee - 2% RPI

PWF - 356 Multi-storey with 64 SL staff spaces	Year 1	Year 2	Year 3	Year 4	Year 5	Year 10	Year 15	Year 20	Year 30	Year 35	Yr 1-35 (Total)
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	1,252	1,252	1,252	1,252	1,314	1,379	1,447	1,518	1,672	1,754	51,379
CPO debt (2% compounded)	-585	-597	-609	-621	-633	-699	-772	-852	-1,039	-1,147	-29,247
CPO Management fee	-275	-275	-281	-286	-292	-322	-356	-434	-479	-529	-13,484
WWL op costs (exc rates)	-40	-40	-40	-40	-40	-40	-40	-40	-40	-40	-1,400
Surplus / deficit	352	340	323	305	349	318	279	192	114	39	7,248

Table 4 – Full business case financial modelling adjusted for updated CPO rental and management fee, with the impact of ANPR on the wider sites - 2% RPI

PWF - 356 Multi-storey with 64 SL staff spaces	Year 1	Year 2	Year 3	Year 4	Year 5	Year 10	Year 15	Year 20	Year 30	Year 35	Yr 1-35 (Total)
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	1,252	1,252	1,252	1,252	1,314	1,379	1,447	1,518	1,672	1,754	51,379
CPO debt (2% compounded)	-585	-597	-609	-621	-633	-699	-772	-852	-1,039	-1,147	-29,247
CPO Management fee	-275	-275	-281	-286	-292	-322	-356	-434	-479	-529	-13,484
ANPR rental	80	80	80	80	80	80	80	80	80	80	2,800
WWL op costs (exc rates)	-40	-40	-40	-40	-40	-40	-40	-40	-40	-40	-1,400
Surplus / deficit	432	420	403	385	429	398	359	272	194	119	10,048

Sensitivity Analysis – Impact of variation in RPI

The funding model with the external partner is subject to a collar of 2% and cap of 5% for the first 15 years and reverts to CPI plus 1% from years 16 onwards. It is unknown how RPI is going to track, the impact RPI increasing to 3% over the term has been modelled through sensitivity analysis.

The tables below reflect the impact of a 3% RPI on CPO debt. Based upon the updated business case model, reflecting an RPI of 3% a deficit from year 24 is forecast. The risk of RPI sensitivity has been reflected in the risk register; to mitigate this risk a funding break option has been requested from year 20 onwards, the final details of which are yet to be confirmed, although confirmation from the external funder that this will be offered has been agreed.

Table 5 – Full business case financial modelling adjusted for updated CPO rental and management fee, with the impact of ANPR on the wider sites - 2% RPI

PWF - 356 Multi-storey with 64 SL staff spaces	Year 1	Year 2	Year 3	Year 4	Year 5	Year 10	Year 15	Year 20	Year 30	Year 35	Yr 1-35 (Total)
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	1,252	1,252	1,252	1,252	1,314	1,379	1,447	1,518	1,672	1,754	51,379
CPO debt (3% compounded)	-585	-603	-621	-639	-658	-763	-885	-1,026	-1,379	-1,598	-35,370
CPO Management fee	-275	-275	-281	-286	-292	-322	-356	-434	-479	-529	-13,484
ANPR rental	80	80	80	80	80	80	80	80	80	80	2,800
WWL op costs (exc rates)	-40	-40	-40	-40	-40	-40	-40	-40	-40	-40	-1,400
Surplus / deficit	432	414	391	366	404	333	246	99	-146	-332	3,924

3. Risk Register

A workshop was held with key staff from across the Trust to systematically identify, appraise, and mitigate risks relating to the project as well as non-project risks. Below is a summary of the risks with a gross score >12. There are two risks for which a material risk remains after mitigation.

The first is the CPI/RPI impact, there is further mitigation which could be applied to this risk by shortening the term. This would reduce the early years bottom line benefit but mitigates the list in the outer years.

The second is the risk of policy change in the NHS relating to changes in the capital regime. WWL have briefed the ICB and will make representation to the National team if required. This is not the first of this type of scheme in NHS England.

Table 6 – Project risks

Ref	Type	Description	Owner	Gross risk score	Mitigating actions	Net risk score
P16	Finance	There is no / insufficient availability of CDEL in 24/25 for the surface car park.	WWL Finance	12	If there is a lack of CDEL to undertake the surface level car park, then the spaces will need to be converted to patient parking and funded via the external partner.	8
P4	Intelligence	The procurement process risks not falling outside of public procurement legislation if not followed in full.	Finance	12	The Trust will issue a VEAT notice. A legal opinion will also be obtained to ensure the procurement process cannot be challenged. The external partner 2-stage structure ensures compliance with a land transaction and therefore falls out of public procurement legislation. This process will be followed in full. Counsel's opinion will be obtained at the end of each stage as well as the publication of a VEAT Notice. At financial close a Contract Award Notice can be issued by the Trust. The VEAT notice for stage 1 was not challenged	4
P6	Finance	The risk of non-compliance with IFRS16 accounting standards.	External Partner	12	There has been ongoing work with KPMG as our External Auditors. WWL has also engaged with Link Asset who are a specialised advisory firm to support the compliance arrangements to ensure the lease structure is accounted for as off-balance sheet.	4
P19	Finance	Income modelling transpires to be inaccurate, resulting in a net financial shortfall.	WWL Finance	12	If the income modelling is inaccurate and there is a shortfall of income resulting in the CPO fees not being met a review of other patient parking can be undertaken to ensure Freckleton Street MSCP is fully utilised i.e. Water Street.	8

The previous risk regarding planning permission has been removed as this has now been awarded.

Table 7 – Non-project Risks

Ref	Type	Description	Owner	Gross risk score	Mitigating actions	Net risk score
E2	External	CPI rises faster than expected car park income, negatively impacting the financial model.	Finance	16	If car park income does not track the rise in CPI / RPI then the CPO fees might not be met resulting in a shortfall in funding which would need to be met by the Trust. To reduce this car park fees would need to be increased.	12
S5	Strategic	Changes in the NHS capital regime may adversely the financial basis of the scheme.	Finance	12	If NHSE capital becomes available and the MSCP could have been funded on balance sheet, then the surplus generated from patient parking would be adverse to the Trust.	12

4. Legal Documents and Support

WWL have commissioned Bevan Britten to support the legal transactions of the project. The proposal is for two stages of support. The first stage supports WWL on the due diligence associated with land transaction, VEAT notice and under write. The second stages supports the agreement of the lease(s), the construction (and warranties) and covenant. Stage 1 legal costs are £22k, and have been previously approved, stage 2 costs are estimated to be £40.7k.

5. External Visuals of Multi Storey Car Park

6. Progress to date

CPO Tender

A competitive tender process was undertaken by Noviniti to appoint the carpark operator for an initial term of 15 years, with bids received from Group nexus and Maple Parking. Three other car park operators elected not to bid.

The bids from both Group Nexus and Maple Parking were outside the original financial model, and whilst not significant in year one would lead to a financial pressure in the later years. Group Nexus provided the most favourable bid and were the preferred supplier by Noviniti

Due to the increased car park operator costs, a clarification was issued to all bidders, even those that did not initially submit. The clarification requested confirmation of a discount to the operating costs for Freckleton Street should they be awarded a contract to provide ANPR on the wider WWL site. Maple Parking bid increased as part of this clarification however Group Nexus suggested a discount of £80 - £100K p.a. The impact of the CPO tender has been included within the financial model as noted within Table 3 and 4 above

ANPR

Neighbouring Trusts within GM operate ANPR solutions on both Patient and Visitor carparks and staff carparks. Both qualitive and financial benefits are achieved following the implementation and ANPR; and as can be demonstrated from the discount proposed from Group Nexus a significant reduction in operating costs can be achieved.

- **Planning –** Wigan council planning department confirmed planning approval on 4th October 2024
- **Design and Construction Costs –** Noviniti are working to finalise designs to RIBA stage 4 and working with the proposed contractor, Goldbeck. Goldbeck have proposed a number of value-engineering options, the removal of the PV Solar Panels is currently under review. A review of the preliminaries is also being undertaken.
- **Timeline –** Stage 2 legals have now commenced with completion early to mid-January 2025. This is subject to the second VEAT notice being issued at the beginning of December. Construction of the carpark is forecast to commence end of January with completion December 2025
- **Stage 1 legals are now complete with the following documents executed**
    - Option agreement
    - Ground lease
    - Leaseback

  In addition to the documents above, insurance policies for rights of light and party wall agreements have been secured due to the constraints of the site and the adjacent residential properties.

- **Temporary Carparking Arrangements**

Water Street Car Parking Spaces

To manage the loss of 225 car parking spaces at the current Freckleton site during the multi storey car park construction phase, it will be necessary to provide these spaces elsewhere.

The Estates & Facilities department have been in negotiations with Wigan Council to provide these spaces at Water Street multi storey car park in Wigan. Wigan council have agreed to provide up to 225 additional spaces at Water Street while construction is taking place of the new MSCP. The construction period is approximately a 10 to 12 months construction programme. New opening hours for both Water Street and Mesnes Terrace car parks will be amended to reflect additional usage.

A communication will be made in November 2024 to all staff and specifically to permit holders of Freckleton Street car park notifying them of the closure of the car park and the alternative arrangements.

THQ Car Park B Additional Car Parking Spaces

A planning application has been submitted to provide an additional 46 car parking spaces to car park B at RAEI, and a determination is expected in November 2024, with work to commence immediately

7. Next steps

Subject to Board approval the next steps of the project are as follows

- Execution of Stage 2 documentation (subject to VEAT 2 notice Expiry) – January 2025
- Financial Close – February 2025
- Commence construction – January 2025 (once all necessary consents and legal documentation has been executed.

8. Recommendation(s)

Trust Board is asked to:

- Note the progress made to date on negotiating the financial terms of the project and the financial commitment
- Agree progress to Financial Close subject to completion of Stage 2 Legals

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Perinatal Quality Surveillance Full Report (Q2 2024-2025, Jul-Sep 24)
Presented to:	Trust Board
On:	December 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. It is a CNST requirement.

Incidents

In Q2 there were 0 moderate or above harm incidents.

In Q2 1 incident (from Q1) was reported to StEIS under PSIRF category sub-optimal care of the deteriorating patient. Immediate learning is detailed in the report.

The highest reported maternity incident sub-categories continue to be term admissions to NNU, undiagnosed small for gestational age (SGA), and post-partum haemorrhage (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 fundal height measurement and plotting, grow 2.0 digital plotting is mandatory.

The new MDT PPH review group hosted it's first MDT review meeting in Q2. 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 continues to be the main reporting category in neonatal services with 1/3 of incidents reported relating to staffing deficits.

All incidents reported in Q2 were no/low harm.

Exceptions -.141 incidents are under investigation in obstetrics/maternity.
6 incidents are under investigation in neonatology.
All incidents are triaged in Division daily.
Ongoing support given 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.

Screening Incidents Assessment forms (SIAFs) will now be reported via the PQSR report (PSIRF national priority). 0 SIAFs were required in Q2.

Exceptions – 1 case awaiting cause of death before completion of PMRT.
1 case on hold due to police investigation. Independent investigation commissioned.
1 case overdue due to investigator capacity– governance team to source new investigator.

Feedback and complaints

In Q2 24/25, 3 complaints have been received for maternity services, which is a decrease from Q1 24/25.

1 of these complaints was resolved as a concern due to the timely intervention of our staff.

0 complaints were received for neonatal services.

There is a downward trend in the number of formal complaints received over the rolling 12-month period in maternity services, with neonatal service complaints remaining very low.

A wealth of positive feedback has been collated from service users via the MNVP and the PPE midwife and has been fed back to staff.

FFT response rates improved in Q2 with a 96.6% positive response rate.

The preliminary results from the 2024 Picker Patient Survey are incredibly positive and the final report will be released in December 2024.

Themes from feedback in Q2 are clinical treatment, communication, values and behaviours and discharge.

No Exceptions.

SCORE survey

WWL Maternity and Neonatal services participated the SCORE staff survey to get a better understanding of team culture and engagement. 169 members of staff responded to the survey, giving a response rate of 54%. Analysis of the SCORE survey was undertaken in Q2.
An action plan is underway with support from external colleagues. Analysis to be shared in next report.

Risks

The Risk Register has been included for maternity and neonatal services. At the end of Q2 24/25,

0 risks under review.

0 risks awaiting approval

1 risk approved
MAT 4003 Inability to provide ultrasound scanning within 24 hours (SBL 3)

3 risks closed
MAT 3604 Obstetrics and Gynaecology On-Call Availability Risk
BOTH 3725 Junior Doctors Strike
MAT 1758 Supernumerary Delivery Suite Co-ordinator

Exceptions - There are 6 risks scoring 6 or less which are under review to establish if can be tolerated or require further action.

Ockenden 2

Q2 has seen some progress against the Ockenden actions and 3 outstanding actions remain.

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

Exceptions - 3 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 barriers to completion identified.

No exceptions

ATAIN

In Q1 24/25, the ATAIN MDT audit has shown the total number of term admissions to the NNU was 4.86% of total term live births. This is a decrease from Q4 23/24. Unexpected term admissions to the NNU accounted for 4.69% of total term live births. This again is a decrease from Q4 23/24.

There is still work to be done with 4 (14.8%) 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.

More recent SPC data shows a rise in admissions in Q2. Preliminary areas of focus are 'cautious admissions' and need for robust processes to support junior staff with decision making to ensure appropriate transfer to the NNU, and the 'elective LSCS pathway' to avoid hurried admissions to either the NNU or the postnatal ward.

No exceptions

Mortality and PMRT

There were 4 stillbirths in Q2 24/25. 3 of the stillbirths were following MTOP for fetal anomaly. There were no immediate care or service delivery issues identified which likely affected the outcome of the 1 antenatal stillbirth. Emerging themes from 72 hr review are staff are listening to and advocating for patient choice.

1 case will be eligible for PMRT review.

There were no neonatal deaths in Q2 24/25.

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.

Raised BMI and maternal age ≥30 years continues as a theme in Q2.
All the women experiencing a stillbirth in Q2 were White British.

2 cases were finalised at PMRT in Q2.
PMRT 100% compliant against MIS 6 Safety Action 1 to date.

No exceptions

Saving Babies Lives 3

The report provides a full gap analysis of our progress against SBL 3 targets. The LMNS has reported significant assurance with 87% compliance (target 70%). Work continues.

No exceptions

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 measures its progress against the GMEC LMNS ambition. Over this rolling 12 period, stillbirth data has continued a steady decline. Data for the rate of HIE is positive and it is vital that we continue to monitor, learn and improve to sustain this figure. One case of suspected HIE was referred to MNSI in Q2 but was rejected as the baby had an underlying anomaly.

The LMNS Mortality and HIE template will be utilised to review all cases from January to September 2024 in Q3 and findings will be fed back 'Floor to Board'.

Mandatory training

Maternity mandatory training is compliant >90% in all staff groups.

No exceptions

Workforce/ Safe staffing

Q2 has seen significant improvement in staffing following the successful recruitment of new midwifery staff. 2.64 WTE externally funded Band 6 immunisation posts & 0.8 WTE Band 6 Infant Feeing posts also went out to advert. At the end of Q2, there are 2.56 WTE Band 6 midwifery vacancies.

At the end of Q2 there are 2.56 WTE neonatal nursing vacancies and 0.81 Band 3 HCA vacancies. Interview for child health matron post pending early Q3.

Staffing Red Flags

There were 8 validated Staffing Red Flags events in Q2. 5 related to delays in commencing the induction of labour process, 1 related in a delay providing an epidural, 2 related to the shift co-ordinator not being able to remain supernumerary. Appropriate escalation took place. All no/low harm incidents.

Maternity Unit Diverts

In Q2 24/25 there was 1 maternity unit divert due to inability to safely staff the unit (temporary junior doctor sickness). 7 women were diverted to local units. 3 women were diverted to Bolton, 2 women to Oldham and 1 woman was diverted to Warrington. A letter of apology was sent to all 7 women. Low/minor harm due to inconvenience caused.

GMEC benchmarking (latest available data on Tableau)

In Q1 24/25, WWL has performed better than the GMEC average in all but 1 metric Apgars <7 at 5 minutes.

*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 celebrate our own success 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% and QI work in all areas continues.

SPC charts (until end 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 the GMEC mean 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.

No exceptions

LMNS Outlier Assurance

No requests from the LMNS for data assurance were made in Q2.

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.

Contents

Maternity Perinatal Quality Surveillance Full Report

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

1. Obstetrics/Maternity Incidents in Q2 – Severity (data pull 19/10//2024 - DATIX)

	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
No Harm	66	80	40	62	67	48	64	71	45	57	67	48
Low	7	5	4	0	6	2	10	7	15	14	5	18
Moderate	0	1	0	0	0	0	0	1	0	0	0	0
Severe	1	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	**74**	**86**	**44**	**62**	**73**	**50**	**74**	**79**	**60**	**71**	**72**	**66**

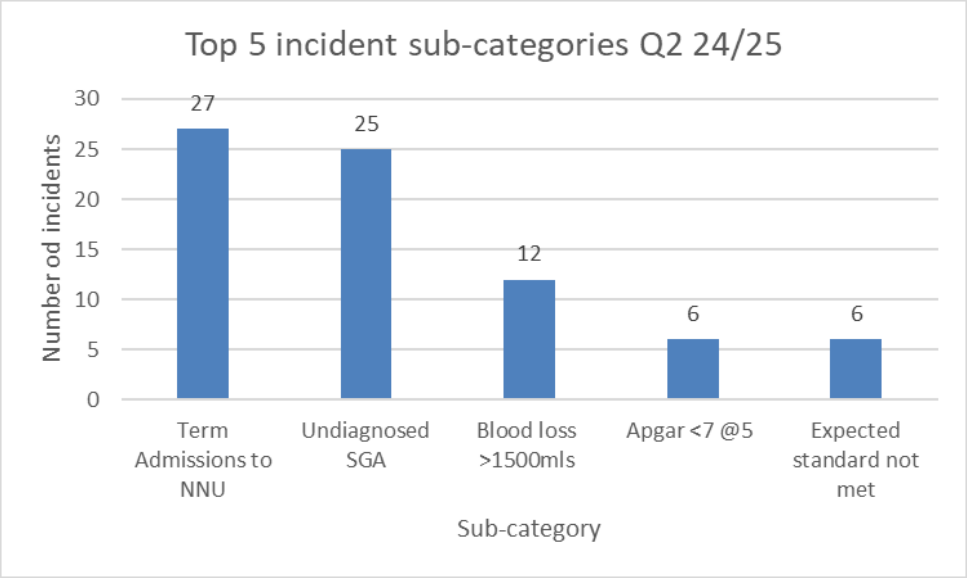
1.1 Neonatal Incidents in Q2 – Severity (data pull 19/10/2024 – DATIX)

	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
No Harm	3	10	9	3	18	21	42	26	8	3	4	12
Low	1	0	2	0	2	1	1	3	1	0	0	2
Moderate	0	0	0	0	1	1	0	0	0	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	**4**	**10**	**11**	**3**	**21**	**23**	**43**	**29**	**9**	**3**	**4**	**14**

There were 0 moderate or above incidents in Q2.

Exceptions
141 incidents are under investigation in obstetrics/maternity.
6 incidents are under investigation in neonatology.
All incidents are triaged in Division daily.
Ongoing support given to staff to complete within 10 days of incident.

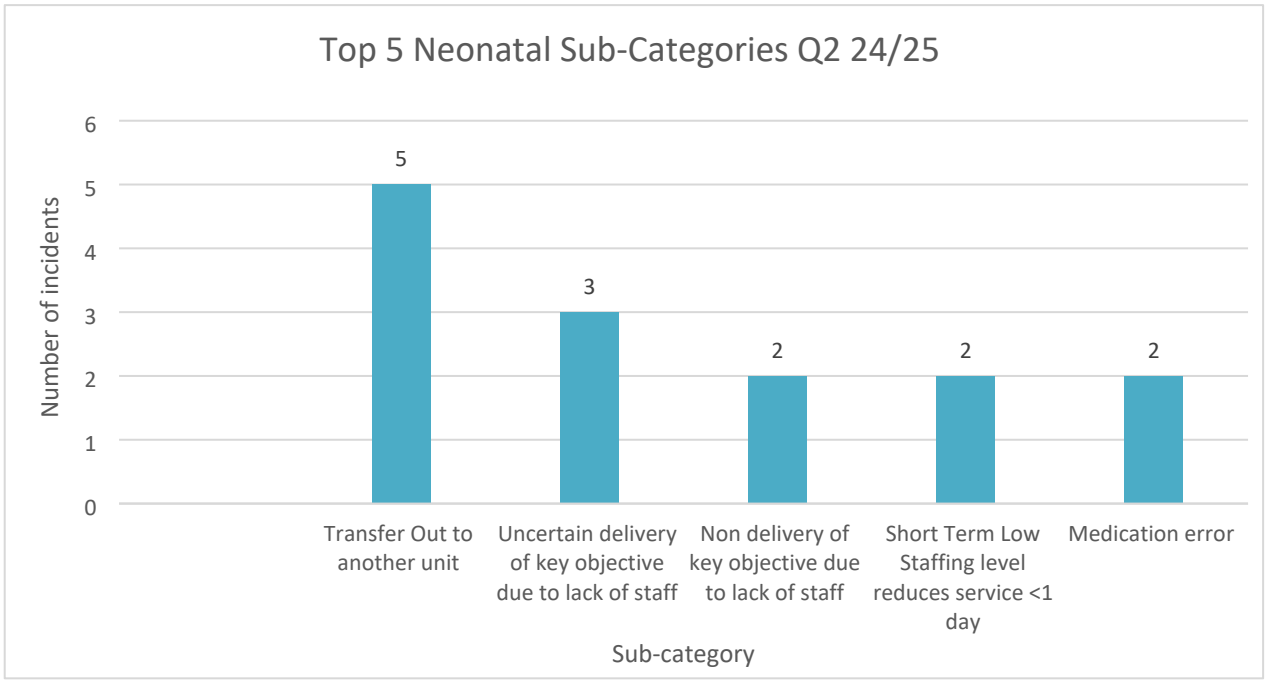
1.2 Top 5 Reported Incident Sub-Categories Maternity– Q2 24/25 (data pull 20/10/2024 - DATIX)



The ATAIN workstream continues to review all term admissions to the NNU and despite a rise in admissions in Q2 there has been an overall downward trend in admissions with ongoing QI work. The GMEC LMNS ATAIN group report a similar increase in admissions in other units in GM in the same time frame and have highlighted 2 key areas which have been raised across the network for consideration. 'Cautious admissions' with a view to supporting junior neonatal staff with decision making, and 'pressured elective caesarean section lists' where transfers to either the postnatal ward or the neonatal unit may be hurried due to pressure to keep to time. These points of consideration are relevant to WWL and there is ongoing QI work exploring both. The elective section pathway is under review supported by the new matron for the maternity ward, and the neonatal team are reviewing ways to better support appropriate admissions to the NNU.

In Q2 the new MDT PPH review group held the first MDT review meeting. Learning/themes will be collated with an overarching action plan.

1.3 Top 5 Reported Incident sub-categories Neonatology – Q2 24/25 (data pull 20/10/2024 DATIX)



Staffing continues to be the main reporting category with 1/3 of incidents reported relating to staffing deficits. All incidents reported were no/low harm.

1.4 Incidents reported to 'StEIS' and external agencies Q2 24/25

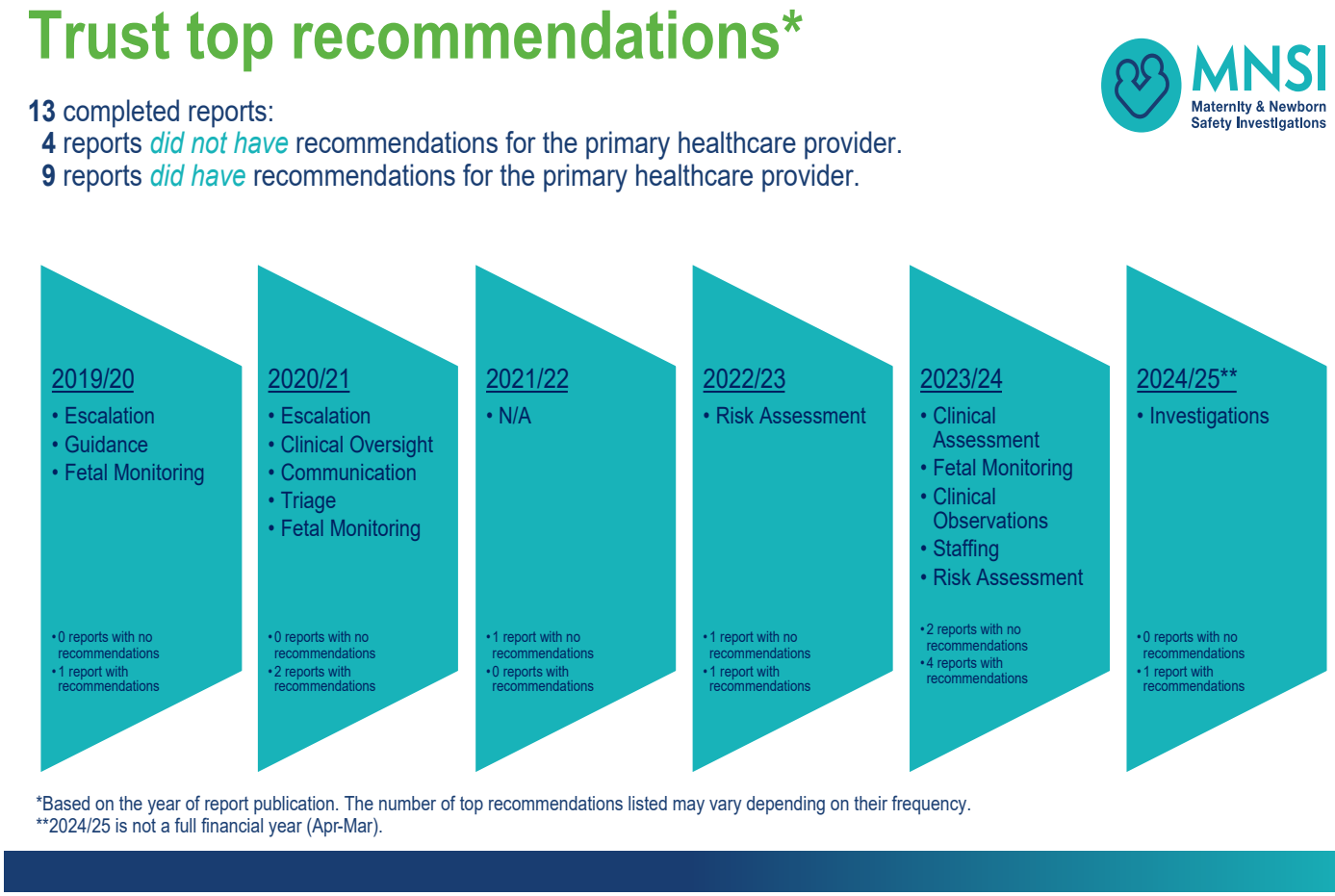
	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
Incidents reported to 'StEIS'	1	3	0	0	0	1	2	0	1	1	0	0
HSIB referrals	1	1	0	0	0	0	0	0	0	1	0	0
Accepted HSIB referrals	0	0	0	0	0	0	0	0	0	0	0	0
Cases referred to NHS R	0	0	0	0	0	0	0	0	0	0	0	0
SIAFs (Antenatal and newborn screening)										0	0	0

WEB/StEIS	Date	Incident	Date StEIS	Immediate Learning	PSIRF tool
WEB161467 StEIS 2027/61467	20/5/2024	Cooled baby – 35 weeks Suboptimal care of deteriorating patient	09/7/2024	Derby Hospital to strengthen communication when high risk patients transfer care. Inadequate monitoring (via either doppler scan or CTG) of baby in the antenatal period when care taken over by WWL. 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.	RR PSII

1.5 MNSI overview

Cases to date	
Total referrals	25
Referrals / cases rejected	12
Total investigations to date	13
Total investigations completed	13
Current active cases	0
Exception reporting	0

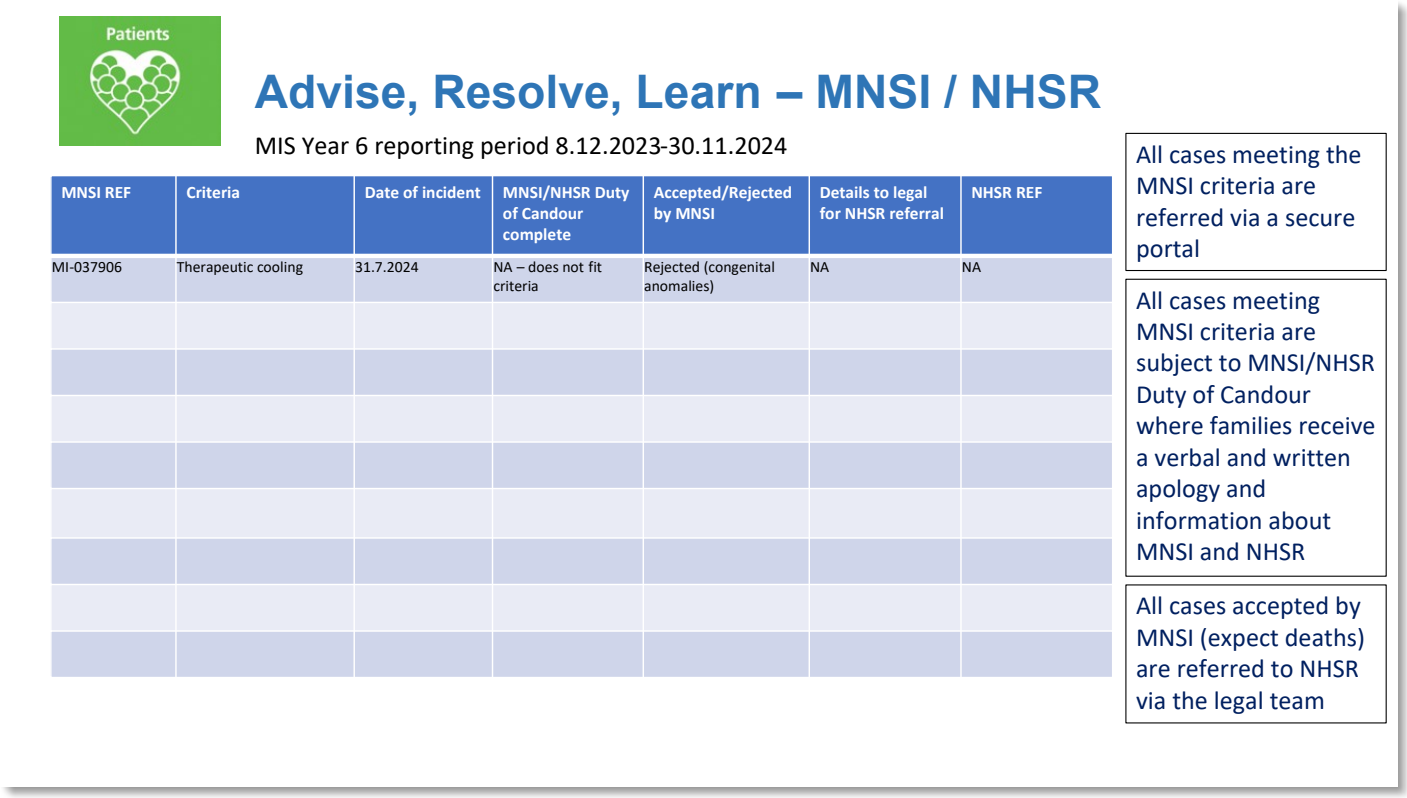
1 case was referred to MNSI in Q2 24/25 but was rejected as the baby was found to have an underlying anomaly.
There are no open MNSI cases at the end of Q2 24/25.



The face-to-face MNSI QRM was held in Q2. Achievements against SBL 3 were showcased and assurance regarding processes for ensuring all potential MNSI cases are captured was given. The meeting was well-attended and positive feedback was given from MNSI.

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 of April 2024 and assurance data will continue to be provided as cases occur.



No Exceptions

1.7 Learning from completed investigations

In Q2 24/25, 2 completed investigations were approved at LfPSE. Action plans will be monitored via LfEG.

WEB number	Date	Incident	Investigation tool/s	Learning

WEB145195 StEIS 2023/16382	29/6/2023	Neonatal death (22+6) (Joint PMRT)	Rapid Review (RR) PMRT	Delivered in WWL with Tier 2 neonatal unit – only specialised in caring for babies >27 weeks gestation. Fetal fibronectin (now Actim Partus) should be offered to women presenting with signs of pre-term labour to support care planning and birth in suitable unit. Difficult intubation due to extreme prematurity. Video laryngoscope should be utilised after 2 or 3 attempts. Training/exposure/equipment deficits identified. Baby was transferred to Royal Bolton hospital who then were necessitated to transfer again to surgical unit. Very traumatic for this gestation. Graded C – care or service issues which may have affected the outcome.
WEB161666 StEIS 2024/5484	24/5/2024	Never Event – Retained Swab	Rapid Review (RR) PSII	LocSSIP process and practice require review to ensure follows WHO principles. Swab trays may support accurate separation of swabs and pads. Dressing pads used as anal pads need changing –very similar to gauze swabs Human factors - Potential for increased human error during the night. High level of noise in the birth room.

1.8 Investigation progress – overview of open investigations

At the end of Q2, 3 serious incident investigations are open.

WEB number	Date	Incident	Progress	Stage	Plan
PSIRF					

WEB156568 StEIS 2024/3444	Feb 24	Suspected co-sleeping death at home	RR presented at LfPSE	Police investigation completed.	Awaiting cause of death. For joint PMRT with Bolton.
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.	Independent investigation commissioned.
WEB161467 StEIS 2027/61467	May 24	Cooled baby – 35 weeks Suboptimal care of deteriorating patient	RR presented at LfPSE	PSII not completed. Investigation handed back to Gov team.	Source new investigator. Update Patient Safety Team.

Exceptions

1 case awaiting cause of death before completion of PMRT.
1 case on hold due to police investigation. Independent investigation commissioned.
1 case overdue due to investigator capacity– governance team to source new investigator.

1.9 Triangulating data slide – Claims, Incidents, Complaints

The latest NHS R score card was received in Division in Q2.
The claims data is from claims received between 01/04/2014 and 31/03/2024.
On a quarterly basis, the Trust's Scorecard is reviewed alongside incident and complaint data and themes triangulated. In Q2 the themes identified were Fail/delay treatment and Psychiatric/Psychological. Actions are instigated based on the findings. NHS R will attend Safety Champions meeting in Q3 to discuss the Scorecard in detail.

Claims scorecard 01/04/2014 - 31/03/2024

Top injuries by volume	Volume	Top injuries by value	Volume
Psychiatric/Psychological Dmge.	7	Brain Damage	2
Adtnl/unnecessary Operation(s)	6	Cerebral Palsy	1
Unnecessary Pain	3		
Loss Of Baby	4	Thrombosis/embolism	2
Fatality	3	Loss of baby	3
Top causes by volume.	**Volume**	**Top causes by value**	**Volume**
Fail / Delay Treatment	12	Fail To Make Resp To Abnrm FHR	1
Failure to perform tests	3	Fail To Act On Abnorm Test Res	2
Inappropriate treatment	3	Fail To Monitor 2nd Stg Labour	2
Fail/delay admitting to hosp.	2	Fail / Delay Treatment	12
Fail to act on abnorm test res	2	Failure To Supervise	1

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Advise, Resolve, Learn

Triangulation Q2 2024-25

Fail/delay treatment - Discharge from community with no follow up or treatment instigated for cellulitis around wound. Screening blood results left in fridge – NIPT offered.
Psychiatric/Psychological – Lack of compassion when delivering positive screening test result over telephone. Lack of compassion in postnatal period when requiring support. Felt not listened to when requested Caesarean.

Complaints Q2 2024-25 (3 formal complaints in Q2 – main themes)

Clinical treatment – Wound management. Screening test left in fridge. Perceived sub - optimal labour and p/n care. Perceived request for Caesarean ignored.
Communication - Conflicting info on receipt of different NIPT results & concerns with how bad news was shared. Conflicting info re possible wound infection. No communication on discharge to GP
Values and behaviours – Lack of compassion in p/n period when req. support
Discharge. – Concerns re discharged too soon by comm. staff.

Incidents Q2 2024-2025 (0 moderate or above harm incidents)

1 antenatal stillbirth – good care

Learning Q2 2024-25

Community staff need support to recognise signs of cellulitis/collection around Caesarean wound.
Discharge summaries to GP must contain all pertinent information
Robust processes req. re screening bloods being transported to lab.
Women's choice is paramount, and they must feel involved in decision making

Actions Q2 2024-5

Training for community staff re abnormal wound	By 31/12/2024 KO	
Learning brief re case involving discharge info	By 31/12/2024 RR	
Screening process review	By 31/12/2024 KC	

2. Patient and staff experience.

2.1 Patient and Public Engagement

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

The PPE midwife has visited 49 women in Q2 on the Maternity Ward who have had emergency procedures during their birth and a further 10 women whilst completing the WWL in-patient survey.
In Q2 24/25 there has been 100% positive feedback given about the care that had been received.
Themes of positive feedback were values and behaviour, clinical treatment and good communication.

24% identified areas for improvement for the Maternity service, themes were communication, staff attitude, clinical care and parking.

The PPE midwife manages an overarching action plan based on service improvement feedback.

2.2 MNVP engagement

Q2 Feedback from MNVP Walk the Patch (Maternity Ward and Neonatal Unit)
I felt very supported. Everyone I came across was reassuring. I was talked through everything and told in advance what would happen. Everything felt very thorough
People go out of their way to look after you. All staff have been lovely – it's been an amazing experience
It felt like staff treated our babies as if they were their own
Neonatal team have been unbelievable – anything we needed, we got.
The midwifery team are amazingly personable
Staff go out of their way to look after you – even when asking for directions to the unit. Everything has been straight forward, and timings have been accurate – when you are told something will happen at a

certain time it does. Had previous births in a different hospital and I thought that they were good, but this has been better.

2.3 Friends and Family Test source Envoy 21.10.2024

	Responses	Positive
Antenatal	5	5
Birth	65	63
Postnatal Community	9	8
Postnatal Ward	97	94
Total	**176**	**170**

According to the Envoy system there has been a significant increase in responses in Q2 as compared to Q1.

170 out of 176 comments were positive, giving an overall positive response rate of 96.6% which again is higher than Q1. The remaining comments were mixed or negative feedback.

2.4 National Picker Maternity Survey (Patient Survey)

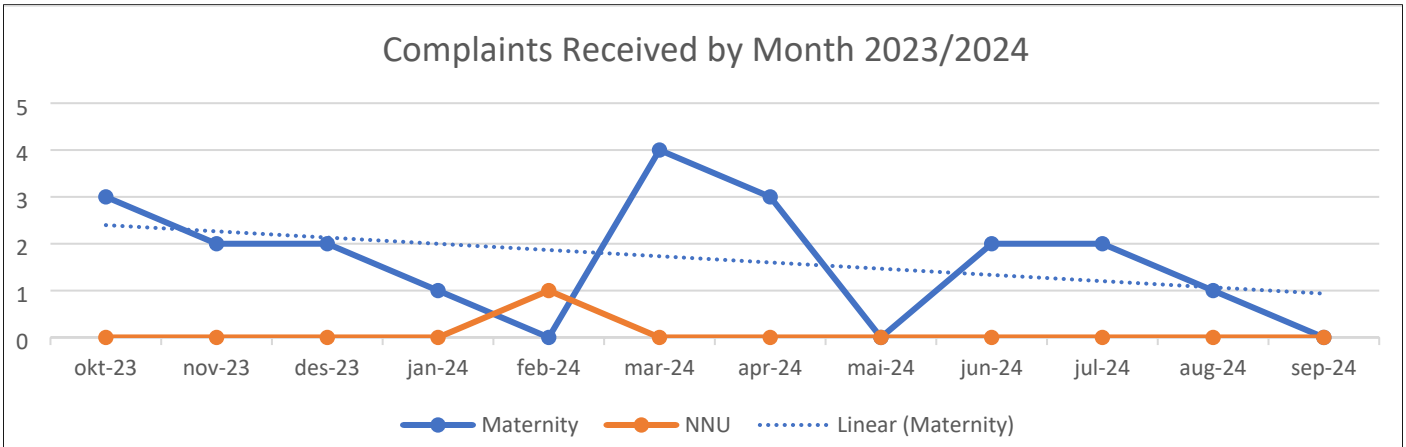
Work continues against the completion of the National Picker maternity survey action plan for 2023.

The results of the 2024 National Picker Maternity survey were received in Q2.
The CQC release the national survey results officially in December 24.
Preliminary results are incredibly positive for WWL.

97% of Mothers felt that they were treated with respect and dignity
98% felt that they were treated with kindness and compassion during labour and birth
96% felt involved in decisions about their care during labour and birth.

2.5 Complaints

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



In Q2 24/25, 3 formal complaints have been received for maternity services, which is lower than the previous quarter.

0 complaints were received for neonatal services.

Themes from complaints

Q4	Jul	Aug	Sept	Total
Clinical Treatment	2	1	0	**3**
Communication	2	1	0	**3**
Values and Behaviours	0	1	0	**2**
Discharge	1	0	0	**1**

Clinical treatment:

- Concerns raised around wound management
- Concerns around a failure to progress with a test: blood results were left in a fridge and not progressed.
- Concerns raised around the management of the complainant's labour and postnatal care: specifically, concerns around pleas for a section being ignored and a perceived lack of care when experiencing leg swelling in the postnatal period.

Communication:

- Concerns around conflicting information being received when in receipt of conflicting NIPT results.
- Concerns around the way in which bad news was shared with the complainant.
- Concerns around conflicting information being received around the possible presence of infection.

Values and Behaviours:

- Concerns raised around a lack of compassion shown in the postnatal period when requesting support.

Discharge

- Concerns around safe discharge from community midwives service when area around mum's wound was red, hot and swollen. Pelvic collection diagnosed later.

No Exceptions

2.6 SCORE staff survey

The SCORE survey is a measure of culture and engagement in the workplace. 169 members of staff across maternity and neonatal services responded to the survey, giving a response rate of 54%.
Analysis of the SCORE survey was undertaken in Q2.
An action plan is being created with support from external experts. Analysis to be shared in next report.

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	-	-	-	-
Approved	MAT	3772	Euroking System Error	20
	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	4003	Inability to provide ultrasound scanning within 24 hours (SBL 3)	10
	MAT	3780	Maternity Ligature Risk	10
	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	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	3727	Euroking To PAS Error Risk	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
	MAT	3362	Midwifery Staffing Shortages	4

At the end of Q2 24/25,

0 risks **under review.**

0 risks **awaiting approval**

1 risk **approved**
MAT 4003 Inability to provide ultrasound scanning within 24 hours (SBL 3)

3 risks **closed**
MAT 3604 Obstetrics and Gynaecology On-Call Availability Risk
BOTH 3725 Junior Doctors Strike
MAT 1758 Supernumerary Delivery Suite Co-ordinator

Exceptions

There are 6 risks scoring 6 or less which are under review to establish if can be tolerated or require further action.

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	0	6		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	3	76	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.

Q2 24/25 has seen some progress against the actions and 3 remain outstanding.

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

Exceptions - 3 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 of April 2024, and we are working closely with the LMNS for shared oversight and quality assurance. All 10 Safety Actions are on track with no barriers to completion.

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	7	0	7
2	0	0	3	0	3
3	0	2	3	0	5
4	0	5	15	0	20
5	0	2	5	0	7
6	0	1	6	0	7
7	0	4	4	0	8
8	0	2	17	0	19
9	0	3	7	0	10
10	0	3	6	0	9
Total	0	22	73	0	95

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

No exceptions

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q1 24/25

	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU	TARGET
April - June 2024	575	28 (4.86%)	27 (4.69%)	4 (14.8%)	<4.6%
In Q1, the total number of term admissions to the NNU was 4.86% of total term live births. This is a decrease from Q4.					

Unexpected term admissions to the NNU accounted for 4.69% of total term live births. This is a decrease from Q4.

There is still work to be done with 4 (14.8%) of total admissions being potentially avoidable.

Findings from Q1 audit

- Rates of term admissions to the NNU are on an overall downward trajectory
- The highest cause of admission in Q1 was respiratory distress (41%)
- Counselling around benefits and risks of earlier IOL/ELCS and steroid use was good
- Compliance around use of the NEWTT 2 tool was good
- There was no correlation between birth centile and NNU admission
- Term babies following induction of labour are more likely to be admitted to the NNU
- The Warm Care Bundle sticker is not used consistently, and hypothermia has slightly increased from Q4
- Antenatal education around colostrum harvesting was not discussed consistently
- Q1 has seen improvements in neonatal resuscitation documentation
- In Q1 33% of admissions to the NNU were from ethnic minority backgrounds

Recommendations

- Embed the Warm Care Bundle tool to improve thermoregulation of the newborn.
- Identify sub-themes to support learning
- Continue to improve the neonatal resuscitation documentation and the development of a new scribe sheet.
- Continue efforts to support colostrum harvesting advice in the antenatal period
- Develop guideline to support the use of the NEWTT 2 tool
- Identify at risk women and birthing people

No exceptions

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

	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
	Q3 23-24			Q4 23-24			Q1 24 -25			Q2 24-25		
Total births	211	221	197	199	194	213	204	223	181	202	211	203
Total Stillbirths	1	1	0	1	1	0	1	0	0	1	1	2
Stillbirths adjusted for MTOP	1	0	0	1	1	0	1	0	0	0	0	1
Total late fetal loss 22 – 23+6	0	0	0	0	0	0	0	0	0	0	0	0
Total Neonatal Deaths	0	0	1	1	1	0	0	1	0	0	0	0

Early neonatal deaths (0-7 days)	0	0	1	1	1	0	0	1	0	0	0	0
Neonatal deaths adjusted for MTOP	0	0	1	0	1	0	0	0	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
July	MTOP	27+6	White British	5	41	32	No	No	46.4	No	-
Aug	MTOP	24+2	White British	8	30	19	No	No	95.5	No	-
Sep	Antenatal	25+2	White British	1	30	42	No	No	0.4	No	Await
Sep	MTOP	28	White British	3	25	29	No	No	42.4	No	-

There were 4 stillbirths in Q2 24/25. 3 were noted to be MTOPs due to fetal anomaly which were all carried out after 24 weeks due to patient choice. There were no immediate care or service delivery issues identified which likely affected the outcome of the 1 antenatal stillbirth. 1 case will be subject to PMRT.

Await PMRT.

7.2 Neonatal Deaths

There were no Neonatal deaths in Q2 24/25.

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.

Raised BMI and maternal age ≥30 years continues as a theme in Q2.
All the women experiencing a stillbirth in Q2 were white British.

7.3 PMRT and MIS Year 6 compliance data source MBRRACE

In Q2 24/25, 2 cases were finalised at PMRT.

Case (date of death)	Standard 1	Standard 2 Seek parents' views of care: For	Standard 3a	Standard 3b Minimum of 60% MDT reviews to be

	Notify all deaths within 7 working days	at least 95% of all the deaths of babies	95% of reviews to be started in 2 months of death	completed/published within 6 months
26/09/24	Notification only	-	-	-
11/09/24	Met (1 day)	Met	Met	Due 11/11/24
30/08/24	Notification only	-	-	-
29/07/24	Notification only	-	-	-
06/04/24	Met (1 day)	Met	Met	Met
14/02/24	Met (2 days)	Met	Met	Met
10/02/24	Not eligible	-	-	-
07/02/24	Not eligible	-	-	-
21/01/24	Notification only	-	-	-
17/01/24	Met (3 days)	Met	Met	Met
27/12/23	Not eligible			

No exceptions

8. Saving Babies Lives (SBL) Q2 progress.

The LMNS has assessed WWL as providing significant assurance with 87% compliance (target 70%).

Element	RAG	Compliancy/ Improvement Plan
Element 1- reducing smoking in pregnancy		CO @ booking -98% for Q2, meets SBL parameter of 95%. CO @ 36 weeks is 96%, meets 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. Under discussion with GM Smokefree group to set the quit date at the second visit to capture more women and allow incentives to be taken up. 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 66.3%- SBL parameter is 50%. All Datix reported and GAP GROW audit completed, with no clear identified issues of with 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. Low Decile is a noted theme in women born with SGA babies. Number of babies born <3rd centile and >37+6 weeks is 29.6% - SBL parameter is <70%. Babies born >3rd centile and <39 weeks is 21%. SBL parameter is <30%. All below stretch target parameters. Digital BP to commence as gold standard as soon as all training and equipment has been purchased, deadline December 2024.
Element 3- Raising awareness of reduced fetal movements.		Audit shows Dawes Redman CTG 100% within SBL parameter of 95%. Next working day scan is 33% which is below minimum of 90 %. 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 0% below the stretch target of < 3 %. Two morning slots for RFM scans now up and running with the new MUP and existing trained staff commencing sessions. Will be re-audited to show assurance.
Element 4- Effective fetal monitoring during labour		Number of audited records that had a risk assessment completed at onset of labour is 92.2% for Q2, SBL parameter is 90%. Maternal and fetal wellbeing hourly review is 94.6% for Q2- SBL parameter is 90%. Sample is a small cross section, and some did not receive a fresh eye within the

		second stage. Fresh eye review within time frame, is 100%. CTG categorisation and escalation is 92.6% for Q2- SBL parameter is 90%.
Element 5- Preterm Births.		All optimisation/ SBL parameters -Place of birth -100%. Livebirths born < 34+0 weeks who receive steroids antenatally -56%- SBL parameter is >60%. Temp - 100%. EBM -56% - SBL parameter is 60%. IV ABX -67% - SBL parameter is 60%. MgS04 -50% - SBL parameter is 90%. Quick access preterm birth box utilised on Delivery Suite. 100% passport use. Cord management < 34 weeks was 67%- parameter is 100%, a QI project is ongoing which is to allow OCM at theatre table while cord remains attached. Overall interventions met are 75% -SBL target is 60%, so overall within parameters. MDT working with SCBU PEF & theatres. Data is subjective due to small numbers and increased stetch targets from GMEC. Preterm birth clinic started in March 2024, dedicated access to consultant and TV scanning. Currently no facility of CV scanning on Triage (option to send to USS dept in working hours) - MDT meeting scheduled for 11Th October to discuss forward planning to meet SBL threshold. 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 @ 100%, measurement for stretch target of 90%. All parameters met.
SBL training Elements 1-6.		94% doctors and midwives compliant with element modules. 6 % non-compliant all contacted via e mail to address any ongoing issues with access, time allocation or learning challenges. Midwives 94.5 % compliant, doctors 100 % compliant. Grow 2.0 training commenced, completed -168 members of staff trained by Q2 end. 93% compliant. Above stretch targets in all categories. Doctors will need to attend face to face sessions moving forward for the new SBL day commenced in September 2024. Rolling twelve-month programme.

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

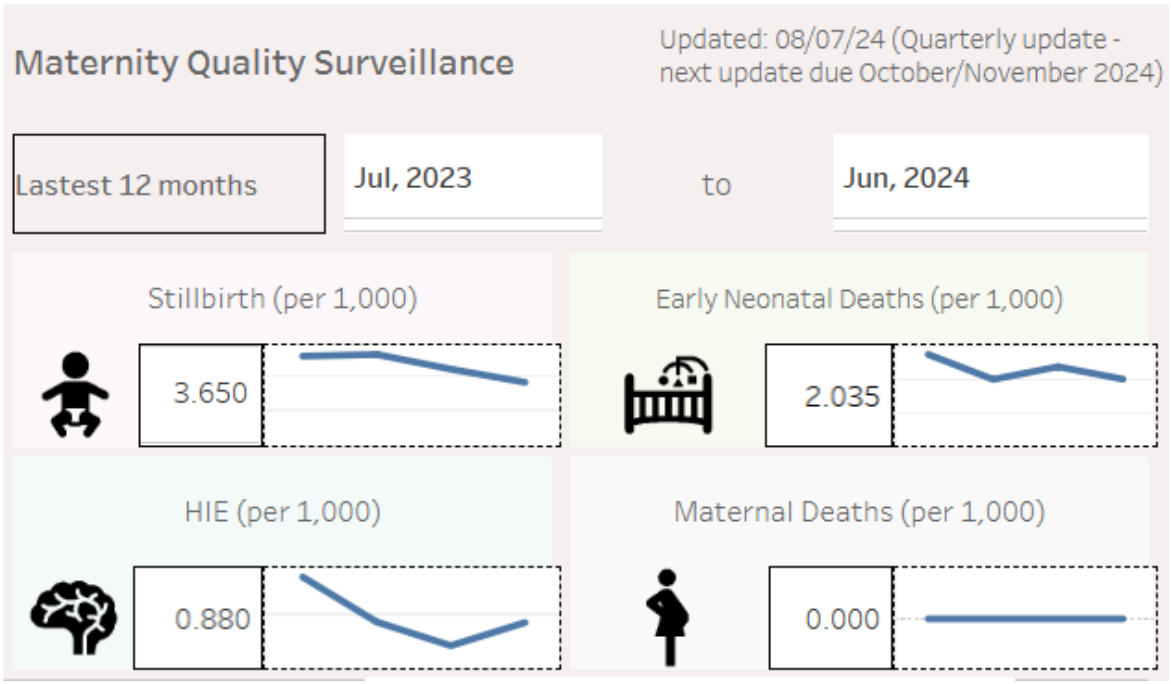
• Reduction of serious intrapartum brain injury to a rate of 1.0 per 1000 live births in 2023/24

• 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 - July 23 - June 24

WWL measures its progress against the GMEC LMNS ambition. Over this rolling 12 period, stillbirth data has continued a steady decline. Data for the rate of HIE is positive and it is vital that we continue to monitor, learn and improve to sustain this figure. One case of suspected HIE was referred to MNSI in Q2 but was rejected as the baby had an underlying anomaly.

The LMNS Mortality and HIE template will be utilised to review all cases from January to September 2024 in Q3 and findings will be fed back 'Floor to Board'.



10. Mandatory Training Compliance Midwifery

	Number attended	Percentage of Staff	Rolling Percent
BLS	32	19%	94%
NLS	32	19%	94%
PROMPT	26	16%	98%
Fetal Physiology	31	19%	95%

In September 2024 the structure of mandatory training was updated. Midwives are now allocated 5 maternity training days per year, covering PROMPT, Fetal Physiology, Maternity Safety, Saving Babies Lives and specialist Services updates, ensuring all elements of MIS and the Core Competencies Framework 2 are covered.

No exceptions

10.1 Mandatory Training Compliance Other Specialities

	PROMPT		Fetal Physiology	
	Number attended	Rolling percentage	Number attended	Rolling percentage
Consultant Obstetrician	1	91%	1	92%
Obstetric Registrar	2	100%	3	100%
Anaesthetist	2	90%		

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

No exceptions

11. Workforce / Safe staffing

Q2 has seen significant improvement in staffing following the successful recruitment of new midwifery staff. 2.64 WTE externally funded Band 6 immunisation posts & 0.8 WTE Band 6 Infant Feeing posts also went out to advert. At the end of Q2, there are 2.56 WTE Band 6 midwifery vacancies.

At the end of Q2 there are 2.56 WTE neonatal nursing vacancies and 0.81 Band 3 HCA vacancies. Interview for child health matron post pending early Q3.

11.1 Maternity Staffing Red Flags events including supernumerary shift co-ordinator

In Q2 2024/2025 there were 8 validated staffing red flag events.

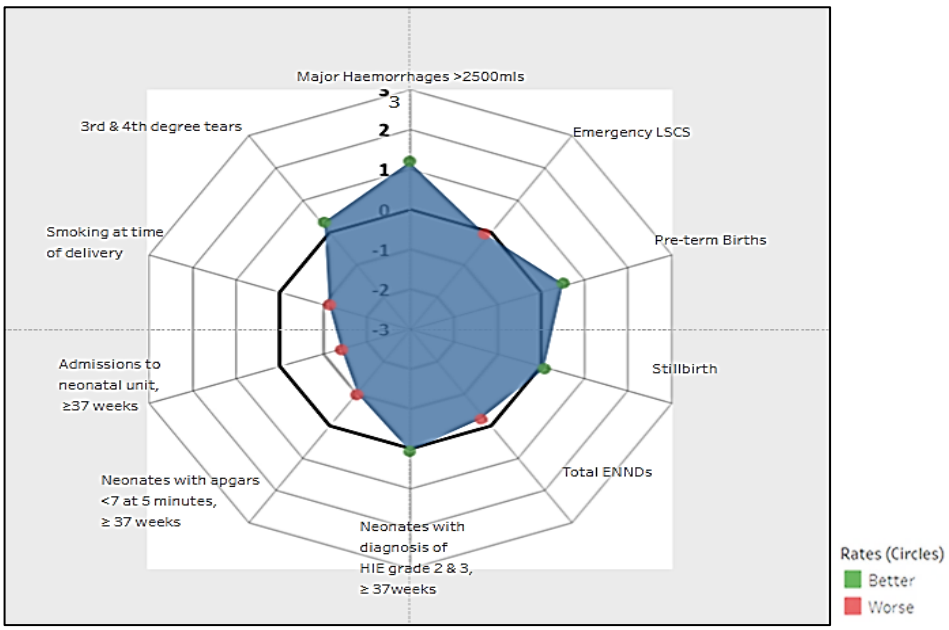
In July, 0 staffing red flag events were reported, reflecting a reduction in sickness levels, the uptake of bank shifts and reduced activity and acuity.
The contributing factors for the 8 staffing red flag events in August and September are related to short-term sickness and high levels of acuity.
5 of the 8 Red Flag were due to delays in induction of labour being commenced. Safety was maintained, and all appropriate monitoring was followed.
1 red flag event was due to a delay in pain relief for a patient awaiting an epidural. A concurrent emergency accounted for the delay. Alternative analgesia was utilised in the interim.
2 red flags were reported due to shift coordinator not remaining supernumerary. Appropriate escalation was followed, the on-call midwifery matron attended, the supernumerary co-ordinator provided care only to post-natal women requiring minimal support to maintain over-sight.

From analysis of the red flag events, it is evident that the appropriate escalation was followed, and safety was maintained, no harm was caused.

11.2 Maternity Unit Diverts

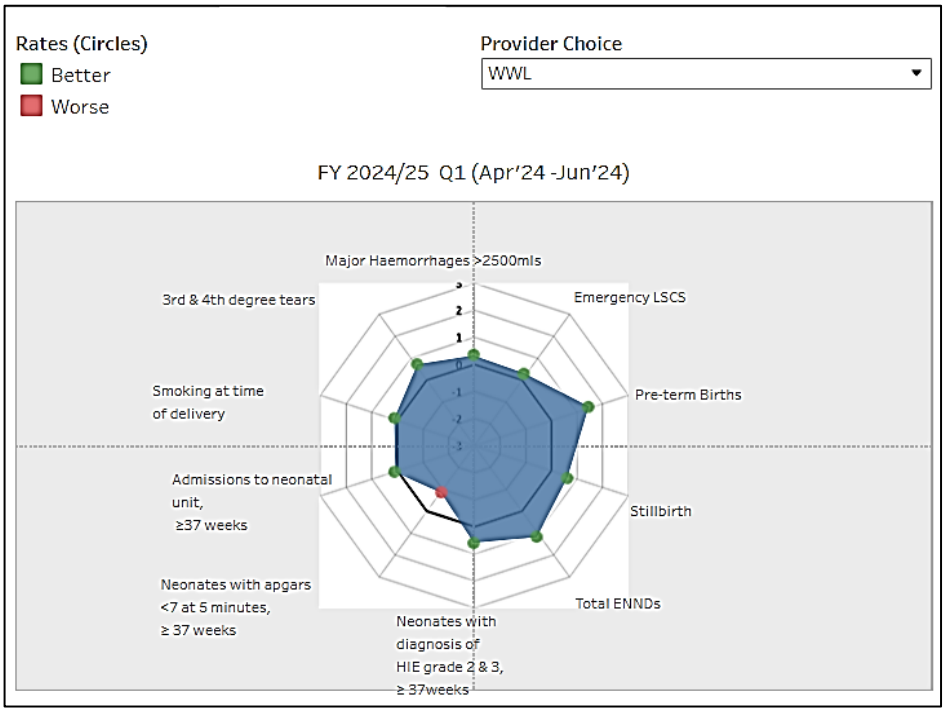
In Q2 24/25 there was 1 maternity unit divert due to inability to safely staff the unit (temporary junior doctor sickness). 7 women were diverted to local units. 3 women were diverted to Bolton, 2 women to Oldham and 1 woman was diverted to Warrington. A letter of apology was sent to all 7 women. Low/minor harm due to inconvenience caused.

12. WWL data as compared to GMEC using spidergraph - rolling 12 months (Jun 23 – Jul 24)



Between July 23 and June 24, WWL performed better than GMEC average for rates of major obstetric haemorrhage >2500mls, 3rd and 4th degree tears, pre-term births, stillbirths and neonates with confirmed diagnosis of HIE 2 & 3 at term.

12.1 WWL Data compared to GMEC average – spider graph Q1 24/25 Apr 24 - Jun 24 (latest data available) Source Tableau



In Q1 24/25, WWL has performed better than the GMEC average in all but 1 metric Apgars <7 at 5 minutes.

*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.

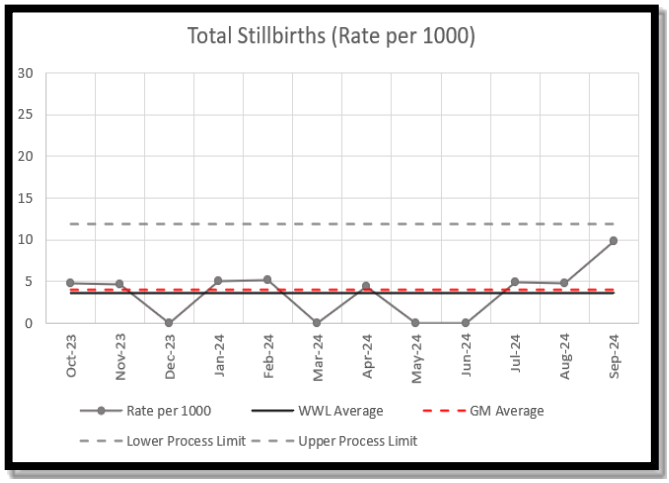
While we celebrate our own success with a downward trend in smoking at the time of delivery, there is still work to be done to reach the national ambition set by NHS England of <6% and QI work in all areas continues.

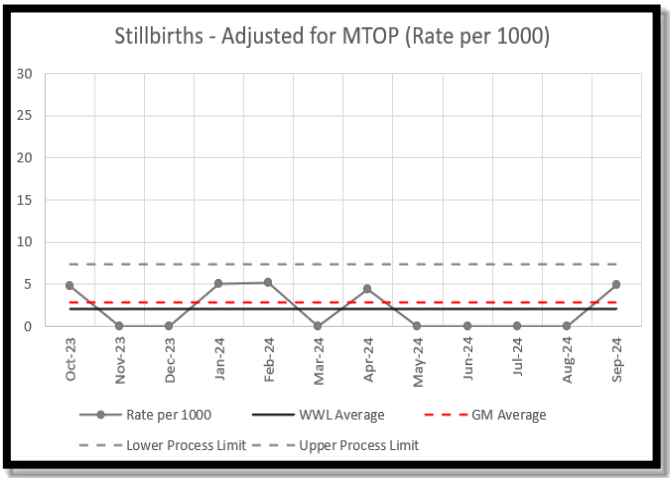
12.2 Statistical Process Control charts Q2 24/25

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.

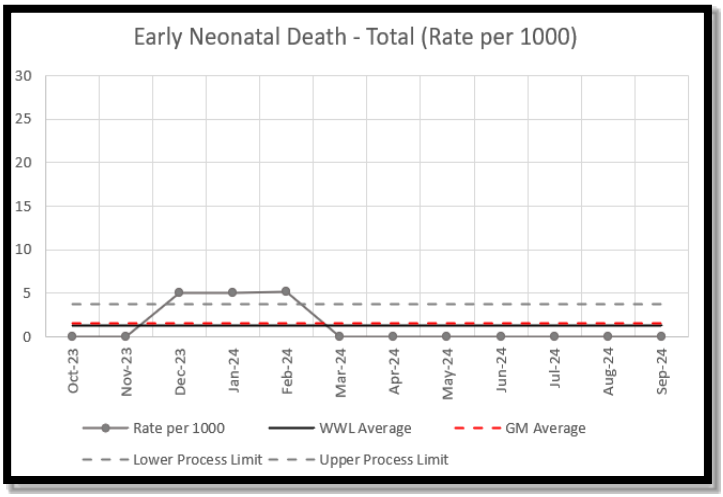
In the last 12 months the only parameters outside the GMEC mean are for term admissions to the NNU and Apgars <7 at 5 minutes.

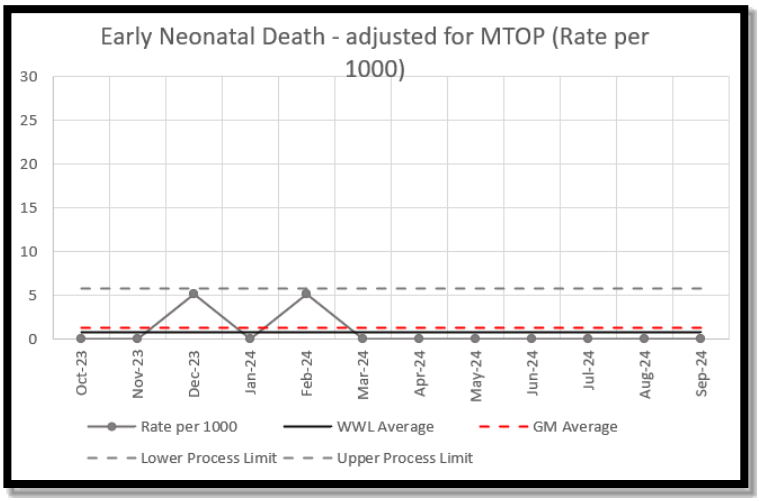
Themed analysis is underway to identify areas for improvement in relation to Apgars <7 at 5 minutes. ATAIN reviews are undertaken weekly with an overarching action plan to drive improvement work and a downward trend in the number of admissions is noted.



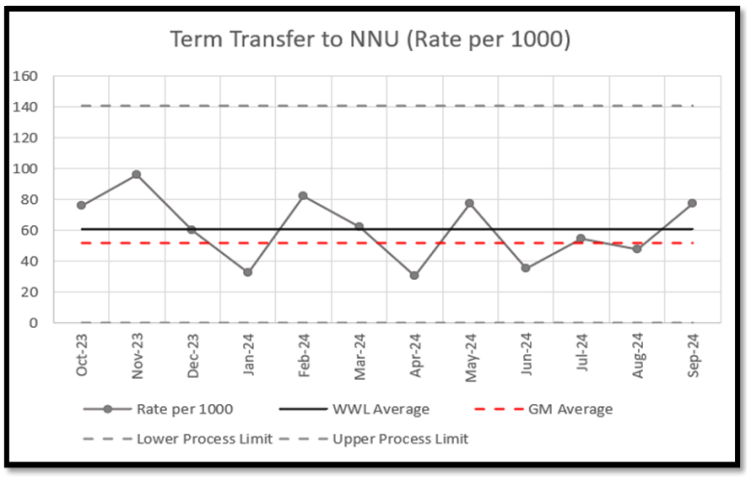


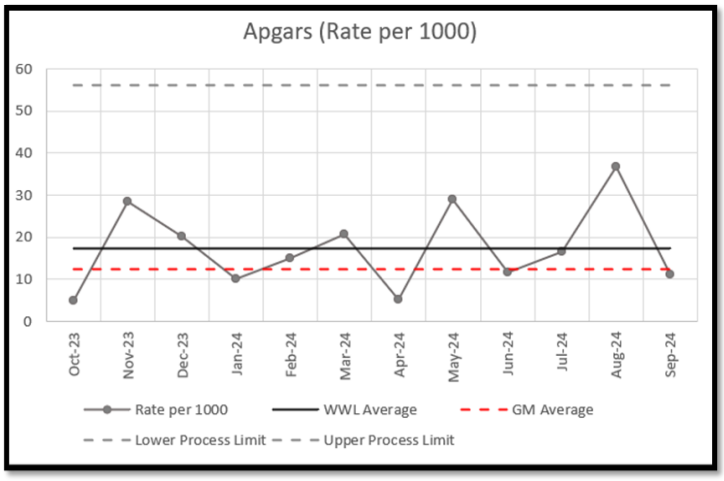
The first of the above two charts shows the total number of stillbirths. The second shows revised figures where medical termination of pregnancy (MTOP) is not included. All figures are shown as a rate per 1000.
There were 4 stillbirths in Q2, 3 of which were MTOP. No care issues identified. Good care theme on review.





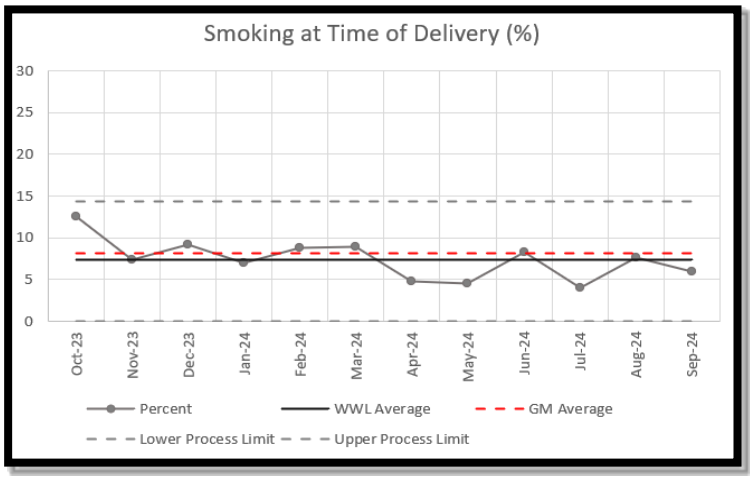
The first of the above two charts shows the total number of early neonatal deaths (ENND). ENND refers to deaths in the first week of life from 20 weeks. The second shows revised figures where MTOP is not included. The figures are shown as rate per 1000.
There were no ENND in Q2



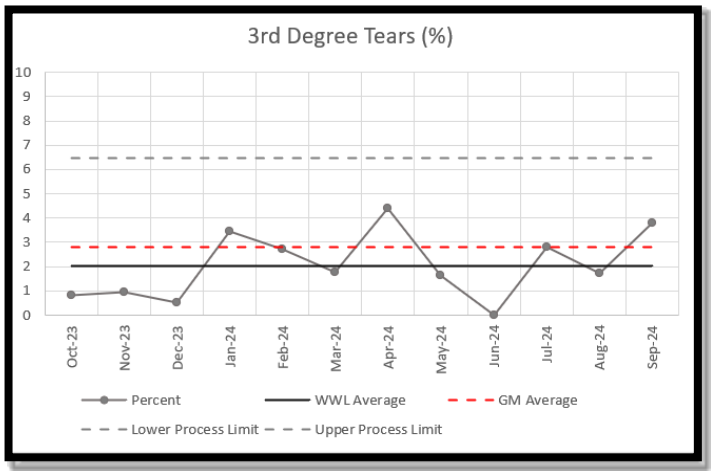


Q2 has seen a rise in term baby admissions to the NNU. Targeted QI work continues via the ATAIN MDT review group action plan. There were 36 term babies admitted to the NNU in Q2 which is a rise from Q1.

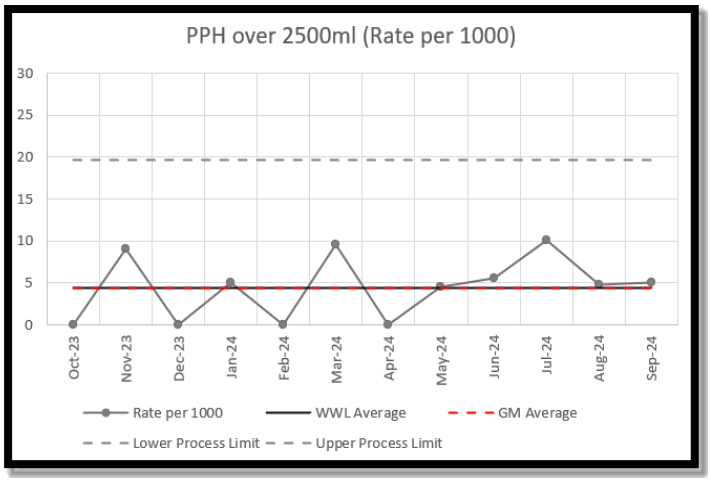
The Apgar score data is shown as a rate per 1000. Themed analysis is underway with a view to identifying learning to support improvement. This metric will continue to be monitored. We remain an outlier against the GMEC mean.



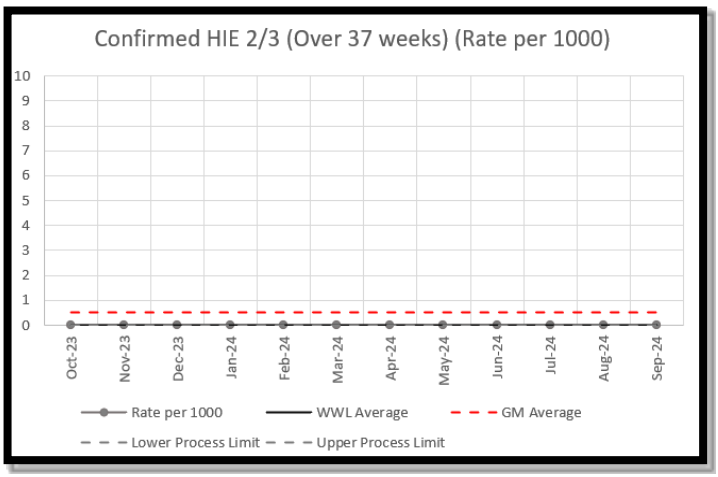
There has been a steady downward trajectory in SaToD data. WWL is now below the GMEC mean in this 12-month rolling period. All SBL 3 initiatives are on track.



The WWL mean is below GMEC mean based on this rolling 12-month period. The OASI bundle was rolled out on 2 April 24 to help improve outcomes.



The WWL mean is below the GMEC mean in this rolling 12-month period. Recent systemic improvements have included bringing the WWL MOH protocol in line with GMEC and initiating the Pack System in Haematology. There were 4 women who had a PPH over 2500mls in Q2. The new PPH review group aims to strengthen MDT learning and improvement.



There have been no babies with confirmed HIE 2/3 (37 weeks +) or meeting the MNSI investigation criteria since August 2023.

12.3 Outlier assurance data Q2 24/25

No data escalation assurance has been requested in Q2 24/25.

Summary

MIS Yr. 6 criteria was published on the 2nd of April 2024 and WWL maternity services are working closely with the LMNS for shared oversight and quality assurance. All Safety Actions are on track with no concerns identified for completion.

The LMNS have reported significant assurance of WWL progress against SBL3 targets with a compliance rate of 87% (target set at 70%).

Q2 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 now below GMEC mean, and our focus has turned to achieving the national ambition of <6%. Despite a rise in term admissions to the NNU in Q2, ATAIN QI work has resulted in a sustained downward trend in term admissions overall 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 has commenced the review of cases in Q2 with a view to identifying areas for improvement to inform an overarching action plan. Q2 saw a rise in stillbirths however it is important to note that 3 of the stillbirths were MTOP due to detected fetal anomaly. No care issues have been identified and an emerging theme is staff are listening to and advocating for women's choice.

There were no data outlier responses requested by the LMNS in Q2.

Active midwifery and nursing recruitment in Q1 brought a significant improvement in staffing in Q2. The interviews for neonatal matron post are pending, scheduled in early Q3.

Analysis of the Score Survey to explore team culture has taken place and an action plan is being developed with external input in response.

No new areas for concern identified.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Wrightington Wigan and Leigh Teaching Hospital NHSFT SCORE Culture Survey
Presented to:	Trust Board
On:	4 December 2024
Presented by:	Kevin Parker Evans, Chief Nurse
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

The SCORE Culture survey measures important dimensions of organisational culture. Looking at

- Safety culture
- Local leadership
- Learning systems
- Resilience/ burnout
- Work life balance

The survey was open to all Neonatal and Maternity/ Obstetric Medical and Nursing/ Midwifery staff, inclusive of support staff within both areas. The survey formed the second phase of the Perinatal Culture & Leadership Programme undertaken by the Perinatal Quadrumvirate, with the third and final phase being Cultural Conversations and planning for improvements.

The three-year delivery plan for maternity and neonatal services published in March 2024 identified that an organisation's culture is shaped by the behaviour of everyone in it. It stated that in maternity and neonatal services, a safety culture improves the experience of care and outcomes

for women and babies and supports staff to thrive. The failures in care that had been identified from collective reviews and reports stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning. Therefore, it recommended that in order to develop and sustain a culture of safety to benefit everyone, NHS England would offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.

Link to strategy and corporate objectives

2024/25 Corporate Objectives: Our People.
To ensure wellbeing and motivation at work and to minimise workplace stress.

Our Strategy 2030 People: To create an inclusive and people centred experience at work that enables our WWL family to flourish

Risks associated with this report and proposed mitigations

None

Financial implications

Any financial implications will be addressed as part of the actions associated with the recommendations

Legal implications

Legal implications will be noted as appropriate.

People implications

The people implications in this paper relate to not only the quality of care provided to our patients but also the health and wellbeing of the staff who provide that care.

Equality, diversity, and inclusion implications

The Division aims to ensure that all staff are treated equitably and without prejudice

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

None

It is proposed that the report will be formally presented at the Safety Champions Forum, Quality and Safety Committee and Trust Board

Recommendation(s)

The report is for assurance, information and noting.

Report

The Perinatal Culture and Leadership Development programme included a series of workshops and action learning sets and provided dedicated time for the quadrumvirate to work and learn together, accompanied by individual time to focus on personal development. The final component of this was the SCORE Culture Survey, an independently facilitated programme with team and quad debriefing sessions to co-design the cultural improvement actions identified. The data collection phase has been completed with the teams achieving a response rate of 54%. (At 40-60% response rate the data requires other corroboration (ie from interviews of staff)

This Improvement Plan, which is in development, identifies the themes taken from the survey results and the cultural conversations which were facilitated by Korn Ferry with staff from all areas of the maternity and Neonatal Service.

However, it should be noted that the results are very heavily weighted towards Nursing and Midwifery as very little engagement was received from Neonatal Medical staff and no engagement from Obstetric Medical staff. Furthermore, no medical staff from either area participated in the cultural conversation sessions.

Collective vision and aspirations for the services

The Perinatal Quadrumvirates vision is to provide excellence in Maternity and Neonatal care for all women, babies and families within our Borough

Perinatal Quadrumvirate

Christos Zipitis Divisional Medical Director and Neonatologist.

Cathy Stanford Divisional Director of midwifery and Child Health.

Shatha Attarbashi Consultant Obstetrician and Gynaecologist Clinical Director.

Natalie Garforth Divisional Operations Manager for Maternity and Child Health.

The main themes identified by the Quadrumvirate from the SCORE report and subsequent focus groups held to further explore the cultural conversations were:

1. Burnout Climate, what is meant by this, there was reference to people working too hard and being exhausted (contributing factor) and to work life balance.
2. Safety – Values alignment, maternity and Ante Natal Clinic in particular scored low . Need to identify what is going on/ what values do we see.
3. Team Working. Communication breakdown in and between teams, understand what is driving this.

4. Improvement readiness- Balancing positive and development feedback.
5. Sharing things that go well.
6. Review and consider suggestions from the staff.
7. Provide access to data and dashboards for context and background.
8. Fairness- perception that staff were not treated fairly in regard to deployment and recruitment
9. What do staff mean when they say Senior Leaders

Areas to focus on within improvement plan to drive change

1. Effective communication in handovers and in general provides an opportunity to improve.
2. Several of the 'Frustration' questions in the survey provide an opportunity for improvement and staff satisfaction and can be quickly addressed.
3. Clarity of expectations will provide an opportunity to reset culture within our teams.
4. There are opportunities to re-engage and motivate staff in their work.
5. Improved collaborative working across the service.
6. Seek to engage medical staff in the ongoing process.

Summary of learning from the Perinatal Culture and Leadership Programme and how this will be sustained in practice, and how these will be approached.

1. During the early phase of the process 4 Culture coaches were trained to support the ongoing feedback and listening events. A Further two coaches will also be trained
2. Listening sessions will be held with the support of the Organisational Development team and the Culture Coaches in each area with Band specific staff in order that they can speak freely to understand any areas of concern and how these need to be improved.
3. Communication lines are all under review with additional feedback disseminated from Senior Leaders weekly meetings as a starting point.
4. Improve the visibility of the Quadrumvirate as a collective team and also for the senior leaders as a whole.
5. Work collaboratively with all disciplines with the service to coproduce sustainable recommendations which will lead to long term benefits.
6. Drive and reiterate accountability of leaders and all staff within the service.
7. Address fairness and consistency in both performance and management
8. Tackle bad behaviours consistently
9. Celebrate Success and share learning more widely

Support required from the Board,

A formal improvement plan is in development and a report will be provided quarterly to update on progress and completion of actions. The Board are asked to support the process by agreeing that Executive

sponsors and the wider expertise of the O&D team is required to be able to successfully address the recommendations.

The SCORE survey results will be mapped to the staff survey themes and any Divisional cultural improvement plans.

Plans to oversee and sustain this work following the Perinatal Culture and Leadership Programme will be overseen by The Quality and Safety Committee and Perinatal Safety Champions with the ongoing support of the Divisional Quadrumvirate and senior teams.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	University Hospital Status: Progress Report
Presented to:	Board of Directors
On:	4th December 2024
Item purpose:	Information
Presented by:	Prof Sanjay Arya, Consultant Cardiologist, Caldicott Guardian, Executive Medical Director and Responsible Officer
Prepared by:	Madeleine Jackson, Service Development Manager
Contact details:	E: Madeleine.Jackson@wwl.nhs.uk

Executive summary

One of WWL's five-year strategic corporate objectives is to become a University Teaching Hospital. The University Hospital Association (UHA) is the body that awards University Hospital Status and there is a list of criteria that an organisation must meet to achieve University Hospital Status. A project group, set up in 2021, made up of key members of WWL's board, Research and Education Teams and Edge Hill University (EHU) are working towards meeting the criteria and collating evidence to support WWL's application to become a University Teaching Hospital in quarter four (January/March) of 2025/26.

Work to meet the criteria was already underway when the UHA changed the criteria in 2021. The key change was to criterion 1ci "A core number of university principal investigators. There must be a minimum of 6% of the consultant workforce with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question." Whilst this does improve our position as it reduces the number of consultants required to thirteen, this criterion remains our biggest challenge.

As a group we believe that all the other criteria can be met by 2026 including the Criterion 1ciii "For all Trusts in England, achieve an average Research Capability Funding (RCF) allocation of at least £200k average p.a. over the previous two years" which in previous years we were unable to achieve.

Link to strategy and corporate objectives

University Hospital status is a key priority within Our Strategy 2030 and continues to be one of our corporate objectives.

Risks associated with this report and proposed mitigations

None

Financial implications

None

Legal implications

None

People implications

Some changes will be required to consultant contracts whereby they will have a substantive contract with EHU and an honorary contract with WWL.

Equality, diversity, and inclusion implications

None

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

None

Recommendation(s)

Paper is for information and the Board is asked to note the progress made to date.

Report

In line with our strategic corporate objective to become a University Teaching Hospital the University Hospital Group, established in 2021 continues to work towards achieving and evidencing where we have met the criteria set out by the University Hospital Association (UHA) which grants University Hospital Status to Trusts.

The University Hospital Group is chaired by Professor Sanjay Arya and is made up of key members of WWL's and EHU's Board, Research, Education and HR Teams.

Considerable progress has been made in meeting the UHA criteria. A copy of the latest rag rated check list of criteria can be found in Appendix 1 which shows the majority are in progress or have been met, including Criterion 1ciii *"For all Trusts in England, achieve an average Research Capability Funding (RCF) allocation of at least £200k average p.a. over the previous two years"* which in previous years we were unable to achieve. REF stands for research excellence framework and is the system by which all the UKs research in higher education institutions is assessed for quality.

However, criterion 1ci *"A core number of university principal investigators. There must be a minimum of 6% of the consultant workforce with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question"* remains our biggest challenge and risk to our ambition to be become a University Teaching Hospital. The key issues are contractual arrangements and meeting the research criteria.

Whilst this criterion changed in 2021 reducing the number of consultants required by WWL to thirteen, the current position is that we have five consultants in place that meet the criterion. One consultant post is in progress and nine consultants are being assessed for eligibility. A copy of the current clinical academic appointment live tracker can be found in Appendix 2.

The group have developed a plan to mitigate against the challenges that are posed by criterion 1ci. These include:

- A review and change to new consultant job descriptions to ensure they have a clinical academic focus where appropriate and making it clear that the substantive employer would be EHU with an honorary contract with WWL when they go out to advert
- Checking if non-medical consultants and education research colleagues are eligible
- Collaborating with our consultant colleagues, already in post, to develop their research portfolios and provide advice on contractual arrangements to enable them to become eligible principal investigators
- Developing a plan to maintain levels of REF returnable research, including an investment plan for the research investment fund
- Continuing to gather evidence where we meet the UHA criteria

Progress is being monitored via the quarterly University Hospital Group meetings.

The Board is asked to note the information in this paper and the progress made so far to meet the criteria set out by the UHA to achieve University Hospital Status.

Appendix 1: University Hospital Association Criteria Checklist

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

Appendix 2: Clinical Academic Appointments Live Tracker

LIVE tracker - clinical academic workforce C

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Assurance Framework (BAF)
Presented to:	Board of Directors
On:	4 December 2024
Presented by:	Nina Guymer, Deputy Company Secretary
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 20 November 2024. There have been no changes to the risk scores for the three existing risks since the last Board meeting in October 2024. No new risks have been escalated or removed from the BAF.

2.3 **People:** Current risks are being reviewed and updated in line with the 2024/25 corporate objectives for approval at the People Committee Meeting on 10 December. There were no changes to the risk scores for the three existing risks at the last People Committee Meeting on 8 October. No new risks have been escalated or removed from the BAF since the last Board meeting on 2 October 2024.

2.4 **Performance:** Current risks were reviewed and updated in line with the 2024/25 corporate objectives at the F&P Committee meeting on 26 November 2024. No new risks have been escalated or removed from the BAF. The following updates were made to the BAF at the meeting:-

PR7 - Financial Performance: Failure to meet the agreed I&E position – current risk score increased from 12 to 16.
PR10 – Cash Balance - current risk score reduced from 10 to 5.

2.5 **Partnership:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the Board meeting on 4 December 2024. There have been no changes to

the risk scores for the six existing risks since the last Board meeting in October 2024. No new risks have been escalated or removed from the BAF.

3. New Risks Recommended for Inclusion to the BAF

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

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

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

6. Review Date

6.1 The BAF is reviewed bi-monthly by the Board. The next review is scheduled for February 2025.

7. Recommendations

7.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

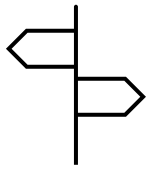
2024/25

The content of this report was last reviewed as follows:

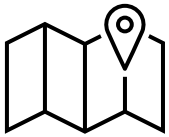
Board of Directors	October 2024
Quality and Safety Committee:	November 2024
Finance and Performance Committee:	November 2024
People Committee:	October 2024
Executive Team:	November 2024

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

How the Board Assurance Framework fits in

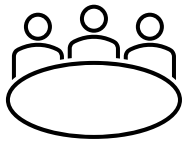


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

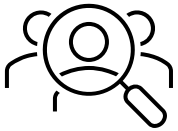


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

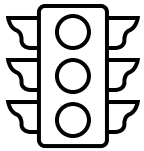
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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



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



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



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

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

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

DIRECTOR LEADS

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

DEFINITIONS	
Strategic ambition:	The strategic ambition which the corporate objective has been aligned to – one of the 4 Ps (patients, people, performance or partnerships)
Strategic risk:	Principal risks which populate the BAF; defined by the Board and managed through Lead Committees and Directors.
Linked risks:	The key risks from the operational risk register which align with the strategic priority and have the potential to impact on objectives
Controls:	The measures in place to reduce either the strategic risk likelihood or impact and assist to secure delivery of the strategic objective
Gaps in controls:	Areas which require attention to ensure that systems and processes are in place to mitigate the strategic risk
Assurances:	The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively. 1st Line functions which own and manage the risks, 2nd line functions which oversee or specialise in compliance or management of risk, 3rd line function which provide independent assurance.
Gaps in assurance:	Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk
Risk Treatment:	Actions required to close the gap(s) in controls or assurance, with timescales and identified owners. Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity.
Monitoring:	The forum which will monitor completion of the required actions and progress with delivery of the allocated objectives
Three Assurance Alarm Bells:	The first bell is triggered if the current risk score has not changed in 6 months. The second bell is triggered if actions are overdue or have not been identified to reduce the risk to target score. The third bell is triggered if the risk has not been reviewed since the last Board meeting.

Our approach at a glance

Our Strategy 2030

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

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

FY024/25 Corporate Objectives

Patients

We will…

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

People

We will…

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

Performance

We will…

- deliver our financial plan, providing value for money services
- minimise harm to patients through delivery of our elective recovery plan
- improve the responsiveness of urgent and emergency care

Partnerships

We will…

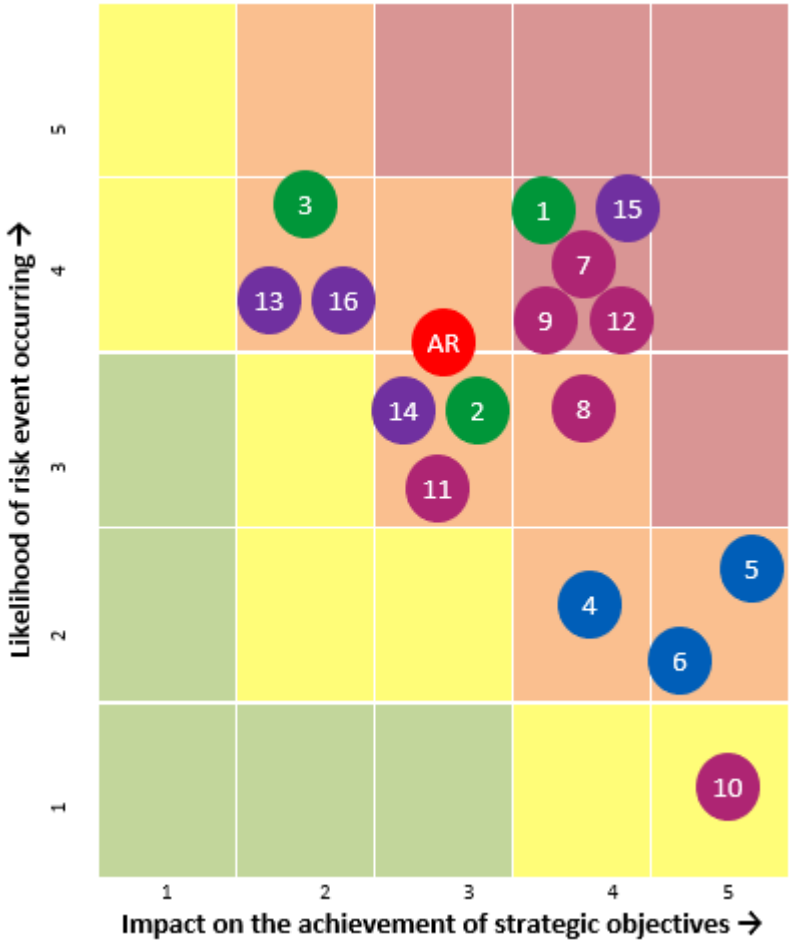
- improve the health and wellbeing of the population we serve
- develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable
- make progress towards becoming a Net Zero healthcare provider
- increase our research activities delivering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

Risk management

Our risk appetite position is summarised in the following table:

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

The heat map below shows the distribution of all 16 strategic principal risks based on their current scores:



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

Patients

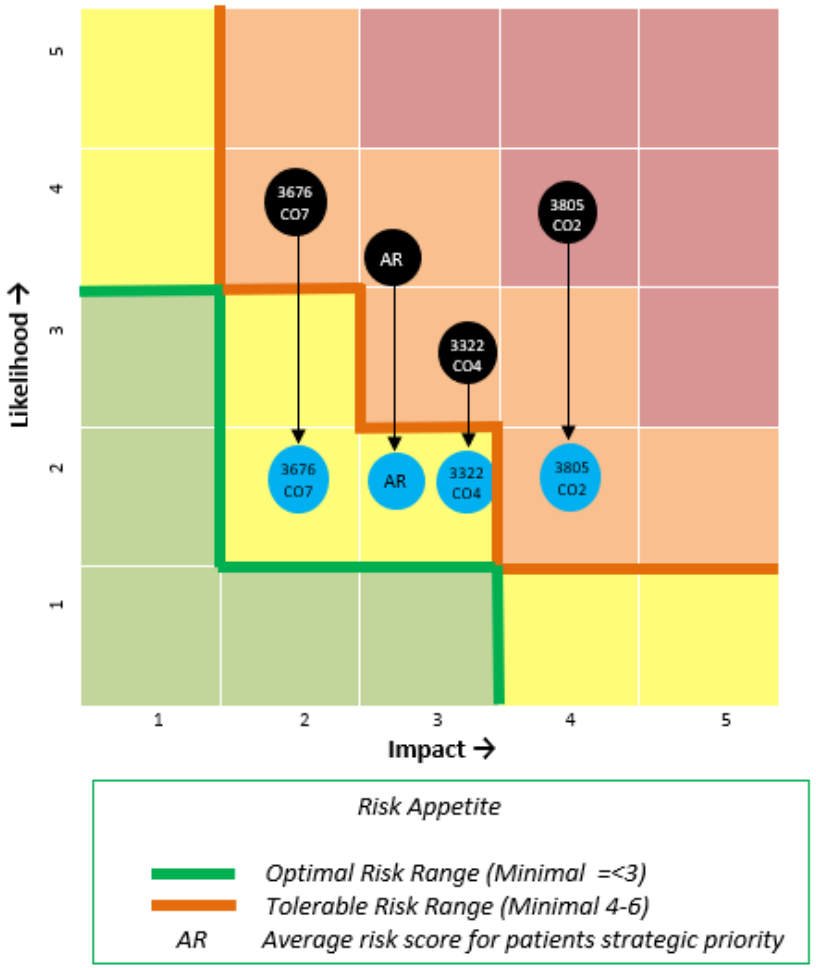
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

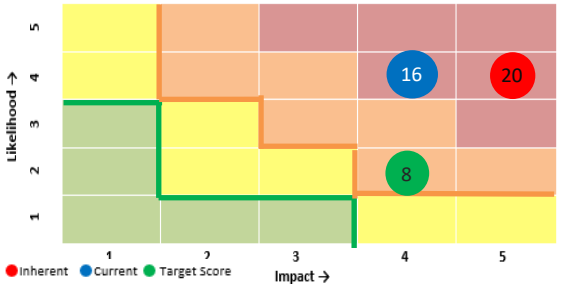
The following corporate objectives are aligned to the **patients** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Tracking
CO1	To improve the safety and quality of clinical services	To enhance patient care through digital transformation.	No risk currently identified
CO2 3805	To improve the safety and quality of clinical services	To improve the compliance of Sepsis-6 care bundle as per Advancing Quality Audit, with aim to reduce mortality from sepsis.	On Track – AQ data shows great progress
CO3	To improve diabetes care for our paediatric population (up to age 19)	To improve the care of paediatric patients with type 1 diabetes up to age 19 focussing on 5 care processes.	No risk currently identified
CO4 3322	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 – risk due to long term absence of the lead for accreditation
CO7 3676	Listening to our patients to improve their experience	Deliver timely and high quality responses to concerns raised by patients, friends and families.	Off Track for 90% of complaints responded to within our agreed timeframes.

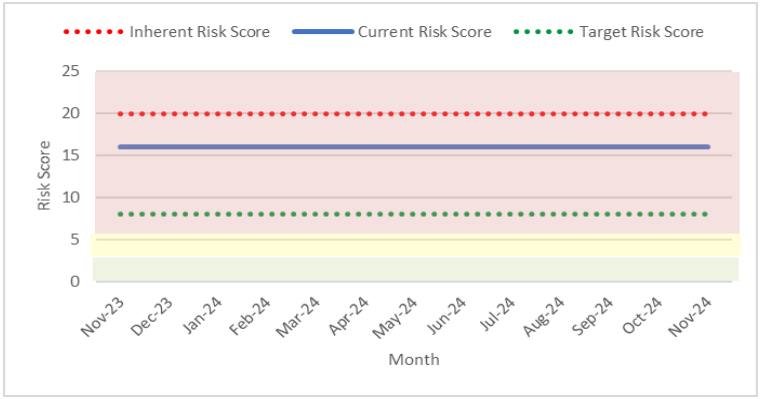
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



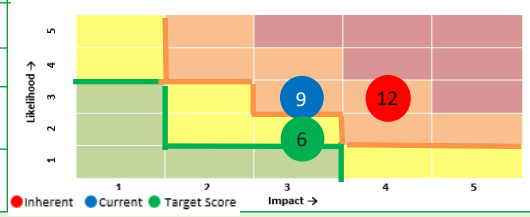
Corporate Objective: CO2 To improve the safety and quality of clinical services	1	2	3	**Overall Assurance level**	**Medium**

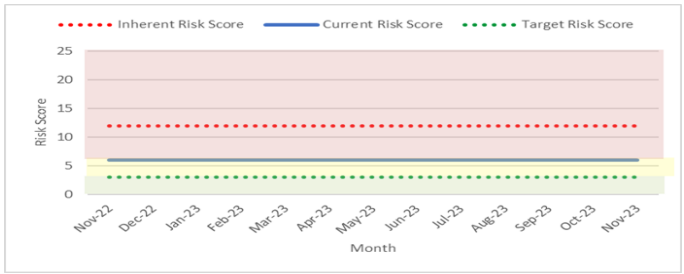
Principal risk	**Risk Title:**	**PR 1: Sepsis Recognition, Screening and Management**			
	Risk Statement:	There is a risk of the under diagnosing of patients with Sepsis, due to Health Care Professionals failing to recognise Sepsis in the deteriorating patient, which may result in patients not receiving Sepsis 6 treatment within one hour of triggering for Sepsis.			
Lead Committee	**Quality and Safety**		**Risk Appetite**	Minimal	
Lead Director	**MD**		**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**19.07.23**		**Linked system risks**	-	
Date of last review	**17.10.24**		**Risk treatment**	Treat	

Risk Score Timeline



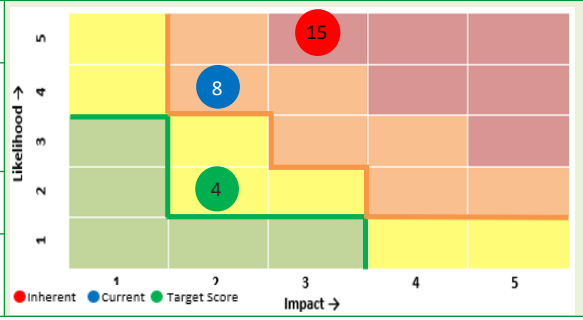
Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date By Whom
Threat: **(ID 3805)**	• Sepsis Nurse = High Visibility, Ward walk rounds. Recommenced by current Sepsis Lead Nurse. • Link Nursing in all wards and department have been reinstated. • Training and Education = Corporate Induction, E-learning Sepsis currently being updated, Sepsis in HIS to be made mandatory. Bespoke training for clinical areas and ECC. • Recommenced reviewing Datix's specifically related to Sepsis. Learning from incidents, information sharing. • QI project ongoing in. Supported by Sepsis Lead Nurse and Consultant. • Monthly Sepsis coding review in which Sepsis Deaths are reviewed and accurately coded. Sepsis Discharges are also reviewed. • Sepsis Improvement Plan developed alongside the MIAA Sepsis action plan. • ED Patient Group Directive for IV Antibiotics re-established in ED. • Blood culture training is being recommenced by Sepsis. Initial training commenced in ED. • Sepsis Nurse to attend AQ Sepsis Clinical Expert Group (CEG) • Community SOP for Paediatrics is now live. • Improvements in recognition, audit and mortality data. • Sepsis Policy and Sepsis SOP – Live on the Intranet	• Sepsis/AKI Specialist Nurse has been appointment at a band 6 level. • Room booking and releasing staff due to operational pressures • Blood culture training is only currently available to ED staff. • HIS sepsis flags are currently over sensitive and do not differentiate between sepsis and a differential diagnosis. • Community SOP for Adults delayed due to absences within community teams. • New Sepsis e-learning module under construction.	**2nd Line:** • Quality & Safety Committee September 2024 • Board October 2024 • ECC Red Flag Sepsis Audit • AQ Audit	**2nd Line:** • None currently identified.	1. Sepsis E-Learning review to incorporate the new NICE Guidance and new policy information 2. Community SOP for Adults	March 2025 Sepsis Lead March 2025 Sepsis Lead

Corporate Objective: CO4 To improve the delivery of harm-free care					1	2	3	Overall Assurance level	Medium
Principal risk	**Risk Title:**	**PR 2: Harm Free Care - Avoidable Pressure ulcers**							
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.							
Lead Committee	**Q&S**			**Risk Appetite**	Minimal				
Lead Director	**CN**			**Risk category**	Safety, quality of services & patient exp				
Date risk opened	**19.10.21**			**Datix ID / Links**	Threat (ID 3322) No linked risks				
Date of last review	**17.10.24**			**Risk treatment**	Treat				

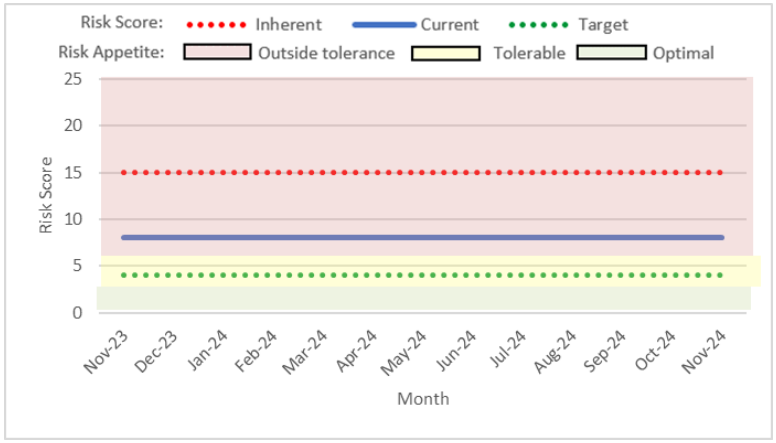


Existing controls	Gaps in existing controls	Assurances	Gaps	Risk Treatment	Due Date
• Pressure ulcer link nurses trained within all areas and extended to community care homes. • Human factors training to continue to be embedded within the organisation building on success of 2022/23. • Category 2/DTI 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 September 2024 • Board October 2024	No gaps currently identified	• Further progress with Business Intelligence; developing a dashboard to illustrate PU data at a glance. • TV service to explore, the relationship between end-of-life skin changes (SCALE) and PU development in the community. • Roll of out the revised MASD pathway to acute and community services. • Review the Purpose T training package to prepare for implementation in the Trust. • System wide pressure ulcer prevention policy to be approved by the Adult Safeguarding board. • TV service to work with the HIS team to revise the referral process on HIS to reduce inappropriate referrals. • Review of the ED improvement plan for 24/25 to measure its effectiveness. • Repositioning chart to be combined with the Intentional Rounding Tool to reduce the end of bed paperwork and improve the compliance with repositioning. • Support the Medical Illustration team in the roll out of the SECTRA application to achieve timely photography of skin damage. • In 24/25 the focus will be on how to maintain a continued reduction in HAPUs throughout the winter months.	PU steering group March 2025

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

Principal risk What could prevent us achieving our strategic objective?	**Risk Title**	**PR 3: Complaint response rates**		
	Risk Statement	There is a risk that complaints received may not be responded to and acted upon within our agreed timeframes, due to operational pressures, resulting in missed targets, unresolved complaints and adverse publicity.		
Lead Committee	**Quality and Safety**		**Risk Appetite**	Minimal
Lead Director	**CN**		**Risk category**	Safety, quality of services & patient exp.
Date risk opened	**24.01.23**		**Linked system risks**	No linked risks
Date of last review	**17.10.24**		**Risk treatment**	Treat

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3676**	• Complaints SOP in place with defined roles, processes and timescales. • How to respond to a complaint training is being delivered. • Training time has been reduced from 6.5 to 4 hours. • Patient relations team provide support and guidance. • There has been a 56% reduction in complaints reported to the Patient Relations and PALS team regarding lost property, from 66 in 2023 compared to 29 in 2022. 01.04.23 to 31.03.24 – 39 records. • DATIX actions improvement has been used for each upheld or partially upheld complaint, a reduction for the top subjects will be realised as time passes. • Full day workshop (21 June) to complete Medicine's outstanding responses.	• There are currently no backlogs. • Requirement to source venues to run further training courses. • Despite training and good feedback from the session, staff are not coming back to us so that we can critic their work • Although there has been the introduction of the boxes, the Patient Relations and PALS team, have recommenced recording concerns when the patient relative have stipulated a record - patients/relatives are directed to Legal when all other resolutions have been explored (following the path of the patient and ringing round).	**2nd Line:** • Quality & Safety Committee September 2024 • Board October 2024 • Task and finish group set up so that divisions use functionalities within Datix.	• No gaps currently identified.	1. Training is continuing with high attendance and waiting list – so more dates are being provided after July.	March 2025 CN

People

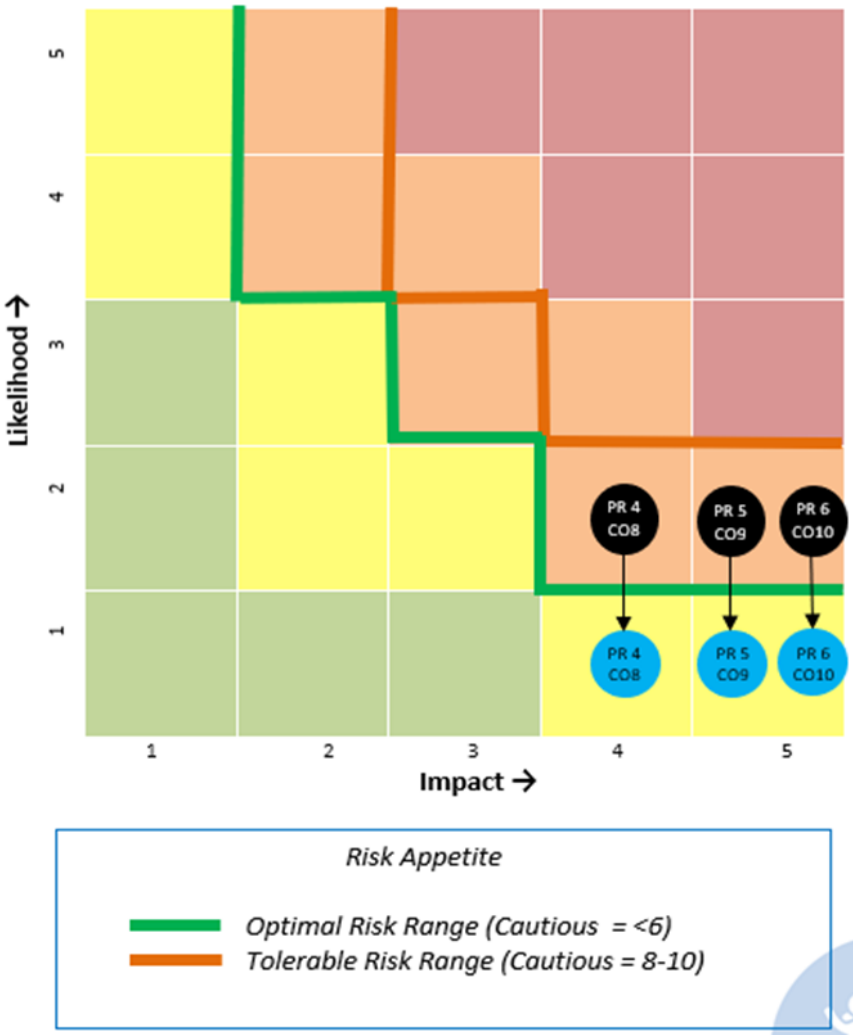
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

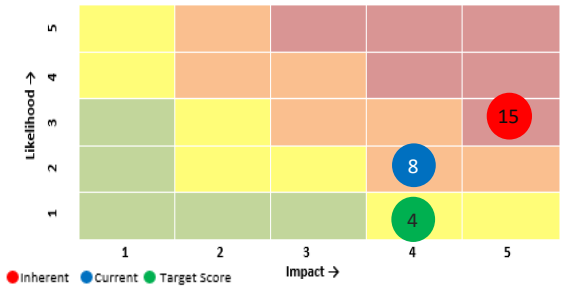
The following corporate objectives are aligned to the **people** strategic priority:

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

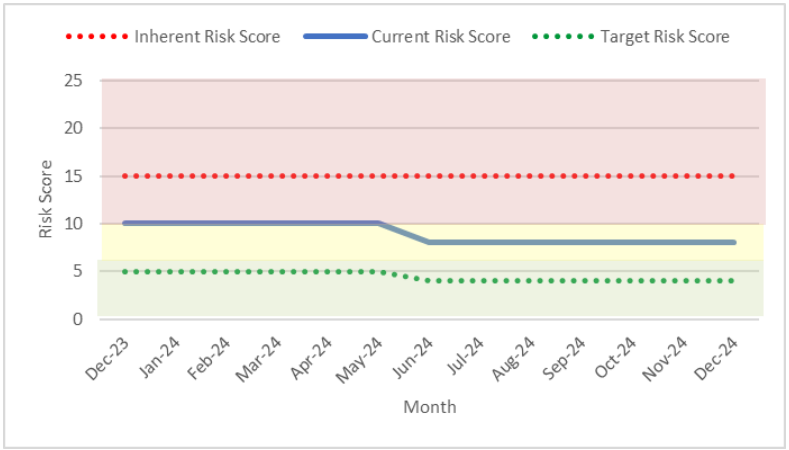
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for the people strategic risk:



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

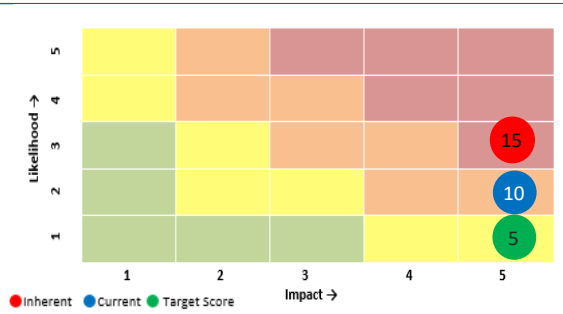
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 4 : Workforce Sustainability**		
	Risk Statement:	There is a risk that we may not deliver the workforce sustainability agenda objective, due to issues with staff retention and keeping colleagues well in work, that may result in an increase in sickness absence, vacancies, time to hire challenges and an increase in employee relations cases.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Capacity & Capability, Staff Engagement Staff Wellbeing.
Date risk opened	**19.06.23**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**20.11.24**		**Risk treatment**	Treat

Risk Score Timeline

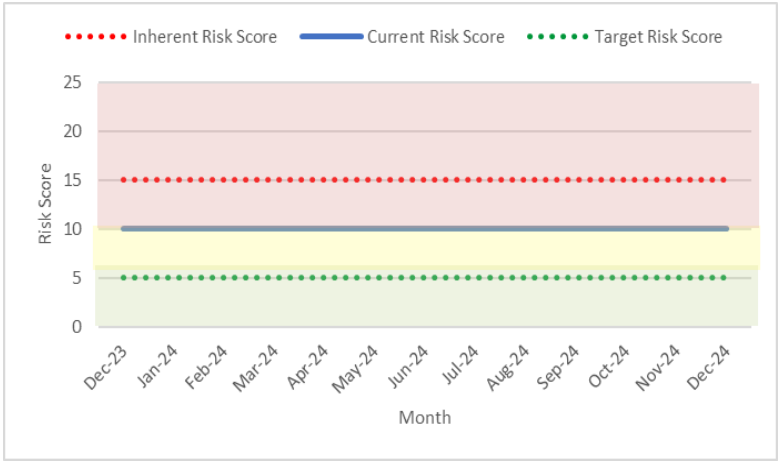


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3783**	• Workforce planning 2024/25 • Empactis relaunch • Civility Programme (just & learning culture) • People Dashboard refresh • Newton 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. March 2025 – D/CPO & AD for SE & W 2. March 2025 -CPO 3. March 2025 - 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	**20.11.24**		**Risk treatment**	Treat

Risk Score Timeline

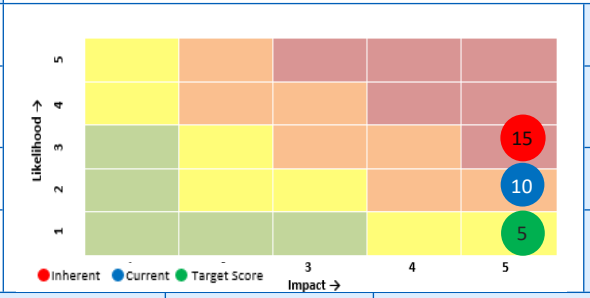


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3871**	• Actions contained within the Draft People & Culture Strategy • National Staff Survey • New Appraisal Framework "My Route Planner" • Local divisions to provide assurance on local staff engagement activities via Divisional Assurance Meetings.	• People Strategy, which will align and coordinate activity under development.	• Culture & Engagement Programme launched. • Turnover of staff, and staff engagement actively monitored at Divisional Assurance and RAPID meetings. • Recruitment and retention standing agenda item for People Committee to enable high level monitoring and assurance. • WWL ranked high nationally in Morale score in 2023 National Staff Survey.	• Data linked to protected characteristics signifies lower staff experience for black, Asian and minority ethnic staff and Disabled staff.	1. Increase understanding of why staff leave through introduction of Exit Questionnaires 2. Development of a Leadership Development Strategy	1. March 2025 - Deputy CPO 2. March 2025 – AD SE

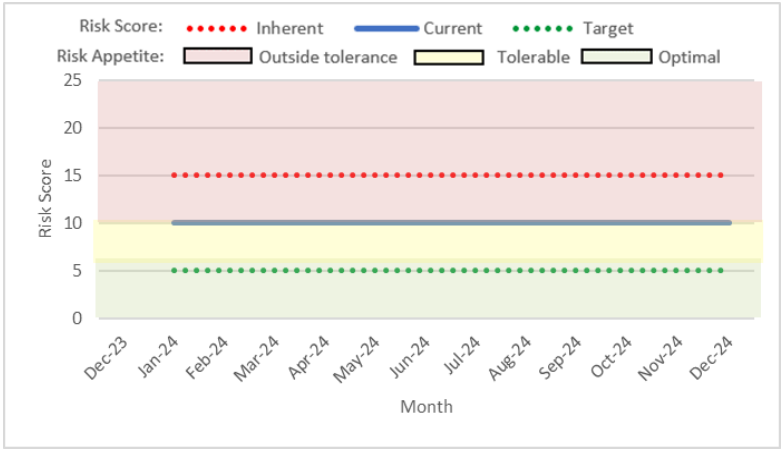
Corporate Objective: CO10 We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.

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 405 internationally educated nurses. There is a risk that we will not retain this valued workforce. Feedback received highlights that colleagues who have been educated internationally have a negative work experience. The Trust also reports less positively with our Disabled workforce.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.
Date risk opened	**31.01.24**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**20.11.24**		**Risk treatment**	Treat

Risk Score Timeline



Strategic Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3928**	• Pastoral Support post within the Nursing Professional Practice Team, who will now be a qualified nurse with lived experience. • Mechanisms in place to enable feedback. • Understanding of data in WRES, WDES and Gender Pay Gap Report • NHSE EDI High Impact Improvement Targets • Board Development Workshop focussing on EDI 14.3.24 Workshop took place January 2024. • WWL accepted on national CNO Global Majority 90 Day Challenge. • EDI Strategy Group now established.	• EDI resource temporarily funded until November 2024.	• Feedback shared with Board colleagues ensuring full understanding of experience of IEN. • Interim Chief Nurse recently recruited has experience of successfully supporting the IEN workforce. • Enhanced EDI Support arranged for Ward Leaders, Matrons and other senior nursing colleagues, in the form of Active Bystander training • New IEN Improvement Group established. • Staff network established. • EDI Steering Group	• 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. March 2025 (CN/CPO) 5. March 2025 (AD SE & W) 6. March 2025 (EDI Lead) 7. March 2025 (EDI Lead) 8. March 2025 (CPO, EDI Lead)

Performance

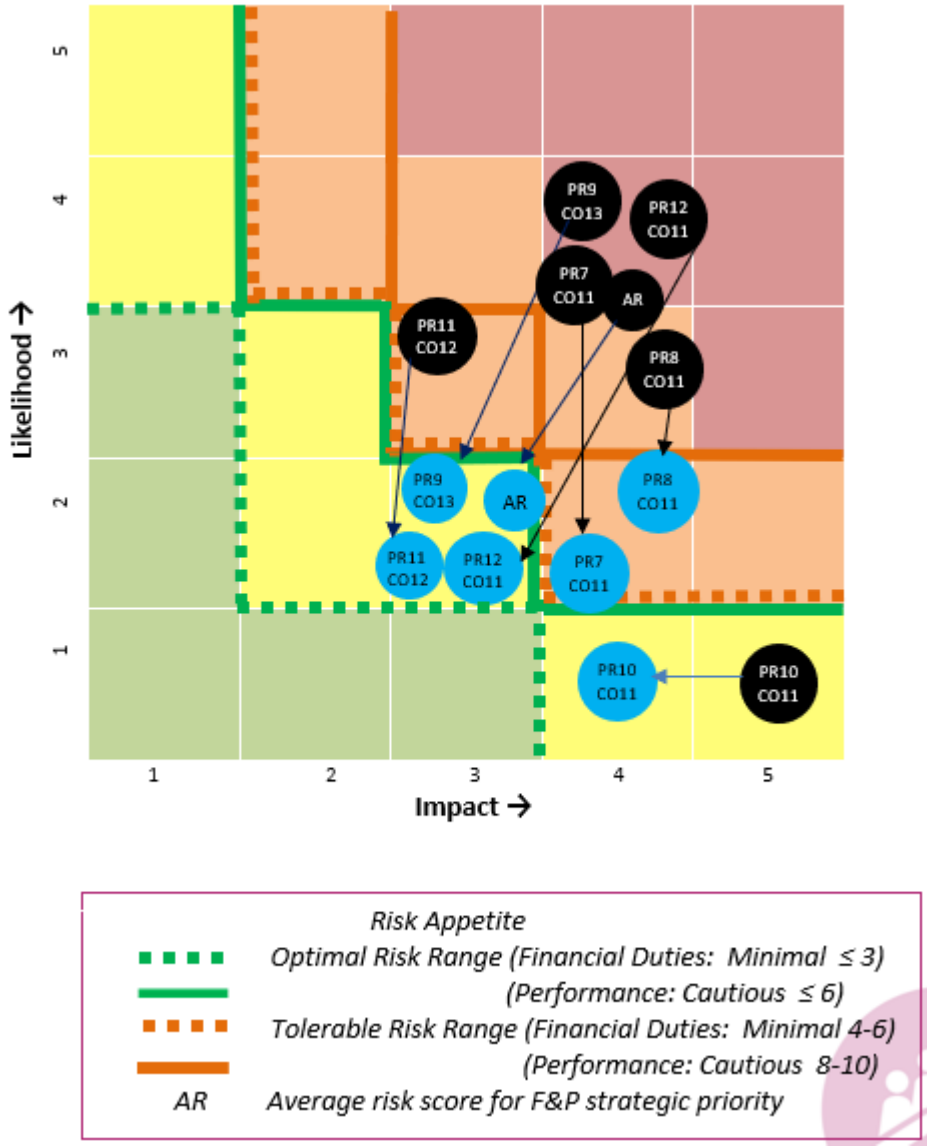
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

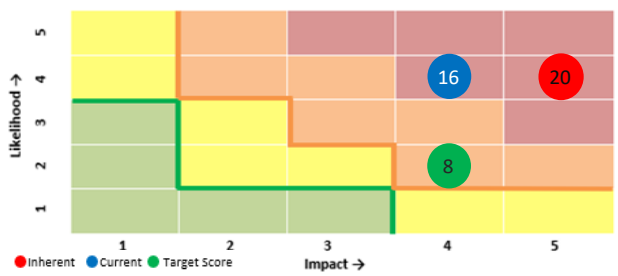
The following objectives are aligned to the **performance** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Status
CO11	To deliver our financial plan, providing value for money services	✓ Delivery of the agreed capital and revenue plans for 2024/25. ✓ Delivery of a medium to long term financial strategy focused on sustainability, positive value and success within a financially constrained environment.	On Track
CO12	To minimise harm to patients through delivery of our elective recovery plan	✓Delivery of more elective care to reduce elective backlog, long waits and improve performance against cancer waiting times standards, working in partnership with providers across Greater Manchester to maximise our collective assets and ensure equity of access and with locality partners to manage demand effectively.	On Track
CO13	To improve the responsiveness of urgent and emergency care	✓Working with our partners across the Borough, we will continue reforms to community and urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay. ✓We will work collaboratively with partners to keep people independent at home, through developing and expanding new models of care, making use of technology where appropriate (e.g. virtual wards) and ensuring sufficient community capacity is in place.	On Track

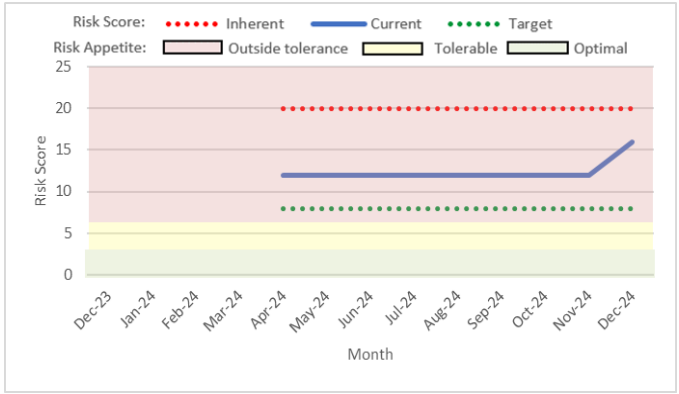
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



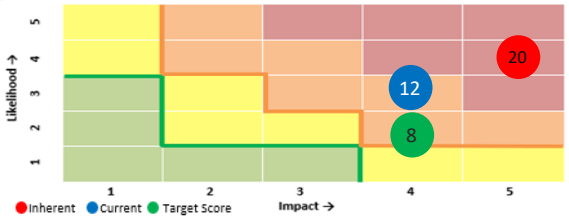
Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

Principal risk	**Risk Title:**	**PR 7: Financial Performance: Failure to meet the agreed I&E position**			
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties. This includes ERF, CIP (see PR8), further impact of industrial action, inflationary pressures and any other unforeseen pressures arising in the year.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal	
Lead Director	**CFO**		**Risk category**	Financial Duties	
Date opened	**20.05.24**		**Threat: System risk**	ID 3292 LSR6 Financial plans	
Date of last review	**26.11.24**		**Risk treatment**	Treat	

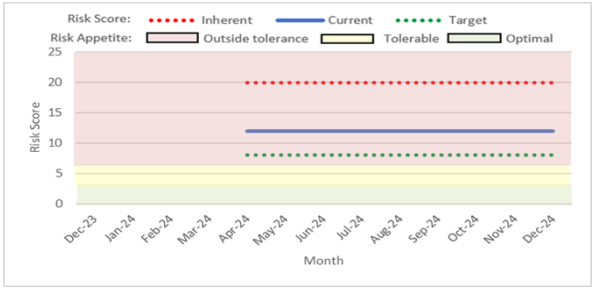
Risk Score Timeline



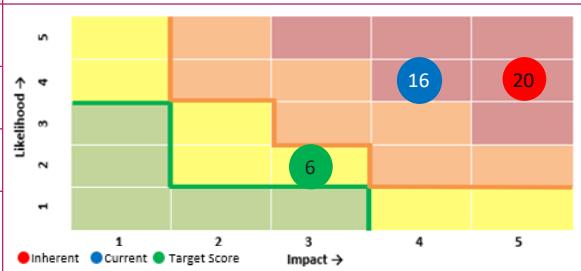
Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
• Final plan signed off by Board and submitted to NHSE – 2nd May 24. Resubmission on 12th June 24in line with GM ICS control total. • Draft and final plans scrutinised through monthly FPRM meetings with GM ICB, NHSE and PWC. • PWC led planning oversight process on behalf of GM ICB during Q4 2023/24 with significant scrutiny on assumptions (Ext) • Final plan is reflective of year 1 of the approved WWL Financial Sustainability Plan (FSP). • FSP was developed during 2023/24 and had F&P and Board Approval. • All divisions accepted budgets in April 24. • CIP target agreed with programme for delivery and actions. • Robust forecasting including scenario planning for worst, most likely and best case will continue from quarter 2. • Executive oversight and challenge of CIP & Financial performance through Divisional Assurance Meetings, Financial Improvement Group, Transformation Board. • Establishment control groups established for non medical and medical staffing with scrutiny and rigour over agency spend in line with national agency controls. • Stringent business case criteria to ensure only business critical investments are approved. • Full review of financial position by locality partners. • GM standardised financial controls implemented in 2023/24 remain in place across WWL. • ERF baseline of 103.6% is in line with NHSE guidance – based on 2023/24 baseline before adjustments for industrial action. • Activity plans based on theoretical maximum capacity have been approved by divisions and submitted to NHSE on 2nd May 24. • ERF plan submitted in excess of baseline to include activity associated with NHSE approved developments • Revenue plan includes income in line with GM ICB contract offer excluding the growth on ERF for developments noted above • Improvement Director with operational portfolio continues to work with the Trust • Finance Improvement Group meeting monthly, chaired by Chief Finance Officer and attended by Chief Executive • Monthly Provider Oversight Meetings established from May 24 (Ext) • GM Controls in place for new expenditure above £100k not within plan (STAR process) (Ext) • All headcount increases are required to be taken through an Exec led QIA process • Piloting GM vacancy control panel (Ext) • National Financial Improvement Programme established (Ext) • PWC engaged by GM to provide investigation and intervention support (Ext) • Year end scenario modelling – worst case, mid case, most likely – in place and reported through Trust Finance Report • AFC and Junior Doctor medical and dental pay awards confirmed August 24 • I&I report issued October 24 with 20 recommendations, discussed through FIG and all being implemented • Mid year review assessing risk to delivery of deficit plan including mitigations developed. Discussed through ETM and FIG with tactical action plan agreed • Change in deficit plan due to nationally agreed deficit funding • Funding for pay award confirmed and calculations indicate no material pressure in year	• NHSE have not confirmed acceptance of the final GM ICS revenue plan (control total discussions ongoing) • FSP to be refreshed to ensure the 3 year trajectory for recovery is achievable • No medium to long term resource confirmation or financial planning (Ext) • Unidentified gap remains in tactical actions	**1st Line:** Monthly Divisional Assurance meetings for all clinical divisions and Finance Improvement Group (FIG) **2nd Line:** Finance & Performance Committee November 2024. **External:** Monthly Provider Oversight Meeting with GM ICB (Ext)	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	Organisational wide communication of the financial position, challenges and controls	Throughout 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	**26.11.24**			**Risk treatment**	Treat				

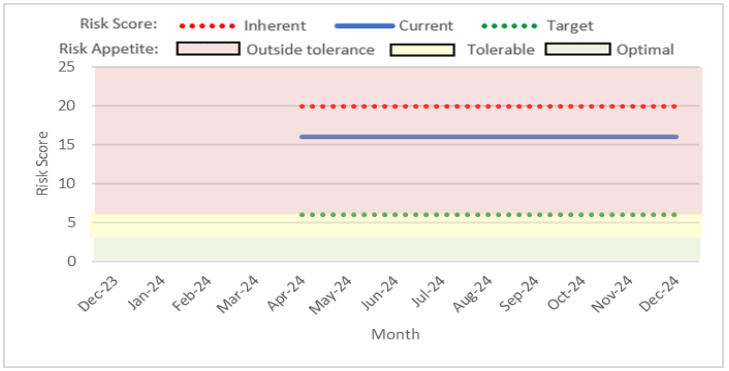
Risk Score Timeline



Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• Robust CIP divisional delivery approach and governance. • Monitored via Divisional Assurance Meetings, with additional escalation to Finance Improvement Group (FIG) • Further oversight at Executive Team, Finance Improvement Group, Transformation Board, F&P Committee and Board of Directors. • Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext). • CIP plan for 2024/25 is made up of Transformation schemes, FSP schemes (Exec Led) and core divisional CIP • CIP Handbook developed providing guidance and oversight processes • MIAA review during 2023/24 gave substantial assurance • Transformation Board input & oversight of strategic programmes. • GM Provider CIP meeting established and meets monthly reviewing all schemes and potential opportunities (Ext) • Diagnostic completed with Newton Europe to address UEC pressures and escalation costs. Discussions ongoing with Wigan Council and ICB re. further work with Newton to implement the changes and deliver recurrent efficiency savings. • Divisional finance performance metrics include recurrent CIP delivery. • Clinical leadership established reviewing benchmarking opportunities for quality improvements through model hospital and GIRFT and reported through CAB, ETM and Divisional Assurance Meetings. • System savings group established across Wigan locality, to be chaired by Deputy Place Based Lead • CIP fully identified in year • Finance Improvement Group meeting monthly with agreed workplan • Executive led Divisional task and finish groups implemented where escalation required • Established QIA process led by Chief Nurse and Medical Director • CIP delivery proposals discussed at ETM June 24 and additional Exec led CIP/FSP schemes identified • Consultancy support engaged to review current approach to project management to ensure that we have the right processes and infrastructure to both maximise delivery and provide assurance • PWC investigation and intervention support will have a key focus on Robustness 2024/25 efficiency programmes and the governance supporting these (Ext) • Newton Europe contract signed August 24 to mobilise UEC transformation project from September 24 • Mid year review discussed at ETM and FIG including tactical actions to improve CIP delivery • Cross divisional CIP group established and chaired by Divisional Director of Ops for Community Services • GM Sustainability Plan endorsed by NHS GM Board to ensure appropriate management of finances and use of resources across GM (Ext)	• Limited mechanisms to facilitate delivery of system wide savings. • Limited PMO resource internally to support delivery of CIP plans	**1st Line:** Monthly Divisional Assurance meetings for applicable divisions and monthly finance improvement group (FIG) **2nd Line:** Finance & Performance Committee November 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	**26.11.24**			**Risk treatment**	Treat				

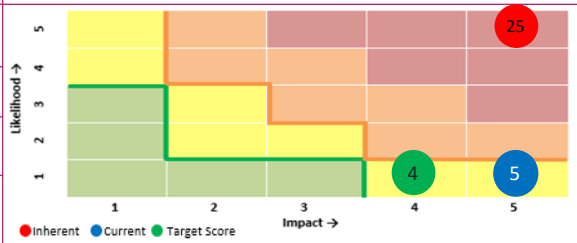
Risk Score Timeline



Strategic Opportunity / Threat Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• Lobbying via Greater Manchester for additional capital into the national process. (Ext). • Capital priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified within plan. • Strategic capital group meeting monthly with oversight of full capital programme. • Operational capital group meeting monthly to manage the detailed programme. • GM Capital and Cash group established, reporting to the Financial Advisory Committee (Ext). • GM Capital Resource Allocation Group (CRAG) established to support prioritisation of capital in 2024/25. • Programme Boards established for major capital schemes. • Design work undertaken for schemes aligned to strategic priorities to support bids for national PDC funding. • Exploring options with commercial partners to facilitate capital investments outside of CDEL in line with strategy. • Cash balances split between revenue and capital, with capital plans below depreciation, to ensure there is sufficient cash balance to support the capital plan. • Five year forward view developed internally to support medium term capital planning and prioritisation • GM ICB required to sign off all new right of use leases (Ext.) • Strategic scheme governance document developed to provide guidance and support decision making. • WWL capital plan is within operational CDEL envelope • Peer review process established for 2024/25 plans focused on clinical, operational and financial risk (Ext) • 10 year infrastructure plan completed and submitted to GM August 24 – refresh ongoing to be submitted 29th November. • Indicative 2025/26 allocation received for planning purposes	• Impact of inflation in terms of project costs and timescales. • GM CDEL plan currently overcommitted by £38m (mitigations yet to be confirmed) – discussions ongoing with NHSE (Ext) • GM lease plan (IFRS16) overcommitted against envelope (significantly reduced from previous reports). • Leases schemes have not all been through GM approval process to progress • Further work required on five year forward view to refine plan.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - November 2024	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring of Capital spend in line with trajectory. 2. Development of capital reporting through the refreshed DFM App. 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 Q3 2024/25 CFO Q3 2024/25 GM ICB (Ext)

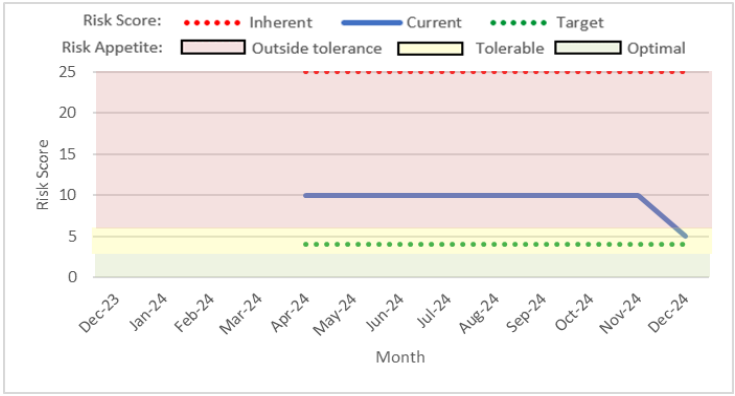
Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

Principal risk	**Risk Title:**	**PR 10: Cash Balance**
	Risk Statement:	There is a risk a that the Trust may have insufficient cash balance to meet normal business activities on a day-to-day basis, due to cash balances potentially becoming too low, resulting in the need to request additional support, financial obligations not being met, or the capital programme being restricted.
Lead Committee	**Finance & Performance**	
Lead Director	**CFO**	
Date opened	**20.05.24**	
Date of last review	**26.11.24**	



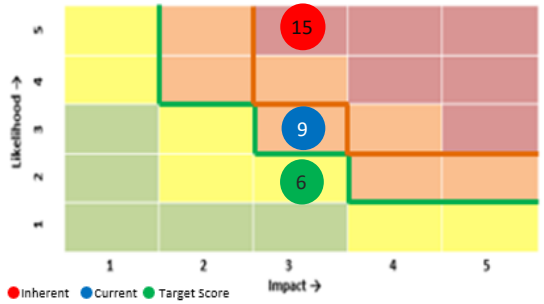
Risk Appetite	Minimal
Risk category	Financial Duties
Threat: System Risk:	**ID 3998** LSR6 Financial plans
Risk treatment	Treat

Risk Score Timeline

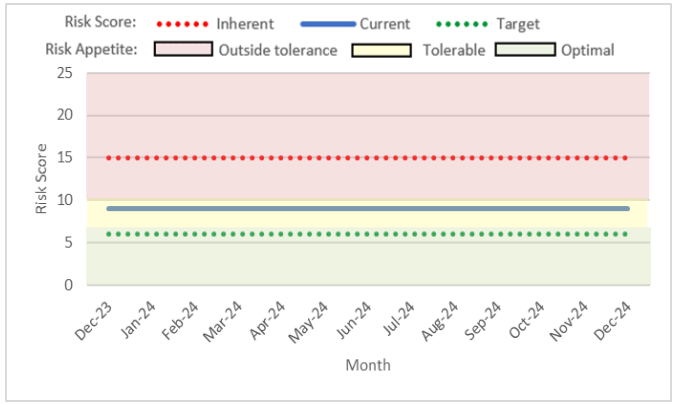


Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• NHSE process exists for providers requesting cash support which is done ahead of each financial quarter. There is an additional mechanism to draw down emergency cash support within the quarter is this becomes necessary, which is subject to additional authorisation. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT. • Enhanced balance sheet reporting including cash metrics to SFT and within monthly finance report. • GM Capital and Cash Group established (Ext.) • Internal cash management group established and strategy developed. • Cash forecast reviewed with no support required in Q1 or Q2 2024/25. • Cash is a standing item on the F&P Committee agenda with papers providing an assessment of the cash position, forecast and mechanism for accessing cash support. • GM cash planning ongoing as part of Trust Provider Collaborative (Ext). • GM ICB continue to make contract payments on 1st of month (rather than 15th) to support cash management. (Ext) • All GM ICB payments outside of contract to be made in a timely manner (Ext) • GM ICB paying additional ERF based on plan (Ext) • See PR 8 for additional controls to ensure that CIP delivery is cash releasing. • GM Deficit plan confirmed cash backed with WWL receiving £7.8m in October 24, £13.4m in total for 2024/25.	• Best practice Cash Management document under development via the GM Technical Issues Group (Ext)	**1st Line:** Cash management Group **2nd Line:** Finance & Performance Committee November 2024	• 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**

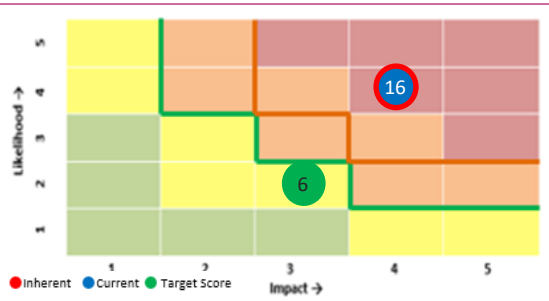
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 11: Elective services**		
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting 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	**26.11.24**		**Risk treatment**	Treat

Risk Score Timeline

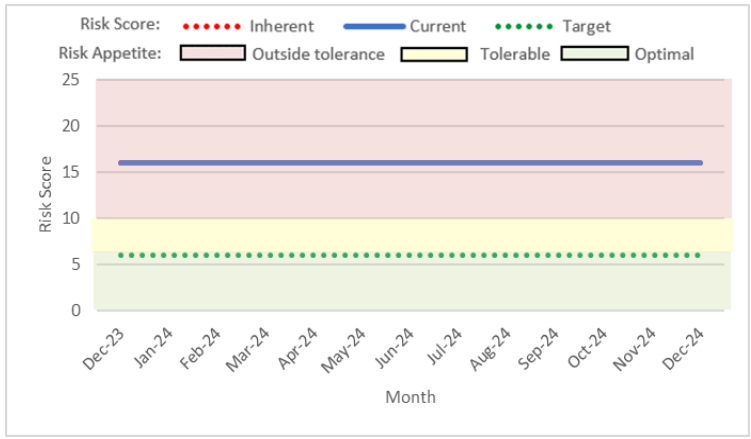


Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: (ID 3289)	• On track to eliminate waits over 65 weeks, except for Gynaecology patients. Exploring options for mutual aid. • Bi weekly meetings with ICB. • Continue to exceed the trajectory for the cancer faster diagnosis standard. • Implementation of Community Diagnostic Centres which will provide more capacity without waiting list initiatives. • Monitor through divisional assurance meetings with clear escalation protocols to exec team meetings and F&P Committee - developed into an app. • Transformation Plan - elective productivity and capacity aims to increase diagnostics and support delivery of electives and develop elective capacity. • Providing mutual support from GM and region for high volume low complexity plus orthopaedic work. • Digital validation of waiting lists.	• No new dates for Industrial action announced, but no resolution provided. • Demand for patients on cancer pathways exceeds capacity and impacts on delivery of non-cancer elective work. • Diagnostic capacity insufficient to deliver elective waiting times in some modalities. • Follow up waiting list is increasing. • Increase productivity to meet organisational targets • Impact of Estates issues on elective activity.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – November 2024 • Elective activity and efficiency board chaired by CFO.	•No gaps in assurance currently identified.	1. Revised endocrine clinic templates agreed. 2. Exploring mutual aid and insourcing options for Gynaecology. 3. GM pilot of external referral management.	March 2025 March 2025 March 2025

Corporate Objective: CO13 Improve the responsiveness of urgent and emergency care	1	2	3	**Overall Assurance level**	**Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 12: Urgent and Emergency Care**		
	Risk Statement:	There is a risk to urgent and emergency care delivery as we are consistently operating above 92% occupancy levels, due to insufficient capacity and bed base in comparison to Acute Trust's across GM and nationally, resulting in longer waits, delayed ambulance handovers, reduced patient flow and more scrutiny through NHS England.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious
Lead Director	**COO**		**Risk category**	Performance / Hospital Demand, Capacity and Flow
Date risk opened	**05.09.22**		**Linked system risks**	LSR8: Statutory duties including the NHS Constitutional targets
Date of last review	**26.11.24**		**Risk treatment**	Treat

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3533)** Linked risk on corporate risk register: **3423** ED – insufficient patient flow	• Emergency Care Intensive Support Team (ECIST) and Newton Europe programme of works to support the existing hospital transformation programme. • A&E 4 hour performance is improving • GM Super Multi agency Discharge Event (MaDE) took place 6th to 12th September. • Flagged to the system that WWL bed base per population is considerably lower than the rest of GM. • Delay in ambulance handovers within 60 minutes has increased due insufficient capacity. • No right to reside recording has been reviewed in line with national guidance which will result in a reduction in number reported. • Hospital Discharge and Flow Programme led by COO. • The urgent and emergency care transformation board supports system wide change. • Full capacity protocol. • Urgent Care Village rated as 'good' at recent CQC assessment.	• Insufficient capacity with over 100% occupancy rate. • Corridor care in spells rather than consistent, but is still occurring. • Work required further upstream regarding higher acuity of patients in borough.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – November 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

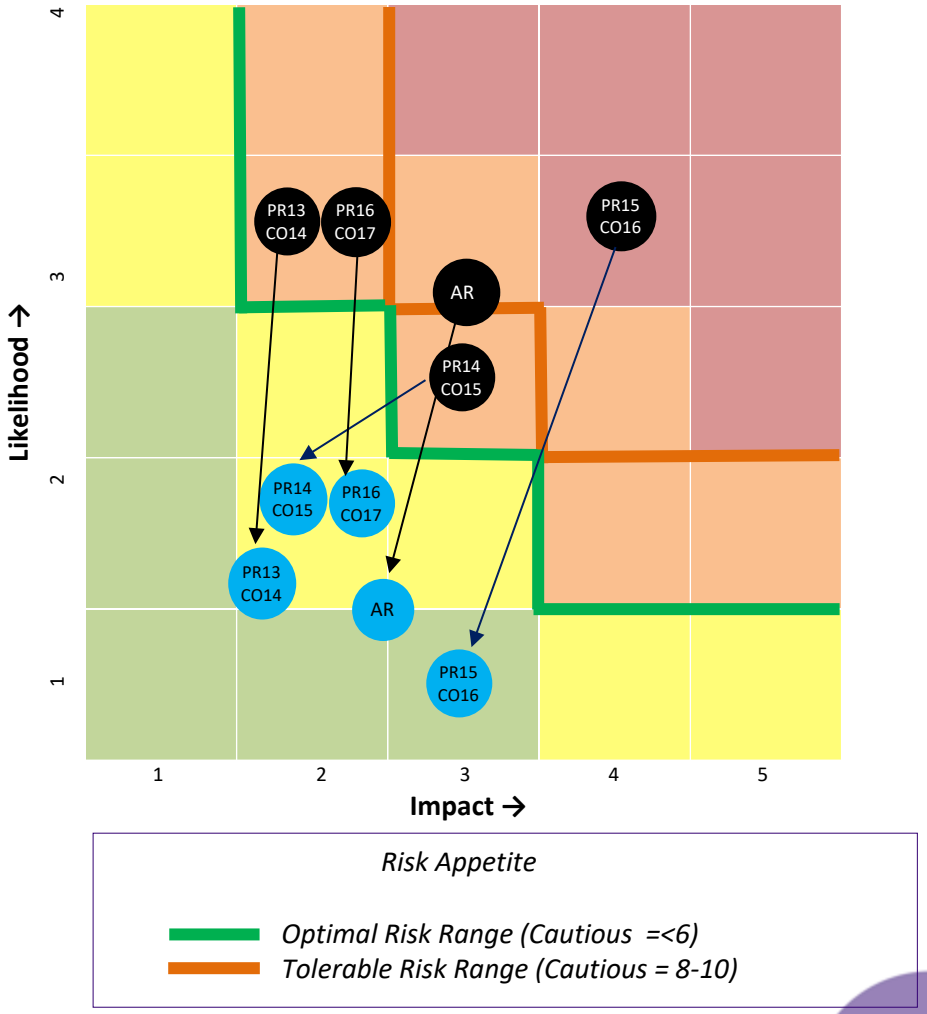
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

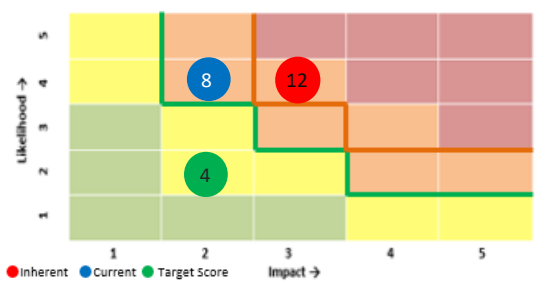
The following objectives are aligned to the **partnerships** strategic priority:

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

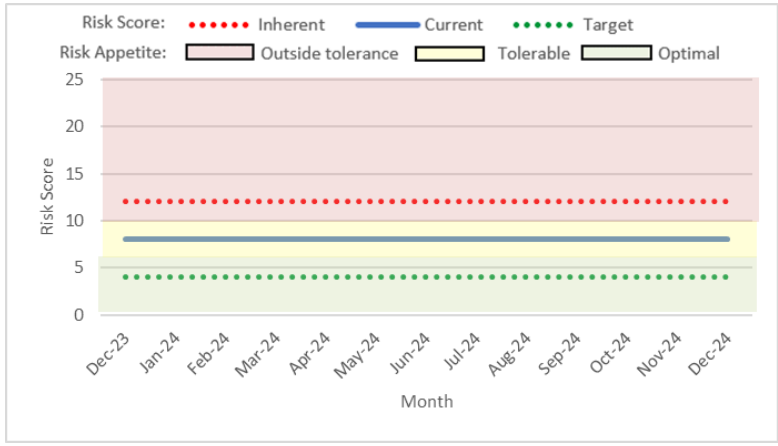
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



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

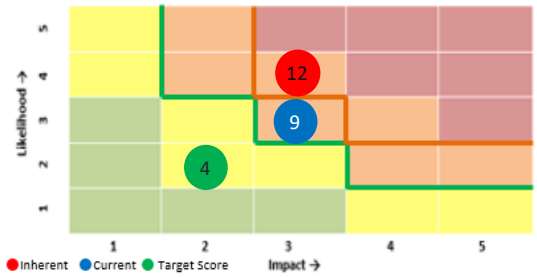
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 13: Supporting widening access to employment for local residents**			
	Risk Statement:	There is a risk that access to funding for support initiatives which support widening access to employment for local residents 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	**19.11.24**		**Risk treatment**	Treat	

Risk Score Timeline

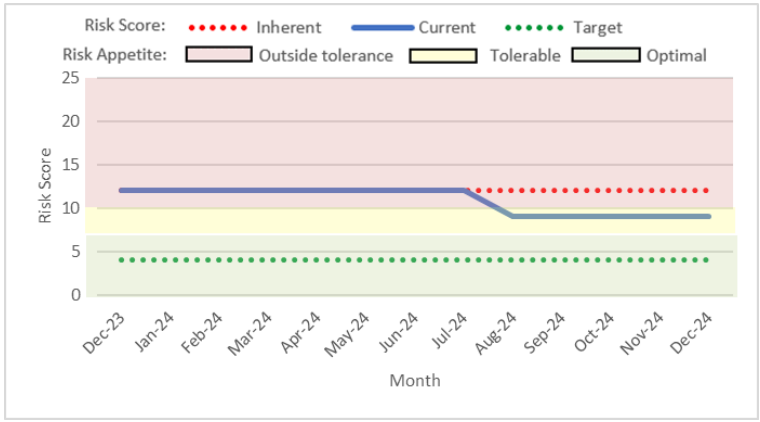


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3852**	• Progress reviewed through Anchor Institution Steering Group. • Wigan and Leigh College have funded a role for 12 months to support our Talent4Care programme. The Talent4Care lead has been in post since September. This is increasing our representation at local careers events and two new cohorts of our sector-based work academy programme to support people boost their employability through placements at the college and WWL.	•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. Review current and potential widening access to employment schemes through the Anchor Institution Steering Group 2. Consider development of approach to business cases which take into account quantifiable social benefits.	March 2025 - DSP

Corporate Objective: **CO15** To develop effective partnerships across GM and the Wigan Locality	1	2	3	**Overall Assurance level**	**Medium**

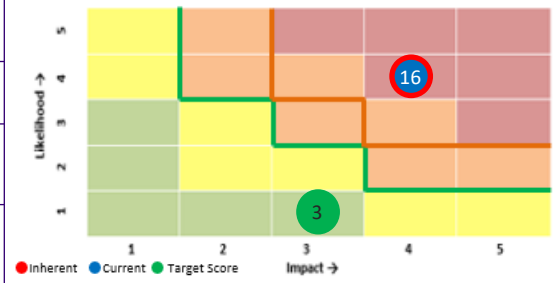
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 14: Partnership working - CCG changes**		
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.		
Lead Committee	**Board of Directors**		**Risk Appetite**	Cautious
Lead Director	**DSP**		**Risk category**	Strategy
Date risk opened	**19.10.21**		**Linked risks**	SR7 - system leadership
Date of last review	**18.11.24**		**Risk treatment**	Treat

Risk Score Timeline

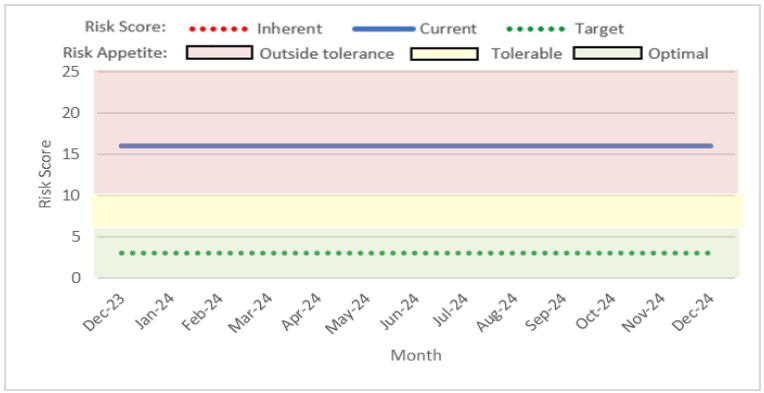


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3300**	• Locality meeting structures in place to support lasting corporate knowledge. • Development of locality UEC transformation programme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

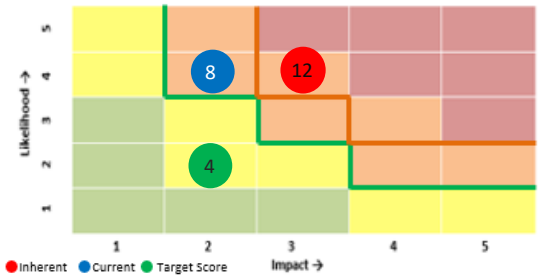
Corporate Objective: C16 Progress towards becoming a Net Zero healthcare provider	1	2	3	**Overall Assurance level**	**Medium**

Principal risk	**Risk Title:**	**PR 15: Estate Strategy - net carbon zero requirements**		
	Risk Statement:	There is a risk that the Trust will not meet its net zero commitments and Climate Change will have an impact on the Trust delivering services, that cannot be mitigated.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious
Lead Director	**DSP**		**Risk category**	Sustainability /Net Zero
Date risk opened	**19.10.21**		**Linked system risks**	SR9 – Drive innovation
Date of last review	**18.11.24**		**Risk treatment**	Treat

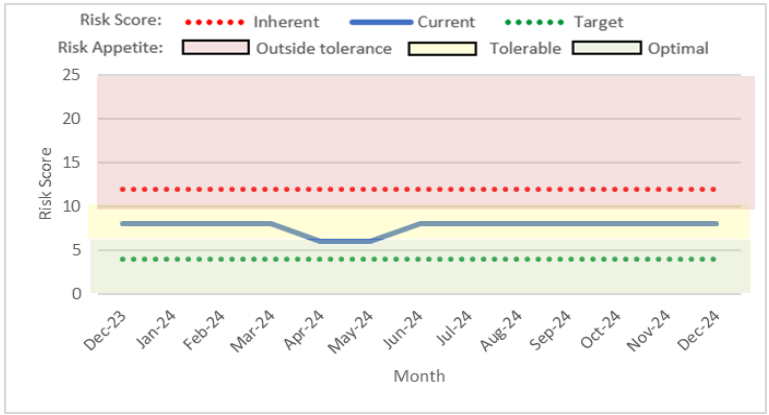
Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3296**	• Sustainability Manager in post. • Band 7 Energy Manager approved. Have not been successful in appointing to post. • Climate Change Adaptation Plan is in development. • Heat Decarbonisation Plan has been produced. • Sustainable Travel Plan has been produced. • Prioritised investment plan, Net Zero Strategy and Green Plan have been produced to outline how the trust will address its impact on climate change. • Net Zero and sustainability e-learning programme rolled out. Governance structures set up to address divisional sustainability issues. • Sustainability and Net zero expected to be included in corporate objectives process for 2024-25.	• Department is under-resourced and has no resilience. The Environmental and Sustainability Officer has resigned. The sustainability manager is acting as energy manager and administrator which takes up the majority of the working week. • Climate Change Adaptation Plan development has paused due to resourcing issues • Sustainability Impact Assessment has been developed but has not been adopted into the QIA process despite requests to. • Capital funds required to fund adaptation measures. Funds this year have been reallocated to next financial year. This places us significantly behind target. • Lack of functioning sub meters to monitor energy use • Struggling to recruit B7 energy manager. Advertised as an apprenticeship post through UCLans matching scheme. Chosen applicants did not respond to our requests to interview. • Our carbon footprint is increasing and investment into sustainability has been cancelled this year. We are significantly behind having any impact on reducing our environmental impact.	**2nd Line:** • Bimonthly Finance & Performance Committee AAA reporting • Bimonthly Greener WWL Steering Group • Annual Sustainability report • Annual Carbon Footprint • Response plans for business continuity, critical and major incidents • Annual self-assessment against the NHS EPRR framework	**2nd Line:** • EPRR Self assessments reflecting climate change risk assessments (in development)	1. Climate change adaptation plan to be produced, approved, and implemented. 2. Complete carbon footprint assessment annually. 3. Map annual progress towards net zero against net zero trajectory 4. Net Zero Investment Plan and Climate Change Adaptation Plan to be integrated into Capital planning. 5. Climate Change Adaptation to be incorporated into Estates Strategy and site masterplans. 6. Heat Decarbonisation strategy to be integrated into Estates Strategy and site masterplans. 7. Sustainable Travel Plan to be produced and incorporated into Estates strategy and site masterplans. 8. Incorporate Sustainability Impact Assessment into Quality Improvement Assessment 9. Further develop governance structures to ensure all areas captured.	March 2025 / DSP

Corporate Objective: CO17 To increase our research activities delivering high quality research with patients and partners across the Wigan Borough						**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 16: University Teaching Hospital - University Hospital Association criteria**					
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to uncertainty regarding achieving the required core number of university Principal Investigators, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.					
Lead Committee	**Board of Directors**			**Risk Appetite**	Cautious		
Lead Director	**MD**			**Risk category**	Strategy		
Date risk opened	**19.10.21**			**Linked system risks**	SR9 – Drive innovation		
Date of last review	**18.11.24**			**Risk treatment**	Treat		

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3299**	• Project documentation including action log in place. • Research Committee assurance • 5 colleagues confirmed as meeting the substantive employment to EHU.	• A core number of university Principal Investigators. There must be a minimum of 6% of the consultant workforce (for WWL this is 13 individuals) with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. •We are achieving the criteria of a 2 year average of £200k/annum Research Capacity Funding awarded by end of March 2026. (An extension grant has been awarded to the NIHR funded SOFF trial which raises the NIHR grant income profile over the next 2 years.)	**2nd Line:** • Board of Directors – December 2024	• None currently identified.	The key actions for increasing University employed research Principal Investigators. Current status: Target is 13. (Based on 217 wte Consultants in post). 5 (previously 6 but 1 EHU substantive has retired) clinical academics in place. (2024 appointments - Diabetes (Banerjee) and Surgery (Lamb - with University of Bristol). 1 in recruitment (readvertised) EHU/WWL Clinical Academic in Microbiology/Infectious Diseases. Therefore 8 (previously 7) appointments required in final 1.5 years to achieve target of April 2026 for UHA application. NEW (REF eligible) criteria being applied to review all potential staff.	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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Standing Financial Instructions Annual Review
Presented to:	Board of Directors
On:	4th December 2024
Item purpose:	Endorsement
Presented by:	Tabitha Garder, Chief Finance Officer
Prepared by:	Amanda Williams – Deputy Head of Financial Services
Contact details:	T: 01942 773786 E: shirley.martland@wwl.nhs.uk

Executive summary

The purpose of this paper is to request that the changes made to the Trust's Standing Financial Instructions (SFIs) and Budgetary Control and Delegation Arrangements, which were approved by Audit Committee on 25th November 2024 are adopted by Trust Board.

These changes have been recommended following the scheduled annual review of the SFIs. It should be noted that further changes may be required in the coming months, due to the implementation of control measures to support grip and control, the business case process and updates required following the implementation of the Procurement Act 2023. These will be taken to Audit Committee for their approval before being presented to the Trust Board for adoption.

Link to strategy and corporate objectives

None.

Risks associated with this report and proposed mitigations

None.

Financial implications

None.

Legal implications

None.

People implications

None.

Equality, diversity and inclusion implications

None.

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

Senior Finance Team.

Recommendation(s)

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

Report

Background

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

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

Key changes

There are no major changes proposed to the SFI's, some minor changes made to update names of Acts, organisations, systems and staffing posts are detailed at Appendix 1.

Future amendments

It should be noted that the following pieces of work are being undertaken which may require amendment to the SFI's following completion:

- Control measures for discretionary non-pay procurement to be implemented to support grip and control as part of the financial sustainability plan, due to be taken to the Executive Team Meeting on 21 November 2024 for approval.

- Updates to the business case process, due to taken to the Wider Leadership Team meeting on 25 November 2024 for approval.

- The transition from the Public Contract Regulations 2015 to the Procurement Act 2023 which is due to take place on 24th February 2025.

Any further changes to the SFI's following completion of the above will be brought back to Audit Committee for approval.

Recommendation

It is recommended that Audit Committee approve the changes made and to recommend these changes for adoption by the Board.

Appendix 1: Changes to the Standing Financial Instructions

SFI 3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING (page 12)

SFI 3.7 (page 14) – updated the name of the financial management system from DFM to the Finance Hub app via Qlik.

SFI3.12(a)(1) (page 15) – replaced reference to balanced score card with Integrated Finance Report.

SFI 7. TENDERING AND CONTRACTING PROCEDURE (page 19)

SFI 7.20 (page21) - Removed references to Crown Commercial Service (CCS), NHS Supply Chain (NHSCC) Shared Business Service Collaborative Procurement Services (SBS), Health Trust Europe (HTE) or another applicable organisation with appropriate frameworks and replaced with "framework operators and their associated framework contracts, as approved by NHSE Central Commercial function"

SFI 7.29 (page 22) – Removed reference e.g. Crown Commercial Services and replaced with i.e. Atamis.

SFI 11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EXECUTIVE COMMITTEE AND EMPLOYEES (page 34)

SFI 11.8c (page 35) - changed reference to Workforce Expenditure Panel to Pay Control Group.

Updated Director of Workforce to Chief People Officer throughout the section.

SFI 17. CHARITABLE FUNDS (page 46)

Updated references of the Charity Act 2011 to Charity Act 2022 throughout the section.

Updated references to the Charity Policy and Guidance document throughout the section.

SFI 21. INTELLECTUAL PROPERTY (page 52)

Updated R&D manager to Head of Research throughout the section

SFI 21.10 (page 53) – Updated NHS Innovation Hub to "use of IP specialist legal advisors".

SFI 22. DECLARATION OF INTEREST (page 53)

SFI 22.9 - Added clarification that the mandatory process is for staff on 8b and above.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

Draft for Audit Committee: 25th November 2024
Review date: September 2025

The WWL Way

FOREWORD

Within the Terms of Authorisation issued by the sector regulator, NHS foundation trusts are required to demonstrate the existence of comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2003.

The standard requires boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to all staff and those representing the Trust. Additionally, the Board has drawn up locally generated rules and instructions, including delegation arrangements and financial procedural notes, for use within the Trust. Collectively these comprehensively cover all aspects of (financial) management and control. They set the business rules which directors, employees and the Council of Governors (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

SFIs are mandatory for all directors, employees including temporary, fixed term and contract staff and members of the Council of Governors.

CONTENTS

Further references and financial procedures are retained in the Finance Department section of the intranet.

The following policies are specifically referenced.

- Intellectual Property Policy
- Commercial Representatives Policy
- Counter Fraud, Corruption and Bribery Policy and Response Plan
- Conflicts of Interest Policy
- Disciplinary Policy
- Code of Conduct Policy
- The Charity's Income and Expenditure Guidance documents.
- Temporary Staffing Policy

The Trust's Constitution, Standing Orders and the Schedule of Matters Reserved are also referenced.

SFI 1. INTRODUCTION

Purpose and scope

SFI 1.1 These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

SFI 1.2 These SFIs also detail the delegation by the Board of powers and approval limits to officers of the Trust, and as such, contain the Trust's Scheme of Delegation.

SFI 1.3 The Trust's Schedule of Matters broadly outlines those decisions and duties specifically reserved to the Board of Directors. These matters are not delegated, and as such, the Schedule of Matters represents the Trust's Scheme of Reservation. It is therefore recommended that the Schedule of Matters is read in conjunction with these SFIs and the Scheme of Delegation contained herein.

SFI 1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer must be sought before acting.

SFI 1.5 Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of Fraud reported to the Local Counter Fraud Specialist.

SFI 1.6 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible. Please refer to Appendix A for further details on compliance.

SFI 1.7 Where failure to comply with this document constitutes a criminal offence it may result in a criminal investigation and criminal sanctions being applied.

SFI 1.8 These Instructions are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

Terminology

SFI 1.9 Any expression to which a meaning is given in the National Health Service Act 2006, National Health Service and Community Care Act 1990 and other acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Financial Instructions, and in addition:

(a) **"Trust"** means **Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.**

(b) "**Accounting Officer"** means the officer responsible to Parliament for the resources under their control. They are responsible for ensuring the proper stewardship of public funds and assets. The National Health Service Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer. The definition of duties and responsibilities of the Accounting Officer are set out within the NHS Foundation Trust Accounting Officer Memorandum.

(c) **"Board"** means the Chairman, Executive Directors and Non-Executive Directors of the Trust collectively as a body.

(d) **"Council of Governors"** means the Council of Governors as constituted within the Constitution.

(e) **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

(f) **"Budget holder"** means the director or employee with delegated authority from the Accounting Officer to manage finances (income and expenditure) for a specific area of the organisation.

(g) **"Budget manager**" means an employee directly responsible to a budget holder.

(h) **"Budget operator**" has delegated power from a budget manager to control a particular budget(s). Such delegation of powers shall be within defined parameters and shall be recorded in writing.

(i) **"NHS England"** means the office of the Regulator of Health Services of England.

(j) **"Chairman of the Board (or Trust)"** is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

(k) **"Chief Executive"** means the Chief Officer (and the Chief Accounting Officer) of the Trust.

(l) **"Chief Finance Officer"** means the Chief Financial Officer of the Trust.

(m) **"Executive Director"** means a Director of the Trust who may also be an officer.

(n) **"Non-Executive Director"** means a member of the Board of Directors who does not hold an executive office of the Trust.

(o) **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

(p) **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and guidance from NHS England and the Department of Health and Social Care.

(q) **"Committee"** means a committee or sub-committee created and appointed by the Trust.

(r) **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

(s) **"Charitable funds"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under s90 of the NHS Act 1977 and the NHS and Community Care Act 1990, as amended.

(t) **"SFIs"** means Standing Financial Instructions.

(u) **"SOs"** means Standing Orders, which are contained within the Trust's Constitution.

SFI 1.10 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

SFI 1.11 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

Responsibilities and delegation

SFI 1.12 **The Board of Directors** exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on members of the Board and employees as indicated within these Instructions.

SFI 1.13 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees as the Trust has established. These provisions are set out in the Trust's Schedule of Matters.

SFI 1.14 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control. Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

SFI 1.15 The Chairman and Chief Executive must ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.

SFI 1.16 It is a duty of the Chief Executive to ensure that members of the Board, employees, and all new appointees are notified of, and put in a position to understand their responsibilities within, these Instructions.

SFI 1.17 In line with the requirements of the NHS Act (2006) the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with NHS Counter Fraud Authority standards for Providers for Fraud, Bribery and Corruption, in accordance with the NHS Standard Contract.

SFI 1.18 The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(a) the provision of financial advice to the Trust, Directors and employees;

(b) the design, implementation and supervision of systems of internal financial control; and

(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

SFI 1.19 All Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, the Schedule of Matters, Standing Financial Instructions (including Schemes of Delegation) and financial procedures.

SFI 1.20 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure, or who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

SFI 1.21 For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

SFI 2. AUDIT, FRAUD, CORRUPTION, BRIBERY AND SECURITY

Audit Committee

SFI 2.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook and in accordance with the Audit Code for NHS Foundation Trusts issued by NHS Improvement, which will provide an independent and objective view of internal control by:

(a) ensuring that there is an effective internal audit function established by management, that meets mandatory Public Sector Internal Audit Standards;

(b) reviewing the work and findings of the external auditors;

(c) reviewing financial and information systems, monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements;

(d) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(e) monitoring compliance with Standing Orders and Standing Financial Instructions;

(f) reviewing schedules of losses and special payments, making recommendations to the Board; and

(g) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

SFI 2.2 Where the Audit Committee considers there is evidence of ultra vires transactions or improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board.

SFI 2.3 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

Chief Finance Officer

SFI 2.4 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS foundation trust audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud, corruption or bribery;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(e) a clear opinion on the effectiveness of internal control in accordance with the current Risk assessment framework issued by NHS England including, for example, compliance with control criteria and standards;

(f) major internal financial control weaknesses discovered;

(g) progress on the implementation of internal audit recommendations;

(h) progress against plan over the previous year;

(i) a strategic audit plan covering the coming three years; and

(j) a detailed plan for the next year.

SFI 2.5 The Chief Finance Officer or designated auditors are entitled, without necessarily giving prior notice, to require or receive:

SFI 2.6 access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

SFI 2.7 access at all reasonable times to any land, premises, members of the Board and Council of Governors or employees of the Trust;

SFI 2.8 the production of any cash, stores or other property of the Trust under a member of the Board or employee's control; and

SFI 2.9 explanations concerning any matter under investigation.

Role of internal audit

SFI 2.10 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data; and

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, or inefficient administration; or

(iii) poor value for money or other causes.

SFI 2.11 Whenever any audit matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

SFI 2.12 The Director of Internal Audit/Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

SFI 2.13 The Director of Internal Audit/Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Director of Internal Audit in the form of an Internal Audit Charter. The Charter will comply with guidance on reporting contained in the Public Sector Internal Audit Standards. The Charter will be reviewed at least every three years.

External audit

SFI 2.14 The external auditor is appointed, through a formal process, by the Council of Governors following recommendation from the Audit Committee which should ensure that a cost efficient service is being provided. Where a problem arises in the provision of this service it should be raised with the external auditor and referred on to NHS England if the issue cannot be resolved.

SFI 2.15 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors, based on recommendations from the Audit Committee. The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by NHS England within the Audit Code for NHS Foundation Trusts, at the date of appointment and on an on-going basis throughout the term of their appointment.

Fraud, corruption and bribery

SFI 2.16 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate counter fraud arrangements. In line with their responsibilities, the Trust Chief Executive and Chief Finance Officer shall monitor and ensure compliance on fraud, corruption and bribery as set out in NHS Counter Fraud Authority Standards for providers.

SFI 2.17 The Trust shall nominate a suitable person to carry out the duties of the Local Counter-Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Manual and guidance.

SFI 2.18 The Local Counter Fraud Specialist shall report to the Chief Finance Officer and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Counter-Fraud Manual.

SFI 2.19 The Local Counter Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. In addition, a Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

SFI 2.20 The Bribery Act (2010) came into force on 1st July 2011. Under the Bribery Act it is a criminal offence for organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

SFI 2.21 The Act:

(a) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) makes it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

Security management

SFI 2.22 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance on NHS security management.

SFI 2.23 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management. The Chief Executive has overall responsibility for controlling and coordinating security.

SFI 3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

Preparation and approval of plans and budgets

SFI 3.1 The appropriate Executive Director will compile and submit to the Board a Business Plan, which considers national and system planning guidance, capacity and demand, and workforce, estates and financial targets. The annual business plan will represent the target operating model for the financial year, operationalising the requirements and focus for the coming year to support the Trust's longer term strategic objectives. The Business Plan will contain:

(a) a statement of the significant assumptions on which the plan is based; and

(b) details of major changes in workload, delivery of services, or resources required to achieve the plan.

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

SFI 3.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit income and expenditure plans for approval by the Board. Such plans will:

(a) be in accordance with the aims and objectives set out in the Business Plan;

(b) triangulate with workforce, activity and efficiency plans

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

SFI 3.3 The Trust shall submit information in respect of its financial plans to the Greater Manchester Integrated Care Board and NHS England, once approved by the Board of Directors.

SFI 3.4 The Chief Finance Officer will monitor actual financial performance against plan and report variances and risks to the Board.

SFI 3.5 All budget holders must provide information as required by the Chief Finance Officer to enable income and expenditure plans to be compiled.

SFI 3.6 Budget holders, with divisional responsibility, will electronically sign off their allocated income and expenditure plans at the commencement of each financial year via the Trust's devolved financial management system, the Finance Hub app via Qlik.

SFI 3.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders, to help them manage their delegated financial performance successfully.

Budgetary delegation

SFI 3.8 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the value of the delegated budget;

(b) the purpose(s) of each budget heading;

(c) whole time equivalents (WTEs) in respect of pay budgets;

(d) individual and group responsibilities;

(e) authority to exercise virement;

(f) achievement of planned levels of service; and

(g) the provision of regular reports.

SFI 3.9 The Chief Executive, Executive Directors, Clinical Directors and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

SFI 3.10 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

SFI 3.11 Non-recurring budgets shall not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

Budgetary control and reporting

SFI 3.12 The Chief Finance Officer will devise and maintain systems of budgetary control and reporting. These will include the following:

(a) Bi-monthly financial reports to Finance and Performance Committee and Board, including:

(i) Key performance indicators via the Integrated Performance Report;

(ii) income and expenditure to date showing trends and forecast year-end position;

(iii) income and expenditure

(iv) movements in working capital;

(v) movements in cash and capital;

(vi) capital project expenditure and projected outturn against plan;

(vii) explanations of any material variances from plan; and

(viii) details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation.

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

(c) Investigation and reporting of variances from financial, activity and manpower budgets.

(d) Monitoring of management action to address variances.

(e) Arrangements for the authorisation of budget transfers.

(f) Advice to the Chief Executive and the Board on the consequences and economic and financial impact on future plans and projects of a change in policy, pay awards and other events and trends affecting budgets.

SFI 3.13 Each budget holder is responsible for ensuring that:

(a) they remain within their budget allocation;

(b) any planned reduction in income or overspending on expenditure, which cannot be addressed by virement, are reported to the Board of Directors;

(c) the amount provided in an approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

(d) all recruitment of fixed term or permanent employees must be approved via the Trust's current recruitment policy. Approval must be gained prior to engaging services of any and all agency workers;

(e) they remain within their funded establishment;

(f) they identify and implement cost improvements and income generation initiatives in accordance with the requirements of the approved budget; and

(g) any proposal to increase revenue spending has an appropriate funding stream identified and that this has been agreed by the Chief Executive. Proposals to increase revenue spending should also be signed off by the Chief Finance Officer. This applies to all revenue developments whether part of Annual Business Plan discussions or separate business case initiatives, however funded.

SFI 3.14 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Business Plan.

Budget transfer - virement

SFI 3.15 The facility of virement is available between budget holders/managers of different budgets. Virement can involve the following different types of transfers:

(a) Transfers between non-pay budgets;

(b) Transfers between staff budgets; and

(c) Transfers from staff to non-pay budgets. NB: Transfers from non-pay to staff budgets are not allowable unless agreed and documented, by the Executive Team or as part of the business planning process.

SFI 3.16 There is no financial ceiling limiting the amount of any one virement transfer. In all cases, the Divisional Finance Manager shall be consulted. It is paramount that virement changes do not undermine the integrity of the budgets.

SFI 3.17 To proceed with budget virements the agreement of both parties should be sought by the Divisional Finance Manager.

Capital expenditure

SFI 3.18 The general rules applying to delegation and reporting shall also apply to capital expenditure.

Monitoring of performance

SFI 3.19 The Chief Executive is responsible for ensuring that

(a) the appropriate monitoring returns are submitted to NHS England;

(b) financial performance measures have been defined and are monitored and reasonable targets have been identified for these measures;

(c) a robust system in in place for managing performance against the targets; and

(d) reporting lines are in place to ensure all performance is managed and arrangements are in place to manage/respond to adverse performance.

Emergency expenditure

SFI 3.20 In instances which are deemed as critical the Chief Executive can approve unbudgeted revenue expenditure up to a value of £10,000 (per instance) and with the additional agreement of the Chairman up to £20,000 (per instance). Applications for such an approval must be submitted to the 'Associate Director of Financial Services and Payroll' who will then forward to the Chief Finance Officer for final submission to the CEO and Chairman**.**

SFI 4. ANNUAL ACCOUNTS AND REPORTS

SFI 4.1 The Chief Finance Officer, on behalf of the Trust, will

(a) keep accounts, and in respect of each financial year;

(b) prepare annual accounts, in such form as NHS England and Department of Health and Social Care may, with the approval of the Treasury, direct;

(c) ensure that, in preparing annual accounts, the Trust complies with any directions given by NHS England and Department of Health and Social Care with the approval of the Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared; and

(ii) the information to be given in the accounts.

(d) ensure that a copy of the annual accounts, and any report of the External Auditor on them, are laid before Parliament and that copies of these documents are sent to NHS Improvement; and

(e) submit financial returns to NHS England for each financial year in accordance with NHS Improvement's timetable.

SFI 4.2 The Trust's audited annual accounts must be presented to the Board for approval and received by the Council of Governors at a public meeting.

SFI 4.3 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented at a public meeting and made available to the public.

SFI 4.4 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health and Social Care Group Accounting Manual.

SFI 5. BANK AND GBS ACCOUNTS

General

SFI 5.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

SFI 5.2 The Chief Finance Officer is responsible for negotiating the Trust's banking contracts, establishing any associated mandates and naming personnel to be signatories for banking transactions.

SFI 5.3 No employee may open or hold a bank account in the name and/or address of the Trust or of its constituent hospitals/departments. Any employee aware of the existence of such an account shall report the matter to the Chief Finance Officer.

Bank and GBS accounts

SFI 5.4 The Chief Finance Officer is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's charitable funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board of any external borrowing requirements; and

(e) ensuring that procedures are maintained that document all transaction processing relating to Trust bank accounts.

Banking procedures

SFI 5.5 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

SFI 5.6 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

Banking tendering and review

SFI 5.7 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

SFI 5.8 Competitive tenders should be sought at least every five years, unless the Board determines otherwise. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

SFI 6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

Income systems

SFI 6.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

SFI 6.2 Credit note authorisation will be determined for each manager depending on their role/responsibility and a list of managers who are set up to undertake such approvals is maintained within Oracle.

SFI 6.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

Fees and charges

SFI 6.4 The Trust shall follow NHS Improvement's guidance in setting prices for NHS Service contracts, where services are not covered by a mandatory National Tariff. The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS England (such as Payment by Results National Tariffs), HM Treasury or by statute. Independent professional advice on matters of valuation shall be taken as necessary.

SFI 6.5 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the NHS Commissioning Board – Standards of Business Conduct shall be followed.

SFI 6.6 All employees must ensure that an appropriate Service Level Agreement is in place in respect of all transactions which they may initiate or deal with that results in an income stream for the

Trust. This will include but is not limited to contracts, leases, tenancy agreements, private patient undertakings. Employees must also ensure that an appropriate mechanism is in place for raising timely invoices to recover income due on such transactions.

Debt recovery

SFI 6.7 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

SFI 6.8 Income which is deemed due, but possibly uncollectable, should be dealt with in accordance with debt recovery procedures, and reported as a write-off loss (SFI 14.5) where appropriate.

SFI 6.9 Overpayments should be detected (or preferably prevented) and recovery initiated.

Security of cash, cheques and other negotiable instruments

SFI 6.10 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

SFI 6.11 Trust cash shall not under any circumstances be used for private transactions such as the encashment of private cheques, bank to bank transfers or temporary loans.

SFI 6.12 Trust accounts should not be used for ad hoc temporary banking of employee funds or other monies unrelated to Trust business and income, except patients' monies held in trust.

SFI 6.13 Trust credit cards should not be used for personal expenditure, even if there is an intention to reimburse the Trust.

SFI 6.14 Trust credit cards should not be used to pay employee expenses without prior approval, as these should be reimbursed via Payroll.

SFI 6.15 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

SFI 6.16 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

SFI 6.17 During the absence (whether sickness or annual leave etc.) of the authorised safe key holder, the officer who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be a written discharge of the safe and/or cash box contents on the transfer of responsibilities, with the discharge document authorised by the relevant senior officer and retained for audit inspection.

SFI 6.18 The opening of incoming post shall be undertaken by two officers except where authorised in writing by the Chief Finance Officer. All cash, cheques, postal orders and other forms of payment received shall be entered in an approved form of remittance register. All cheques and postal orders shall be crossed "Not Negotiable Account Payee Only – Wrightington, Wigan and Leigh NHS Foundation Trust". The remittance register should be passed to the cashier from whom a signature should be obtained.

SFI 6.19 All unused cheques and GBS orders will be held as controlled stationery and issued in accordance with controlled stationery procedures.

SFI 6.20 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately. Where there is prima facie evidence of fraud, corruption and bribery it will be necessary to follow the Trust's Counter Fraud Corruption and Bribery Policy and Response Plan. Where there is no evidence of fraud and corruption the loss shall be reported in line with losses procedures.

SFI 7. TENDERING AND CONTRACTING PROCEDURE

General

SFI 7.1 The procedure for making all contracts by, or on behalf of, the Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions.

SFI 7.2 The approval of business cases prior to the procurement process is covered in SFI 23.

SFI 7.3 **In all instances, the intended expenditure should be reflective of the total life cycle costs of provision of the goods and / or services.**

EU Directives governing public procurement

SFI 7.4 Directives by the Council of the European Union promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

Competitive quotations

SFI 7.5 Competitive quotations are required where the intended expenditure or income is equal to, or is reasonably expected to exceed £10,000 but not exceed £50,000 ex VAT.

(a) Quotations should be obtained from at least three suppliers based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(b) Quotations should be submitted by email or via electronic sourcing software, as deemed appropriate by the Procurement Department.

(c) All quotations should be treated as confidential and should be retained for inspection.

(d) The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation (if payment is to be made by the Trust), or not the highest (if payment is to be received by the Trust), then the choice made and the reasons why should be recorded in a permanent record.

SFI 7.6 Contract and tendering procedures within these SFIs should be applied to quotations as best practice.

Competitive tendering

SFI 7.7 Competitive tenders are required where the intended expenditure or income is equal to or is reasonably expected to exceed £50,000, but not exceed the relevant European Union threshold ex VAT.

SFI 7.8 The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) disposals of Trust property or goods (unless specified in **Error! Reference source not found.**).

SFI 7.9 Formal tendering procedures need not be applied where:

(a) the estimated expenditure or income does not, or is not reasonably expected to exceed £50,000 excluding VAT;

(b) the supply is proposed under special arrangements negotiated by the DH, in which event the said special arrangements must be complied with;

(c) the Trust is disposing of Trust assets, as set out in SFI 7.70

(d) the requirement is covered by an existing contract (this includes contracts let by external agencies on behalf of the NHS e.g. NHS Supply Chain); or

(e) there is a national or regional sole supplier agreement in place.

Non–competitive waivers

SFI 7.10 In exceptional instances where competitive quotations and tenders are not deemed possible, Trust officers should seek the approval of the Trust to waive these requirements.

SFI 7.11 Requirements of a statutory nature, and/or services provided by other public sector organisations that are sole suppliers are excluded from these tendering procedures and will not require a non-competitive waiver.

SFI 7.12 Continued professional development and/or training courses that are either sole supplier, provided by another public sector organisation or selected on the basis of geographical location will not require a non-competitive waiver.

SFI 7.13 Contracts for the purchase or rental of land, existing buildings or other immovable property or concerning rights on such property are excluded from the Public Contract Regulations and as such will not require a non-competitive waiver

SFI 7.14 A waiver is not required where a repair is needed to equipment that is covered by an existing approved framework maintenance agreement, and the value of the repair is below £20,000 (ex VAT).

SFI 7.15 Quotation and tendering procedures may only be waived in the following circumstances:

(a) very exceptionally, where the Chief Executive decides that formal tendering procedures would not be appropriate, however in such instances the benefits and rationale must be clearly demonstrated;

(b) timescales - where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(c) sole supplier - where specialist expertise is required and is available from only one source;

(d) maintaining continuity – when there is a clear benefit to be gained from maintaining continuity with an earlier project and/or engaging a different supplier for the new task would be inappropriate. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering (financial evidence must be provided in support); or

(e) standardisation where the requirement is an addition to a previously tendered range of goods and services and clearly supports the Trust policy for standardisation.

SFI 7.16 The waiving of competitive quotation or tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

SFI 7.17 Where it is decided that a competitive quotation/ tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

Authorisation of waivers

SFI 7.18 Where competitive tendering or a competitive quotation process is to be waived, the authorisation limits stipulated are as follows.

Amount	Authorisation
Less than £10,000 ex VAT	No waiver required
£10,001k - £50,000 ex VAT	Deputy Director of Operational Finance
£50,001 - £100,000 ex VAT	Director of Operational Finance
£100,001 to EU Threshold ex VAT	Chief Finance Officer
Up to and over EU Threshold ex VAT	Chief Executive (or Deputy)

SFI 7.19 Expenditure exceeding the relevant European Union threshold may not be waived, unless specified in the European Regulations. The Trust Procurement Department will advise in these circumstances.

Frameworks and approved supplier lists

SFI 7.20 The Trust shall use framework operators and their associated framework contracts, as approved by NHSE Central Commercial function. If the Trust does not use frameworks as mentioned in SFI 7.20, and where tenders or quotations are not required because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

SFI 7.21 The Trust shall ensure that the suppliers invited to tender for estates-related contracts (and where appropriate, quote) are among those on approved lists such as, ProCure22 or the latest DHSC framework providing design and construction services or those outlined in SFI 7.20.

SFI 7.22 All firms who have applied for permission to tender must satisfy the Trust as to their technical and financial competence. All suppliers must adhere, where appropriate, to the standard NHS Terms and Conditions.

Exceptions to using approved contractors

SFI 7.23 If, in the opinion of the Chief Executive and either the Chief Finance Officer or the Director with lead responsibility for clinical governance, it is impractical to use a potential contractor from the list of approved suppliers (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

Contracting/tendering procedure

SFI 7.24 The Trust has adopted an "e-tendering" system to issue and receive all tenders electronically.

SFI 7.25 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders, and no tender will be considered for acceptance unless submitted through the e-tender system, as instructed within the tender documentation.

SFI 7.26 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

SFI 7.27 Every tender for goods and services shall embody the NHS Terms and Conditions and, as appropriate, the contract form required for the specific goods and services.

SFI 7.28 Where the Trust is tendering to undertake the provision of goods/services for another organisation then a full financial appraisal must be undertaken and approved by Executive Team Meeting (ETM) prior to any invitation to tender being submitted. Where approval has been granted a full business case must be completed and approved in accordance with the business case approval process during the period in which the contract is being agreed.

Receipt and safe custody of tenders

SFI 7.29 All tenders must be issued and managed via the Trust's, or other approved, electronic tendering systems i.e. Atamis . No hard copy tenders will be accepted.

SFI 7.30 Electronic tenders will be held and locked electronically until the allocated time and date for opening.

Opening tenders

SFI 7.31 The electronic tendering system is a fully automated, auditable system which seals bids until the response deadline has passed. Therefore, the originating Contract Manager will be deemed authorised to access the electronic tenders and release them once the sealed date and time has passed.

SFI 7.32 A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

Admissibility of tenders

SFI 7.33 In considering which tender to accept, if any, the designated officer(s) shall have regard to whether value for money will be obtained and whether the number of tenders received provides adequate competition.

SFI 7.34 Tenders received after the due time and date may be considered only if the tenders received on the due date have not been opened and the designated officer(s) decide that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, being satisfied that there is no reason to doubt the bona fides of the tenders concerned.

SFI 7.35 The Chief Executive or the Chief Finance Officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition.

SFI 7.36 Technically late tenders (i.e. those dispatched in good time but delayed through no fault of the tenderer) will be regarded as having arrived in due time.

SFI 7.37 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

SFI 7.38 Where examination of tenders reveals errors, which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

SFI 7.39 Necessary discussions with a tenderer regarding the contents of their tender, in order to elucidate before the award of a contract, need not disqualify the tender.

SFI 7.40 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

SFI 7.41 Where only one tender/quotation is received, the designated officer(s) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

SFI 7.42 A tender other than the most economically advantageous tender shall not be accepted unless for good and sufficient reason and a record of that reason be created and approved by the Chief Executive and held with the appropriate tender documentation.

SFI 7.43 Where the form of contract includes a fluctuation clause, all applications for price variations must be submitted in writing by the tenderer and shall be approved by either the Chief Executive or the Chief Finance Officer.

SFI 7.44 All Tenders should be treated as confidential and should be retained for inspection.

Acceptance of tenders

SFI 7.45 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

SFI 7.46 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless the Chief Executive determines that there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

SFI 7.47 It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach; and

(d) ability to complete the project on time.

SFI 7.48 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

SFI 7.49 Post tender negotiations on price shall not be entered into without the specific prior approval of the Chief Finance Officer in writing and must be in accordance with UK and EU Procurement Regulations. Such approvals shall not be given without prior consultation with the Chairman of the Audit Committee or the Chairman of the Finance & Performance Committee. Such negotiations are to be carried out by a senior manager specifically designated by the Chief Finance Officer, witnessed by a second manager, and approved by the Chief Executive. The range and scope of the negotiations are to be determined by the Chief Finance Officer on each and every occasion.

SFI 7.50 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions, except with the authorisation of the Chief Executive.

SFI 7.51 The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate/price current at the time the contract was awarded, and that best value for money was achieved.

SFI 7.52 All tenders should be treated as confidential and should be retained for inspection.

Signing of contracts

SFI 7.53 In all instances, the Trust's Procurement Team must be engaged in the tender procurement process prior to an official order being raised.

SFI 7.54 SFI 7.53 to SFI 7.57 refers specifically to circumstances where a contract needs to be signed (see DHSC guidance document available on the www.gov.uk website).

SFI 7.55 Contracts should be approved as follows:

Amount	Contracts on NHS T&Cs	Contract on Non-NHS T&Cs
Less than £10,000 ex VAT	Associate Director of Procurement	Associate Director of Procurement
£10,001k - £25,000 ex VAT	Associate Director of Procurement	Deputy Director of Operational Finance
Up to £50,000 ex VAT	Director of Operational Finance	Director of Operational Finance
Up to EU Threshold ex VAT	Chief Finance Officer	Chief Finance Officer
Over EU Threshold ex VAT	Chief Executive (or Deputy)	Chief Executive (or Deputy)

Tender reports to the Board of Directors

SFI 7.56 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

Fair and adequate competition

SFI 7.57 The Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and, unless not practicable, in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

Expenditure to be within financial limits

SFI 7.58 No tender or quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

Reverse e-auctions

SFI 7.59 Where appropriate, the Trust will use e-auctions, and partner organisations to conduct e-auctions on its behalf, and will determine throughout the year the most appropriate product areas that will achieve the best value by being managed through an e-auction.

SFI 7.60 The results of the e-auction will be made available for scrutiny and ratification using a similar process to that of electronic tenders, and a record will be kept of the submissions in full.

Health care services

SFI 7.61 Where the Trust elects to invite tenders for the supply of health care services, these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

Items which subsequently breach thresholds after original approval

SFI 7.62 Items estimated to be below the limits set in these Standing Financial Instructions for which formal tendering procedures are not used, which subsequently prove to have a value above such limits, shall be reported to the Audit Committee on a quarterly basis and be recorded in an appropriate Trust record.

Authorisation of tenders and competitive quotations

SFI 7.63 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided in line with SFI 7.53.

SFI 7.64 In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

Private finance for capital procurement

SFI 7.65 When considering PFI funding the Trust should normally market-test. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) a business case must be referred to the Department of Health and Social Care, NHS Improvement, or as per current guidelines;

(c) the proposal must be specifically agreed by the Board of the Trust; and

(d) the selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Compliance requirements for all contracts

SFI 7.66 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) the Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Health Building Note 00-08: Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable; and

(e) appropriate NHS guidance regarding the form of contracts with foundation trusts.

SFI 7.67 Where appropriate, contracts shall be in, or embody, the same terms and conditions of contract as the basis on which tenders or quotations were invited.

SFI 7.68 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all available systems in place.

SFI 7.69 Commercial negotiations and the establishment of a contract management framework may only be undertaken by members of the Procurement Department, unless otherwise authorised by the Chief Executive or Chief Finance Officer.

Disposals

SFI 7.70 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the relevant disposal policy of the Trust;

(c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

(d) land or buildings subject to compliance with DH guidance.

In-house services and benchmarking

SFI 7.71 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering. This will be undertaken adopting a two-stage process.

SFI 7.72 The process for undertaking the Best Value Review is set out below.

(a) Establish a cross-functional project team, to include senior representatives from the department which is the focus of the exercise, Finance, Procurement, staff-side and HR, with project management responsibility residing with the Associate Director of Procurement.

(b) The project team will be responsible for the scope and specifics of the departmental review. This should include quality targets and innovations, as well as cost analysis. Specific metrics would include the range of services offered, head count, and comparison of KPI data, with the aim of providing the Trust with a holistic view of the value received from the existing in-house service provider. For benchmarking, at least one comparator must be an external provider.

(c) The project team are responsible for the production of a report in which improvements/opportunities are identified. The department or service in question is then given a period of 3 months to make any necessary improvements to the in-house service provision, to align itself to the 'best in class' targets. Where improvements are not achieved, escalation to a full 'market testing' exercise is an executive decision.

SFI 7.73 On the basis of the outcome of the benchmarking exercise, the Trust may determine that in-house services should be market tested by competitive tendering.

SFI 7.74 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) specification group, comprising the Chief Executive or nominated officer(s) and specialist;

(b) in-house tender group, comprising a nominee of the Chief Executive and technical support; and

(c) evaluation team, comprising normally a specialist officer, a Procurement officer and a representative of the Chief Finance Officer.

SFI 7.75 All groups should work independently of each other, and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

SFI 7.76 The evaluation team shall make recommendations to the Board.

SFI 7.77 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

Applicability of SFIs on tendering and contracting to funds held in trust

SFI 7.78 These Instructions shall equally apply to expenditure from charitable funds.

SFI 8. NON-PAY EXPENDITURE

Delegation of authority

SFI 8.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

SFI 8.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

SFI 8.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

Authorisation levels for approval of purchase orders

SFI 8.4 The below table details the internal approval levels and limits applicable for the procurement of goods and services through the Trust's procurement order processing system (Oracle).

Approval Level	Approval Level - Posts	Approval Limit
1	Chief Executive/Deputy Chief Executive/Chief Finance Officer	£1,000,000
2	Director of Operational Finance	£300,000
3	Executive Director	£250,000
4	Associate Director / Deputy Director	£150,000
5	Head of Department or Service	£20,000
6	Deputy Head of Department/Head of Service	£10,000
7	Senior Department/Service Manager	£5,000
8	Department/Service Manager	£2,500
9	Department/Service Approver	£1,000
10	Requestor Only	N/A

SFI 8.5 In cases where expenditure is over £1,000,000, the Chief Executive's limit will be increased to allow electronic authorisation in instances where the business case has been approved by the Board and evidence can be shown of this.

SFI 8.6 The table below details the internal approval limits applicable within the Procurement Department for the approval of purchase orders once authorisation has been given to expenditure.

Position	PO Approval Limit
Associate Director of Procurement	£25,000,000
Procurement Manager	£250,000
Contracts Officers (Capital)	£100,000
eProcurement Manager/Contracts Manager/Assistant Contracts Manager	£100,000
Contracts/eProcurement Officer/Assistant	£50,000

SFI 8.7 The procurement process for goods, services or works depends upon whether expenditure is incurred from capital or revenue budgets, and refers to expenditure not already covered by existing NHS national or local contracts.

SFI 8.8 The limits below refer to whole life cost of the contract (i.e. an annual contract value of £70,000 over 3 years requires OJEU tender in respect of revenue) to incur non-pay expenditure (ex VAT):

SFI 8.8.1. Revenue expenditure

1.	Below £10,000	Purchase order
2.	£10,001 to £49,999	Official quotations
3.	£50,000 to EU threshold for goods/services	Official tender exercise
4.	Over current EU threshold for goods/services	OJEU tender exercise

SFI 8.8.2. Capital

1.	Below £10,000	Purchase order
2.	£10,001 to £49,999	Official quotations
3.	£50,000 to EU threshold for goods/services	Official tender exercise
4.	Over current EU threshold for goods/services	OJEU tender exercise

Choice, requisitioning, ordering, receipt and payment for goods and services

SFI 8.9 *Requisitioning:* To ensure best value for money all purchases of goods and services must be made utilising the advice and services of the Trust's Procurement Department. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted. All requisitions shall be priced and include the relevant financial code.

SFI 8.10 *System of payment and payment verification:* The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

SFI 8.11 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds should be incorporated in these SFIs and regularly reviewed;

(b) prepare procedural instructions or guidance within these SFIs on the procurement of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, with the only exceptions set out in SFI 8.12 below; and

(e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for the following:

(i) A list of Directors/employees authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

SFI 8.12 *Prepayments:* Prepayments are only permitted where exceptional circumstances apply.

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.

(b) The appropriate authorised staff member must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is, at some time during the course of the prepayment agreement, unable to meet their commitments.

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold).

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

SFI 8.13 *Official orders:* Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Finance Officer;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

They may be transmitted by a system of Electronic Data Interchange (EDI) approved by the Chief Finance Officer.

SFI 8.14 *Duties of managers and staff:* Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and the relevant staff must ensure that:

(a) all contracts (except as otherwise provided for in these SFIs), leases, tenancy agreements and other commitments which may result in a liability are notified to the Procurement Department in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) all intellectual property (IP) benefits, such as copyright, patents, design rights, trademarks and confidentiality are protected and applied in all cases via the Trust's authorised representatives, (as established in the Trust's Intellectual Property Policy);

(e) discussions with suppliers in respect of commercial terms must not be undertaken other than by members of the Procurement Department;

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(g) all goods, services, or works are ordered on an official order except purchases from petty cash and purchases from suppliers identified on the agreed list of non-PO suppliers/services maintained by Financial Services and Procurement.

(h) verbal orders must only be issued very exceptionally and be accompanied by a purchase order number - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) requisitions/orders/petty cash requests are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(m) petty cash records are maintained in a form as determined by the Chief Finance Officer; and

(n) the Conflicts of Interest Policy (incorporating) Gifts and Hospitality Policy must be adhered to at all times, with no orders issued to or business transacted contrary to this policy.

SFI 8.15 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current guidance.

SFI 8.16 In the case of contracts for building or emergency works which require payment made on account during progress of the works, the Chief Finance Officer shall make payment upon receipt of a certificate from the appropriate technical consultant or works officer appointed to a particular building or engineering contract.

SFI 9. STORES AND RECEIPT OF GOODS

General position

SFI 9.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take; and

(c) valued at the lower of cost and net realisable value, or a weighted average in the case of Pharmacy.

Control of stores, stocktaking, condemnations and disposal

SFI 9.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of any fuel oil and coal shall be the responsibility of a designated estates manager.

SFI 9.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as Trust property.

SFI 9.4 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

(a) All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note should be obtained from the supplier at the time of delivery/service and signed by the staff member receiving the goods/service.

(b) Particulars of all goods/services received shall be registered on the day of receipt, with unsatisfactory goods returned to the supplier within the set timescales.

(c) Stock shall only be issued/released upon receipt of an authorised requisition.

SFI 9.5 All stock records shall be in such form and shall comply with such systems of control as the Chief Finance Officer may require.

SFI 9.6 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

SFI 9.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

SFI 9.8 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 14 Disposals and condemnations, losses and special payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

Goods supplied by NHS Supply Chain

SFI 9.9 For goods supplied via the NHS Supply Chain regional stores, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note ('priced advice note') before forwarding this to the Chief Finance Officer/Director of Operational Finance, depending on value, who shall satisfy him/herself that the goods have been received before accepting the recharge.

SFI 10. CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

Commissioner-related contracts

SFI 10.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Finance Officer regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

SFI 10.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices should comply with NHS Improvement's and NHS England's National Tariff Guidance.

SFI 10.3 The Chief Finance Officer shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

Non commissioner-related contracts

SFI 10.4 Where the Trust enters into a relationship with a non-NHS body or another NHS organisation for the supply or receipt of other services, either clinical or non-clinical, or collaborative arrangements and non-financial contracts, the responsible contracting officer should ensure that an appropriate Service Level Agreement (SLA) or other appropriate contract/collaboration agreement (e.g. in the context of research) is in place and has been signed by both parties. SLAs and other Research Contracts/Collaboration Agreements must be signed off as follows:

(a) For corporate SLAs, the Lead Executive (or nominated deputy)

(b) For divisional SLAs, the Divisional Director of Operations.

(c) For research contracts/collaboration agreements, the Chief Executive (or nominated deputy: Executive Director for Strategy and Planning or Clinical Director for Research

Plus, in all circumstances:

(d) Director of Operations and Performance (or nominated deputy)

(e) Chief Finance Officer (or nominated deputy)

(f) Either: Chief Nurse, or Medical Director (or nominated deputies)

SFI 10.5 This contract should incorporate:

(a) a description of the service and indicative activity levels;

(b) the term of the agreement including termination arrangements;

(c) the value of the agreement;

(d) the operational lead;

(e) performance and dispute resolution procedures; and

(f) risk management and clinical governance arrangements.

SFI 10.6 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

SFI 10.7 Copies of signed SLAs should be retained on file by the contracting officer and, where the contract specifies financial information, a copy should be issued to the appropriate Divisional Management Accountant within Finance.

SFI 10.8 Electronic copies of the SLA and sign off schedule should be submitted to the Head of Legal Services with summary details of the SLA expiry date and any review dates which occur during the term of the SLA.

SFI 10.9 All research contracts/agreements must be expedited and managed by the Research and Development Department in accordance with the National Institute for Health and Care Research (NIHR) standardised contract templates and in compliance with Department of Health and Social Care standard terms and conditions. The Research & Development Department manages all research costings and associated research income and expenditure with Divisional Financial Management oversight. This is performed in accordance with the Trust's Research and Development Policy and national research costing templates and guidelines. Bi-annual financial reports are provided to the Research Committee for review and assurance to the Board.

SFI 11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EXECUTIVE COMMITTEE AND EMPLOYEES

Remuneration and terms of service

SFI 11.1 The Board shall establish a Remuneration Committee comprised of non-executive directors. Such Committee shall have clearly defined terms of reference which specify which posts fall under its remit as well as its composition and the arrangements for reporting.

SFI 11.2 The Committee will undertake the following:

(a) Decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors and any other senior employees under its remit, including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) payable expenses and compensation payments; and

(iv) arrangements for termination of employment and other contractual terms.

(b) monitor and evaluate the performance of the executive directors and any other senior employees under its remit; and

(c) oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

SFI 11.3 When deciding the remuneration, allowances and the other terms of service of the executive directors and any other senior employees under its remit, the Committee shall ensure that they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

SFI 11.4 The allowances paid to the non-executive directors shall be determined by the Council of Governors**.**

Funded establishment

SFI 11.5 The manpower plans incorporated within the annual budget will form the funded establishment.

SFI 11.6 The funded establishment of any department may not be varied without the approval of the Chief Executive unless in accordance with an establishment control procedure approved by the Board.

SFI 11.7 All budget holders must remain within their funded establishment unless prior consent has been granted by the Board.

Staff appointments

SFI 11.8 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; or

(b) unless the changes are within the limit of their approved budget and funded establishment; or

(c) the change is temporary and within the delegated powers of Pay Control Group.

SFI 11.9 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

Processing payroll

SFI 11.10 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

SFI 11.11 The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the current Data Protection Legislation;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque or bank credit to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) segregation of duties in preparing records and handling cash; and

(m) a system to ensure the recovery of sums of money and property, from those leaving the employment of the Trust, due by them to the Trust.

SFI 11.12 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

SFI 11.13 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

SFI 11.14 Advances of pay may only be given to staff to ensure timely remuneration of pay earned or reimbursement of legitimate expenses incurred in advance of normal pay processing. Loans may not be made to staff even if against potential future earnings.

SFI 11.15 Expenses should only be reimbursed via payroll. There should be no reimbursement for Trust purchases via payroll.

Contracts of employment

SFI 11.16 The Board shall delegate responsibility to the Chief People Officer for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment. Local pay variations require the written approval of the Chief People Officer.

SFI 11.17 The Chief Finance Officer will be responsible for maintaining up-to-date procedures, to ensure that assurance can be obtained from off-payroll workers to determine that the correct tax and NI contributions are being paid to HMRC.

SFI 12. EXTERNAL BORROWING AND INVESTMENTS

Public Dividend Capital

SFI 12.1 On authorisation as a foundation trust, the public dividend capital (PDC) held immediately prior to authorisation continues to be held on the same conditions.

SFI 12.2 Additional public dividend capital may be made available on such terms the Secretary of State for Health (with the consent of HM Treasury) decides.

SFI 12.3 Draw down of additional public dividend capital will be authorised by the Chief Executive or Deputy Chief Executive, and by the Chief Finance Officer or the Director of Operational Finance.

SFI 12.4 The Trust shall be required to pay annually to the Department of Health and Social Care a dividend on its public dividend capital at a rate to be determined from time to time, by the Secretary of State.

Commercial borrowing and investment

SFI 12.5 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay interest on, or repay principal on, borrowings held, and will advise the Board on any proposed new borrowing. The Chief Finance Officer is responsible for reporting periodically to the Board concerning all loans and overdrafts.

SFI 12.6 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Finance Officer.

SFI 12.7 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI 12.8 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

SFI 12.9 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Finance Officer.

SFI 12.10 All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Board of Directors.

Investments

SFI 12.11 Temporary cash surpluses must be held only in such public or private sector investments as approved and authorised by the Board in line with the Trust's Treasury Management Policy.

SFI 12.12 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

SFI 12.13 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

SFI 13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

Capital investment

SFI 13.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

SFI 13.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements; and

(b) that the Chief Finance Officer has certified professionally the costs and revenue consequences detailed in the business case.

SFI 13.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Health Building Note 00-08: Estatecode.

SFI 13.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

SFI 13.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall delegate to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender; and

(c) approval to accept a successful tender.

SFI 13.6 The Chief Finance Officer shall issue procedures for the regular reporting of capital expenditure and commitment against authorised capital expenditure.

Asset registers

SFI 13.7 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a rolling programme of physical checks of assets against the asset register.

SFI 13.8 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Department of Health and Social Care Group Accounting Manual and IFRS accounting standards.

SFI 13.9 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

SFI 13.10 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

SFI 13.11 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

SFI 13.12 The value of each asset shall be depreciated using methods and rates as specified in the Department of Health and Social Care Group Accounting Manual.

SFI 13.13 The Chief Finance Officer shall calculate and pay public dividend capital charges as specified in the Department of Health Group and Social Care Accounting Manual.

Security of assets

SFI 13.14 The overall control of fixed assets is the responsibility of the Chief Executive.

SFI 13.15 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

SFI 13.16 The up-to-date maintenance and checking of asset records shall be the responsibility of designated budget holders for all items for which the initial purchase or replacement is within

their service area. All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Chief Finance Officer.

SFI 13.17 Whilst each employee has a responsibility for the security of Trust property, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

SFI 13.18 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

SFI 13.19 The Chief Finance Officer shall be the authorised officer to be responsible for the disposal of assets surplus to requirements.

SFI 13.20 Where practical, assets should be marked as Trust property and have a bar coded tag correlating to the record held on the asset register.

SFI 14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

Disposals and condemnations

SFI 14.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

SFI 14.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will notify the Chief Finance Officer to determine the asset's current valuation and the impact the disposal may have on the Trust's finances. Advice will be given as to the disposal procedure and obtaining the estimated market value of the item, taking account of professional advice where appropriate.

SFI 14.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and

(b) recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

SFI 14.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

Losses and special payments

SFI 14.5 The Chief Finance Officer must prepare procedural instructions on the recording of, and accounting for, condemnations, losses, and special payments, with regard to HM Treasury's Managing Public Money, and NHS-specific guidance and directions.

SFI 14.6 Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery, must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer, or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then inform the Chief Finance Officer and/or Chief Executive.

SFI 14.7 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved.

SFI 14.8 Where property loss/damage is suspected, including theft of or criminal damage (including burglary, arson, and vandalism) to staff, patient or NHS property or equipment, the Chief Finance Officer must immediately inform NHS Protect.

SFI 14.9 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify the Board.

SFI 14.10 Any employee discovering or suspecting fraud, corruption or bribery, or anomalies which may indicate fraud or corruption, must inform the Trust's Local Counter Fraud Specialist (LCFS).

SFI 14.11 The LCFS and/or Chief Finance Officer must report all frauds in accordance with the provisions of the Trust's Local Protocol on the Conduct of Investigations and Application of Sanctions and Redress in Respect of Fraud and Corruption.

SFI 14.12 The Chief Finance Officer will

(a) refer any novel, contentious or repercussive cases to the Department of Health and Social Care for approval, including extra-statutory and extra-regulatory payments, in accordance with HM Treasury direction; and

(b) refer severance payments on termination of employment (not including Treasury-approved MAS scheme payments) to NHS Improvement, who will deal directly with HM Treasury to get the necessary approval.

NHS England and the general public are informed of specific individual losses and special payments which exceed £250,000 via the Annual Reports and Accounts process.

SFI 14.13 The delegated limits approved by the Board for the approval of losses are set out below:

Category of loss	Approval delegated to:	Nominated deputy
1. Losses of cash (a) Theft, fraud, arson etc. (b) Overpayments of salaries, wages, fees and allowances (c) Other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b), loss of cash by fire (other than arson), physical losses of cash, cash equivalents and stamps other than those covered by 1(a) **2. Fruitless payments and constructive losses** (including abandoned capital schemes, except where work is purely exploratory) **3. Bad debts and claims abandoned** (a) Private patients (b) Overseas visitors	≤ £25,000: Chief Finance Officer ≤ £50,000: Chief Executive > £50,000: Audit Committee and Board of Directors	For Chief Finance Officer: Director of Operational Finance or Deputy Director of Operational Finance For Chief Executive: Executive Director

(c)	Cases other than 3(a) and 3(b)		
4.	**Damage to buildings, their fittings, furniture and loss of equipment and property in stores and in use**		
(a)	Culpable causes e.g. theft, fraud, arson or sabotage, whether proved or suspected, neglect of duty or gross carelessness		
(b)	Stores losses		
(c)	Other causes e.g. weather damage or accidental fire		

SFI 14.14 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in respect of bankruptcies and company liquidations. This shall include the requirement for parent company guarantees or banker's bonds in circumstances where a review of company financial credit ratings requires further guarantees to be made prior to awarding contracts.

SFI 14.15 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

SFI 14.16 The delegated limits approved by the Board for the approval of special payments are set out below:

Category of special payment	Approval delegated to:	Nominated Deputy
5. **Compensation payments made under legal obligation** (such as court order or arbitration award for personal injury, property damage or unfair dismissal) **6.** **Extra-contractual payments to contractors** (such as payments for non-contractual obligations which might arguably have been upheld in court)	≤ £25,000: Chief Finance Officer ≤ £50,000: Chief Executive > £50,000: Audit Committee and Board of Directors	For Chief Finance Officer: Director of Operational Finance or Deputy Director of Operational Finance For Chief Executive: Executive Director
7. **Ex-gratia payments** (a) Loss of personal effects (b) Clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied (c) Personal injury claims involving negligence where legal advice is obtained and relevant guidance has been applied	≤ £10,000 Legal Services Department ≤ £50,000 Chief Nurse > £50,000 Audit Committee and Board of Directors	Not applicable

(d) Other clinical negligence cases and personal injury claims (e) Other employment payments (f) Patient referrals outside the UK and EEA guidelines (g) Other (h) Maladministration, such as bias, neglect, or delay		
8. Severance payments on termination of employment (beyond contractual obligations and not including Treasury-approved MAS) **9. Extra statutory and extra regulatory payments**	See SFI 14.12	

SFI 14.17 The Chief Finance Officer shall maintain a Losses and Special Payments Register, which is completed on an accrual's basis.

SFI 14.18 All losses and special payments must be reported to the Audit Committee each quarter, as a minimum.

SFI 15. INFORMATION TECHNOLOGY AND GOVERNANCE

Responsibilities and duties of the Chief Finance Officer

SFI 15.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware, for which the Chief Finance Officer is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for current Data Protection Legislation;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.

SFI 15.2 The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

Responsibilities and duties of other directors and officers

SFI 15.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of trusts in the region wish to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirements; and

(c) support arrangements for the system including business continuity and disaster recovery plans.

Contracts for computer services with other health bodies or outside agencies

SFI 15.4 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

SFI 15.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

Risk assessment

SFI 15.6 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk.

Requirements for computer systems, which have an impact on corporate financial systems

SFI 15.7 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) only appropriate staff have access to such data; and

(d) computer audit reviews are carried out, as considered necessary.

Freedom of information

SFI 15.8 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

Information governance "principle 7 compliance statement"

SFI 15.9 The NHS holds the most sensitive and confidential information about individuals and is bound by current Data Protection Legislation. When sharing data with external parties or data

processed by a third party, we must adhere to General Data Protection Regulations Article 5 (1) (f) which states that: " data must be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures." Therefore, all data processors acting on behalf of the Trust or under instruction from the Trust must adhere to all current Data Protection Legislation and afford the appropriate security to the information they may hold/process where the Trust is the Data Controller. Measures include statements regarding information security; implementation of physical security and access controls, and business continuity measures; information governance training for staff; and incident reporting procedures. Failures may lead to the Trust seeking damages if a breach/data loss occurs.

SFI 16. PATIENTS' PROPERTY

SFI 16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

SFI 16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are notified before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

SFI 16.3 This notification is through:

(a) notices and information booklets;

(b) hospital admission documentation and property records; and

(c) the oral advice of administrative and nursing staff responsible for admissions.

SFI 16.4 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patient's money.

SFI 16.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

SFI 16.6 Patient lockers are available for use by patients, and those wishing to use these facilities may do so following an assessment of competence and capability. For patients who have property that needs to be handed in for safekeeping, and who are unable to use the lockers provided, a Patient Property Record, in a form determined by the Chief Finance Officer, shall be completed in respect of the following:

(a) property handed in for safekeeping by any patient (or guardian as appropriate); and

(b) property taken into safe custody having been found in the possession of:

(i) mentally ill patients;

(ii) confused and/or disoriented patients;

(iii) unconscious patients;

(iv) patients dying in hospital;

(v) patients found dead on arrival at hospital; or

(vi) patients severely incapacitated for any reason.

A record shall be completed in respect of all persons in category (b) including a nil return if no property is taken into safe custody.

SFI 16.7 The Patient Property Record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient or their personal representative, where practicable. The record shall then be signed by both members of staff and the patient, except where the latter is restricted by mental or physical incapacity.

SFI 16.8 Property and money handed over for safe keeping shall be placed immediately into the care of the cashier or designated member of the General Office staff except where there are no administrative staff available, in which case the property shall be placed in the care of the most senior member of nursing staff on duty.

SFI 16.9 Except as provided in SFI 16.10 and SFI 16.11 below, refunds of cash handed in for safe custody will be dealt with in accordance with written instructions from the Chief Finance Officer. Property other than cash that has been handed in for safe custody shall be returned to the patient as required. The return shall be receipted by the patient (or guardian as appropriate) and witnessed. The receipts are then retained by the hospital cashier for audit inspection.

SFI 16.10 The disposal of the property of deceased patients shall be effected by the hospital cashier, or the staff member who has had responsibility for its security. Particularly where cash and valuables have been deposited, they shall only be released after written authority given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other persons entitled the deceased's property.

SFI 16.11 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

SFI 16.12 In respect of a deceased person's property, if there is no will and no lawful kin, the property vests in the Crown and the Chief Finance Officer shall notify the Duchy of Lancaster.

SFI 16.13 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. No other expenses or debts shall be discharged out of the estate of a deceased patient.

SFI 16.14 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

SFI 17. CHARITABLE FUNDS

The charity framework and the applicability of standing financial instructions to the Charity

SFI 17.1 The Trust's SFIs are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

SFI 17.2 The Standing Financial Instructions state the Board of Directors responsibilities as a Corporate Trustee for the management of charitable funds and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, Corporate Trustee responsibilities must be discharged

separately, and full recognition given to its accountabilities to the Charity Commission. The Trustee must ensure compliance with the Charity Commission's latest guidance and best practice, and charity law, including the Charities Act 2022.

SFI 17.3 The discharge of the Board of Directors Corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. The Charitable Trust Committee is a Committee of the Trust Board with delegated powers to administer charitable matters and authorise expenditure.

SFI 17.4 Within these Standing Financial Instructions, 'charitable funds' are defined as the total net assets of Wrightington, Wigan and Leigh Health Services Charity (also known as 'Three Wishes'), which is a registered charity in support of purposes relating to the National Health Service. These chiefly represent the cumulative cash donated and bequeathed to the Charity, net of charitable expenditure to date. Management of the funds is governed by charity legislation.

Approvals

SFI 17.5 The Chief Finance Officer must prepare procedural guidance for raising, handling, and accounting for charitable income, and for the proper expenditure of charitable funds, and shall ensure that each charitable fund is managed appropriately with regard to its purpose, the Charity Commission's latest guidance and best practice, and charity law.

SFI 17.6 No new fund or fundraising activity (except those 'for the general purposes of the Charity', and not undertaken during work time) shall be established without first obtaining the written approval of the Charitable Trust Committee.

SFI 17.7 As Corporate Trustee, the Committee has delegated limits for the approval of expenditure as follows:

Type of charitable fund	Nominated Deputy
Divisional funds and restricted funds (such as appeal funds)	≤ £20,000 including VAT and carriage Divisional Fund Committee > £20,000 Charitable Trust Committee
Fundraising expenditure	≤ £5,000 including VAT and carriage Associate Director of Financial Services and Payroll ≤ £20,000 including VAT and carriage Chief Finance Officer > £20,000 Charitable Trust Committee
The Charitable Trust Committee reserves the right to veto expenditure approved by Divisional Fund Groups and to recharge divisional funds for administrative, governance or other costs.	

Fund management and expenditure

SFI 17.8 All Divisional Fund Committees shall be responsible for the management of funds held within their areas of responsibility including the implementation of initiatives to increase donations.

SFI 17.9 Divisional Fund Committees will be responsible for ensuring that all expenditure incurred through charitable funds meets the public benefit test as outlined in the Charity Act 2022; and that such expenditure is timely, without the unnecessary accumulation of funds.

SFI 17.10 All expenditure must be for 'appropriate charitable purposes', in accordance with the Charity Policy and Guidance document. Exceptionally, strategic and governance expenditure is approved by the Charitable Trust Committee.

SFI 17.11 In the first instance, it is the responsibility of a Divisional Fund Committee or equivalent to ensure that all commitments against a charitable fund represent the best available value for money in terms of direct patient benefit, and are consistent with 'appropriate charitable purposes' as defined by

(a) the fund's objectives;

(b) Charity policies; and

(c) patient benefit criteria set out in charity law.

SFI 17.12 Under no circumstances shall a fund be allowed to go into deficit. It is a responsibility of the Divisional Fund Committee to ensure this does not occur.

SFI 17.13 Where possible, the use of exchequer funds to discharge charitable fund liabilities should be avoided, and any indebtedness to exchequer should be discharged by the charitable fund at the earliest possible time.

Income

SFI 17.14 All charitable gifts, donations and fundraising activities are governed by the Charity Policy and Guidance document. All charitable proceeds must be handed immediately to the Chief Finance Officer via an authorised Cash/General Office, to be banked directly to the Charity's charitable fund bank account. All gifts received shall be confirmed to the donor in the Trust's authorised form of receipt that will ensure the donor's wishes are observed without unnecessarily creating new trusts.

SFI 17.15 Gifts which are intended to personally and directly benefit staff, such as 'thank-you' presents, flowers or contributions to staff recreation are not charitable donations, as they have no link to public or patient benefit, but are, rather, gifts to individuals. As such, they are expected to be modest, and are covered by the Trust's Conflicts of Interest Policy.

SFI 17.16 Under no circumstances shall any income (cash, cheques, or other forms of payment) be retained on any Ward or Department, excepting when a Cash/General Office is closed. Where a donation occurs at night or at weekends, the income shall be retained in a secure environment, with an internal receipt given to the donor at the time the donation is made. In the event of this occurring, the income shall be deposited with a Cashier at the next earliest opportunity.

SFI 17.17 All gifts and income accepted shall be administered in accordance with the relevant fund's charitable objectives, subject to the terms of specific trusts. As the Charity can only accept cash or non-cash donations for all or any purpose related to the Health Service, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting gifts of any kind.

SFI 17.18 In respect of legacies and bequests, the Chief Finance Officer shall be kept informed of all enquiries regarding legacies and bequests, which should be filed on a case-by-case basis. Where required, the Chief Finance Officer shall:

(a) provide assistance covering any approach regarding the wording of wills and the receipt of funds/other assets from executors; and

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration.

Banking

SFI 17.19 The Chief Finance Officer shall be responsible for ensuring that appropriate banking services are available in respect of administering the charitable funds.

Investment management

SFI 17.20 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the Charity's approved Treasury Management Policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Trust Committee include:

(a) the formulation of a Treasury Management Policy, which meets statutory requirements and Charity Commission guidance with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers and, where appropriate, investment fund managers;

(c) pooling of investment resources in line with Charity Commission legislation;

(d) the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds; and

(e) the review of investment performance and of brokers and fund managers.

Asset management

SFI 17.21 Donated assets in the ownership of, or used by, the Trust as Corporate Trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Chief Finance Officer shall ensure that:

(a) appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; and

(b) appropriate measures are taken to protect and/or to replace assets. These are to include decisions regarding insurance, inventory control, and the reporting of losses.

Reporting

SFI 17.22 The Chief Finance Officer shall:

(a) ensure that regular reports are made to the Charitable Trust Committee with regard to, inter alia, fund balances, investments, expenditure, expenditure approvals, and any policies in line with Department of Health and Social Care and Charity Commission guidance;

(b) prepare annual accounts in the required manner, which shall be submitted to the Charitable Trust Committee and Audit Committee within agreed timescales;

(c) prepare an annual Trustee's report and required returns for the Charity Commission for adoption by the Committee;

(d) prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for charitable funds; and

(e) maintain such accounts and records as may be necessary to record and protect all transactions and funds of the charitable funds.

SFI 18. ACCEPTANCE OF GIFTS HOSPITALITY AND COMMERICAL SPONSORSHIP BY STAFF

SFI 18.1 The Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy, the Conflicts of Interest Policy, should follow the guidance contained in the NHS England model policy document. This policy guides officers and should be adhered to in all business dealings with organisations and people outside of the Trust.

SFI 18.2 The Trust will publish on its website, its Register of Interests and Register of Gifts and Hospitality on a bi-annual basis and Registers of Interests and Registers of Gifts and Hospitality will be discussed at each Audit Committee meeting.

SFI 18.3 Gifts to staff, including cash, intended to benefit individual staff members or teams, are not charitable donations to the Trust's charity.

SFI 18.4 Staff should not ask for or accept gifts, rewards or hospitality that may affect, or be seen to affect, their professional judgement. Gifts of cash or cash equivalent should always be declined.

SFI 18.5 Hospitality includes offers such as transport, refreshments, meals, accommodation etc, and should only be accepted where it is secondary to a business event i.e. there is a legitimate business reason. Hospitality must be appropriate and not out of proportion to the occasion i.e. subsistence only.

SFI 18.6 Commercial sponsorship agreements must always be declared. Before entering into a commercial sponsorship agreement written approval should be sought from the individual's line manager.

SFI 18.7 Sponsored post holders must not promote or favour the sponsor's products.

SFI 18.8 Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored post.

SFI 19. RETENTION OF RECORDS

SFI 19.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines NHS Records Management Part 1 and Part 2.

SFI 19.2 The records held in archives shall be capable of retrieval by authorised persons.

SFI 19.3 Records shall only be destroyed in accordance with latest Department of Health and Social Care guidance and a record shall be maintained of those records so destroyed, together with the date of their destruction.

SFI 20. RISK MANAGEMENT AND INSURANCE

Programme of risk management

SFI 20.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS Improvement's Risk Assurance Framework, which must be approved and monitored by the Board.

SFI 20.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) promotion among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including internal audit, clinical audit, and health and safety review;

(f) a clear indication of which risks shall be insured; and

(g) arrangements to review the risk management programme.

SFI 20.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by Department of Health and Social Care Group Accounting Manual.

SFI 20.4 The Chief Finance Officer shall ensure that appropriate insurance arrangements exist in accordance with Department of Health and Social Care guidance. This will be a mixture of NHS Resolution cover and, in some instances, commercial insurance.

SFI 20.5 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some, or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

SFI 20.6 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, exceptions when trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

(b) private finance initiative (PFI) contracts where the other consortium members require that commercial insurance arrangements are entered into;

(c) pressure vessels such as boilers and other associated risks; and

(d) income generation activities – if not related to normal business activity, these should normally be insured using commercial insurance. If the income generation activity is an activity normally carried out by the Trust for an NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

SFI 20.7 All other commercial, or alternative insurance policies, are to be approved by the Chief Finance Officer.

Arrangements to be followed by the board in agreeing insurance cover

SFI 20.8 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

SFI 20.9 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed to the Trust.

SFI 20.10 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

SFI 21. INTELLECTUAL PROPERTY

Intellectual property (IP)

SFI 21.1 The Trust has an approved Intellectual Property Policy.

SFI 21.2 It is appropriate therefore to include IP references in the Standing Financial Instructions.

Definition of intellectual property

SFI 21.3 Intellectual Property can be defined as products of innovation and intellectual or creative activity and can include inventions, industrial processes, software, data, written work, designs and images. IP can be given legal recognition of ownership through intellectual property rights (IPR) such as patents, copyright, design rights, trademarks or "know how."

SFI 21.4 Examples of IP that may be developed in the NHS include: training manuals, clinical guidelines, books and journal articles, PowerPoint presentations, inventions, new or improved designs, devices, equipment, new uses for existing drugs, diagnostics tests, and new treatments.

Ownership of intellectual property

SFI 21.5 Ownership of IP will, in most cases, rest with the Trust. This applies to all IP produced by Trust employees in the course of their employment, specifically when undertaken on Trust premises, using Trust equipment and in contact with Trust patients. IP developed by an employee outside the course of their employment, not utilising Trust assets or Trust patients will usually belong to the employee, subject to agreement.

SFI 21.6 This is in accordance with the Patent Act 1977, and the Copyright, Designs and Patent Act 1988.

SFI 21.7 IP ownership can vary according to the circumstances under which the IP was generated. Such circumstances include:

(a) joint/honorary appointments/trainees;

(b) externally funded work;

(c) commissioned work; and

(d) collaborative projects.

Disputes of ownership

SFI 21.8 If the ownership of IP is disputed, dated written records relating to the IP in question will be assessed to establish the inventor(s), and their proportionate contribution. If such material is not available, the Chief Executive of the Trust will make a final decision, taking professional advice if necessary.

SFI 21.9 Persons covered by the Intellectual Property Policy include:

(a) all staff that are full time or part time employees of the Trust;

(b) full-time or part-time staff who are self-employed (e.g. private practice);

(c) trainee professionals (e.g. Specialist Registrars);

(d) staff seconded to other organisations; and

(e) staff with joint or honorary contracts with another organisation.

Intellectual property management

SFI 21.10 The Trust should use IP specialist legal advisors or NHS Innovation Hubs where relevant in the protection, management and development of commercial opportunities relating to IP. Staff obligations

SFI 21.11 All employees, including those covered by the Intellectual Property Policy, have an obligation to inform the Trust's Head of Research about identified or potential IP activities, and must not, under any circumstances, sell, assign, license, give or otherwise trade IP without the Trust's approval.

SFI 21.12 The Trust brand and logos should not be used unless in connection with Trust business.

Monitoring intellectual property

SFI 21.13 The Head of Research will provide to the Board updates with regards to:

(a) the risks and rewards in respect of approving IP initiatives; and

(b) potential and ongoing IP initiatives.

SFI 22. DECLARATION OF INTERESTS

General

SFI 22.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes.

SFI 22.2 Staff members at Agenda for Change band 8d and above, and any member of staff on any other salary scale at that level and above including all consultants and medical staff, will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

SFI 22.3 A declaration of interest must be submitted by any grade of employee in the event where a relationship exists when involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices and/or equipment.

Bribery Act 2010

SFI 22.4 Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

SFI 22.5 The offences of bribing another person or being bribed carry a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.

SFI 22.6 This Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor will it accept bribes or improper inducements. It is important that all employees, contractors and agents are aware of the standards of behaviour expected of them contained in this policy.

SFI 22.7 It is the duty of Trust employees, including all agency and contracted staff, who have the powers to enter into transactions on behalf of the Trust, not to influence or enter into negotiations or purchases with an individual or entity where a relationship with the other party exists. For clarification relationships include, but are not limited to, spouse, parent, child, brother, sister (and relations of any of these). Relationships also include friendships and are deemed to exist when the employee has any financial interest in the other party.

SFI 22.8 If in doubt, Trust employees and representatives must inform their line manager and, in all circumstances, should declare his/her interest by completing a declaration of interest form which can be found in the Trust's Code of Conduct Policy, and should not take any part in the negotiation process.

Declaration of interest

SFI 22.9 An annual completion of declarations of interest exercise will be undertaken as part of the Trust's annual accounts process and is mandatory for all staff on band 8b and above. Any disclosures not made and later discovered will be considered a breach of Trust Standing Financial Instructions, which could subsequently lead to disciplinary action being taken.

SFI 23. BUSINESS CASE PROCESS

Introduction

SFI 23.1 The Trust's business case process has been established to ensure there is full involvement from any party within the organisation that could be affected by the intended direction of travel. Auditability, governance and financial principles are critical to ensure there is no unforeseen service, quality or financial consequences from our investment decisions.

SFI 23.2 All approved business cases must satisfy one of more of the investment criteria established by the Executive Team. Business cases must include key performance indicators for how the investment will be assessed or measured once implemented.

SFI 23.3 All business cases must have a reference number assigned by the finance department, referenced within the minutes of the meeting of the approving entity.

Revenue and capital expenditure

SFI 23.4 All revenue and capital investments must be submitted for a formal decision using the Trust's current business case process and template. Business cases for national funding should be on the appropriate NHSE template.

SFI 23.5 Should the Trust approve, it may also be necessary to seek approval from the Greater Manchester Integrated Care Board or NHS England.

SFI 23.6 Business cases will be approved in accordance with the following table:

Type of Business case	Capital Medical Equipment Group	Executive Team Meeting	Finance and Performance Committee	Board of Directors
Capital medical equipment, within the delegated capital limit for Capital Medical Equipment and with no revenue implications.	£500k	N/A (CME cases over £500k still require ETM endorsement before going to F&P)	£1m	>£1m
All other business cases	N/A	£500k	£1m	>£1m

The value of a business case is defined as the total combined revenue and capital expenditure (calculated as total capital expenditure, plus recurrent revenue expenditure plus one-off revenue expenditure).

Executive Team may delegate the approval of business cases to the Wider Leadership Team (WLT) through its terms of reference.

Appendix 1

As an organisation that is publicly funded with stringent financial duties to achieve, it is essential for the Trust to have robust financial controls in place. This will ensure that we are providing value for money, that our colleagues are working within this guidance framework and that we do not become vulnerable to the risk of fraud. A strong financial governance and control framework will contribute toward the Trust managing its finances on an effective and sustainable basis.

The Standing Financial Instructions (SFI's) form a key role in the Trust's financial governance and control framework, and it is important that employees are aware of their responsibilities for financial governance by understanding and working within the guidance of this policy.

To support the Trust's governance and control framework, a monitoring and reporting process has been implemented to ensure that employees are following the SFI's correctly and that processes and procedures are working effectively.

The following matrix highlights the key areas of the SFI's, how monitoring of compliance will be undertaken and when issues or incidents arise, how these will be managed. In some cases, where there are repeated occurrences of issues or disregard for the framework that put the Trust at risk of Fraud, these will be escalated formally.

It is acknowledged that in the majority of instances staff will have acted in good faith, and there may be situations where further training or guidance is required to support staff to ensure they are working in line with the framework, however, it is important that the Trust does not leave itself open to the risk of fraud. Exploring and understanding issues or incidents that don't comply with this framework will allow for a review of the procedures and controls in place.

We aim to work collectively with staff to understand the root cause of issues and learn from these to prevent future incidents. Whilst our priority is to support staff in following this framework, careless disregard for the processes within this framework or fraud related matters are unacceptable and will be addressed via a formal process.

Chapter of SFI	**Areas for potential non-compliance** ***(This list is not exhaustive)***	**How it will be monitored**	**Applicable to**		**Monitoring by**	**Point at which breach will be escalated for review under Trust disciplinary policy.**
Audit fraud corruption bribery and security	• All instances of fraud, corruption or bribery ***(Section 2)***	Referrals to Local Counter Fraud Specialist	All employees		Local Counter Fraud Specialist	**Immediately**
Business planning budgets budgetary control and monitoring	• Exceeding budgetary total, or virement limits set by the board ***(3.2.2)***	Monthly monitoring of budget statements	Budget holders		Management Accounts	Clinical divisions report on their performance via bi-monthly divisional assurance meetings (DAMs) which are chaired by an Executive Director. An escalation process called RAPID (recovery, action, planning, implementation and delivery) has been introduced where performance metrics can trigger the DAM meeting to convert to a RAPID meeting to provide further scrutiny and support on the financial position.
	• Use of non-recurring expenditure to fund recurring budget expenditure without authority ***(3.2.4)***					
	• Use of approved budget for a purpose other than as specially authorised ***(3.3.2, c)***					
	• Engaging services of agency workers without approval ***(3.3.2, d)***	Budget statements Review of agency invoices	Budget holders		Financial Services	**After 3rd Notification**

Bank and GBS Accounts	• Opening a bank account in Trust name ***(5.1.3)***	As and when the situation arises.	All employees		Financial Services	**Immediately**
Income fees and charges	• Employees must report income due on transactions which they initiate/ deal with including all contracts, leases and tenancy arrangements ***(6.2.3)***	As and when the situation arises.	Budget holders		Management Accounts	**Immediately**
	• Use of Trust cash for private transactions, encashment of cheques bank to bank transfers and loans ***(6.4.2)***	As and when the situation arises.	Cash office		Financial Services	**Immediately**
	• Use of Trust Credit card for personal expenditure ***(6.4.4)***	Via monthly reviews of credit card statements	Credit card holders		Financial Services	**Immediately**
	• Use of Trust credit card for expenses which should be reimbursed through payroll without prior approval ***(6.4.5)***					**After 2nd notification**
	• Holders of safe keys should not accept unofficial funds for depositing in their safes without sealed envelopes or locked containers ***(6.4.7)***	Audits of Cash Office	Cash office		Financial Services	**Immediately**
	• Failure to report losses of cash cheques and other negotiable instruments ***(6.4.11)***	As and when the situation arises.	Cash office		Financial Services	**Immediately**

Tendering and contracting procedure	• Failure to obtain competitive quotes for expenditure expected to exceed £10,000 but not exceed £50,000 ***(7.3.1)***	Requisition entered onto Oracle and checked by buyer	Oracle users		Procurement	**After 2nd notification**
	• Failure to undertake competitive tendering exercise for expenditure that is equal to or reasonably expected to exceed £50,000 ex VAT ***(7.4.1)***	Requisition entered onto Oracle and checked by buyer				**After 2nd notification**
	• Waivers unsupported by procurement (7.6.1)	As and when the situation arises.				**After 2nd notification**
	• Failure to involve procurement in the tender process ***(7.14.1)***	As and when the situation arises.				**After 2nd notification**
	• Unauthorised approval of NHS and Non NHS Contracts ***(7.14.3)***	As and when the situation arises.				**After 2nd notification**
	• Failing to ensure that all items received under a prepayment agreement have been received ***(8.3.4,d)***	As and when situation arises				**After 2nd notification**
	• Failing to comply with requisitioning and ordering processes ***(8.3.6, a- n)***	Monthly reviews of invoice process via Non PO route.	Oracle users		Procurement	**After 2nd notification**
Contracting for provision of healthcare	• Failure to ensure that a SLA is in place for the supply or receipt of services either clinical or non- clinical ***(10.4)***		Legal Team		Legal team	**Immediately**

Terms of services allowances and pay	• Failure to remain within funded establishment without prior consent to changes ***(11.2.3)***	Monthly monitoring of budget statements	Budget holders		Management Accounts	Escalated through divisional internal reporting structure and review meetings with finance managers, Directorate Managers and Directors of Performance. Ultimate outcome is representation at the divisional assurance review with members of the executive team and then Finance and Performance Committee. Finance reports to include details of breaches."
	• Engagement, re-grade, hire of agency staff or changes to any employees remuneration unless authorised to do so ***(11.3.1)***	Monthly monitoring of budget statements	Budget holders		Management Accounts/Payroll	**Under review pending update to temporary staffing policy (Aug 2021)**
	• Late submission of time records to payroll ***(11.4.3,a)***	Monitoring of payroll related information	Payroll authorised signatories		Payroll	**After 3rd Notification**
	• Failure to submit termination forms to the payroll department immediately on					**After 2nd notification**

	knowing the effective date of the an employee's resignation, termination or retirement ***(11.4.3, c)***					
	• Changing an individual's pay outside of agenda for change terms and conditions without the appropriately authorised Local Pay Variation form ***(11.5.1)***					**Controls in place to prevent this happening**.
	• Damage to premises, vehicles and equipment or any of equipment stores or supplies must be reported. ***(13.3.5)***	As and when the situation arises.	All employees		Financial Services	**After 2nd notification**
Disposals and condemnations, losses and special payments	• Failure to dispose of assets in accordance with disposal policies. ***(14.1.2)***	As and when the situation arises.	Budget holders		Financial Services	**After 2nd notification**
	• Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery must immediately inform their head of department. ***(14.2.2)***	As and when the situation arises.	All employees		Financial Services	**Immediately**
Patients Property	• Failure to complete patient property record in respect of patient property handed in for safekeeping ***(16.6)***	As and when the situation arises.	Ward Staff		Financial Services	**After 2nd notification**

	• Failure to hand patient property into the Cash office ***(16.7)***					
Charitable Funds	• Undertaking fundraising activity for the Trust Charity without appropriate approval ***(17.2.2***	As and when the situation arises.	All employees		Financial Services	**After 1st notification**
	• Commitment to expenditure which does not meet charitable purposes and public benefit test ***(17.3.2, 17.3.3)***	Monthly review of expenditure purchases	Charitable Fund Managers		Financial Services	**After 1st notification**
Acceptance of gifts and hospitality	• Failure to disclose commercial sponsorships & Gifts and Hospitality ***(18.6, 8.3.6.n, 17.4.2)***	Gifts and hospitality register	All employees		Local Counter Fraud Specialist/Company Secretary	**After 1st notification**
Risk management and insurance	• Entering in to commercial insurance arrangements without authorisation ***(20.1.6)***	As and when the situation arises.	All employees		Financial Services	**After 2nd notification**
Intellectual property	• Selling, assign license or trade IP without approval ***(20.1.6)***	As and when the situation arises.	All employees		Financial Services	**After 1st notification**
Declarations of interest	• Influencing or entering into negotiations or purchases with an individual or entity where a relationship with the other party exists ***(22.2.4, 22.2.5 & 22.3.1)***	Via MES software	All employees		Local Counter Fraud Specialist /Company Secretary	**After 1st notification**
Business case and tender process	Incurring expenditure where the business case process has not been followed. **(S23)**	Via monthly budget statements and capital to revenue approvals	Budget holders		Management Accounts and Capital Accountant	**After 1st notification**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard and Optimisation Report
Presented to:	Trust Board
On:	04/12/2024
Item purpose:	Information
Presented by:	Consent agenda
Prepared by:	Gemma Weinberg (Digital Midwife)
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

Link to strategy and corporate objectives

The dashboard aids in providing the safest care for birthing people. It is submitted to GM to ensure that WWL is performing at the required level.

Risks associated with this report and proposed mitigations.

The September dashboard has highlighted that there two areas for increased observation. The knife to skin times for Category 2 caesarean sections is flagging as red. Further investigation into this metric may be necessary in addition to the small audit done recently. Additionally, the shift coordinator was unable to remain supernumerary for one shift in September. This was due to high activity and acuity across the Maternity floor.

As many of the figures recorded are small numbers, they cannot be assessed for any themes immediately. Themes will usually be assessed over time using larger numbers of data.

Financial implications

N/A

Legal implications

N/A

People implications

Areas where the figures flag as red can indicate that there are areas which need auditing to ensure that birthing people and their families are receiving the safest possible care.

Equality, diversity, and inclusion implications

Where audits and deep dives are required, these factors are included to see if flagged issues are more prevalent in certain groups.

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

None

Recommendation(s)

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

Report

October 2024 Exception report - Maternity
Summary

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

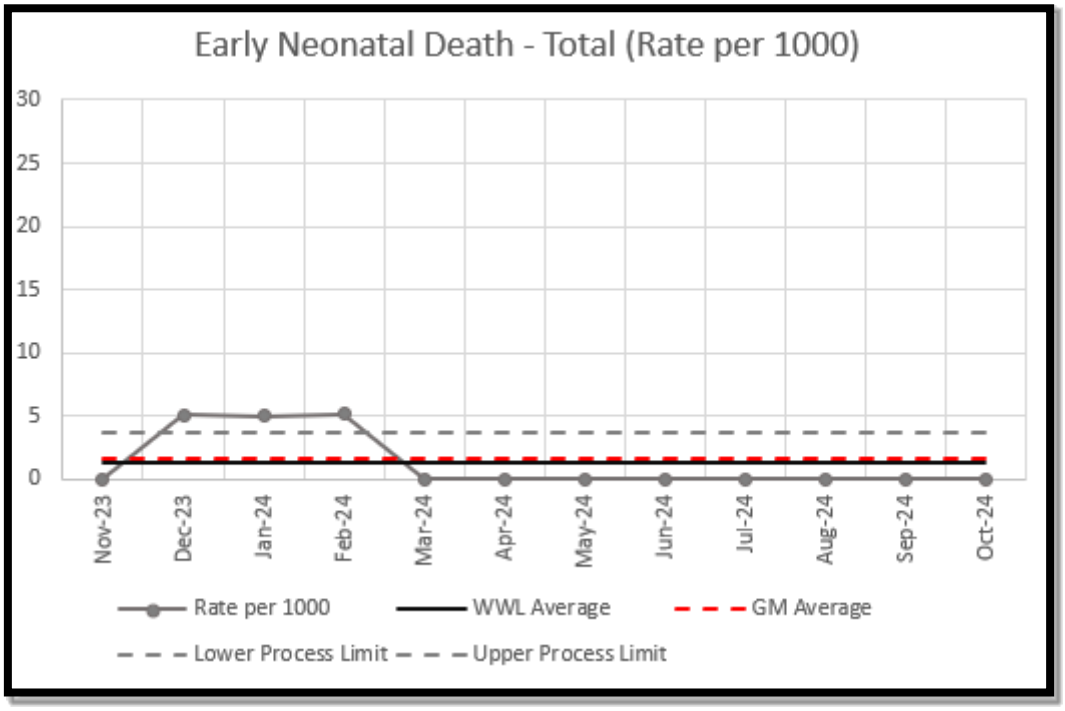
- There were nine validated midwifery red flags reported in October. It should be noted here that the method of collecting red flag reports has changed. We are now pulling these figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. There is a separate red flag report which investigates the red flags in more detail.
- The shift coordinator was able to remain supernumerary for all shifts in October.
- 1:1 care is at 100% in October.
- There were 3 Maternity complaints received in October, and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

PSII Commissioned Incidents

There were no PSII Commissioned incidents reported in October.

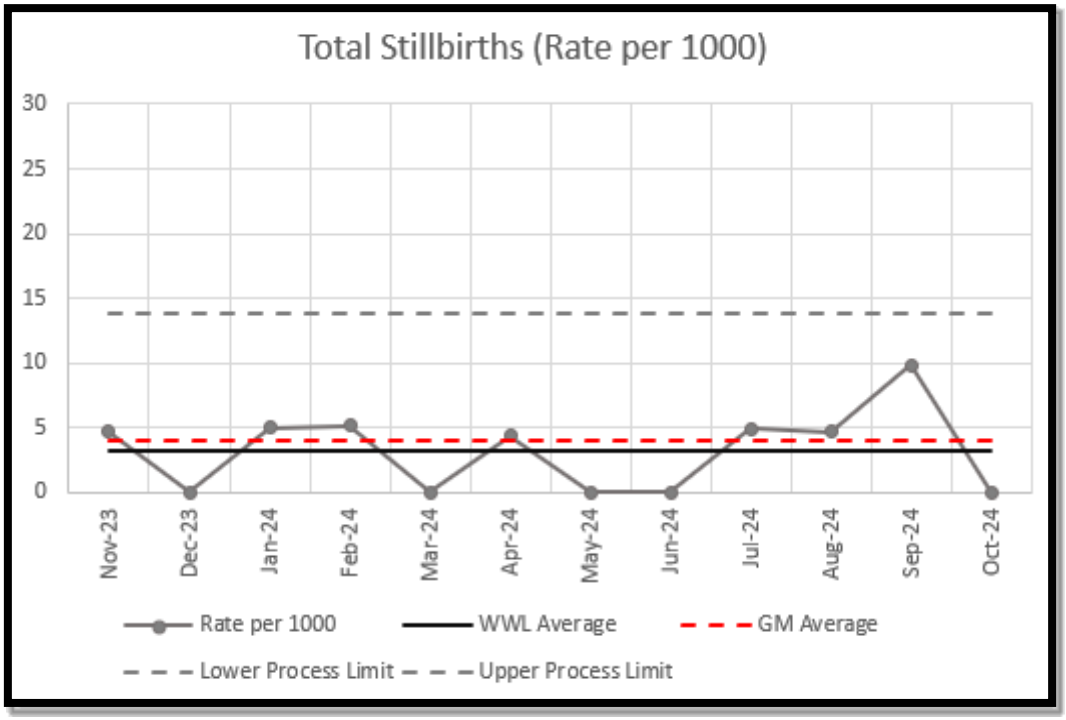
Green

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

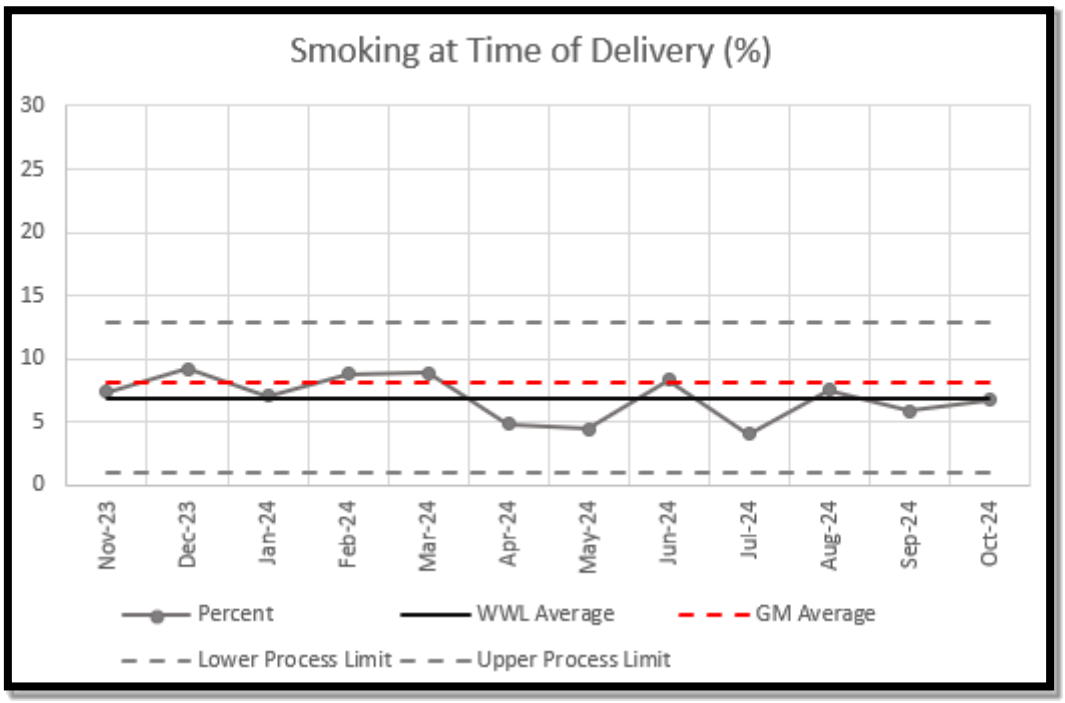


Supernumerary Shift coordinator (%) – There were no shifts in October where the shift coordinator was unable to remain supernumerary.

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



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



Women booked by 12+6 weeks (%) This saw a drop into amber levels in January but the months following have seen the metric return to normal levels and have remained green for 10 months. Wigan remains one of the highest performers in GM for this metric.

The number of mothers who have opted to breastfeed (%) – May saw the highest figure since it started being recorded on the dashboard. June and July see a slight dip in this metric, but higher levels have been seen since. Work continues to improve this metric.

Skin to skin contact (%) This metric saw a small dip in April, but it has seen a return to normal levels since. Work continues to improve this metric.

Women readmitted within 28 days of Delivery (rate per 1000). There were 2 maternal readmissions to the obstetric unit in October. One was for raised BP and the other was for a possible DVT. No omissions in care were noted.

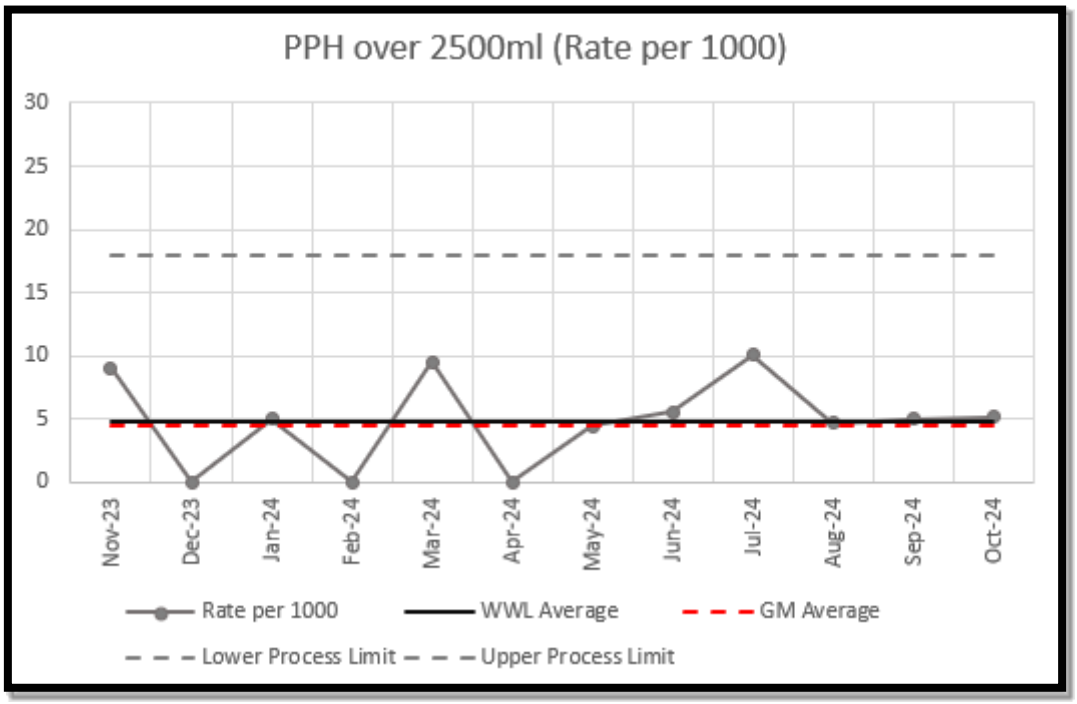
Induction of Labour (IOL) – (%) These levels have been very up and down over the past few months. August and September saw a significant drop into amber levels. October sees improvement into green levels. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes.

1:1 care in labour (%). There were no women in October reported to have not had 1:1 care.

Category 1 Caesarean Sections with no Delay in Knife to Skin (%). This metric rose into red levels in July and August. Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and knife to skin. October figures show that 1 woman out of 15 had an interval of more than 30 minutes (42 minutes).

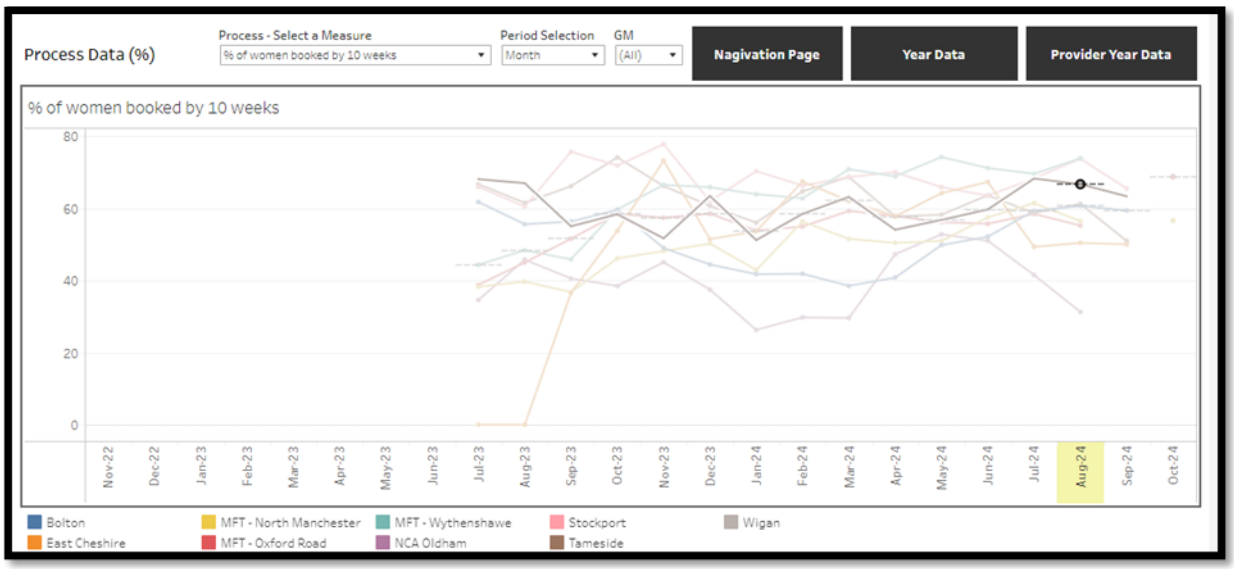
Amber

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



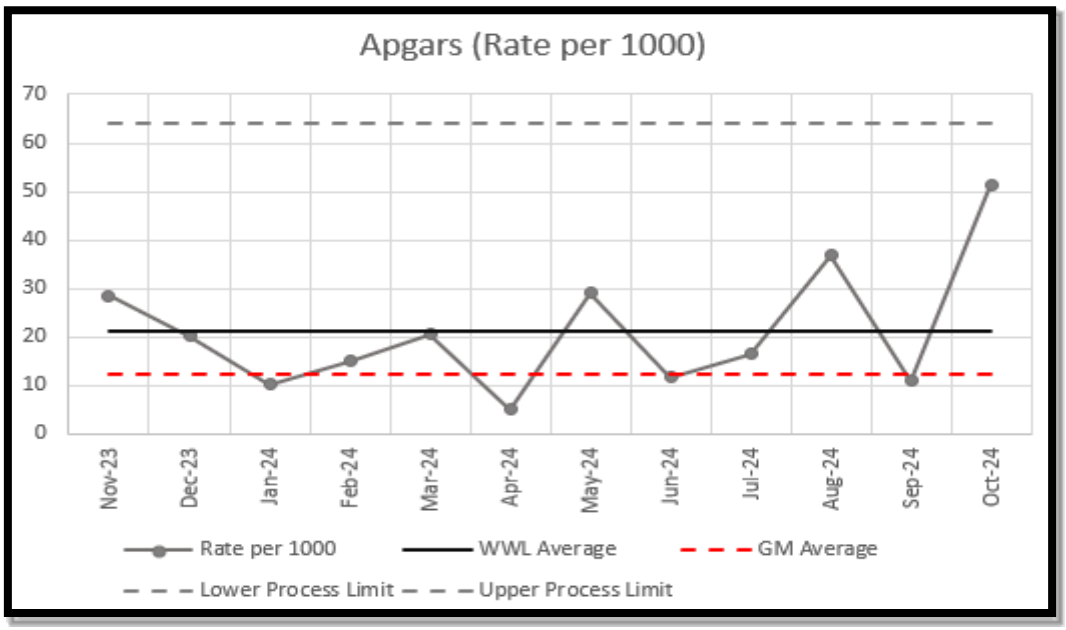
Category 2 Caesarean Sections with no Delay in Knife to Skin (%). This metric saw a further spike into red levels in September. Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and knife to skin. In October there were 5 women out of 40 who had an interval time of more than 75 mins. These intervals ranged from 80 minutes to almost 163 minutes.

Booked by 9+6 – This parameter is a relatively new addition to the GM data. The aim is to work towards booking all women before 10 weeks of pregnancy. Whilst our figures are in amber levels, they have seen significant improvement since the start of 2024. The chart below shows how WWL is performing in relation to GM. As this is not currently one of the key parameters assessed by GM there is no GM average to be able to provide an SPC chart.

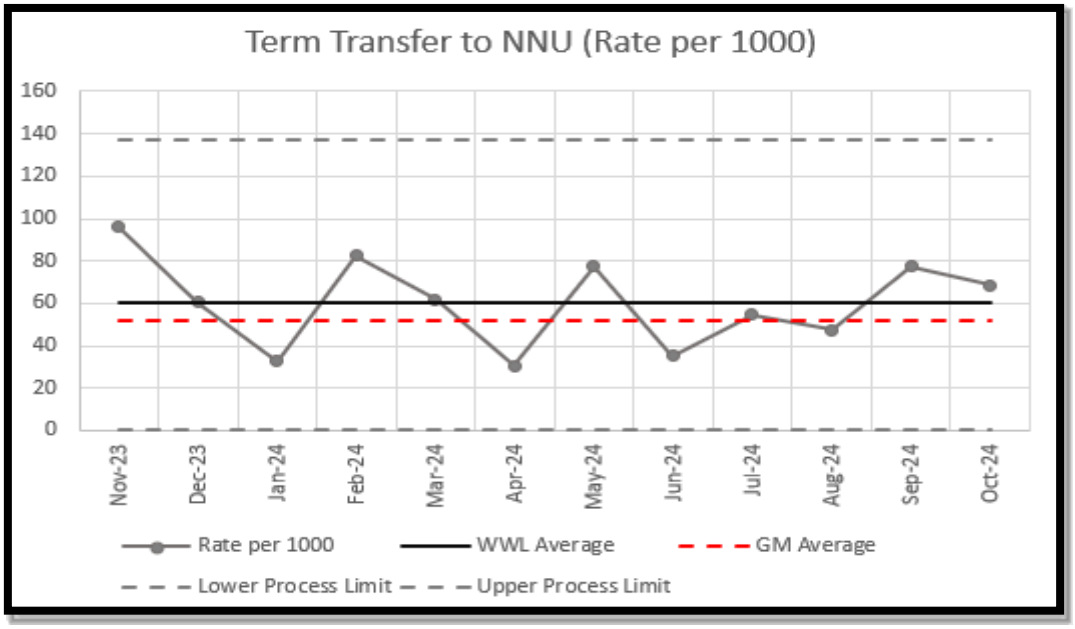


Red

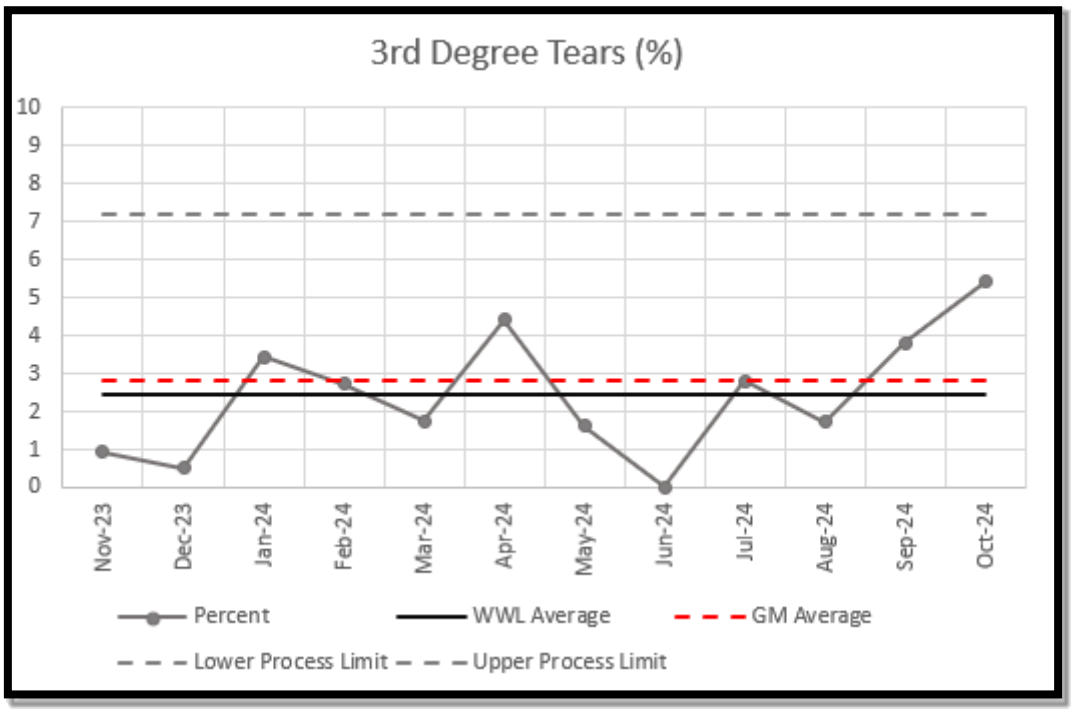
All infants with Apgar's less than 7 (rate per 1000). This metric has seen a significant rise into red levels in October. The rate per 1000 in October equates to 9 babies. All cases are fully investigated. The below SPC chart shows how our figures compare to the GM average (red line).



Term admissions to NNU (rate per 1000). This metric continues in red levels in October. This figure is recorded as rate per 1000 and equates to 12 babies in October. 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).



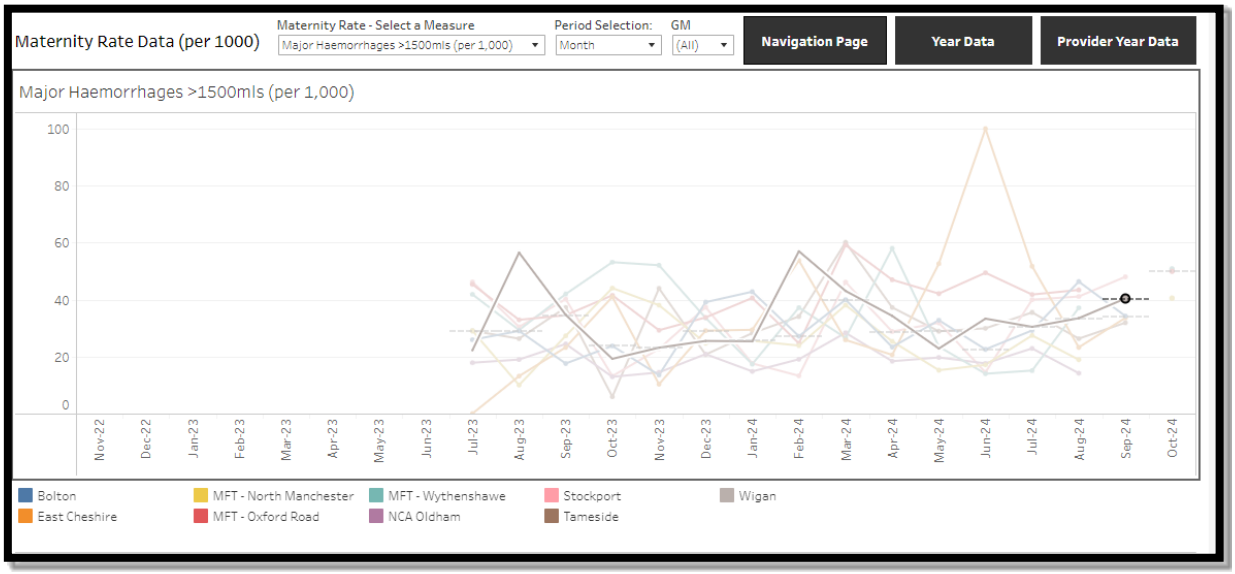
3rd / 4th degree tear (%). The figure is recorded as a rate per 1000. There were five women who had a 3rd degree tear in October. The below SPC chart shows how we compare to the rest of GM for this metric.



Other areas not RAG rated

PPH 1500mls – 2500mls – The figure shown on the dashboard is shown as a rate. The rate in October equates to 6 women. The chart below shows how WWL is performing in relation to the rest of GM. As this is not

currently one of the key parameters assessed by GM there is no GM average to be able to provide an SPC chart. WWL are currently participating in a nation PPH study called OBSUK. It is hoped that the data from this study may help to reduce the PPH figure nationally in the future.



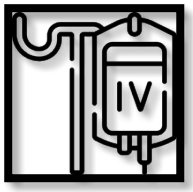
Conclusion

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.

Optimisation Metrics - October

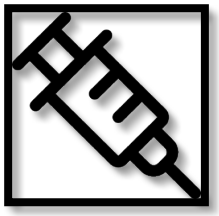
The below relates to 5 mothers who delivered 5 babies.

- All babies were born in an appropriate care setting.
- 2 baby born < 30 weeks gestation.
- 3 babies born < 34 weeks gestation.

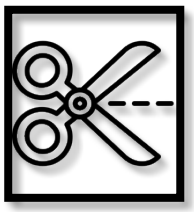


100% of mothers who delivered under 30 weeks received MgSO4.

80% of babies received steroids within 7 days of delivery (< 34 weeks).



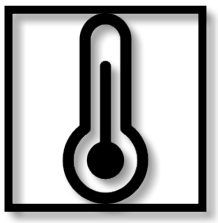
- 4 mothers received a full course of steroids in the week before delivery.
- One mother received a full course more than a week prior to delivery.



80% received optimal cord management (< 34 weeks).

- 4 babies received delayed cord clamping at delivery.
- 1 baby did not receive delayed cord clamping as the placenta detached at delivery

100% of babies had a Normothermic Temperature (36.5-37.5C) on admission to NNU, measured within one hour of birth (< 34 weeks).

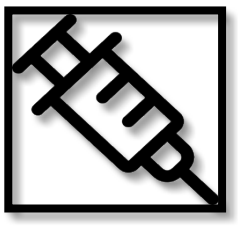


- 5 babies had a normothermic temperature taken within an hour of birth.

80% of babies received maternal breast milk (EBM) within 24 hours of birth (< 34 weeks).

- 4 babies received EBM within 24 hours of birth.
- 1 baby did not receive EBM – maternal choice.

100% of mothers had Intrapartum Antibiotics >4 hrs prior to delivery (< 34 weeks).



- 3 mothers received Intrapartum antibiotics.
- 2 mothers had a CS with no labour so N/A

Safety Dashboard 2024

Optimisation

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

	2024											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of singleton babies born under 27 weeks or < 800g	0	1	0	0	0	0	0	0	0	0		
Number of multiple babies born under 28 weeks gestation	0	0	0	0	0	0	0	0	0	0		
% of babies <30/40 gestation whose mothers received MgS04	100.00%	0.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	50.00%	100.00%		
% of babies <34/40 gestation whose mothers received Antenatal Steroids within 7 days of delivery	50.00%	60.00%	57.00%	100.00%	33.33%	N/A	100.00%	0.00%	60.00%	80.00%		
% of Babies Receiving Delayed Cord Clamping	50.00%	66.60%	71.00%	100.00%	100.00%	N/A	100.00%	50.00%	60.00%	80.00%		
% of babies <34/40 gestation who had a Normothermic Temperature (36.5-37.5C) On admission to NNU measured within one hour of birth	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	100.00%		
% of babies <34/40 gestation who received Maternal Breast Milk (EBM) Within 24 hrs of birth	100.00%	80.00%	71.00%	100.00%	100.00%	N/A	0.00%	100.00%	60.00%	80.00%		
% of babies <34/40 gestation whose mothers received Intrapartum Antibiotics >4 hrs prior to delivery	N/A	66.66%	0.00%	N/A	100% X1 N/A and X2 had full course	N/A	100% x1 N/A and x1 full course	N/A	60.00%	100.00%		

2024					
Q1	Q2	Q3	Q4	YTD	Trend

Safety Dashboard 2024

Maternity

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 Q1	Q2	Q3	YTD	Trend
Activity	Bookings (Total bookings)				254	231	217	242	232	236	255	219	229	272			702	710	703		
	Booked by 10 weeks (as % of total bookings – Exclude transfer to area)	Above 80%	Below 50%		51.18%	58.44%	64.02%	54.04%	56.77%	59.66%	68.24%	66.67%	63.30%	63.90%			57.88%	56.82%	66.07%		
	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%	94.12%	93.15%	93.89%	91.18%			90.38%	92.81%	93.72%		
	Registerable births				199	194	213	207	222	180	202	211	203	192			606	609	616		
	Planned home births (as % of all births)				0.00%	0.51%	0.46%	1.93%	1.80%	1.11%	0.50%	1.42%	1.48%	0.52%			0.32%	1.61%	1.13%		
	Unplanned home births (as % all births) – BBA				3.01%	0.00%	0.00%	0.00%	0.00%	0.56%	0.50%	0.47%	0.49%	0.52%			1.00%	0.19%	0.49%		
	NVD (as % of total births)				51.20%	47.93%	43.19%	42.03%	49.10%	48.33%	42.08%	48.82%	44.83%	35.42%			47.44%	46.49%	45.24		
	Instrumental deliveries (as % of total births)				7.53%	8.76%	10.33%	12.56%	6.31%	5.00%	10.89%	6.16%	6.90%	12.50%			8.87%	7.96%	7.98%		
	Total number of Caesarean Sections (all categories – as % of total births)				41.70%	43.29%	46.01%	44.93%	44.59%	46.67%	47.03%	44.08%	46.31%	52.08%			43.67%	45.39%	45.80%		
	Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour				2	4	10	4	6	4	2	9	7	7			16	14	18		
	Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour				22	16	23	24	25	19	17	18	19	17			61	68	54		
	Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS				8	8	10	12	11	12	10	12	11	21			26	35	33		
	Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour				0	0	0	0	1	5	1	1	1	5			0	6	3		
	Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour				4	7	10	2	7	3	4	4	7	6			21	12	15		
	Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS				4	9	6	8	7	8	9	6	6	4			19	23	21		
	Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy				25	24	19	25	24	22	30	25	17	23			68	71	72		
	Robson Group 6: Nulliparas; single breech pregnancy				5	9	7	4	5	2	1	5	6	1			21	11	12		
	Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus)				4	3	2	6	1	3	2	1	5	4			9	10	8		
	Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus)				2	0	5	3	4	0	8	2	8	1			7	7	18		
	Robson Group 9: All women with a single oblique or transverse pregnancy (including women with a scarred uterus)				0	1	0	0	2	2	3	0	0	1			1	4	3		
	Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus)				7	3	6	5	6	4	8	10	7	10			16	15	25		
	Number successful VBAC				3	3	2	3	3	0	1	5	4	2			8	6	10		
	% 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%	77.77%	64.28%	100%	93.30%			84.00%	88.00%	80.68%		
	% 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%	72.72%	86.66%	66.66%	87.50%			78.83%	79.43%	75.35%		
	Number of Caesarean Section at Full Dilatation				3	3	8	5	2	6	5	1	4	6	.	.	14	13	10		
	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%	42.08%	36.49%	38.42%	35.42%			40.36%	39.07%	39.00%		
	Number of women induced when RFM is the only indication <39 weeks				1	2	0	2	1	2	0	0	0	0	.	.	3	5	0		

		Goal	Red Flag	Measure	2024											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	Number of women induced for Suspected SGA				14	14	16	6	13	14	9	10	5	8		
	Number of In-utero transfers in from other units				4	4	4	5	4	4	4	2	7	3		
	Number of In-utero transfers out to other units				0	2	0	1	2	0	1	1	2	2		
	Average Postnatal Length of Stay				1.7	1.7	1.8	1.7	1.8	1.5	1.5	1.6	1.8	1.9		
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%	2.80%	1.72%	3.81%	5.43%		
	Of which 4th degree tears (number)				0	0	0	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	20.3	33.17	40.4	31.25		
	Number of women with a PPH 1500 - 2500mls				5	11	9	7	5	6	6	7	8	6		
	PPH > 2500mls (Rate per 1000)	Under 4	Above 6		5	0	9.56	0	4.5	5.55	10.1	4.73	5.05	5.2		
	Number of Women Requiring Level 2 Critical Care				1			1	1	1	2	1	1	0		
	Number of Women Requiring Level 3 Critical Care				0			0	0	0	0	0	0	0		
	Number of Blood Transfusions > 4 Units				0	0	0	0	0	0	0	0	0			
	Number of Maternal deaths				0	0	0	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	10.3	14.35	5.05	10.41		
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis (Number)				0	0	1	2	1	1	1	0	0	0		
Morbidity and Mortality	Total stillbirths (as rate per 1000)	Under 3.5	Above 4		5.02	5.15	0	4.83	0	0	4.95	4.73	9.85	0		
	Stillbirths (excluding MTOP as rate per 1000)				5.02	5.15	0	4.83	0	0	0	0	4.93	0		
	Number of stillbirths (excluding MTOP)				1	1	0	1	0	0	0	0	1	0		
	Early neonatal deaths (as rate per 1000)	Under 1	Above 1.77		5.02	5.15	0	0	0	0	0	0	0	0		
	Early neonatal deaths (excluding MTOP as rate per 1000)				0.00	5.15	0	0	0	0	0	0	0	0		
	Number of Early Neonatal Deaths (excluding MTOP)				0	1	0	0	0	0	0	0	0	0		
	Number of babies born below 37 weeks				14	12	19	9	14	9	19	19	21	17		
	Shoulder Dystocia (as % of total births)				1.51%	1.0%	0.93%	1%	0.45%	2%	1%	0.47%	1%	2%		
	Number of singleton babies born under 27 weeks				0	0	0	0	0	0	0	0	0	0		
	Number of multiple babies born under 28 weeks gestation				0	0	0	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	N/A	N/A	N/A	N/A		
	Number of women delivered under 34 weeks (livebirth)				2	4	4	1	3	0	2	2	5	5		
	% of Mothers who delivered under 34 weeks who received a complete course of AN steroids				50%	50.00%	50%	100%	33%	N/A	100%	100%	60%	80%		
	% of Mothers who delivered under 34 weeks who received AN Magnesium Sulphate				100%	75%	75%	100%	100%	N/A	N/A	50%	80%	100%		
	Number of women delivered under 30 weeks (livebirth)				1	1	1	1	0	0	0	0	2	2		

2024					
Q1	Q2	Q3	YTD	Trend
44	33	24		
12	13	13		
2	3	4		
1.73	1.66	4.63		
2.64%	2.02%	2.78%		
0	0	0		
41.72	30.09	31.29		
4.85	3.35	6.62%		
	3			
	0	.		
0	0	0		
0	0	0		
11.82	20.02	9.9		
1	4	1		
3.39	1.61	6.51		
3.39	1.61	0		
2	0.33	0		
3.39	0	0		
1.72	0	0		
1	0	0		
45	32	59		
1.16%	1%	1		
0%	0%	0%		
0	0	0		
0	0	0		
10	4	9		
50.00%	67%	87		
83.00%	100%	65		
3	0.33	0.66		

		Goal	Red Flag	Measure	2024											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Neonatal	% of Mothers who delivered under 30 weeks who received AN Magnesium Sulphate				100%	0.00%	100.00%	100.00%	N/A	N/A	N/A	N/A	50.00%	100.00%		
	% 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	N/A	N/A	100%	100.00%		
	Number of mothers who delivered under 34 weeks who received a partial dose of steroids				1	1	2	N/A	1	N/A	N/A	N/A	1	1		
	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	N/A	N/A	0	0		
	% of babies who had delayed cord clamping (% of total births)				84.85%	89.7%	88.73%	89%	91.44%	93.89%	92%	88%	88%	86%		
	% 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%	63.1%	68.42%	60%	52.94%		
	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	16.57	36.84	11.05	51.42		
	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	54.60	47.37	77.35	68.57		
	Number of babies re-admitted with 28 days of birth				13	16	14	13	18	13	18	16	15	12		
	Number of babies born < 3rd centile				14	15	12	9	9	14	14	14	4	7		
	Number of babies born < 3rd centile >_ 38 weeks				7	6	7	6	4	8	3	6	2	4		
Public Health	% women smoking at time of booking (as % of total bookings)				5.12%	11.7%	8.41%	7.23%	7.42%	9.44%	9.02%	10.05%	5.68%	5.51%		
	% 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%	4.06%	7.58%	5.91%	6.77%		
	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%	80.20%	75.36%	74.88%	75.52%		
	Percentage of Women Initiating Breastfeeding	Above 58%	Under 50%		60.80%	54.12%	57.28%	60%	66.67%	57.22%	52.48%	59.72%	59.61%	65.63%		
	Number of women who report that they are drinking alcohol at booking				0	1	0	0	1	0	0	0	0	1		
Workforce	1:1 Care in Labour (as % all births - excluding El CS and BBA)		Under 100%		100%	100%	100%	99.5%	100%	100%	100%	100%	99.08%	100%		
	Percentage of shifts where shift Co-ordinator able to remain supernumerary		Under 100%		100%	100%	100%	98.33%	100%	100%	100%	98.38%	98.33%	100%		
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	1	1	0	1	1	0	0		
	Number of vacancies				7.63	6.17	6.31	8.13	8.91	7.07	7.93	7.62	8.58	2.5		
	Midwife : Birth Ratio				1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28		
	Prospective Consultant hours on Delivery Suite				60	60	60	60	60	60	60	60	60	60		
	Number of Midwifery Red Flags Reported				0	3	5	5	8	1	0	5	4	9		
Incidents	Number of incidents reported				78	75	55	70	86	64	75	76	66	59		
	Number of MNSI Investigations				0	0	0	0	0	0	0	0	0	0		
	Number of PSII Comissioned Incidents reported				1	0	0	1	0	1	1	0	0	0		
	Number of Complaints received in the month				1	0	4	3	0	2	4	1	0	3		
	Number of Letters of Claim Received in the month				0	0	0	0	0	0	1	1	0	1		
	HIE 2 &3 > 37 weeks (rate per 1000)			GM average 2023 0.555/1000	0	0	0	0	0	0	0	0	0	0		

2024					
Q1	Q2	Q3	YTD	Trend
67.00%	100.00%	50.00%		
33.00%	100.00%	100%		
4	1	1		
0	0	0		
87.76%	91%	89		
8.96%	16%	63.8		
17.38	15.25	21.49		
59.01	47.61	59.77		
43	44	49		
41	32	32		
20	18	11		
8.41%	8.03%	8.25%		
8.24%	5.75%	5.85%		
78.86%	79.00%	76.81%		
57.40%	61.00%	57.27%		
	0.33	0		
100.00%	99.80%	100%		
100.00%	99.44%	.		
0	0.66	0.66		
6.7	8.03	8.04		
1.28	1.28	1.28		
180	180	180		
8	14	10		
208	220	217		
0	0	0		
1	0.66	1		
5	5	1.66		
0	0	0.66		
0	0	0		

Maternity Perinatal Quality Surveillance Dashboard October 2024

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

CQC Maternity Rating – Last assessed 2023

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

Stillbirths	CNST	Maternity Red Flags reported
• There were 0 stillbirth in October2024.	Evidence collection for all standards is underway	• There were 8 validated midwifery red flags reported in September. • 1 Delayed recognition of and action on abnormal vital signs. Delay in treatment of urology outlier due to digital records not currently used in maternity • 7 Delayed delay in admission for induction and beginning the process Due to activity, acuity and staffing Safety maintained at all times and no harm caused
Supernumerary Shift coordinator	**1:1 care in labour**	**All cases eligible for referral to MNSI**
• The shift coordinator remained supernumary throughout October 2024. No Red Flags submitted	100 % of women received 1:1 care in labour (excluding BBA)	• There were 0 case eligible for referral to MNSI.

Cardiotocograph (CTG) training	Practical Obstetric Multi-Professional Training (PROMPT)
Overall compliance for fetal physiology in October is 96%	Midwives attended = 17 rolling complaince % 93%
Midwife = 19 94% rolling compliance	MSW attended = 3 rolling complaince % 91%
Obstetric Consultant = 1 100% rolling compliance	Obstetric Consultants attended = 3 rolling complaince % 100%
Obstetric Registrar = 1 95% rolling compliance	Obstetric registrars attended = 3 rolling complaince % 90.9%
All midwives who were due in Ocotber are all booked in the upcoming teaching sessions.	Anaesthetists attended = 8 rolling complaince % 94%

Service User Voice Feedback	Staff Feedback from Frontline Champions & Walkabouts (Bi-Monthly)
Feedback from MNVP Thank You Thursday "My daughter Emilia was delivered by emergency c section. Thank you to the full team who looked after us during labour and subsequent days I am particularily grateful to the team who took swift action to deliver Emilia safely when things took an unexpected turn in what was an uncertain and scary situation. I feel I was given the best possible care and reassurance, particularily by the lead midwife who was on shift Afterwards, things were explained in detail which has helped me and my husband and Mum as birth partners to process what happened. Emilia then spent 2 days on neonatal, once again the staff were incredible"	**External Visit** Baroness Merron visited Maternity and Neonates with Cathy Stanford Divisional Director of Maternity and Child Health and Safety Champion "I am grateful to you and your team for sharing your insights and expertise with me and I found our discussions to be very informative and thought provoking It was excellent to hear about the work of the Daisy and Fern Team in approaching the most compex cases with such personalised and compassionate care. Similarly, seeing the dedication and approach of the maternity and neonates team was impressive."

Maternity Perinatal Quality Surveillance Dashboard 2024

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

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	Jul-24	Aug-24	Sep-24	Oct-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)	13 (98% compliant)	(98.7% compliant)	21 (95% compliant)	19 (94% compliant)
	Consultants		1 (83% compliant)	2 (92.8% compliant)		0 (78 % compliant)	1 (84% compliant)	1 (100% compliant)	(100% compliant)	0 (92% Complaint)	1 (100% Complaint)
	Registrars		2 (100% compliant)		1 (90% compliant)	1 (100 % compliant)		2 (100% compliant)	(100% compliant)	2 (100% compliant)	1 (95% 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)	9 (5.5%) (97% compliant)	No PROMPT training took place in August	18 (10.9%) (90% compliant)	17 (93% 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)	4 (10.8%) (91% compliant)		2 (15.8%) (94% compliant)	3 (91% 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)	1 (6.6%) (100% compliant)		0 (0%) (100% compliant)	3 (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)	1 (16.6%) (84.6% compliant) (1 now on LTS)		3 (15.7%) (100% complaint)	3 (90.9% complaint)
	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)	1 (5.5%) (95% compliant)		0 (0%) (94% compliant)	8 (94% compliant)
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)		60	60	60	60	60	60	60	60	60	60
1:1 care in labour		100%	100%	100%	99%	100%	100%	100%	100%	99%	100%
Maternity Red Flags reported (>3)		0	3	5	5	8	1	0	5	4	8
Diverts: Number of occasions unit unable to accept admissions(>1)		0	0	0	1	1	0	1	1	0	0
Supernumeray Shift Co-ordinator		100%	100%	100%	98%	100%	100%	100%	98%	98%	100%
The number of incidents logged graded as moderate or above (>5)		0	1	1	2	1	0	3	0	0	0
All cases eligible for referral to MNSI.		0	0	0	0	0	0	1	0	0	0

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24		
Number of Datix submitted when shift co-ordinator not supernumerary*	0	0	0	1	0	0	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	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0
Progress in achievement of CNST 10	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	Review of all standards underway	Evidence collection for all standards underway	Evidence collection for all standards underway	Evidence collection for all standards underway	Evidence collection for all standards underway
Number of StEIS Reportable Incidents**	0	0 (1 NN)	0	0	0	1	0	0	0	0
Number of Stillbirths	1	1	0	1	0	0	1	1	2	0
Number of Early Neonatal Deaths * **	1	1	0	0	0	0	0	0	0	0
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0

* acuity app from November 2023

** date reported to StEIS

*** before 7 days