Board of Directors - Public Meeting

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

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

19. Declarations of Interest

Information *Mark Jones*

Verbal item

20. Minutes of the previous meeting

Approval *Mark Jones*

Minutes_Board of Directors - Public Meeting_030424.pdf (5 pages)

21. Action Log

21a. Public Board Action Log - April 2024.pdf (1 pages)

22. Chair's report

Information *Mark Jones*

23. Chief Executive's report

Information *Mary Fleming*

23. CEO Board Report June 2024_FINAL.pdf (3 pages)

24. Committee chairs' reports

Information *Non Executive Directors*

24.1. Quality and Safety

Information *Francine Thorpe*

24.1. AAAQ&SMay24.pdf (2 pages)

24.2. Research

Information *Clare Austin*

Verbal item due to close proximity of the meeting

24.3. Finance and Performance

Information *Julie Gill*

Report to follow due proximity to committee meeting

24.4. Audit Committee

Information *Ian Haythornthwaite*

24.4. AAA - Audit Committee - 29 Feb 2024.pdf (2 pages)

24.5. People Committee

Information *Lynne Lobley*

24.5. AAA People - April 2024.pdf (2 pages)

25. Safe nursing staffing biannual review

Information *Kevin Parker-Evans*

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

26. Maternity reports

Approval *Kevin Parker-Evans*

26. Maternity Dashboard Report April 24.pdf (8 pages)
26a. Maternity Dashboard - April 2024.pdf (4 pages)
26b. Neonatal Dashboard - April 2024.pdf (3 pages)
26c. Optimisation Dashboard - April 2024.pdf (1 pages)
26d. Maternity Perinatal Quality Surveillance Q4 (For Board).pdf (29 pages)
26e. Perinatal Dashboard - April 2024.pdf (2 pages)
26f. Perinatal Exception Report - April 2024.pdf (1 pages)

27. Integrated performance report

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

27. M1 2425 IPR Report.pdf (17 pages)

28. Finance report

Information *Tabitha Gardner*

28. Trust Financial Report 23-24 March Month 12 Board.pdf (10 pages)
28a. Trust Financial Report 24-25 April Month 1 Board.pdf (10 pages)

29. Freedom to Speak up Biannual Report

Information *Selina Morgan*

29. FTSU Biannual-report-010324 to 210524 Final.pdf (7 pages)

30. Board Assurance Framework

Information *Paul Howard*

30. BAF Report Board June 2024 v2.pdf (29 pages)

31. Reflections on equality, diversity and inclusion

Discussion *Mark*

Consent Agenda

32. Corporate Objectives

Noting

32. Trust Board paper - 2024-25 Corporate Objectives 05-06-24.pdf (2 pages)
32a. Corporate Objectives 2024-25 - Final version for Trust Board 05-06-24.pdf (15 pages)

33. Annual Declarations of Interest Report

Information

33. Directors DoIs - 2024.pdf (4 pages)

34. Changes to Standing Financial Instructions

Approval

34. SFI Changes.pdf (5 pages)
34a. SFIs 23-24 after changes.pdf (65 pages)

35. Date, time and venue of the next meeting

Information

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

Board of Directors - Public Meeting

Wed 03 April 2024, 14:00 - 16:15

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Board members

Mark Jones (Chair), Sanjay Arya (Medical Director), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Ian Haythornthwaite (Non-Executive Director), Paul Howard (Director of Corporate Affairs), Lynne Lobley (Non-Executive Director), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Richard Mundon (Director of Strategy and Planning), Kevin Parker-Evans (Interim Chief Nurse), Juliette Tait (Chief People Officer), Claire Wannell (Interim Chief Operating Officer)

In attendance

Nina Guymer (Deputy Company Secretary (Minutes))

Meeting minutes

53. Declarations of Interest

Information

Mark Jones

No declarations of interest were made.

54. Minutes and action log of previous meeting

Approval

Mark Jones

20/24 System partnerships report

The Director of Strategy and Planning advised that the work to include a link to the joint strategic needs assessment with the local authority on WWL's anchor institution landing page is in progress and that the WWL are waiting to establish which part of the Council's webpage the link should be made with.

Minutes_Board of Directors - Public Meeting_070224.pdf
Public Board Action Log - Feb 2024.pdf

55. Chair's opening remarks

Information

Mark Jones

The Chair highlighted that despite the challenges, WWL made much positive progress in the year 2023/24. He cited work done with the Emergency Care Improvement Support Team (ECIST) to improve emergency care provision, work done through several multi-agency discharge events to improve discharge and upcoming programmes of work including the multi-story car parking proposal and the urgent and emergency care reformation programme, to be led by Newton Europe, which are hoped to be progressed in 2024/25.

55.1. Stakeholder update

In terms of his work with stakeholders since the February board meeting, he reported upon frequent face to face meetings with the Greater Manchester Integrated Care Board (GM ICB) team, including the Chief Executive and Turnaround Director, largely around finance. He explained that the team from Rochdale NHS FT had visited WWL's Board to assist WWL and its locality partners from the Council to consider how they can take forwards partnership working in the most effective way, based on Rochdale NHS FT's own model.

56. Chief Executive's report

Information

Mary Fleming

WWL's newly appointed Chief Executive began by sharing how proud she was to have been recently appointed to the role. She explained that, although the Trust's journey to outstanding is important from a CQC perspective, to her, but is so much more than a rating and encompasses work done in every discipline and directorate.

She highlighted four consecutive months of financial improvement and the need to continually ensure that quality and patient safety is maintained alongside financial stability.

Mrs L Lobley noted the recently introduced digital solutions such a the bed management system and the award WWL had received for use of artificial intelligence and asked that the board receive a wider update on its use of digital solutions and how these are assisting with financial, service and staff improvements.

ACTION: M Fleming

CEO Board Report April 2024_FINAL.pdf

57. Staff survey report

Presentation

Juliette Tait

The Chief People Officer provided a summary of WWL's National Staff Survey results for 2023/24.

A recurring theme was noted around the struggles of ethnic minority staff and those with long term health conditions in respect of how they are treated by colleagues, with reference made to a staff story shared the previous day at the People Committee meeting around the struggles of a colleague for whom reasonable adjustments had not been forthcoming following a return to work after a period of sickness.

She highlighted the 10% response rate within the estates and facilities division and the board were complimentary of the efforts of the Director of Estates and Facilities in driving this forwards with his staff, which has historically for many trusts, been a difficult division to engage with.

She concluded by summarising WWL's greatest achievements as being both the highest scoring in GM for staff recommending WWL as a place of work and, more so, the significant increase in morale and its position as being 13th nationally for this rating.

She caveated that there is no score available for any trust for the 'we are safe and healthy' domain due to a national issue with the data gathered here.

In response to the figure of 3% of staff reporting experiencing incidents of sexual harassment, the Chair queried whether there are any particular areas of the Trust where these incidents were more prevalent.

The Chief People Officer advised that since this is such a small figure, albeit still unacceptable, to ensure that the data remains anonymised, the is no ability to review this in detail. The Board appreciated that WWL is now signed up to the NHS Sexual Safety Charter.

Mr I Haythornthwaite recognised that work ongoing currently is likely only to take effect in around a year's time,

The Board noted a positive picture overall, particularly in consideration of the persistent periods of strike action seen over the previous year and the position of the NHS as a whole.

The Board received and noted the update.

17. Staff Survey Board Presentation April 2024.pdf

58. Annual sustainability report

Information

Richard Mundon

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

Mrs F Thorpe noted that at a previous organisation staff had been mandated to become 'carbon literate' through training. She noted the benefits of this in improving individual accountability.

The Director of Strategy and Planning advised that there is a national training package available on WWL's learning hub, following a review of voluntary take up, consideration will be given to whether this should be made mandatory.

The Board received and noted the paper.

Annual Sustainabilty Report 23 24.pdf

59. Finance report

Approval

Tabitha Gardner

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

Mrs L Lobley asked what support would be required for the medical division to assist them to improve, given that they face the most pressures and periods of escalation.

The Chief Finance Officer advised that there is a budget which is made available to the team when the area is deescalated and therefore acts as an incentive. It was noted that the investment in the Newton Europe work will support that division in the main.

The Chief Finance Officer advised that the ICB continue to push for WWL to reduce its planned deficit to £10.4 from £13.2, however, have continued to advise that this is not possible. The savings generated through the cost improvement programme (CIP) must take costs out to deliver the financial position.

Mrs F Thorpe recalled that the Finance and Performance Committee, on review of the plan, appreciated the difficulty in setting out plans to achieve the pledged position and were supportive of maintaining that position and resisting pressure to commit to anything further.

The Chair recalled that the Board had agreed at the previous weeks' meeting that any changes to the plan would be handled by himself, the Chief executive and the Chief Finance Officer on its behalf.

The Board received and noted the paper.

Trust Financial Report 23-24 February Month 11 Board.pdf

60. Integrated performance report

Information

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

The Chief Operating Officer presented the holistic narrative contained within the report. She highlighted that in the recent CQC inspection, the question was asked as to whether corridor care is now being normalised, which she felt that to some existent, due to constant pressures, it is. She explained that herself and the Chief Nurse would be asking the relevant wards to accept patients at 12 noon each day, regardless of whether the requisite amount of daily discharges had taken place.

The Chief People Officer presented the 'People' quadrant of the scorecard, adding that a stretch target will be introduced to assist in reducing turnover.

The Medical Director and Chief Finance Officer went on to present the quality and safety and finance quadrants respectively.

The Board received and noted the report.

M11 Board of Directors Balanced Scorecard Report FINAL.pdf

61. Committee chairs' reports

Information

Non Executive Directors

The respective non-executive committee chairs presented their reports.

61.1. Quality and Safety

Information

Francine Thorpe

The Chair asked how the Trust is progressing with patient initiated follow-up (PIFU).

The Medical Director advised that the government has set a target of a 3% pathway adoption rate for this and that WWL are the second best performing in GM in this regard, reaching 2.8% to date.

AAAQ&S March 24.pdf

61.2. Research

Information

Clare Austin

The Board reflected on how research carried out by WWL staff assists to actively improve the organisation's performance and that the organisation would benefit from more sharing of research stories and how research projects have improved care, evidenced by measurable metrics.

It was noted that research stories would be brought to the board moving forwards, in the cycle along side patient and staff stories.

21.2. AAA - Research - Mar 2024.pdf

61.3. Finance and Performance

Information

Julie Gill

The Board received and noted the updates provided by the committee chairs.

AAA F&P - March 2024.pdf

62. Board Assurance Framework 2023/24 closing down the year

Information

The Director of Corporate Affairs summarised that the document provided gives a year end position in respect of progress with achievement of strategic objectives for 2023/24 and also presents the new iteration of the document for 2024/25. Progress against each objective has been reviewed and discussed by the relevant committee.

The Board received and noted the report and the progress made during 2023/24.

The Board briefly reviewed the items which it has previously **AGREED** would appear on the consent agenda:

Closing BAF Report Board April 2024 v3.pdf

Consent Agenda

63. Corporate objectives 2024/2025

Information

The Chair noted that the coming year would be a year of system wide transformation and asked that this be reflected in the document

Mrs F Thorpe asked that there is a clearer definition as to how the improvements in diabetic care will be achieved.

The Chief Executive added that she would meet with the Medical Director and the system wide lead for diabetes to establish where and how WWL will feed in to the prevention agenda.

Prof C Austin noted in relation to corporate objective nine, success is measured by an increased level of contact with the Freedom to Speak-Up (FTSU) Guardian and it was agreed that to aim for increased awareness of FTSU services and that increased contact is not necessarily the right metric to measure.

ACTION: R Mundon

Appendix 1 - Corporate Objectives 2024-25 FINAL draft.pdf
Trust Board paper - 2024-25 Corporate Objectives Final Draft 03.04.24.pdf

64. Board Assurance Framework 2024/25

Approval

The Board **APPROVED** the revised format of the document for use in 2024/25.

BAF Template 2024-25 Board April 24.pdf

65. Modern Slavery and Human Trafficking statement

Approval

Lady R Bradley queried the processes in place where concerns are raised in line with the statement. The Chair asked that the People Committee consider this, on advice from the Director of Corporate Affairs. An update would be provided for the Board subsequently.

ACTION: P Howard

Modern slavery statement 2024-25.pdf

66. 7 day services report

Approval

The report be received and the positive fact that 97% of acutely admitted patients are seen by a consultant within 24 hours of admission.

Seven Day Services Audit 2023_24_ FINAL.pdf

67. Equality, diversity and inclusion focussed reflections

Discussion

Mark Jones To Invite Comments

No observations were put forward although the findings of the staff survey were reiterated and it was appreciated that now the Trust is aware of the position actions can be put in place to improve the experience for all staff.

68. Date, time and venue of the next meeting

Information

5 June 2024, 1:15pm Boardroom, Trust HQ

Action log: May 2024

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
7 Feb 2024	20/24	System partnerships report	Add the joint strategic needs assessment to the anchor institution landing page.	R Mundon	3 Apr 2024	**In progress.** Verbal update.
3 Apr 2024	56/24	Chief Executive's report	Report on WWL's use of digital solutions and how these are assisting with financial, service and staffing improvements	M Fleming	5 Jun 2024	Item on agenda for Board away day – 17 July 2024 to provide more opportunity for discussion. **Action completed.**
3 Apr 2024	63/24	Corporate objectives 2024/2025	Bring back final version document	R Mundon	5 Jun 2024	**Item on consent agenda.**
3 Apr 2024	65/24	Modern Slavery and Human Trafficking statement	Clarify for the People Committee the processes in place where concerns are raised in line with the statement.	P Howard	Referral to People Committee	**In progress.** The People Committee will meet on 11 Jun 2024. A statement will be provided for the Board thereafter to clarify the position.

Agenda item: [23]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	05/06/2024
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with this report.

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

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

Report

At WWL, we continue to experience pressures on our services, and I would like to thank all my colleagues on their relentless focus to maintain patient safety and provide care with compassion to our patients. I am pleased to report that our four-hour Emergency Department (ED) performance has seen a considerable improvement, going from 71.6% in April to 73% in May. We are, however, continuing to see too many 12-hour waits within our ED and work is ongoing to help reduce this; we are working with both the Emergency Care Intensive Support Team (ECIST) and Newton Europe to support our teams to achieve sustainable improvements.

Throughout the Trust, we are continuing to develop our services to improve outcomes for patients, and as part of this I am delighted to say that WWL has been chosen by NHS England (NHSE) as one of the 143 NHS Trusts in England for a pilot scheme following the introduction of 'Martha's Rule' back in April of this year. At WWL this will include the introduction of a 'Martha's Rule' helpline that patients' loved ones will be able to use should they wish to raise concerns in the event that the patient's condition is believed to be deteriorating. The pilot is set to launch in June and more information on the progress of the scheme will be shared over the coming months.

This past month we have been enhancing our patient experience with support from our local partners. Our Frailty Same Day Emergency Care unit (Frailty SDEC) at the Royal Albert Edward Infirmary (RAEI), together with Wigan and Leigh College ran a pilot in May to provide an innovative engagement session, aimed at improving patient experience and to help prevent deconditioning. Beauty students from the college came onto the unit to offer patients upper body massages for relaxation. It was an incredible success with the massages being enjoyed by the patients with further sessions to come in the next few months.

Our patients on the Jean Heyes Reablement Unit (JHRU), located at Leigh Infirmary, were visited by to Alpacas from 'Poppywood Alpacas' to provide comfort, rehabilitation and wellbeing. Alpacas have been shown to lower heart rates and blood pressure as well as leading to a sense of calm and relaxation, so they were the perfect visitors for our patients at JHRU. The visit was enjoyed by all who attended and it provided a memorable experience for our patients on the unit.

WWL were hosts to two VIP visits earlier in the month when we were delighted to welcome the Rt Hon Andrew Stephenson, Minister of State in the Department of Health and Social Care for Health and Secondary Care to Wrightington Hospital and a visit from Professor Sir Stephen Powis, NHSE Medical Director (MD) who delivered a speech at this year's Clinical Audit and Effectiveness Celebration Event. Minister Stephenson was given a tour of Wrightington Hospital, meeting with staff and patients to showcase the site as an excellent example of the positive impact high performing Surgical Hubs, such as Wrightington, are having on NHS waiting lists. As well as a visit to our new Theatre 11 development, Minister Stephenson toured our Enhanced Care Unit and our Physiotherapy Team and was extremely impressed with the hard work and dedication he witnessed from our colleagues. At our Clinical Audit and Effectiveness event, a variety of questions were posed to the NHSE MD on a whole host of topics including regional health inequalities, COVID response and the effects an aging population will have on the NHS. Afterwards, Professor Powis was given a tour of our RAEI site by our Medical Director, Professor Sanjay Arya where he met with colleagues across the site.

Our inaugural Nurses, Midwives and Operating Department Practitioners (ODP) Day Event was held to thank and recognise colleagues for their hard work at the beginning of May. The special event celebrated the dedication provided by each of the staff groups, their contribution to society, and their professions, and was truly inspiring as those in attendance heard from leaders and colleagues alike. Into the evening, a multi-faith celebration service, led by our Chaplaincy Team and local faith leaders was held and further awards were presented including The Chief Nursing Officer of England Award and The Pauline Jones Nursing Leadership Award.

Continuing with the theme of celebrations and recognition, Diabetes Specialist Nurse - Pregnancy, Jane McAllister, has been named as a finalist in the Secondary Care Nurse of the Year category at

this year's Diabetes Nursing Awards. Jane joins the Trust's Community Diabetes Service, who have also been named as finalists in the Primary Care Nurse of the Year category. Both were praised by judges for their clear commitment to their patients and the innovative approaches and tireless efforts to make a significant difference in the lives of people living with diabetes. We wish them well as they attend the awards ceremony on Friday 7th June.

As I look back on my first two full months as CEO, I have strived to continually demonstrate my commitment to visible leadership and engagement with colleagues, both internally and externally. This open communication with all colleagues across the Trust continues to go from strength to strength as we are seeing growing attendances each month at All Staff Team Brief and Leaders' Forum. In addition, I am pleased to say that a series of rolling six-month divisional visits, led by myself and the Executive Directors are now underway. I recently visited Edge Hill University, a Higher Education Institution that WWL has a strong relationship with, and during this visit I had the opportunity to deliver a keynote speech at the Teachers and Carers Advisers Conference. During this speech I shared the journey of my career in the NHS over 27 years, and the importance of pursuing a career in healthcare, as well as the opportunities available and the impact we can have on peoples' lives. This visit intertwined with our commitment to the expansion of new roles and our shared commitment to provide opportunities for people to join the NHS from a range of different backgrounds and with a wealth of different experiences.

As I look ahead, in June we will re-launch our organisational values and also publish our commitment to becoming an Anti-Racist Organisation, both of which are critical to ensuring we are an inclusive environment for everyone and this is a really important priority for me as new CEO, with full support from the Board of Directors. In June, we will also complete the recruitment process that is currently underway for our substantive Chief Operating Officer and Chief Nurse.

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	8th May 2024
Chair:	Francine Thorpe

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

ALERT

- The AAA report from the Resuscitation Group highlight ongoing concerns in relation to audit of resuscitation trolleys; work is being undertaken to address this and the Committee has scheduled an update for a future meeting.
- Issues in relation to the recruitment of microbiologists was discussed which impacts a number of areas including infection prevention and control and antimicrobial stewardship. A paper was received outlining a range of options to address this issue. Further updates will be provided at a future meeting.
- The Quarter 4 Harm Free Care Report highlighted an increase in pressure ulcers and falls within the Emergency Department. This is directly attributable to the numbers of patients being cared for in this area. Actions being taken to mitigate this risk were highlighted and the Committee will continue to track progress through regular reports.
- A number of reports continue to highlight issues in relation to patients being 'lost to follow up.' These are being directed through the working group for resolution. The Committee continues to receive regular updates on progress.

ASSURE

- The Surgical Division Deep Dive highlighted:
  - Ongoing improvement work to address corporate work programmes including the recognition and appropriate management of sepsis.
  - Improvement programmes as part of the Lost to Follow up work.
  - Excellent performance in complaints response times and targeted work on de-escaltion to resolve patient experience issues.
  - Evidence of learning from patient safety events and complaints
- The Biannual Medicines Incident report provided a good level of assurance in relation to the reporting, investigation and learning from medication incidents.
- The Q4 Harm Free Care Report confirmed that the Community Division has exceeded the improvement target in relation to pressure ulcer reduction for 2023/24. A number of wards have also been recognised for zero acquired pressure ulcers during 2023/24. The good practice in these areas is being shared through relevant groups.

- The Patient Safety Incidents Report provided assurance that the organisation has made good progress in transitioning to the new Patient Safety Incident Response Framework. The Committee will continue to receive regular reports to track progress and learning.
- A number of reports were received in relation to maternity services that highlighted.
    - Improving metrics against a number of GM Standards including smoking status at the time of delivery, stillbirths, and term admissions to the neo-natal unit
    - Good progress in the implementation of the Ockenden 2 recommendations, this was confirmed with significant assurance from Mersey Internal Audit
    - Progress against improvement plans relating to Saving Babies Lives
    - Lowest number of vacancies in maternity services in several years
- A report providing further information on corporate objective C03 for 2024/25 was received by the committee that highlighted targeted work to improve the management of children with type 1 diabetes. The Committee was supportive of the objective and recognised the potential impact on reducing health inequalities within the Borough.
- A presentation from the mortality group identified improvement in the following areas:
    - Summary Hospital-level Mortality Indicator (SHMI) over the period January to December 2023
    - SHMI for Acute Kidney Injury over the same time-period and is now at lowest level.
    - SHMI for sepsis on a downward trend
    - Good level of assurance on monthly review of data with deep dives into relevant areas to understand causes and variation.
- The AAA report from the Patient Experience and Engagement Group highlighted:
    - Positive feedback from patients and relatives about the introudction of open visiting
    - The proposed establishment of a Lived Experience Group for people with neurodiversity and the recruitment of 3 Liveed Experience Partners who are receiving training from AQUA

ADVISE

- The Committee noted that further assurance in relation managing ‘overheating incidents’ and mitigating any potential risk to patients is still required. Information has been requested for the next Estates and Facilities Divisional Deep Dive.
- The Surgical Divisional Deep Dive highlighted ongoing issues with delayed discharges from ICU. An audit had been undertaken which confirmed that approriate access to an ICU bed for relevant patients was not impacted. This issue does impact negatively on mixed sex accommodation breaches and mitigating actions are in place to maintain the privacy and dignity of patients.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the board assurance framework were reviewed and no changes requested.
- The Surgical Divisional Risks were presented as part of their Deep Dive. Mitigating actions were highlighted for those scoring fifteen or above

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Audit Committee
Date of meeting:	29 February 2024
Chair:	Ian Haythornthwaite

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

ALERT
▪ There are no areas of concern where the committee feels it needs to alert the board
ASSURE
▪ The committee undertook a review of the risk register and was assured that a robust system of risk management is in place and that there is good, executive-led oversight of high-level risks within the organisation. The committee also received confirmation from the internal auditors that the assurance framework meets NHS requirements and is used by the organisation. ▪ The committee received five internal audit reports – one had received high assurance, three had received substantial assurance and one had received moderate assurance. The committee was satisfied that the management responses to the recommendations were appropriate ▪ The committee was pleased to note that the external auditor's work on Value For Money had concluded and that no significant risks in relation to the three areas of focus (financial sustainability, governance and improving economy, efficiency and effectiveness) had been identified.
ADVISE
▪ The committee noted that a competitive procurement exercise in relation to the provision of internal audit services had recently been undertaken, and noted that this had been done in conjunction with The Christie NHS FT in order to achieve best value for money. The committee recommends that the board approves the contract. ▪ The committee received a report on single-tender waivers and undertook a deep dive into two of the waivers. As a result, the committee has asked for some further work to be done to refine the associated approval process. ▪ The draft accounting policies for 2023/24 were approved by the committee. ▪ The committee agreed to a request to amend the internal audit plan for 2023/24 and asked for further assurance to be provided to it on the management of service level agreements, noting that this was a specific area of focus within the Financial Sustainability Plan.

▪ The committee considered the internal audit follow-up report and was satisfied with progress made, although expressed some concern at deadlines which are subject to multiple revision or those where a year-end deadline is routinely provided. This is being taken forward by the Chief Executive through the executive team's regular meeting. ▪ The committee agreed the external audit plan for 2023/24.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ The committee undertook a review of the risk register and was satisfied as to the arrangements for managing risks. No new risks were identified and no specific risks were highlighted during the meeting.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	2 April 2024
Chair:	Lynne Lobley

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

ALERT
▪ The Committee noted two internal audits which had taken place which had delivered low levels of assurance. Actions relating to an audit around medical safe staffing would be addressed in new financial year and the Committee noted that actions relating to an audit on medical e-rostering have been properly progressed. The Committee noted advice that an adequate assurance level will be given on re-audit. ▪ The Committee noted that 'Talent for Care' initiatives are being limited due to a lack of resource given the current financial position. ▪ Compliance levels in respect of fire safety and infection control training – which are both delivered face to face - were noted once again as requiring more focus. The Chief People Officer will take this forwards as an action. ▪ The Committee noted the message from the staff survey around the need to provide better support for staff who require reasonable adjustments, which triangulated well with the staff story provided by a colleague who had struggled when returning to work with hidden disabilities.
ASSURE
▪ The equality diversity and inclusion plan is now in place and was reviewed by the Committee. ▪ The Director of Estates and Facilities provided the Committee's first divisional a deep dive which gave assurance around the measures in place to attract and train or retain and develop staff working within the division, to mitigate against the risks posed by its aging workforce. The report highlighted various initiatives being taken forward, such as apprenticeships. ▪ The recruitment and retention report showed a reduction in the number of leavers in the previous 12 months as well as a reduction in sickness absence, despite this still being a challenge. ▪ The Committee noted the Trust investment in digital workforce and workforce transformation and planning. ▪ WWL's scores for morale through the staff survey were received positively. ▪ WWL's new Freedom to Speak Up Guardian (FTSU) attended and the Committee heard how she planned to increase her visibility amongst staff. It was also noted that FTSU featured within the internal audit plan for 2024/25, which is hoped to provide further assurance around the future of the revised service. ▪ Assurance around implementation of the NHSE board level competency framework

was noted. ▪ The Committee noted that the annual operational plan is soon to be submitted and took assurance from the Chief People Officer around its content, which it noted will be in line with the national planning requirements. ▪ The Committee noted that it will receive future reports to allow monitoring of progress with head count reduction. These would be developed to also provide assurance to the Finance and Performance and Quality and Safety Committees to ensure that workforce related matters have the full oversight required at committee level. ▪ The Committee noted progress made with development and succession planning within the executive team, as well as the focus on ensuring that the process for board level recruitment now has a strong focus on attracting and developing individuals which strengthen its diversity. ▪ The corporate objectives for 2024/25 were received and endorsed - a minor change to the wording of one objective only was noted as being required.
ADVISE
▪ The Committee received the Equality Delivery System (3) report and noted that good progress had been made across the domains but that there is still work to do before significant assurance will be evidenced. ▪ The first iteration of the new format People Dashboard was well received.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ The Committee agreed that the reduction in headcount required should be reflected in the board assurance framework moving forwards.

Title of report:	Bi-annual (Board) Staffing Review March 2024
Presented to:	Executive Team Meeting & Trust Board of Directors
On:	23rd May 2024
Presented by:	Kevin Parker-Evans, Interim Chief Nurse
Prepared by:	Allison Luxon, Deputy Chief Nurse Divisional Director(s) of Nursing and AHP
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Executive summary

On behalf of the Interim Chief Nurse the Senior Nursing leadership team have undertaken an establishment and acuity review for the bi-annual reporting from ward to board in line with the Nursing Quality Board and Developing workforce safeguards mandate.

In line with the aforementioned documents the following methodology is utilised to inform the board of the safe staffing and acuity updates of all inpatient wards across WWL's 3 sites:

Triangulated Methodology:

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

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

The WWL Way

The report demonstrates that there are **no recommendations** for investment following this review associated to the inpatient annual staffing review. The report, has identified areas that will need further review that are either:

- Not in scope for the inpatient review
- Are new areas that are subject to capacity and demand and benefits realisation reviews following investment.

They are as follows:

- CAU are currently looking at a revised staffing model following the relaunch. The community division already have funding allocated to enhance the frailty model and the plan is to work within this financial envelope. They are currently utilising bank HCAs to support the revised model which are not in the substantive establishment.
- The review has further supported the need for a full review of the enhanced care provision, including the policy, patient group, requesting and approval process and the need for distraction/diversional therapy training at a ward level.
- There is the seasonal requirement to review inpatient areas that house specialist care provisions i.e. Winstanley ward and the 'enhanced respiratory unit'. The Interim Chief Nurse has requested a season staffing plan to be revised in line with acuity and capacity and demand data from 20234/24.
- Whilst out with the scope of the establishment review the staffing in PECC is noted as a risk within the division of medicine that will require a separate review and plan to mitigate the risk and provide assurance of safe staffing.
- A full review of areas with variance in occupancy i.e. inpatient areas at the Wrightington site
- The board are asked to conder the recommendations associated with the local and national benchmarking in relation to uplift percentages as a further discussion to this review.

A further full report inclusive of the above has been shared with the Nursing, Midwifery and AHP Leadership team for further work and review at the request of the Interim Chief Nurse

Link to strategy

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

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

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

Risks associated with this report and proposed mitigations.

Financial implications

There is a risk to achieving the corporate objective of financial balance due to overspend on temporary staffing. The report has identified further works and staffing reviews and improved ways of working that are required which have been a coincidence find alongside this review.

Legal implications

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

People implications

Investment in the unregistered workforce provides an opportunity for the Trust to continue the ambition to be the employer of choice within the locality. Furthermore, this presents the opportunity to further develop the workforce to engage in cross boundary working within social care and the care home sector.

Wider implications

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

Investment in the nursing team will impact further on financial stability and headcount both within the Trust and within GM and may negatively impact on system performance.

Recommendation(s)

The board is asked to accept the review and the guidance within the review and as a collective support the Interim Chief nurse with the approval of the biannual safe staffing report. The report has been undertaken utilising the national guidance mandated.

Bi Annual Nurse Staffing Review (March 2024)

1 Introduction

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

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

1.3 This report covers adult inpatient areas only, however the report will take the opportunity to identify further reviews and ways of working that are required in other areas.

1.4 The Maternity staffing review and associated recommendations will be reported separately to the Board as per the requirements for CNST and include recommendations for neonatal unit staffing as well as the paediatric inpatient ward.

2 Background

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

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

2.3 In November 2014 NHS England published 'Safer Staffing: A Guide to Care Contact Time[2]. This report outlines further requirements to provide assurance of staffing levels and the importance of the provision of nurse-to-patient direct care time.

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

3 Methodology

3.1 Since 2011 WWL has undertaken adult nursing establishment review on a quarterly basis changing to bi-annual in line with National Guidance; March, and September utilising the Safer Nursing Care Tool™ (SNCT). This tool was developed in collaboration with the Association of United Kingdom Hospitals (AUKUH) utilising the research evidence undertaken by Keith Hurst[3]. The tool is

[1]NHS England (2012): *Compassion in Practice*
[2] NHS England (2014): *Safer Staffing: A Guide to Care Contact Time.*
[3] Hurst, K (2012): *Safer Nursing Care Tool Staffing Multipliers (2012) – Method and Results*

recognised by the Quality Management Board (QMB)[4]. SNCT utilises methodology to determine the staffing required to deliver nursing care to patients within a given area dependent on actual individual patient levels of acuity and dependency. The tool also takes into consideration patient flow and nurse sensitive indicators (NSI's) in determining the appropriate level of care. Professional judgement is required to determine the skill mix of the staff employed within each area, and to assess the variability of staffing requirements which may be affected by changes in acuity and dependency levels of patients, and the environment that the patients are cared for (e.g., individual ward layout).

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

4 Safer Nursing Care Tool (SNCT)

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

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

4.3 The Trust holds current licences to utilise the SNCT within adult inpatient areas, children and young people's inpatient areas, the emergency department (ED), and a Community Safe Nurse Staffing Tool (CSNCT). These latter 2 tools have not been utilised for the purposes of this report as the roll out of the programme has stalled. It is anticipated that this information will be provided within the September 2024 staffing review paper.

4.4 When establishment reviews are undertaken additional SNCT data is collected at 1500hrs across all participating areas for 30 consecutive days. This data is verified by divisional Matrons prior to submission to provide assurance with regards to the accuracy of the assessment of the patients and to prevent gaming; gaming is the term used when the needs of the patients are scored higher than required.

4.5 There have been some changes within the SNCT which are reflected within the report for clarity these are articulated below. The changes have been introduced following extensive beta testing nationally and reflect the enhanced care needs of patients and also the added complexity of care in single rooms and the ability to observe patients.

- Introduction of category 1c; this is to be used for those patients who are receiving 1:1 care that is being paid for from the ward budget.
- Introduction of category 1d; this is to be used for those patients who are receiving 2:1 care that is being paid for from the ward budget.

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

- New multipliers for areas where 50% or more of the beds are single rooms. These multipliers have been used in the following areas: JCW, Ward A, and Ward B at Wrightington Hospital (WTN), and Pemberton Ward at the Royal Albert Edward Infirmary (RAEI).

5 Quality Indicators

5.1 Data with respect to hours of time required based on acuity and dependency cannot be viewed in isolation but must be viewed alongside quality metrics, which provide an indication of outcomes and avoidable harms that occur within our clinical areas. These are reported monthly to the Trust Board within the performance report and also included in the safe staffing reports received quarterly by Q&S. These metrics are CDT rates, number of falls, number of pressure ulcers, number of medicine administration errors and number of red flags reported, and these are usually referred to as Nurse Sensitive Indicators (NSI's).

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

6 Professional Judgement

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

7.Skill Mix

7.1 The RCN[5] recommends a ratio of 65:35 registered nurses/unregistered staff in inpatient areas and 70/30 for assessment areas. Following nursing establishment review in 2017 the Trust Board agreed the minimum ratio for registered/unregistered staff was to be set at 55:45 and 65:35 within assessment areas.

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

8 Uplift

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

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

9 Supervisory Ward Leaders

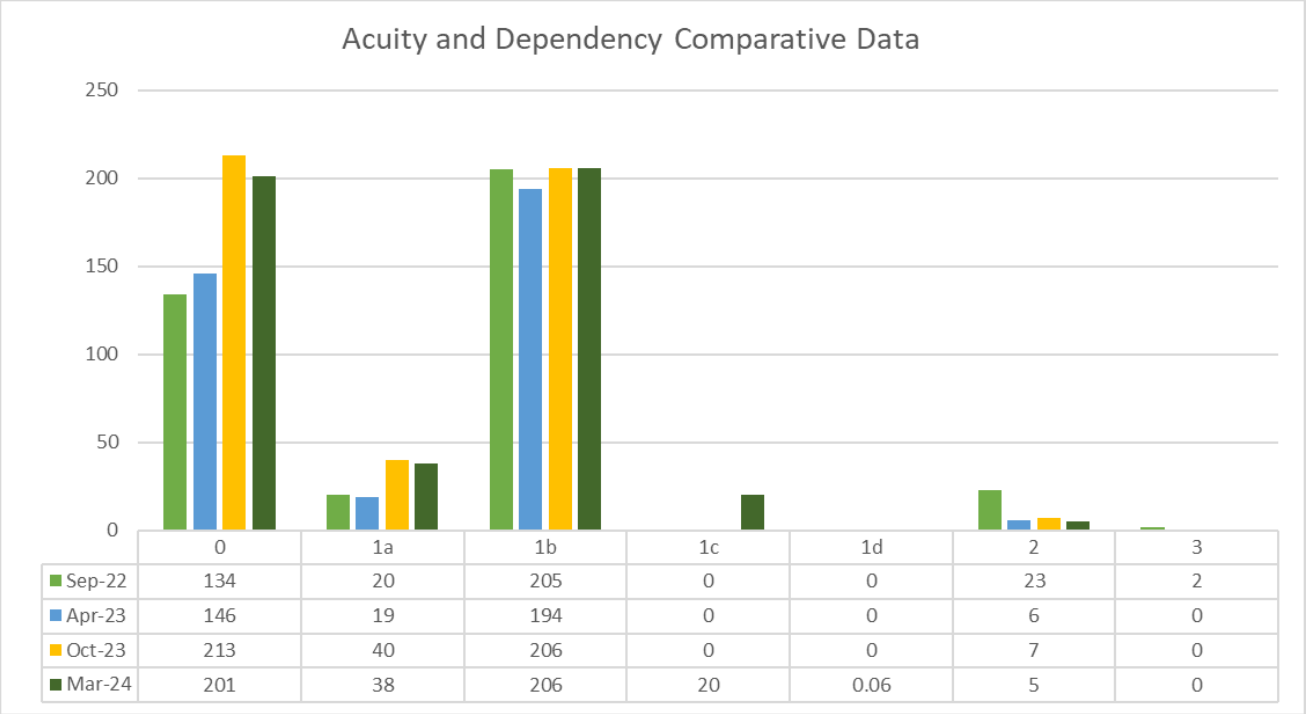
9.1 The Trust Board approved the funding of supervisory ward leaders in October 2021 as part of the strategy to improve local leadership and quality across inpatient areas. The Interim Chief Nurse has undertaken a full benefits realisation and presented this at the Trusts finance and performance committee. The report suggest further metrics and outputs were required to further understand the impact of the supernumerary status of the Ward leader role within the Trust.

10 Position Regarding Acuity and Dependency.

10.1 Comparison of acuity and dependency data is provided in Charts1.

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

10.3 Level 2 patient needs are aligned to a requirement for either HDU care, enhanced respiratory care, e.g CPAP/BiPaP, or those patients who are acutely unwell requiring a lot of registered nurse input but for whom the ceiling of care is at ward level.



	0	1a	1b	1c	1d	2	3
Sep-22	134	20	205	0	0	23	2
Apr-23	146	19	194	0	0	6	0
Oct-23	213	40	206	0	0	7	0
Mar-24	201	38	206	20	0.06	5	0

Chart 1

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

11 Nurse Sensitive Indicators (NSI's)

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

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

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

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

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

.12 Current Position, SNCT and Professional Judgement

Division of Medicine

12.1 Data relating to the Division of Medicine can be found in Appendix 1.

12.2 Across the division of Medicine the funded establishment is higher than the required except for MAU and Lowton wards which are at or below recommended levels.

12.3 It should be noted that whilst the categorisation of patients utilising SNCT is of benefit, the tool is not effective in small bed bases which accounts for the significant discrepancy is SNCT recommended staffing on CCU. It should also be noted that the recommended staffing levels would be insufficient to staff the ward 24/7.

12.4 Within the division the worked WTE and the temporary staffing WTE exceeds the funded establishment in all areas except for Winstanley Ward, where the worked and additional temporary staffing utilisation is in line with the funded WTE establishment for the clinical area.

12.5 Actual rostered WTE for the data capture period was 412.57 WTE against a funded establishment of 460.33 WTE. NHSP shifts booked equate to an additional 149.23 WTE staff.

12.6 Chart 4 provides detail of the acuity and dependency of the patients within the division.

12.7 Throughout the data capture period it should be noted that on average there were 17.76 patients where the division advised the patient was receiving 1:1 care. SNCT advises that an additional 58.07 WTE staff are required to deliver care to these patients (Appendix 1, chart 5). Actual divisional WTE temporary staffing utilisation was 51 WTE suggesting that substantive staff were used to support care delivery on occasion.

12.8 Shevington Ward was the only clinical area where 2:1 care was provided, this occurred over a 24-hour period and was for one patient only.

12.9 Winstanley Ward houses the Enhanced Respiratory Unit with 7 beds. Patients within this area should be receiving non-invasive respiratory support and therefore the patients are categorised as level 2 patients. From the data submitted it is evident that patients are being split across Winstanley

and Ince Wards. Maximum demand across both areas was 7 beds with average occupancy being 3.03 beds throughout the 30 days.

12.10 As previously mentioned within section 11 of the report NSI's are provide a helpful indication of nurse staffing risk factors. Appendix 1, chart 6 provides detail of the NSI indicators for the inpatient areas in the Division of Medicine that were reported during the data capture period.

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

- There were 53 incidents reported and 18 nursing red flags during the data capture period. All of the red flags related to a reduction in registered nurse time and would appear to be linked to either short term sickness or temporary staffing deployment to support areas of escalation. The 5 medication incidents that occurred on one ward are directly linked to a shortfall in RN staffing, the remaining incidents cannot be triangulated to RN staffing shorfalls.
- Nine falls were reported on Standish Ward, 6 of which are linked to the same patient, and were associated with their clinical presentation; the falls occurred despite mitigating actions being appropriately used.
- Drug administration errors were reported to have occurred on 8 of the 11 wards. Five errors were reported on one shift on Bryn Ward resulting in no or low harm to patients. There were no specific themes or trends.
- There was 1 CDT reported which remains subject to investigation to identify and share the learning from these incidents.
- The function of Bryn Ward was changed in September 2023 from an acute medical area to a discharge ward. The funded establishment for 2023/24 was 43.49 WTE, this was reduced to 35.53 WTE in April 2024. The actual staffing required based on the acuity and dependency of the area including the requirement for enhanced care is 36.1 WTE.
- Winstanley Ward; staffing for the clinical area was uplifted to support the professional of an enhanced respiratory unit (ERU) in 2019. In 2023/24 the bed base for the area was reduced to 7 beds. It is evident from review of the data collected that not all patients requiring the service are being admitted to Winstanley and some patients are receiving care on Ince Ward. Flow of patients in and out of the area needs to be reviewed by the division to ensure that patients receive the right care on the right ward and to reduce the risk of mixed gender breaches when there are delays to step down from the area.
- Astley ward had no reported harms within the data capture period. This area has the highest utilisation of additional staff to support the delivery of enhanced care.

12.13 Further to the inpatient wards the Division of Medicine have also raised staffing pressures within the Paediatric Emergency Care Centre (PECC). Since 2019/20 PECC has seen an increase in the number of attendances to the department. Staff are scheduled to be trained to use the ED SNCT tool in April 24 which will enable the provision of recommendations for staffing across the ED footprint in the September report to Board.

12.14 Overall the funded establishment across the division of medicine is sufficient to deliver the care needed for the patients. It is suggested that further work is undertaken over the course of the next 6 months to review the requirement for enhanced care, review of the use of the Enhanced Respiratory Unit and the flow of patients which will assist in resetting the establishments between Ince and Winstanley, and continue to monitor acuity and dependency needs and the quality of the data capture.

Division of Surgery

12.15 The divisions funded WTE v SNCT recommended WTE can be found in Appendix 2 Chart 1.

12.16 Based on the nursing care needs across the surgical inpatient wards Langtree and Swinley wards are under-established to meet the needs of the patients. It should be noted that from April 2024 Langtree ward's funded establishment has been increased following the change of function of Bryn Ward and therefore this has now been rectified.

12.17 On Swinley ward the actual staff rostered and NHSP worked WTE equates to the funded budget. Langtree ward staff rostered and temporary staffing WTE is over the funded establishment but in line with the staffing model proposed at the last staffing review which will be funded from April 2024 (Appendix 2 Chart 2).

12.18 Appendix 2 Chart 3 provides detail of the acuity and dependency needs of the patients within the division.

12.19 On average there was 1 patient a day receiving 1:1 care within the division which requires an additional 3.27 WTE above the establishment to deliver the care needed; the greatest demand for this level of care was on Langtree Ward.

12.20 When considering the data provided in Appendix 2 Chart 4 relating to the NSI the following points need to be taken into consideration.

- No nursing red flags were raised across any of the inpatient wards.
- There were no reportable harms during the data capture period on Swinley Ward despite the shortfall in staffing between funded and SNCT recommended. It should be noted that additional staff are available on the ward to support the delivery of clinic services and these staff may have been utilised, alongside the supernumerary ward leader, to mitigate patient safety risks.
- Four inpatient falls were reported in total across Langtree and Orrell Wards, none of which resulted in moderate or above harm to the patient.
- Four medication administration errors were reported all of which were no harm incidents.
- One pressure ulcer was noted on Langtree Ward which did not result in moderate or above harm to the patient.
- Langtree ward has a higher proportion of medical outlying patients than the other 2 wards which drives the demand for nursing hours and for enhanced care.
- Swinley Ward is an assessment ward and therefore the multipliers used to calculate the staffing requirements are higher than the other 2 wards. The use of the ward has changed over time and the establishment has not been adjusted to reflect this.

12.21 The October 2023 biannual staffing review recommended an increase in staffing on Swinley Ward, however the division planned to undertake a service review which would result in combining workforces and would address the shortfall. This change has not occurred. It is likely that the establishment on Swinley Ward will need to be increased if the acuity and dependency needs of the patients remain the same over the next 6 months.

Specialist Services Division

12.22 The data provided in Appendix 3 Chart 1 provides the funded v the SNCT recommended establishment and the acuity and dependency of the clinical area.

12.23 Across the division the funded establishment exceeds the SNCT requirements, however it should be noted that JCW is a smaller ward footprint and the recommended staffing would be insufficient to staff the ward 24/7 in line with operational demand.

12.24 The rostered WTE worked and NHSP used exceeds the budgeted establishment on Aspull, Ward A and Ward B, considering the additional staff required to support the delivery of enhanced care (Appendix 3 Chart 2)

12.25 Acuity and dependency data for the division can be found at Appendix 3 Chart 3.

12.26 In March 24 on average there was 0.88 WTE patients a day receiving 1:1 care across the 4 inpatient wards.

12.27 Aspull Ward has a higher proportion of level 1b patients than the other wards. This is likely to be associated with the frailty of the patients and potential impacts of long lies following trauma. Aspull length of stay is also higher than the other orthopaedic wards reflecting the complexity of the patients and the increased input into discharge planning.

12.28 With the exception of Aspull Ward all the other inpatient wards are on the Wrightington site. Given the nature of the elective work undertaken on the site it is expected that these patients are optimised and medically fit for their planned surgery, and this is reflected in the reported lower-level acuity and dependency date provided.

12.29 It can also be seen at Appendix 3 Chart 3 that bed occupancy is lower on the Wrightington site than the acute site and this is directly impacted by both the type and volume of surgery requiring overnight stay on the site.

12.30 When considering the NSI data provided in Appendix 3 Chart 4 the following points should be taken into consideration.

- JCW is the private patient ward on the Wrightington site and comprises of 16 individual rooms of which, on average, only 10 were occupied. 2 falls occurred as demonstrated within Appendix 3 Chart 3 all resulting in no patient harm. The new single room multiplier was utilised to determine staffing requirements.
- Wards A and B design are 50% bay 50% single room configurations and therefore the new single room multiplier was used within the clinical area as per revised guidelines. Not all the beds were occupied on average during the data capture period, and this is therefore reflected in the SNCT required staffing data. It should also be noted that the configuration of the wards do not support ease of visibility of patients. In total 3 harms were reported across these wards in March 2024, there was no moderate or above harm to patients arising from these harms.
- Aspull Ward was the only area where nursing red flags were raised. These all related to a delay in the administration of pain relief. 3 falls and 3 pressure ulcers were also reported. There is no direct triangulation to shortfalls in staffing to these harms occurring and the rostered WTE staffing with NHSP WTE worked over the data capture period was equal to both the recommended total SNCT numbers and the funded establishment for the area.

12.31 It is not recommended that staffing is increased within the division.

Community Division

12.32 The data presented in Appendix 4 Chart 1 provides the funded v the SNCT recommended establishment.

12.33 The data indicates that in both areas the SNCT recommended establishment is higher than the current funded establishment. It should be noted that the patient cohort currently being admitted to JHRU has changed from the original operational model following the opening of reablement beds on Kenyon Unit at Bedford Care Home. This has been further impacted by a

reduction in Intermediate Care Beds within the locality resulting in longer periods of rehabilitation on JHRU. It should also be noted that the model for CAU has amended and is still being modelled to support the introduction of a true frailty model of care, including ambulatory care. It should also be noted that both these areas have a dedicated therapy resource who will also be involved in the delivery of direct care as part of their blended roles.

12.34 When considering the budgeted establishment against the worked and temporary staffing used CAU's worked and NHSP WTE are almost equal to the budgeted establishment for the area (Appendix 4 Chart 2).

12.35 The acuity and dependency data for the division can be found at Appendix 4 Chart 3. As expected, the majority of the patients on JHRU are level 1b patients and reflects the requirements of the more complex patients the unit is currently accepting.

12.36 On CAU there remains a higher volume of level 1b patients, which is reflective of patient frailty on admission and again the rehabilitation of the patients that takes place currently.

12.37 Both units had 100% occupancy on average throughout the data capture period.

12.38 NSI data for the 2 inpatient areas can be found in Appendix 4 Chart 4.

12.39 On CAU there were 8 reported falls over the course of the 30 days of data capture. Previous reports have noted that the ward layout makes patient observation difficult and, because of the harms noted in this and previous reports, an additional Band 2 nurse is used on every shift throughout the 24-hour continuum so there is a nursing presence in each bay throughout all shifts. This resource is currently unfunded and is a cost pressure to the division. It should also be noted that there were no patients on the ward that were receiving 1:1 care, and that there is a focus on the prevention of deconditioning with patients being actively encouraged to mobilise.

12.40 There is currently no recommendation to increase the staffing establishment within the inpatient wards in the division, however, it is recommended that the work that has been commenced on CAU to review the staffing model continues with the caveat that the overspend on B2 staff will continue until this is completed. The hybrid staffing model currently in place on JHRU and the blending of roles results in some 'nursing' activities being undertaken by therapy staff alongside their therapeutic interventions. It is suggested that the model remains unchanged as it is felt that the current staffing model is sufficient to meet the needs of the patients.

13 **Enhanced Observations**

13.1 NHSE recommends that staffing reviews take into consideration requirements for the delivery of enhanced care and as previously stated, this need to provide 1:1 and 2:1 care is now reflected in the categorisation of patient care within the SNCT tool.

13.2 Chart 1 in the main body of the report indicates that on average there were 20 patients/day who were in receipt of 1:1 care throughout March 2024. SNCT advise that an additional 64.21 WTE staff were needed to meet the patient needs. Analysis of the data from NHSP indicates that on average 2112 additional staff hours were used to support the delivery of enhanced care which equates to 56.32 WTE staff. This suggests that substantive staff were utilised alongside temporary staff to deliver care.

13.3 There remains concerns that the level of 1:1 care being provided is higher than would be expected. Benchmarking of data from a neighbouring Trust indicates that on average they have 8 patients/day requiring this level of care. It is therefore not recommended that the establishments are increased currently as the level of staffing need cannot be validated currently.

14 Care Hours Per Patient Day (CHPPD)

14.1 Care Hours Per Patient Day (CHPPD) is the metric recognised by NHS to benchmark staffing data (Appendix 5, Charts 1,2 &3). CHPPD includes total staff time spent on direct patient care and also on activities such as preparing medicines, updating patient records and sharing care information with other staff and departments. It covers both temporary and permanent care staff but excludes student nurses and student midwives, and staff working across more than one ward. CHPPD relates only to hospital wards where patients stay overnight. When used in isolation, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective, or responsive. It should therefore be considered alongside measures of quality and safety and with the application of professional judgement.

14.2 The data is derived from planned and actual hours to be worked by registered and unregistered staff from e roster and divided by beds occupied at 23:59hrs.

14.3 The data indicates that we have the second highest CHPPD for nursing and midwifery staff within the ICB for both registered and unregistered staff.

15 Recommendations

The report identifies **no recommendations** to increase staffing at this juncture however does recommend the following actions are taken/continued.

- CAU are currently looking at a revised staffing model following the relaunch. The community division already have funding allocated to enhance the frailty model and the plan is to work within this financial envelope. They are currently utilising bank HCAs to support the revised model which are not in the substantive establishment.
- The review has further supported the need for a full review of the enhanced care provision, including the policy, patient group, requesting and approval process and the need for distraction/diversional therapy training at a ward level.
- There is the seasonal requirement to review inpatient areas that house specialist care provisions i.e Winstanley ward and the ‘enhanced respiratory unit’. The Interim Chief Nurse has requested a season staffing plan to be revised in line with acuity and capacity and demand data from 20234/24.
- Whilst out with the scope of the establishment review the staffing in PECC is noted as a risk within the division of medicine that will require a separate review and plan to mitigate the risk and provide assurance of safe staffing.
- A full review of areas with variance in occupancy i.e. inpatient areas at the Wrightington site
- The board are asked to conder the recommendations associated with the local and national benchmarking in relation to uplift percentages as a further discussion to this review.

Appendix 1 Medicine

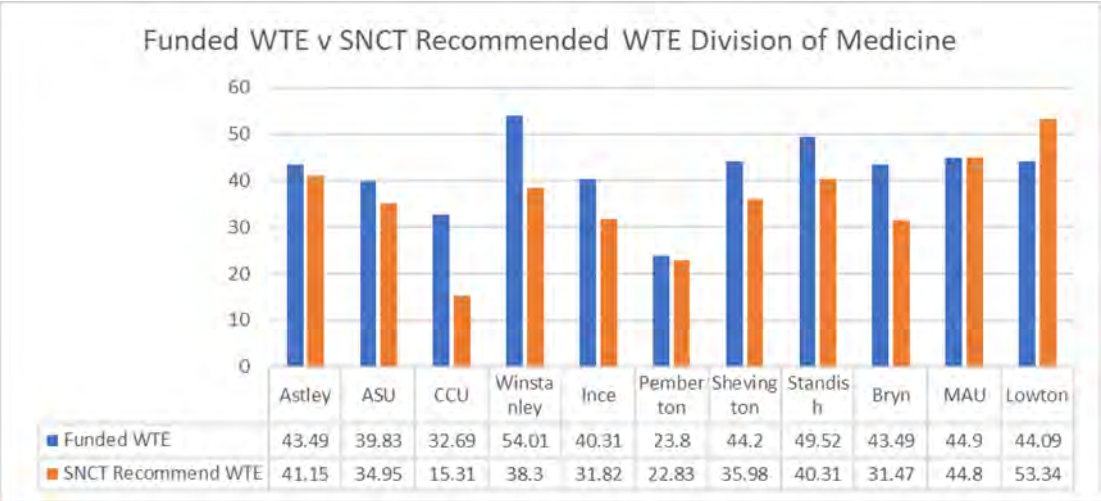


Chart 1

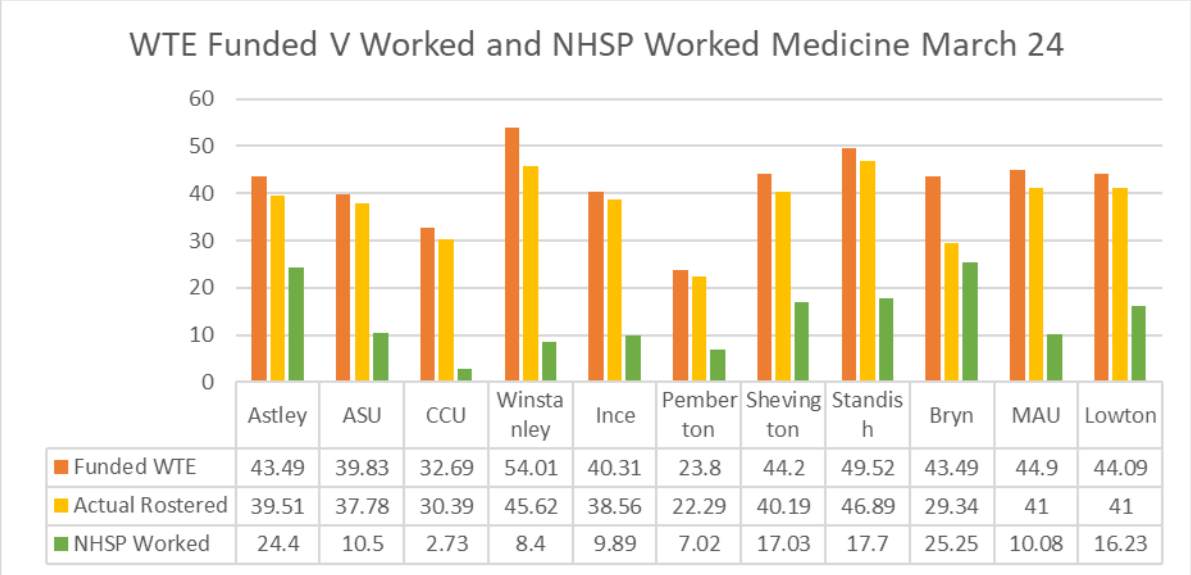


Chart 2

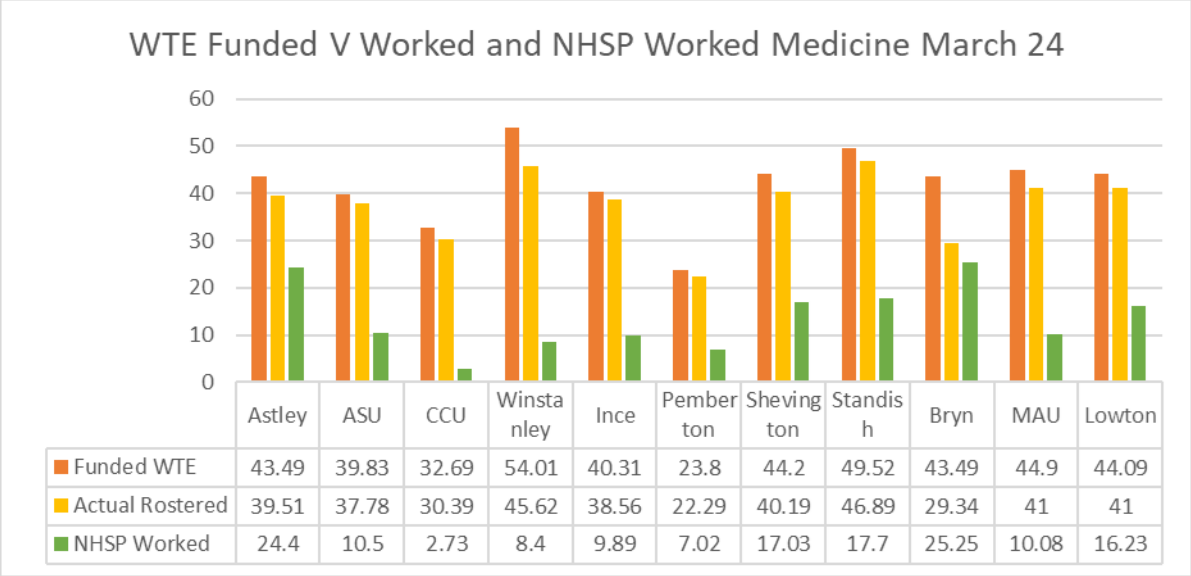
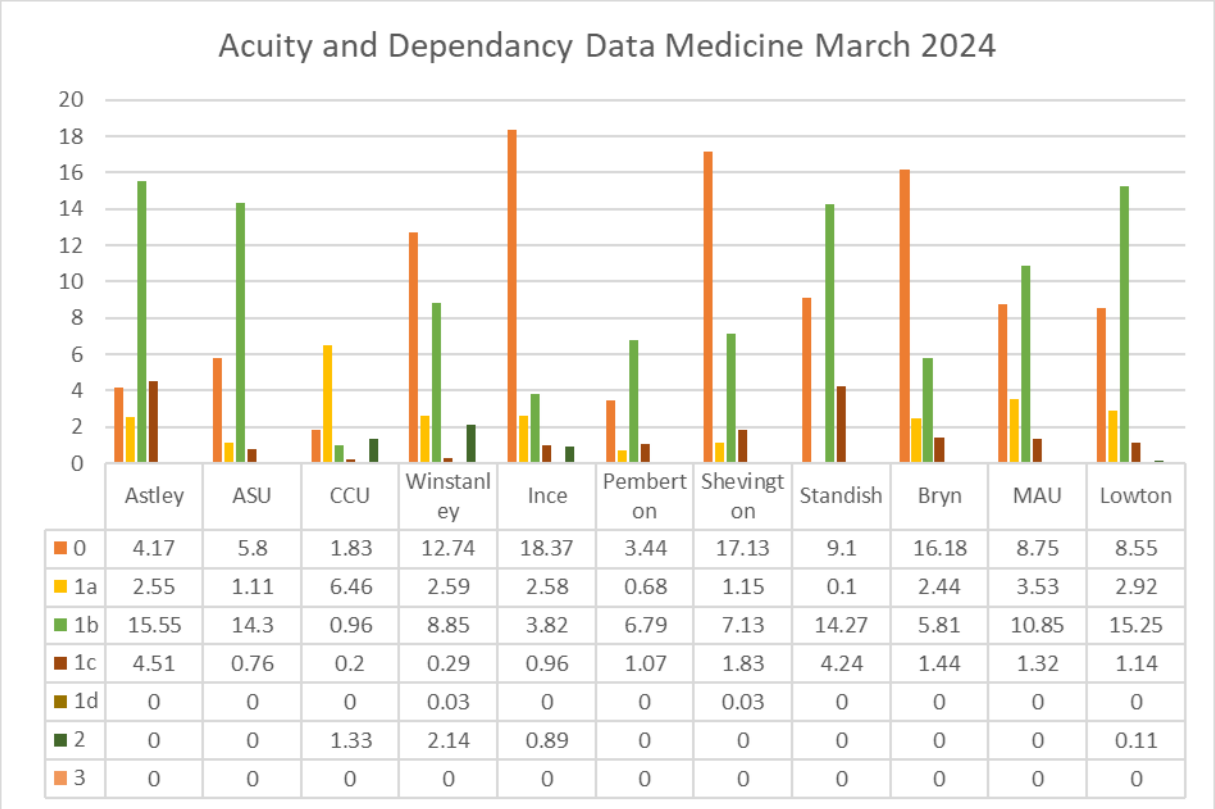
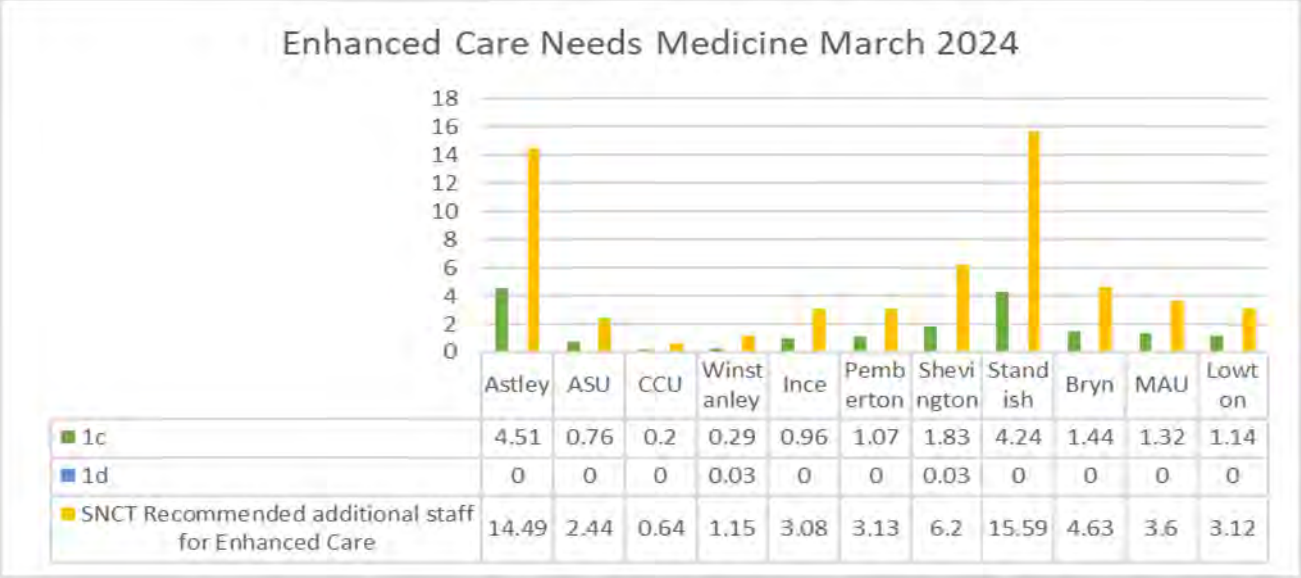


Chart 3



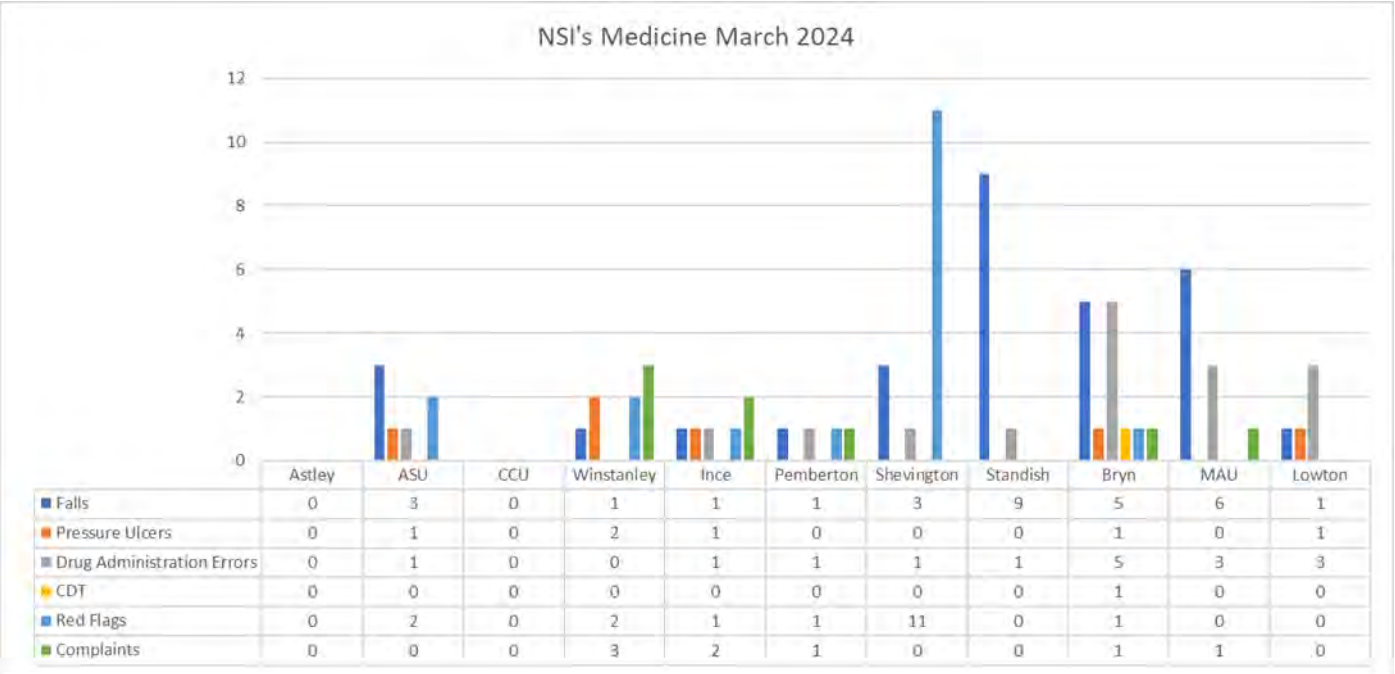
	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
0	4.17	5.8	1.83	12.74	18.37	3.44	17.13	9.1	16.18	8.75	8.55
1a	2.55	1.11	6.46	2.59	2.58	0.68	1.15	0.1	2.44	3.53	2.92
1b	15.55	14.3	0.96	8.85	3.82	6.79	7.13	14.27	5.81	10.85	15.25
1c	4.51	0.76	0.2	0.29	0.96	1.07	1.83	4.24	1.44	1.32	1.14
1d	0	0	0	0.03	0	0	0.03	0	0	0	0
2	0	0	1.33	2.14	0.89	0	0	0	0	0	0.11
3	0	0	0	0	0	0	0	0	0	0	0

Chart 4



	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
1c	4.51	0.76	0.2	0.29	0.96	1.07	1.83	4.24	1.44	1.32	1.14
1d	0	0	0	0.03	0	0	0.03	0	0	0	0
SNCT Recommended additional staff for Enhanced Care	14.49	2.44	0.64	1.15	3.08	3.13	6.2	15.59	4.63	3.6	3.12

Chart 5



	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Falls	0	3	0	1	1	1	3	9	5	6	1
Pressure Ulcers	0	1	0	2	1	0	0	0	1	0	1
Drug Administration Errors	0	1	0	0	1	1	1	1	5	3	3
CDT	0	0	0	0	0	0	0	0	1	0	0
Red Flags	0	2	0	2	1	1	11	0	1	0	0
Complaints	0	0	0	3	2	1	0	0	1	1	0

Chart 6

Appendix 2 Surgery

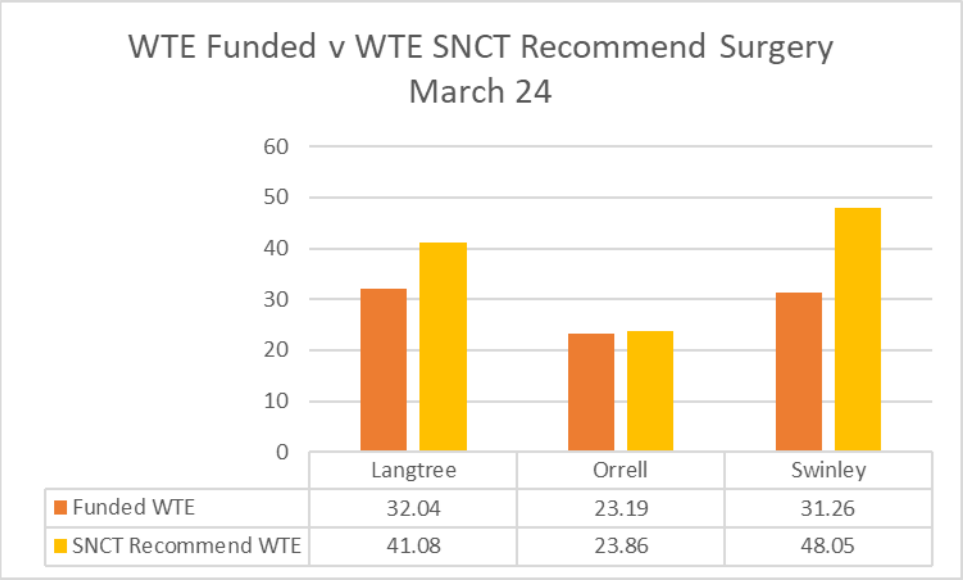


Chart 1

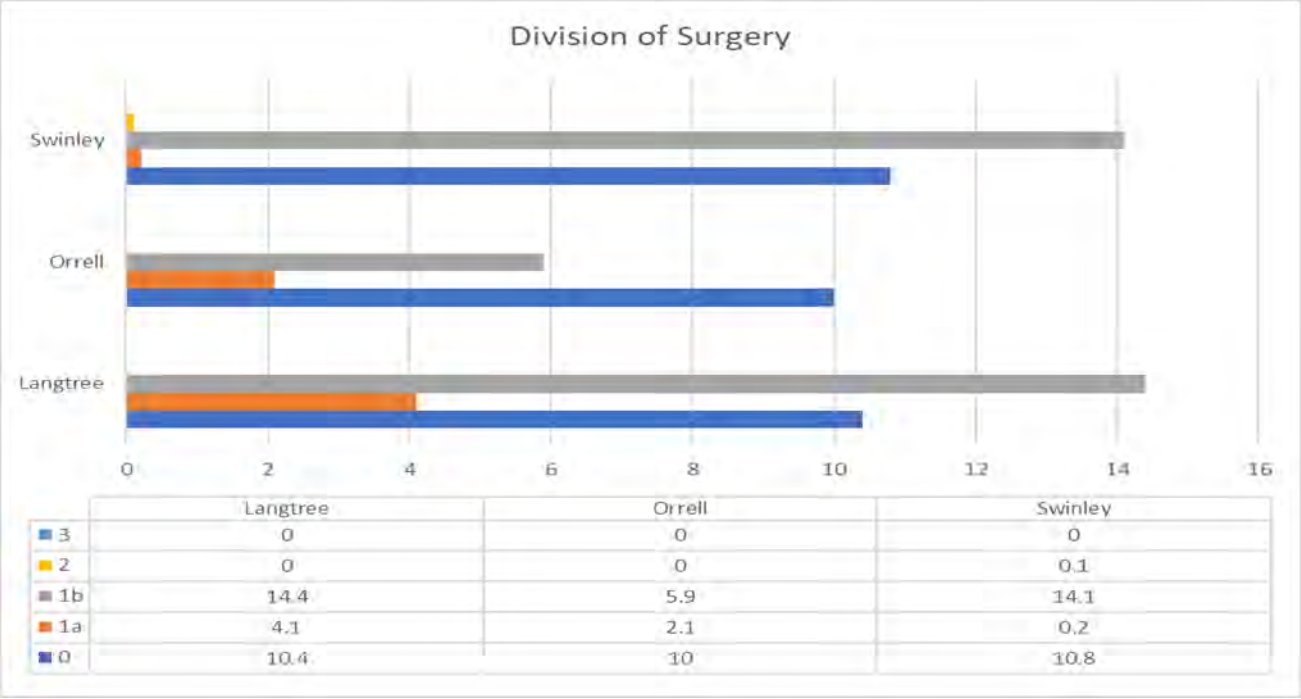
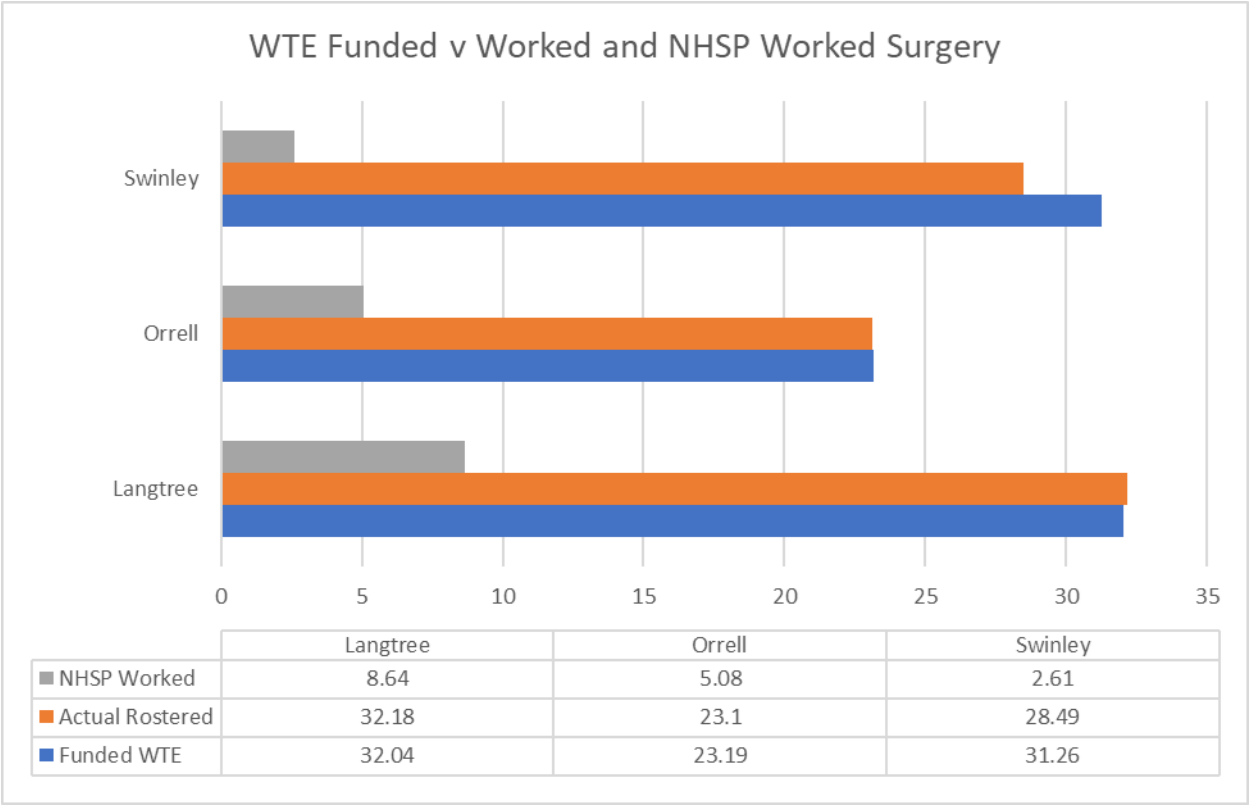
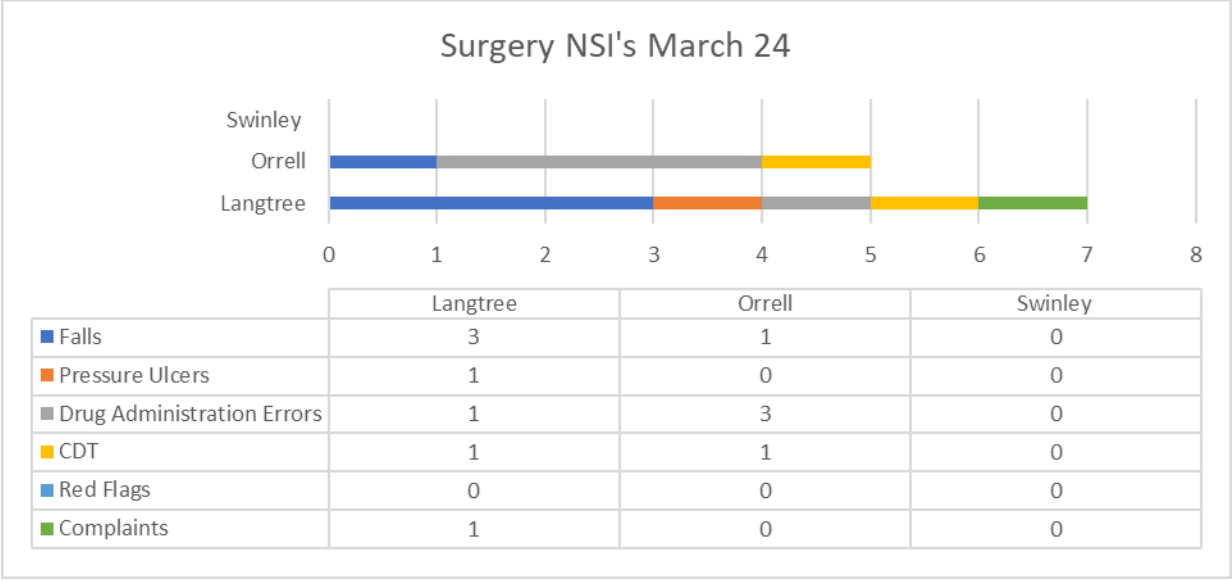


Chart 2



	Langtree	Orrell	Swinley
NHSP Worked	8.64	5.08	2.61
Actual Rostered	32.18	23.1	28.49
Funded WTE	32.04	23.19	31.26

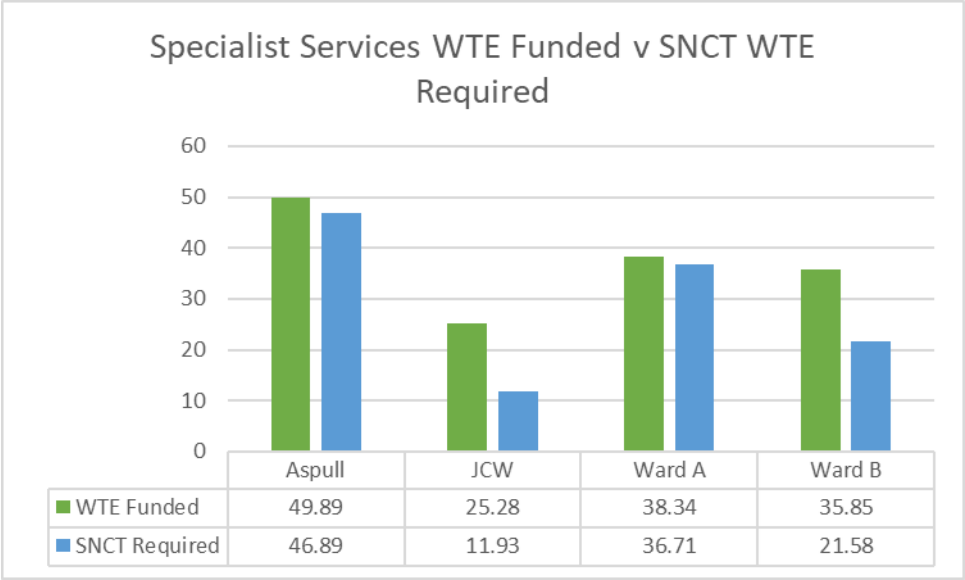
Chart 3



	Langtree	Orrell	Swinley
Falls	3	1	0
Pressure Ulcers	1	0	0
Drug Administration Errors	1	3	0
CDT	1	1	0
Red Flags	0	0	0
Complaints	1	0	0

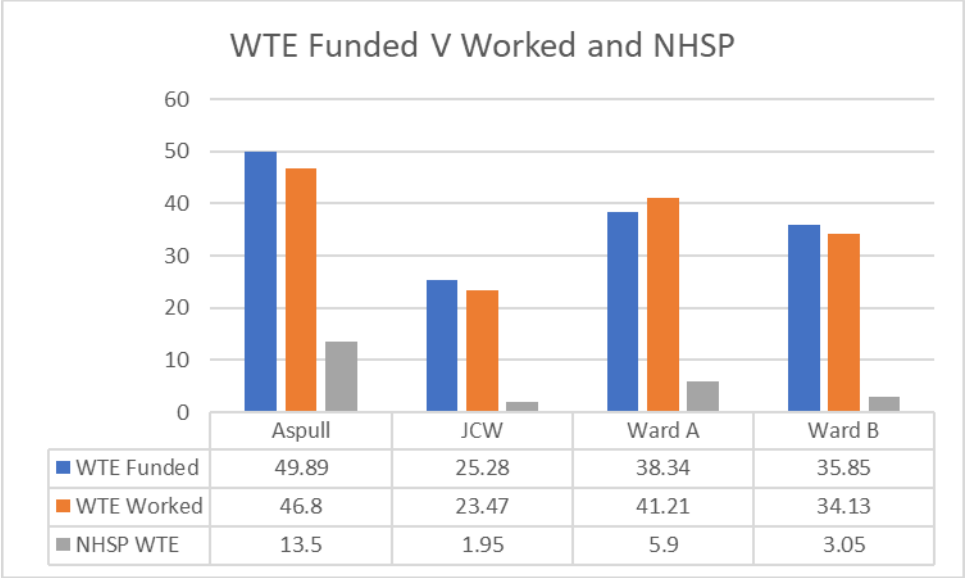
Chart 4

APPENDIX 3 Specialist Services



	Aspull	JCW	Ward A	Ward B
WTE Funded	49.89	25.28	38.34	35.85
SNCT Required	46.89	11.93	36.71	21.58

Chart 1



	Aspull	JCW	Ward A	Ward B
WTE Funded	49.89	25.28	38.34	35.85
WTE Worked	46.8	23.47	41.21	34.13
NHSP WTE	13.5	1.95	5.9	3.05

Chart 2

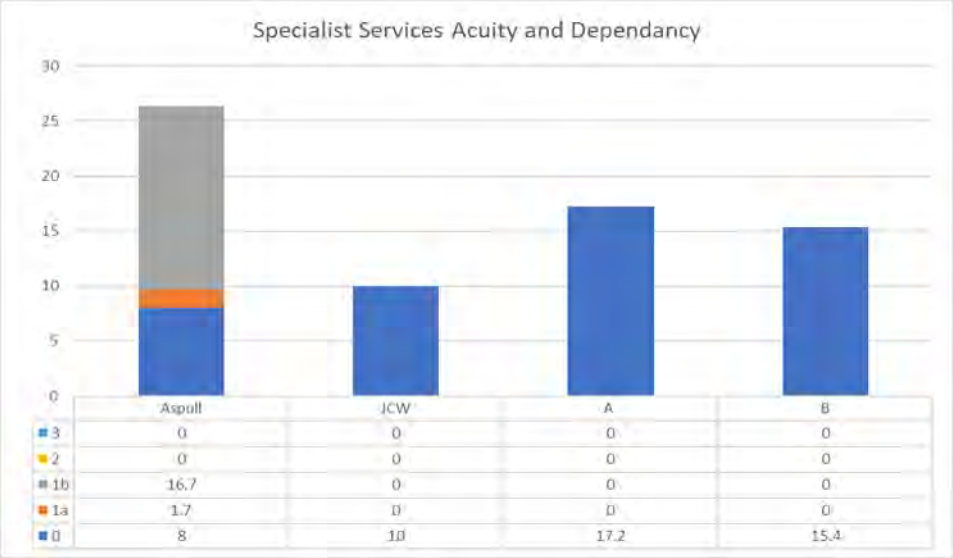


Chart 3

Chart 4

Appendix 4 Community Services

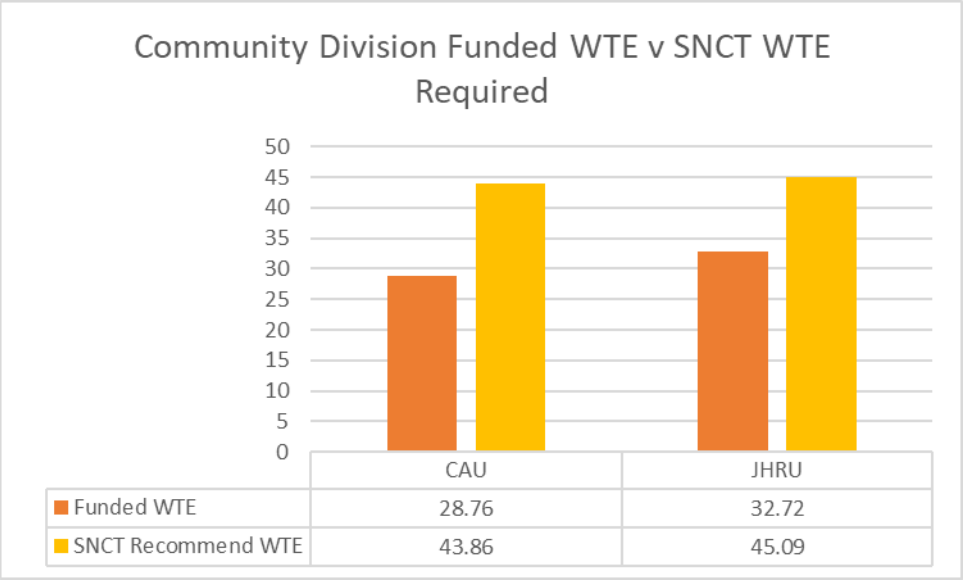


Chart 1

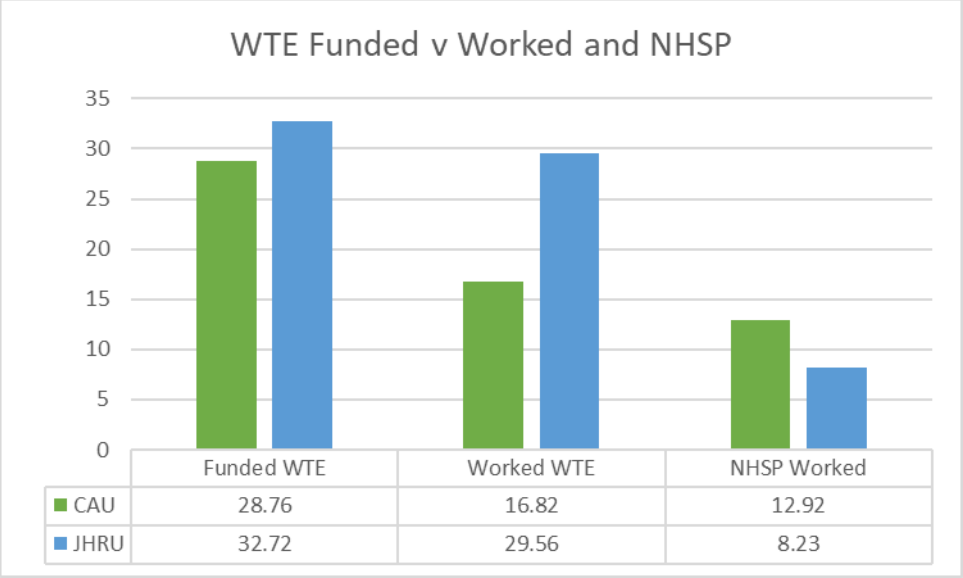


Chart 2

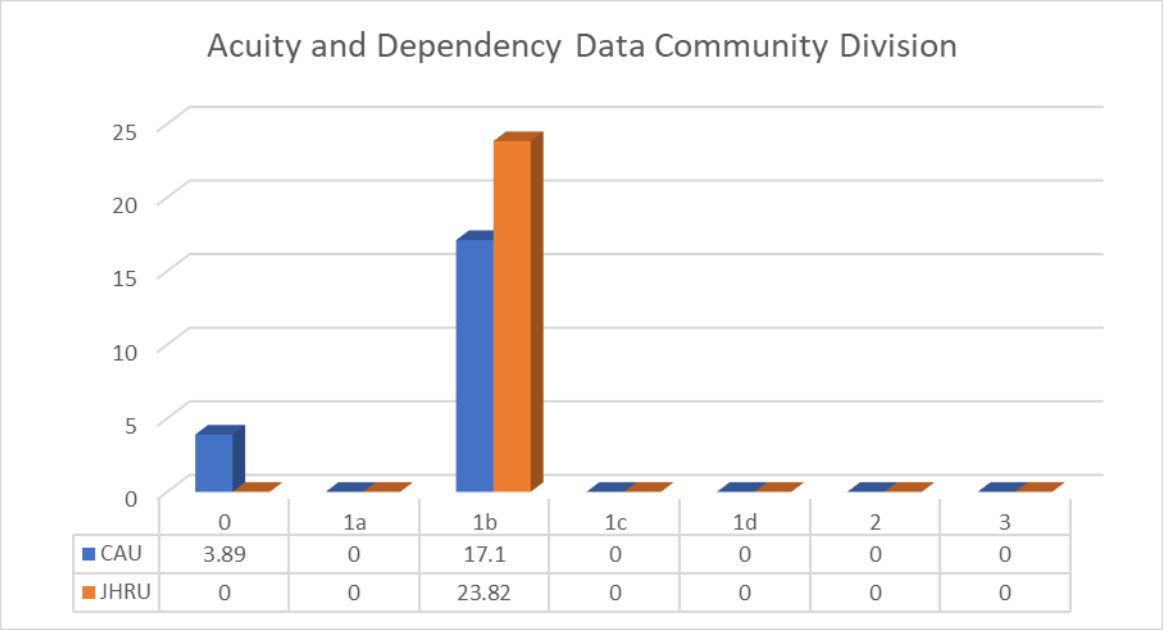


Chart 3

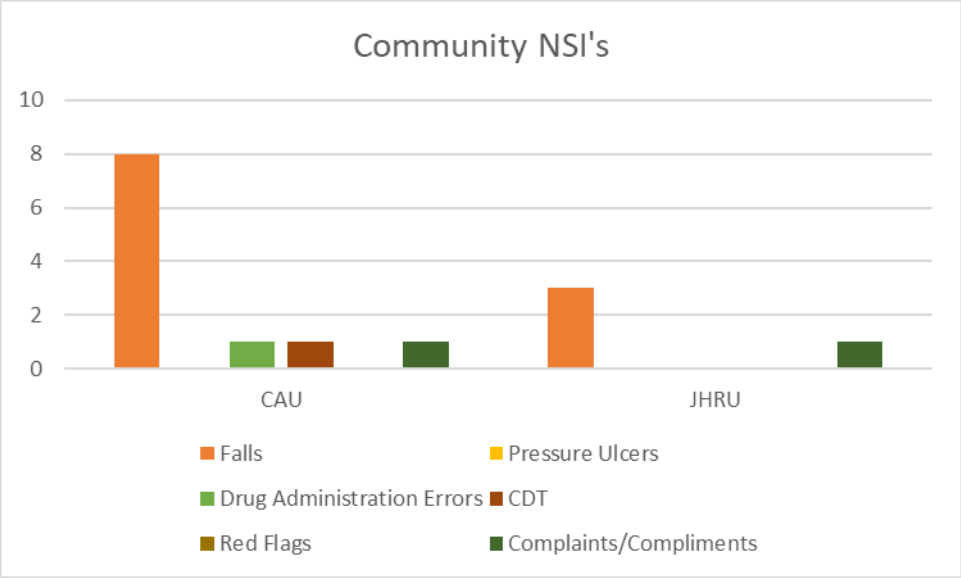


Chart 4

Appendix 5

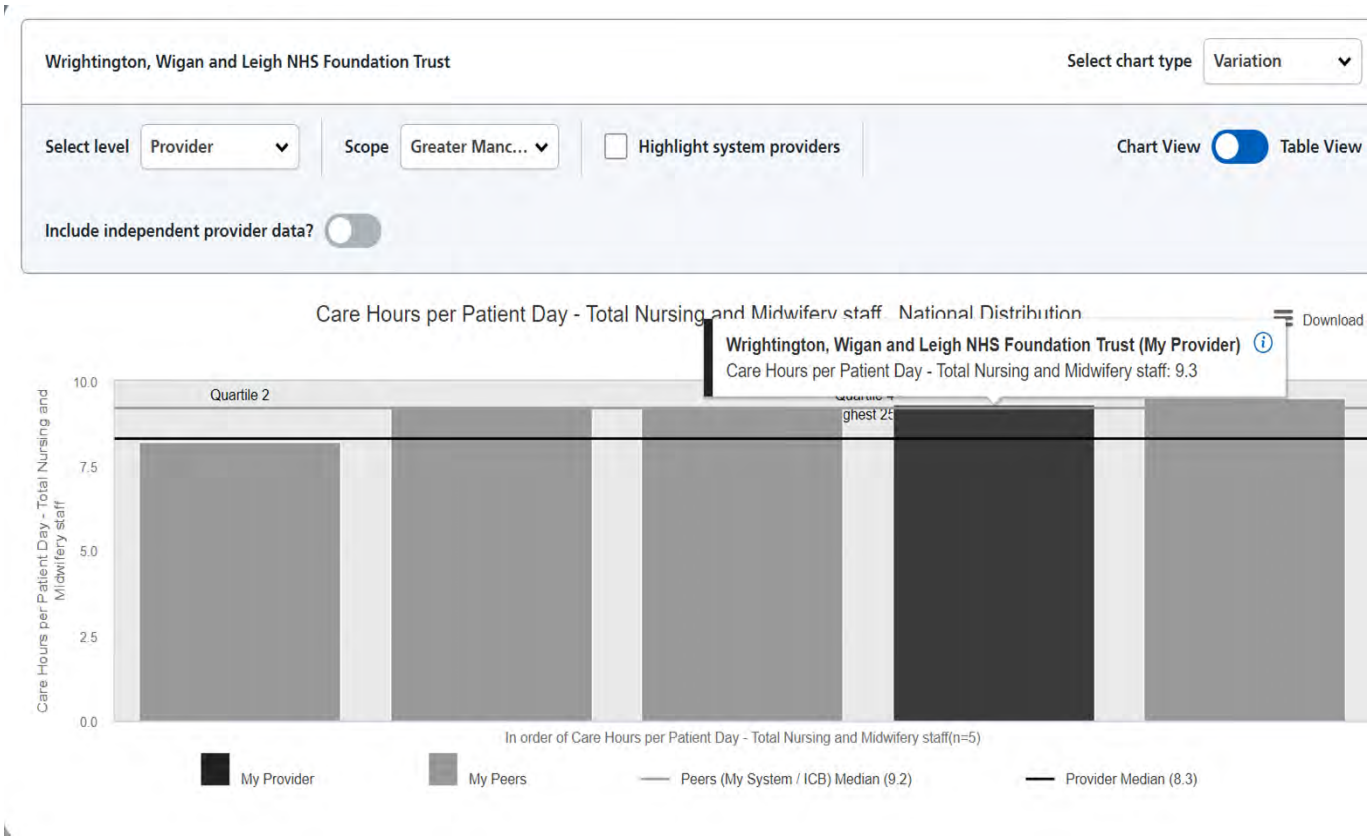


Chart 1 CHPPD V GM ICB

Chart 2 CHPPD Registered Staff v GMICB

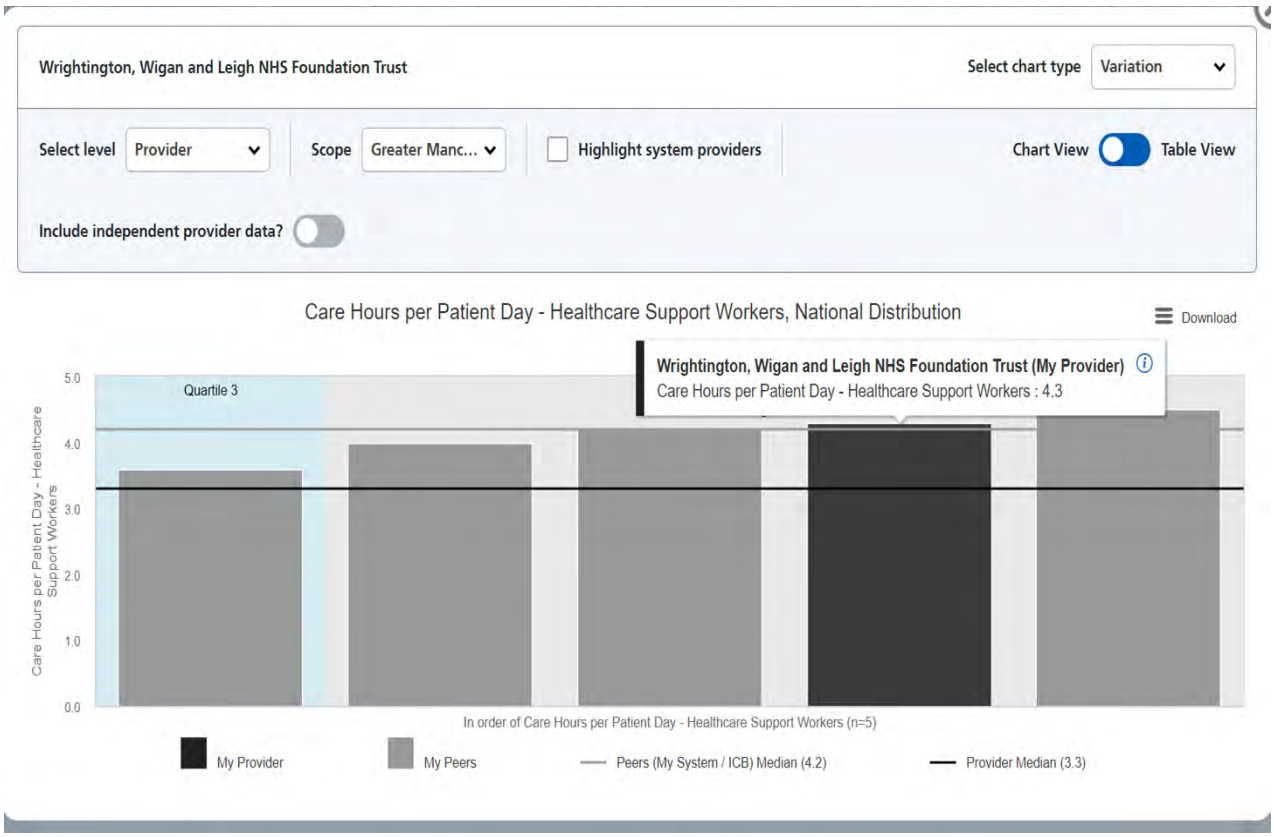

Wrightington, Wigan and Leigh NHS Foundation Trust
Select chart type
Variation
Select level
Provider
Scope
Greater Manc...
Highlight system providers
Chart View
Table View
Include independent provider data?
Care Hours per Patient Day - Healthcare Support Workers, National Distribution
Download
Wrightington, Wigan and Leigh NHS Foundation Trust (My Provider)
Care Hours per Patient Day - Healthcare Support Workers : 4.3
Quartile 3
5.0
4.0
3.0
2.0
1.0
0.0
Care Hours per Patient Day - Healthcare Support Workers
In order of Care Hours per Patient Day - Healthcare Support Workers (n=5)
My Provider
My Peers
Peers (My System / ICB) Median (4.2)
Provider Median (3.3)

Chart 3

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity and Dashboard Report
Presented to:	Trust Board
On:	05 June 2024
Presented by:	Kevin Parker - Evans
Prepared by:	Gemma Weinberg for Cathy Stanford
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

Recommendation(s)

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

Maternity and Neonatal Dashboard April 2024

Introduction

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

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

April 2024 Exception report - Maternity
Summary

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

- There were five midwifery red flags reported. It should be noted here that the method of collecting red flag reports has changed. We are now pulling these figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. The shift coordinator was unable to remain supernumerary on one occasion in April. There is a separate red flag report which investigates the red flags in more detail.
- 1:1 care is at 99.5% as there was one woman reported to have not had 1:1 care due to high activity and acuity.
- There were three Maternity complaints received in April, and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

Steis reportable Incidents

There were no Steis incidents reported in April.

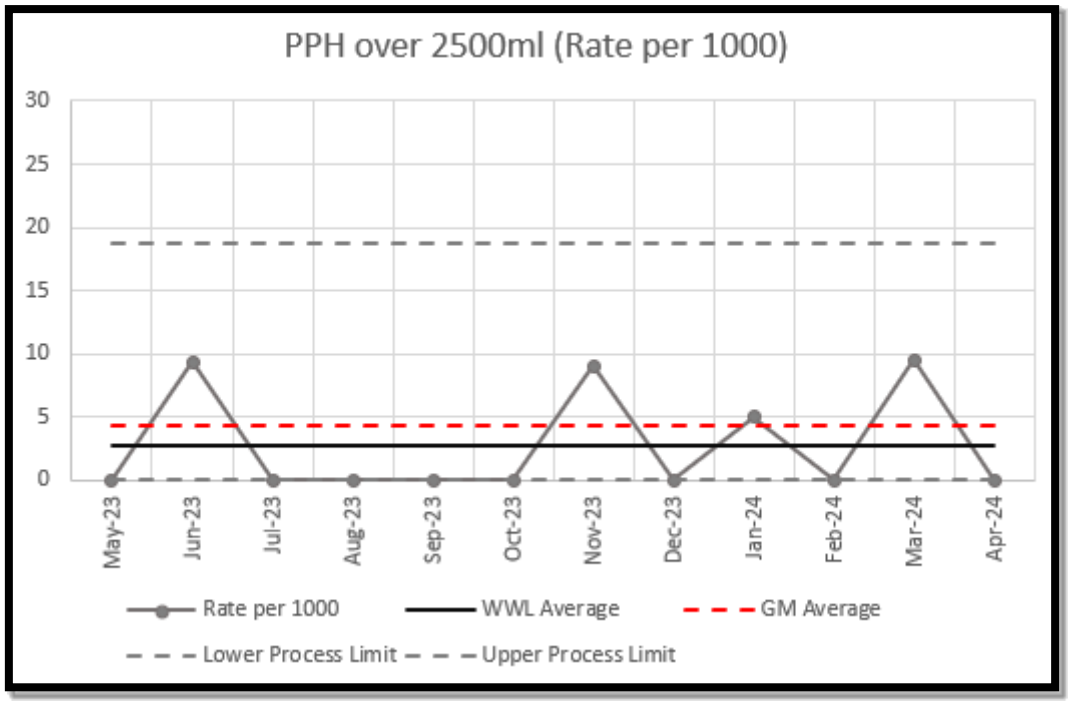
Green

Women booked by 12+6 weeks (%) This saw a drop into amber levels in January but the three months following have seen hr metric return to normal levels and have remained green for 3 months.

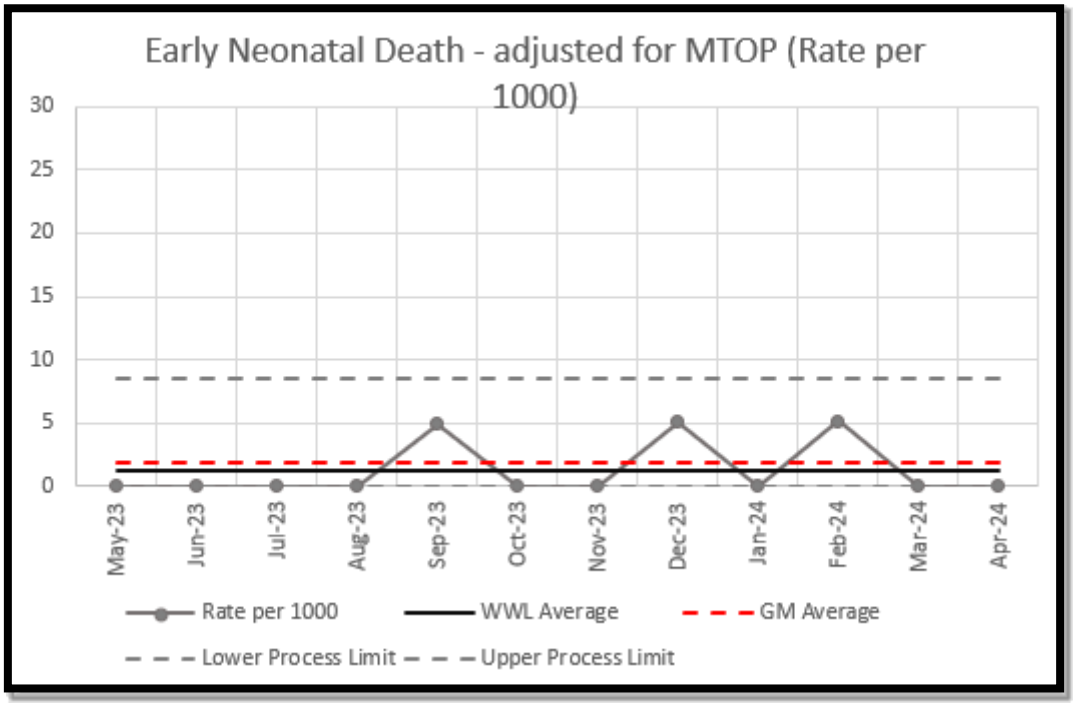
Induction of Labour (IOL) – (%) These levels have been very up and down over the past few months. March saw a rise into red levels. April sees a significant drop into green levels. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes. There is an ongoing audit as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

Women readmitted within 28 days of Delivery (rate per 1000). There were 4 maternal readmissions to the obstetric unit in April. Two of these were for a secondary PPH and two were for treatment for mastitis. No omissions in care were noted. There were also two women admitted to the surgical team for possible gallbladder issues. These are not recorded in our parameters as they are not obstetric admissions.

PPH over 2500mls (rate per 1000). There were no women who had a PPH of over 2500mls in April. The below SPC chart shows how WWL compare with GM (red line). The figures for this metric are recorded as rate per 1000.

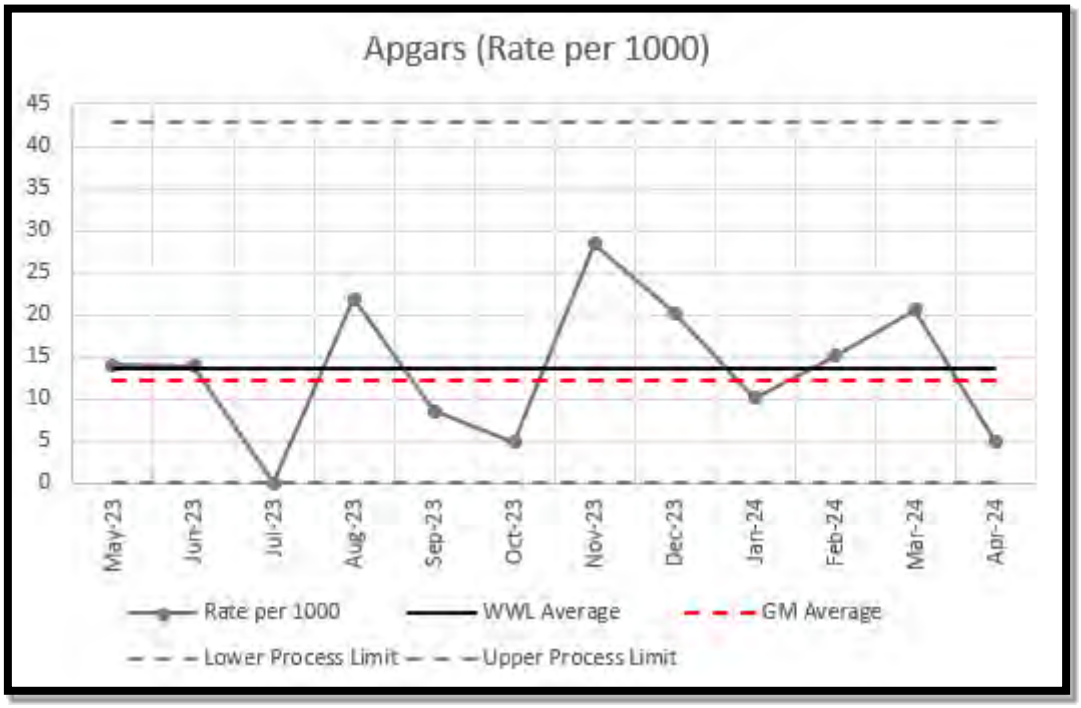


Number of Neonatal Deaths (rate per 1000). The figure is recorded as a rate per 1000. There were no NND in April. The below SPC chart shows how WWL compare with GM (red line).

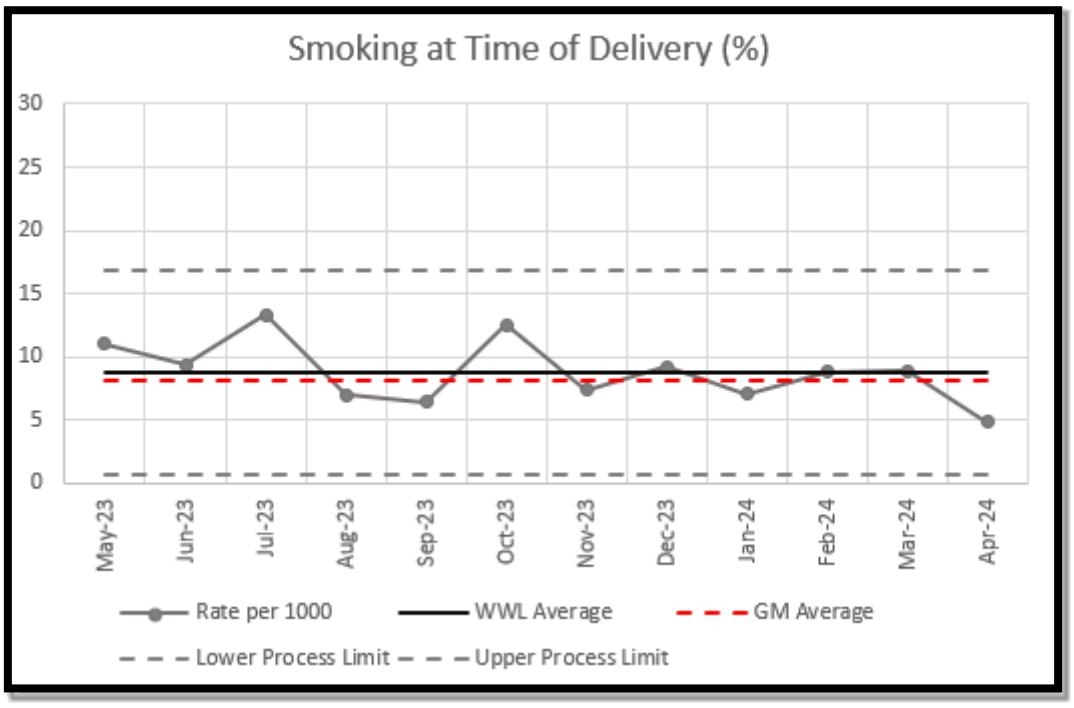


Category 1 Caesarean Sections with no Delay in Knife to Skin (%). This saw a significant drop into red levels in March but have returned to green levels in April. Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and knife to skin. The April figure equates to 1 out of 10 women having a delay of more than 30 mins.

All infants with Apgar's less than 7 (rate per 1000). This metric has saw a slight rise into amber levels in March. April sees the figure return to green levels. The rate per 1000 in April equates to 1 baby. All cases are fully investigated. The below SPC chart shows how our figures compare to the GM average (red line).

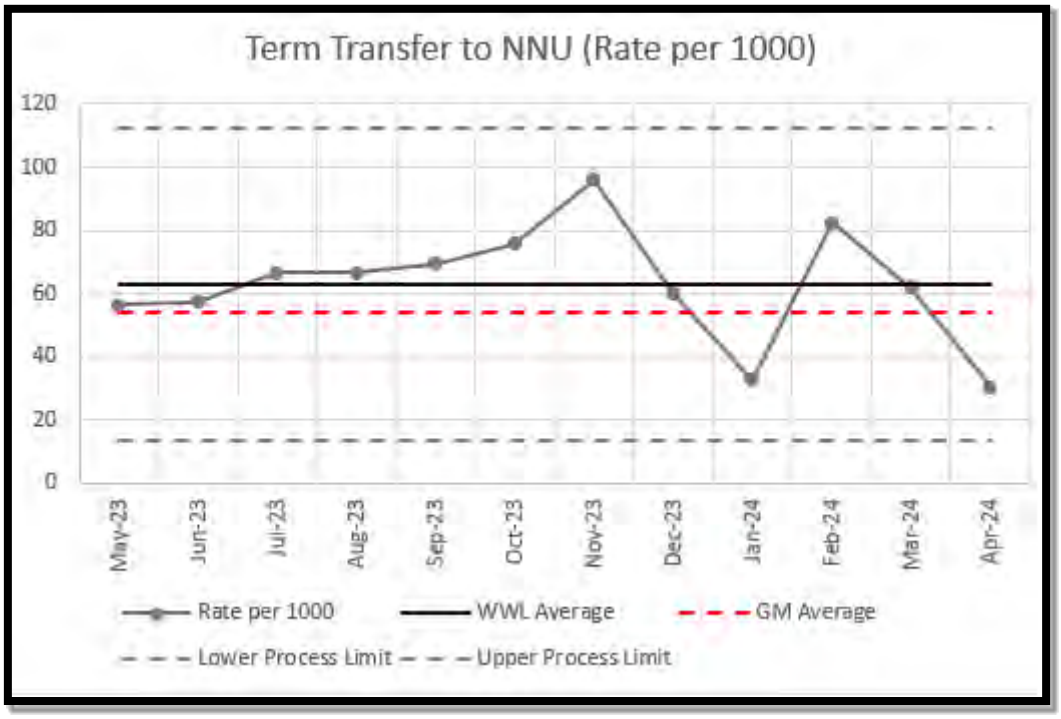


Smoking at the time of Delivery (SATOD) (%). This metric has seen a significant improvement in April. The figure is at the lowest recorded on these dashboards. Work continues to promote and encourage smoking cessation throughout pregnancy. The below SPC chart shows our % SATOD rates in comparison to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



The number of mothers who have opted to breastfeed (%) – This has seen a slight increase into green levels in April. Work continues to improve this metric.

Term admissions to NNU (rate per 1000). This metric had seen a rise after a low level in January. April sees the metric drop significantly into green levels. This figure is recorded as rate per 1000 and equates to 6 babies in April. 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).



Amber

Skin to skin contact (%) This metric had been green for the past three months but sees a small dip in April. Work continues to improve this metric.

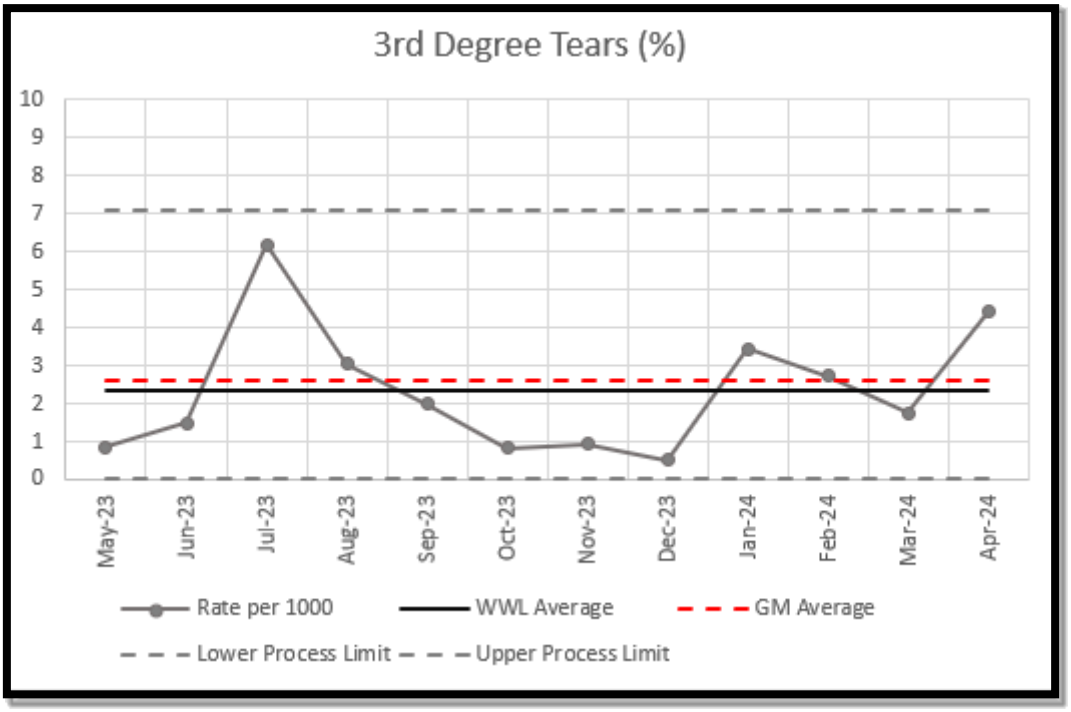
Category 2 Caesarean Sections with no Delay in Knife to Skin (%). This saw a significant drop into red levels in March. April sees some improvement in this metric. Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and knife to skin. This equates to 4 out of 31 women having a delay of more than 75 mins.

Red

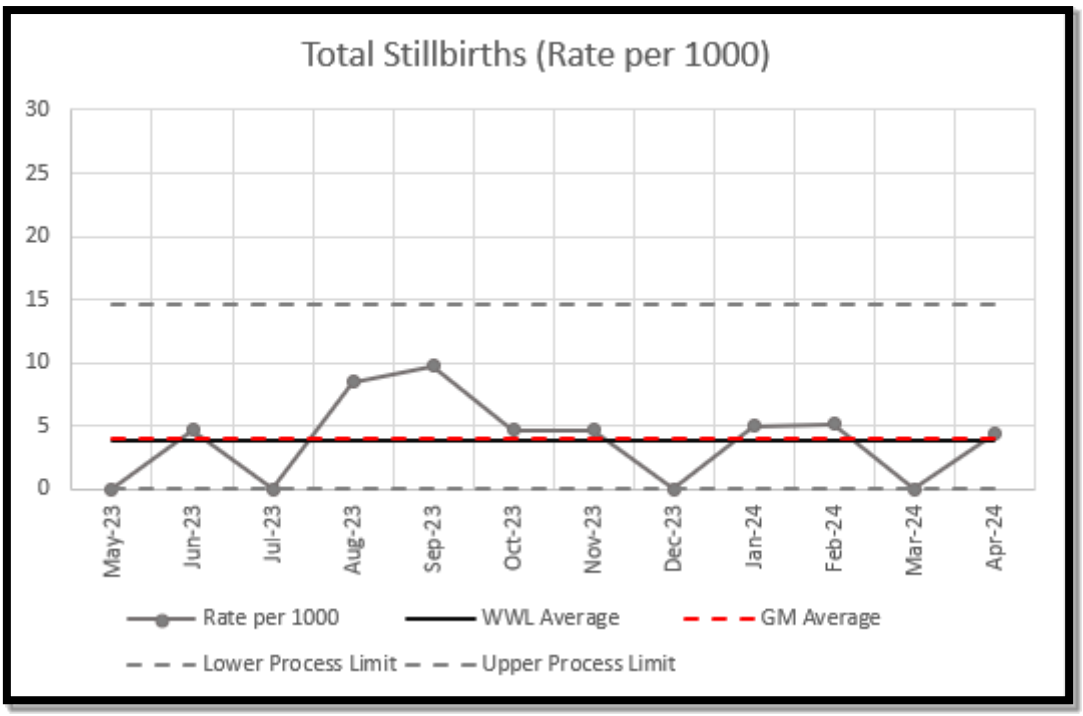
1:1 care in labour (%). This figure has dropped below 100% in April as there was one woman who was unable to receive 1:1 care due to high activity and acuity on the unit.

Supernumerary Shift coordinator (%) – There was one shift in April where the shift coordinator was unable to remain supernumerary. This takes the figure to 98.33% for April.

3rd / 4th degree tear (%). The figure is recorded as a rate per 1000. This and equates to 5 women who had a 3rd degree tear in April. The below SPC chart shows how we compare to the rest of GM for this metric.



Number of stillbirths (rate per 1000). This figure is recorded as a rate per 1000. This figure equates to one stillbirth in April. The below SPC chart shows how WWL compare with GM (red line).



Conclusion

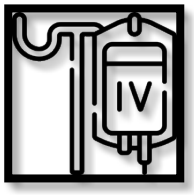
Normal variation and fluctuations are noted with the figures this month and positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show green and amber indicators but do show several red areas which will be observed going

forward. Persistently amber areas will also be closely observed for patterns. The maternity dashboard continues to be reviewed quarterly by GM and the Maternity Dashboard steering group.

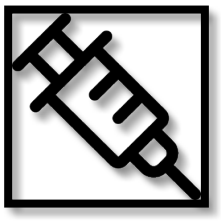
Optimisation Metrics

The below relates to 1 mother who delivered 1 baby

- All babies were born in an appropriate care setting.
- 1 baby born < 30 weeks gestation.
- 1 baby born < 34 weeks gestation.

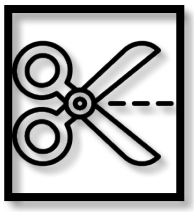


- 100% of mothers received MgSO4 (under 30 weeks).



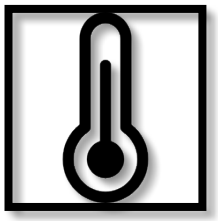
100% of babies received steroids within 7 days of delivery (< 34 weeks).

- 1 mother received a full course of steroids in the week before delivery.



100% received optimal cord management (< 34 weeks).

- 1 baby received delayed cord clamping 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).

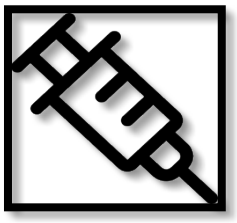
- 1 baby had a normothermic temperature taken within an hour of birth.

100% of babies received maternal breast milk (EBM) within 24 hours of birth (< 34 weeks).

- 1 baby received EBM within 24 hours of birth.

Intrapartum Antibiotics >4 hrs prior to delivery (< 34 weeks).

- There was one eligible mother, but she had a pre labour CS so Intrapartum antibiotics are N/A



Safety Dashboard 2024

Maternity

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun	2024 Q1	Q2	Q3	Q4	YTD	Trend
Activity	Bookings (Total bookings)				254	231	217	242			702					
	Booked by 10 weeks (as % of total bookings – Exclude transfer to area)				51.18%	58.44%	64.02%	54.04%			57.88%					
	Booked by 12+6 weeks (as % of total bookings – Exclude transfer to area)	Above 90%	Below 80.9%		88.58%	90.04%	92.52%	93.61%			90.38%					
	Registerable births				199	194	213	207			606					
	Planned home births (as % of all births)				0.00%	0.51%	0.46%	1.93%			0.32%					
	Unplanned home births (as % all births) – BBA				3.01%	0.00%	0.00%	0.00%			1.00%					
	NVD (as % of total births)				51.20%	47.93%	43.19%	42.03%			47.44%					
	Instrumental deliveries (as % of total births)				7.53%	8.76%	10.33%	12.56%			8.87%					
	Total number of Caesarean Sections (all categories – as % of total births)				41.70%	43.29%	46.01%	44.93%			43.67%					
	Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour				2	4	10	4			16					
	Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour				22	16	23	24			61					
	Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS				8	8	10	12			26					
	Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour				0	0	0	0			0					
	Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour				4	7	10	2			21					
	Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS				4	9	6	8			19					
	Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy				25	24	19	25			68					
	Robson Group 6: Nulliparas; single breech pregnancy				5	9	7	4			21					
	Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus)				4	3	2	6			9					
	Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus)				2	0	5	3			7					
	Robson Group 9: All women with a single oblique or transverse pregnancy (including women with a scarred uterus)				0	1	0	0			1					
	Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus)				7	3	6	5			16					
	Number successful VBAC				3	3	2	3			8					
	% of Category 1 Caesarean Sections with no Delay in Knife to Skin (over 30 minutes) – as % total cat 1 CS	Above 90%	Below 80.9%		90.90%	100.00%	61.11%	90%			84.00%					

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun
Activity	% 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%		
	Number of Caesarean Section at Full Dilatation				3	3	8	5		
	IOL (as % of all women delivered – excluding pre labour SROM)	Under 35.9%	Above 40%		39.20%	39.18%	42.72%	34.78%		
	Number of women induced when RFM is the only indication <39 weeks				1	2	0	2		
	Number of women induced for Suspected SGA				14	14	16	6		
	Number of In-utero transfers in from other units				4	4	4	5		
	Number of In-utero transfers out to other units				0	2	0	1		
	Average Postnatal Length of Stay				1.7	1.7	1.8	1.7		
Maternal Morbidity	3rd and 4th degree tears (as % vaginal births)	Under 2.5%	Above 3.5%		3.45%	2.73%	1.75%	4.42%		
	Of which 4th degree tears (number)				0	0	0	0		
	PPH 1500 – 2500 mls (Rate per 1000)				25.12	56.99	43.06	34.13		
	PPH > 2500mls (Rate per 1000)	Under 4	Above 6		5	0	9.56	0		
	Number of Women Requiring Level 2 Critical Care				1					
	Number of Women Requiring Level 3 Critical Care				0					
	Number of Blood Transfusions > 4 Units					0	0	0		
	Number of Maternal deaths				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		
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis (Number)				0	0	1	2		
Neonatal Morbidity and Mortality	Total stillbirths (as rate per 1000)	Under 3.5	Above 4		5.02	5.15	0	4.83		
	Stillbirths (excluding MTOP as rate per 1000)				5.02	5.15	0	4.83		
	Number of stillbirths (excluding MTOP)				1	1	0	1		
	Early neonatal deaths (as rate per 1000)	Under 1	Above 1.77		5.02	5.15	0	0		
	Early neonatal deaths (excluding MTOP as rate per 1000)				0.00	5.15	0	0		
	Number of Early Neonatal Deaths (excluding MTOP)				0	1	0	0		
	Number of babies born below 37 weeks				14	12	19	9		
	Shoulder Dystocia (as % of total births)				1.51%	1.0%	0.93%	1%		

2024	Q1	Q2	Q3	Q4	YTD	Trend
	78.83%					
	14					
	40.36%					
	3					
	44					
	12					
	2					
	1.73					
	2.64%					
	0					
	41.72					
	4.85					
	0					
	0					
	11.82					
	1					
	3.39					
	3.39					
	2					
	3.39					
	1.72					
	1					
	45					
	1.16%					

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun
Neonatal Morbidity and Mortality	Number of singleton babies born under 27 weeks				0	0	0	0		
	Number of multiple babies born under 28 weeks gestation				0	0	0	0		
	Number of above babies where transfers out not facilitated				0	0	N/A	N/A		
	Number of women delivered under 34 weeks (livebirth)				2	4	4	1		
	% of Mothers who delivered under 34 weeks who received a complete course of AN steroids				50%	50.00%	50%	100%		
	% of Mothers who delivered under 34 weeks who received AN Magnesium Sulphate				100%	75%	75%	100%		
	Number of women delivered under 30 weeks (livebirth)				1	1	1	1		
	% of Mothers who delivered under 30 weeks who received AN Magnesium Sulphate				100%	0.00%	100.00%	100.00%		
	% of Mothers who delivered under 30 weeks who received a complete course of AN steroids				0%	0.00%	100.00%	100.00%		
	Number of mothers who delivered under 34 weeks who received a partial dose of steroids				1	1	2	N/A		
	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		
	% of babies who had delayed cord clamping (% of total births)				84.85%	89.7%	88.73%	89%		
	% of babies born <37 weeks whose mother received intrapartum IV Antibiotics (% of births under 37 weeks)				7.14%	16.7%	3.09%	2%		
	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		
	Term Admissions to NNU (births >_ 37 weeks gestation) - Rate per 1000	Under 54	Above 65		32.79	82.4	61.86	30.46		
	Number of babies re-admitted with 28 days of birth				13	16	14	13		
	Number of babies born < 3rd centile				14	15	12	9		
	Number of babies born < 3rd centile >_ 38 weeks				7	6	7	6		
Public Health	% women smoking at time of booking (as % of total bookings)				5.12%	11.7%	8.41%	7.23%		
	% women smoking at time of delivery (as % of total births)	Under 8.5%	Above 10%		7.04%	8.8%	8.92%	4.41%		
	Babies in Skin-to-Skin within 1 hour of birth	Above 75%	Under 65%		82.91%	75.26%	78.4%	74%		
	Percentage of Women Initiating Breastfeeding	Above 58%	Under 50%		60.80%	54.12%	57.28%	60%		
	Number of women who report that they are drinking alcohol at booking				0	1	0	0		
Workforce	1:1 Care in Labour (as % all births - excluding El CS and BBA)		Under 100%		100%	100%	100%	99.5%		
	Percentage of shifts where shift Co-ordinator able to remain supernumerary		Under 100%		100%	100%	100%	98.33%		
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	1		
	Sickness (as % of overall staffing) – report quarterly									

2024 Q1	Q2	Q3	Q4	YTD	Trend
0%					
0					
0					
10					
50.00%					
83.00%					
3					
67.00%					
33.00%					
4					
0					
87.76%					
8.96%					
17.38					
59.01					
43					
41					
20					
8.41%					
8.24%					
78.86%					
57.40%					
100.00%					
100.00%					
0					

					2024					
		Goal	Red Flag	Measure	Jan	Feb	Mar	Apr	May	Jun
Workforce	Number of vacancies				7.63	6.17	6.31	8.13		
	Prospective Consultant hours on Delivery Suite				60	60	60	60		
	Number of Midwifery Red Flags Reported				0	3	5	5		
Incidents	Number of incidents reported				78	75	55	70		
	Number of MNSI Investigations				0	0	0	0		
	Number of StEIS Reported Incidents				1	0	0	0		
	Number of Complaints received in the month				1	0	4	3		
	Number of Letters of Claim Received in the month				0	0	0	0		
	HIE 2 &3 > 37 weeks (rate per 1000)			GM average 2023 0.555/1000	0	0	0	0		

2024					
Q1	Q2	Q3	Q4	YTD	Trend
6.7					
180					
10					
208					
0					
1					
5					
0					
0					

Safety Dashboard 2024

Neonatal

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

					2024						2024					
		Goal	Red Flag	Measure	Jan	Feb	Mar	Apr	May	Jun	Q1	Q2	Q3	Q4	YTD	Trend
Safety	% of Shifts Staffed to BAPM	100.00%	< 90%	Badger	98.39	84.21	48.39	58.33	.	.						
	% of Shifts with Supernumeary Shift Leader	100.00%	< 50%	Badger	91.94	77.19	48.39	46.67	.	.						
	Unit Closed Due to Capacity	0	≥ 1	Datix	0	1	1	0								
	Unit Closed Due to BAPM/Staffing	0	≥ 1	Datix	0	0	0	1								
Admissions	Number of Births from Maternity			Maternity Data	199	194	213	207								
	Admissions Under 27 Weeks to NNU	< 1	≥ 1	Badger	0	0	0	0								
	Admissions 27+1 – 34 Weeks to NNU			Badger	2	7	7	1								
	Total Admissions to Neonatal Unit			Badger	23	25	32	20								
	Transitional Care Admissions: 34 – 36+6			Badger	2	4	0	2								
	Transitional Care Admissions: 37+			Badger	4	8	6	8								
	Total TC Admissions			Badger	6	12	6	10								
	Number of unexpected Term Admissions to NNU				6	15	12	6								
	Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)	5.40%	6.50%	Maternity/Badger	3.27%	8.24%	6.18%	3.46%	.	.						
	Unexpected Term Admissions to NNU (*as % of Total Admissions*)			Badger/ NWNODN	26.08%	60%	37.50%	30%								
NNAP	Mothers Eligible for AN Steroids (*< 34 Weeks*)			NNAP/ NWNODN	2	4	4	1								
	% of Mothers Who Received Full Course of Antenatal Steroids	≥ 93%	< 89%	NNAP/ NWNODN	50%	25%	50%	100%	.	.						
	Mothers Eligible for AN $MgSO_4$ (*< 30 Weeks*)			NNAP/ NWNODN	1	1	1	1								
	% of Mothers Receiving Antenatal $MgSO_4$	≥ 85%	< 73%	NNAP/ NWNODN	100%	0.00%	100%	100%								
	Babies Eligible for Delayed Cord Clamping			NNAP/ NWNODN	2	5	7	1								
	% of Babies Receiving Delayed Cord Clamping	≥ 85%	< 73%	NNAP/ NWNODN	50.00%	80.00%	71.42%	100%								
	Babies Eligible for Temperature on Admission (*< 32 Weeks*)			NNAP/ NWNODN	2	5	7	1.00								
	% of Babies With Temperature Within First Hour of Admission (*< 32 Weeks*)			NNAP/ NWNODN	100%	80%	71.40%	100.00%								

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun	2024 Q1	Q2	Q3	Q4	YTD	Trend
NNAP	% of Babies With Temperature on Admission of 36.5°C – 37.5°C (< *32 Weeks*)			NNAP/ NWNODN	100%	80%	71.40%	100.00%								
	Babies Eligible for Senior Review			NNAP/ NWNODN	18	17	28	15								
	Number of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	18	17	28	12								
	% of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	100%	100%	100%	80%								
	Total Ward Rounds Where Parents Present			NNAP/ NWNODN	17	20	31	15								
	% of Ward Rounds Where Parents Present			NNAP/ NWNODN	100.00%	100.00%	100.00%	100.00%								
	% of Eligible Babies Reciving Retinopathy Screening (*ROP*)			NNAP/ NWNODN	100.00%	100.00%	100.00%	0.00%								
	% of Babies With Central Line Blood Infections			NNAP/ NWNODN	0.00%	0.00%	0.00%	0.00%								
	Babies Eligible for Follow-Up At 2 Years			NNAP/ NWNODN	1	2	0	0								
	% of Babies Receiving Follow-Up At 2 Years			NNAP/ NWNODN	0.00%	50.00%	N/A	N/A								
Incidents	Number of Incidents Reported			Datix	5	28	27	39								
	Number of Network Exception Reports			NWNODN	1	1	1	0								
	Number of Concise Investigations	0	≥ 1	Datix	0	0	0	0								
	Number of StEIS Reported Incidents	0	≥ 1	Datix	0	1	0	0								
	Number of Complaints	< 2	≥ 2	Datix	0	1	0	0								
	Number of Letters of Claim Received	0	≥ 1	Datix	0	0	0	0								
Breastfeeding	% of Mothers Expressing Breast Milk in First 24 Hours Following Baby's Admission to NNU			Unicef/ NWNODN	26.10%	20.00%	21.90%	5.00%								
	% of Babies Receiving Human Milk in First 24 Hours Following Admission to Neonatal Unit			Unicef/ NWNODN	17.40%	16.00%	15.60%	10.00%								
	% of Babies Receiving Human Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	7.70%	53.10%	33.30%								
	% of Mothers Expressing Breast Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	7.70%	0.00%	0.00%								
	% of Mothers Breastfeeding on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	3.80%	50.00%	26.70%								
	Number of Babies Eligible to Receive Breast Milk in the First Two Days of Life (< *34 Weeks*)			NNAP/ NWNODN	2	5	7	1								
	% of Babies < 34 Weeks Receiving Breast Milk in First Two Days of Life			NNAP/ NWNODN	100.00%	40.00%	71.40%	100.00%								
	Number of Babies < 34 Weeks Eligible for Breast Milk at Day 14			NNAP/ NWNODN	2	1	7	1								
	% of Babies < 34 Weeks Receiving Breast Milk at Day 14			NNAP/ NWNODN	50.00%	100.00%	85.70%	100.00%								

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun	2024 Q1	Q2	Q3	Q4	YTD	Trend
Breastfeeding	Number of Babies < 34 Weeks Eligible for Breast Milk at Discharge			NNAP/ NWNODN	4	3	8	1								
	% of Babies < 34 Weeks Receiving Breast Milk at Discharge			NNAP/ NWNODN	50.00%	66.70%	75.00%	100.00%								
Activity	Care Days ICU (*HRG1*)			Badger	4	4	20	7								
	Care Days HDU (*HRG2*)			Badger	46	54	96	106								
	Care Days SC (*HRG3, HRG4, HRG5, and code9*)			Badger	181	183	202	216								
	Cot Capacity ICU %			Badger	12.90%	13.79%	64.50%	23.30%								
	Cot Capacity HDU %			Badger	49.46%	62.06%	103.22%	117.77%								
	Cot Capacity SC %			Badger	58.37%	63.10%	65.16%	72.00%								
	Overall Cot Capacity %			Badger	53.22%	59.35%	73.27%	78.33%								
	Care Days TC (*HRG3*)			Badger	0	0	0	0								
	Care Days TC (*HRG4*)			Badger	27	42	31	57								
	Care Days TC (*HRG5*)			Badger	0	0	2	0								
	Care Days TC (*code 9*)			Badger	0	2	2	4								
	Total TC Care Days			Badger	27	44	35	0								
	Overall TC Cot Capacity %			Badger	21.77%	37.93%	26.12%	50.80%								
Training	NLS Accrediated	≥ 70%	< 70%	WWL	86.80%	86.10%	86.10%	86.10%								
	NLS In-House	≥ 90%	< 90%	WWL	97.60%	95.10%	95.10%	95.10%								
	Qualified In Speciality of Intensive Neonates	≥ 70%	< 70%	WWL	92.10%	94.90%	94.90%	94.90%								
	Foundation In Neonates	≥ 70%	< 70%	WWL	.	.	.	.	.	.						
	Family Intergrated Care	≥ 85%	< 85%	WWL	100.00%	100.00%	88.40%	88.40%								
	Unicef BFI	100%	< 80%	WWL	100.00%	97.80%	95.70%	95.70%								
	Perinatal Mental Health	≥ 80%	< 80%	HEE	100.00%	100.00%	100.00%	100.00%								

Optimisation Dashboard 2024

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

	2024					
	Jan	Feb	Mar	Apr	May	Jun
Number of singleton babies born under 27 weeks or < 800g	0	1	0	0		
Number of multiple babies born under 28 weeks gestation	0	0	0	0		
% of babies <30/40 gestation whose mothers received MgS04	100.00%	0.00%	100.00%	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%		
% of Babies Receiving Delayed Cord Clamping	50.00%	66.60%	71.00%	100.00%	.	.
% 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%		
% of babies <34/40 gestation who received Maternal Breast Milk (EBM) Within 24 hrs of birth	100.00%	80.00%	71.00%	100.00%		
% of babies <34/40 gestation whose mothers received Intrapartum Antibiotics >4 hrs prior to delivery	N/A	66.66%	0.00%	N/A		

2024					
Q1	Q2	Q3	Q4	YTD	Trend

Title of report:	Perinatal Quality Surveillance Full Report (Q4 2023-2024, Jan-Mar 24)
Presented to:	Trust Board
On:	5th June 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
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Executive summary

The Perinatal Quality Surveillance model incorporates the 5 principles outlined in NHSE/I document *Implementing a revised perinatal quality surveillance model* (2020) with a view to increasing oversight and perinatal quality at trust-board, local, regional, and national level, integrating perinatal clinical quality into the ICS structures, and providing clear lines of responsibility and accountability in addressing quality concerns at each level of the system.
The purpose of quarterly Perinatal Quality Surveillance report is to provide oversight and assurance to the Board that there are effective systems of clinical governance and monitoring of safety for Maternity and Neonatal services.

Incidents and investigations

MatCH Division successfully closed all incidents prior to the move to LfPSE in March 24.

In Q4 there were 2 moderate or above incidents, with 1 StEIS reported by WWL at end of Q4 (both on StEIS register). Duty of Candour has been served in both cases.

WEB157774 Unplanned Transfer to Level 3 Unit (neonatal death). A detailed rapid review & timeline are in progress and staff statements underway. For escalation to LfPSE and recommend WWL StEIS report. (StEIS report and Duty of Candour have been served by Royal Oldham Hospital). Immediate learning re systems and processes in Triage and Transitional care, and poor documentation in regard to the administration of Vitamin K.
Coroner's case.

WEB156790 / StEIS 2024/2667 Delay in responding to call for assistance (incident date 14.2.2024) – Escalated to LfPSE. For PSII under PSIRF local priority category 'Sub-optimal care of deteriorating patient'. Immediate learning re oversight of unit & apnoea alarm inaudible from medication room. Duty of Candour served.

Undiagnosed SGA is the highest reported incident in Q4. WWL remains in the top 10 Trusts in the country for diagnosis of SGA on scan. All scans with >10% discrepancy between estimated fetal weight and birth weight have been reviewed by the Sonography team and the images were of good quality and no learning has been found. The SBL team have strengthened training and now individual assessment of fundal height measurement is undertaken as part of mandatory training to ensure a standardised approach.

Work continues with ATAIN as the second highest reported sub-category in Q4. New initiatives planned include a midwifery Transitional Care lead to strengthen collaborative working and oversight in the event that the neonatal nurse is called back to the neonatal unit due to staffing pressures. Transitional care documentation is under review to support robust care planning and handover between the 2 teams.

Staffing incidents were the highest reported neonatal sub-category.

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. CNST Yr.6 is due for publication on the 2nd April 2024 and assurance data will continue to be provided.

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

Feedback and complaints

In Q4, 5 formal complaints have been received for maternity services.

In Q4, 1 formal complaint has been received for the neonatal service and remains active. This is additionally being responded to via the PSII process, with the complainant's questions being fed into the investigation.

The introduction of the Patient, Public and Staff Engagement Midwife in February 24 aims to improve our oversight and response to concerns, and progress will continue to be monitored.

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

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

Risks

The Risk Register has been included for maternity and neonatal services.
At the end of Q4
-0 new risks under review
-0 new risks awaiting approval
-1 risk approved
MAT 3880 Daisy Team future funding uncertain.
-5 risks closed
MAT 140 Backflow of raw sewage
MAT 1037 CTG misinterpretation
MAT 3659 Insufficient number of Resuscitaires on Delivery Ward
MAT 3672 Lack of availability of NLS accredited training

NEO 2281 Significant number of staff without current accreditation for NLS course
-2 risks proposed for closure at Divisional Risk Group in April 24
MAT 3616 Risk of non-compliance with CNST Yr. 5
MAT 2581 Sustainability of Maternity Services

MAT Risk 1469 reviewed following feedback from LMNS re lack of robust system to mitigate risk of abduction from maternity unit. New action added, increased score to 8.

The Governance team continue to support staff progress risks through the risk management process and workings meetings are being embedding to support this.

Exceptions

- A number of risk actions are overdue.
- Several risks have been mitigated to target levels – to review for closure (risk tolerated).
- Several risks have not been progressed with scores remaining unchanged.

Ockenden 2

Q4 has seen minimal progress against the remaining 5 Ockenden actions.
MIAA audit is in progress.

Exceptions - 5 actions remain, all are in progress. The outstanding actions were reviewed in March 24, progress updated and timeframes extended. All action leads have been prompted to provide regular updates on the progress of their actions.

Maternity Incentive scheme

On the 26th March 24, WWL were informed that they had met all 10 CNST Safety Actions for Year 5.
Year 6 of the Maternity Incentive Scheme will be published on 2 April 2024, and Trusts will be notified as soon as the updated guidance is made available.

No exceptions

ATAIN

Q3 23-24 audit found unexpected term admission rate to the neonatal unit to be **7.26%.** There is still work to be done, with 5 (11.36%) of admissions thought to be potentially avoidable on review and QI work is ongoing. The national target is <6% with the NWNODN setting the target at <4.5%. ATAIN action plan oversight by Board. Learning from potentially avoidable admissions has been provided within the report and will be shared widely with staff.

No exceptions

Mortality and PMRT

There were 2 stillbirths in Q4 at WWL.
There was also 1 stillbirth that occurred at another Trust following an in-utero transfer from WWL.
No immediate care or service delivery issues identified affecting the outcome. Await PMRT.

There were 2 neonatal deaths in Q4 at WWL. No care issues identified affecting outcome. Await PMRT. There was also 1 neonatal death which occurred at Royal Oldham Hospital following transfer from WWL on Day 5 of life. Coroner's case. Immediate learning identified regarding Triage and Transitional Care systems and processes, and Vitamin K documentation. For StEIS.

Data for stillbirths and neonatal deaths has been tabulated within the report from January 2023 until the end of Q4 to facilitate the early recognition of themes and trends.

In Q4, 4 cases were finalised at PMRT. Incidental learning was identified

- Ensure LWMH is given as per guidelines
- Triage telephone assessment document now strengthened to ensure appropriate information re fetal movements is obtained
- Ensure all missed appointments are documented on Euroking and pathway followed.
- Diabetes specialist midwife to be notified of all missed GTT appointments. New process commenced.

No exceptions

Saving Babies Lives 3

WWL areas of improvement have been recognised and SBL action plans provided. Next working day scan compliance is 74% which is below minimum of 80%. A new facility in Triage commenced on the 14.03.2024. Two morning sessions now in place by midwife sonographer. Two Midwife Ultrasound Practitioners (MUPs) currently in training - complete in September 2024.

SBL Tool 'Soft Touch Point' completed in March 2024. LMNS feedback from the action plan review identified no concerns. Deep dive on SBL data due in September/October (date TBA), next review will be assessed against the 'stretch ambition targets'.

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 will monitor its progress against the GMEC ambition.

Mandatory training

BLS/NLS and PROMPT training compliance has been affected in Q4 by the junior doctors industrial action & short-term sickness. Will be back on trajectory by June 2024.

UNICEF Baby Friendly Audit

3/5 BFI standards met.
1/5 BFI standards partially met.
1/5 BFI standards non-compliant.

Areas for improvement
- 66% of mothers confirmed that they were aware of breastfeeding support available and how to access this.
- 83% of mothers confirmed that they had been supported with learning about making up feeds and that they had been supported with responsive bottle feeding however only 77% of mothers confirmed that they been advised to use first milk until their baby is a year old.

Workforce/ Safe staffing
At the end of Q4 there were 5.31 WTE midwifery vacancies and 2 WTE MSW vacancies.

There is 1 WTE Band 5 neonatal nurse vacancy and 1.73 WTE HCA vacancies.

GMEC data
In Q3, WWL has performed better than the GMEC average in rates of 3rd and 4th degree tears, major haemorrhage >2.5 litres, emergency LSCS, and pre-term births and term babies with HIE grade 2 &3.

In Q3, WWL has performed worse than the GMEC average in rates of smoking at the time of delivery, term admissions to NNU, stillbirth, early neonatal death, neonates with Apgars <7 at 5 at term, and smoking at time of delivery.

Q4 SPC charts below give assurance of continued improvement and QI work continues in all areas and themes and trends monitored. Outlier assurance data was provided to the LMNS for stillbirths and neonatal deaths in January and February and no concerns were identified through analysis of the cases. It is noted that rates of Apgar scores < 7 @ 5 at term have risen over Q4 and it is a recommendation of the report that in line with PSIRF a themed analysis is undertaken of all cases within Q4 with a view to identifying any learning.

No exceptions – Improvement work already underway

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 Q4 – NPSA Severity (data pull **17/04/2024** - DATIX)

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
No Harm	67	79	81	91	67	69	66	80	40	62	67	48
Low	8	8	3	7	7	5	7	5	4	0	6	2
Moderate	1	0	1	1	1	1	0	1	0	0	0	0
Severe	0	0	0	0	0	0	1	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total	**76**	**87**	**84**	**99**	**75**	**75**	**74**	**86**	**44**	**62**	**73**	**50**

1.1 Neonatal incidents in Q4 – NPSA Severity (data pull **18/4/2024** – DATIX)

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
No Harm	18	5	21	1	8	10	3	10	9	3	18	21
Low	1	1	2	0	1	0	1	0	2	0	2	1
Moderate	0	0	0	0	0	0	0	0	0	0	1	1
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	**19**	**6**	**23**	**1**	**9**	**10**	**4**	**10**	**11**	**3**	**21**	**23**

MatCH Division successfully closed all outstanding incidents prior to the move to LfPSE in March 2024.

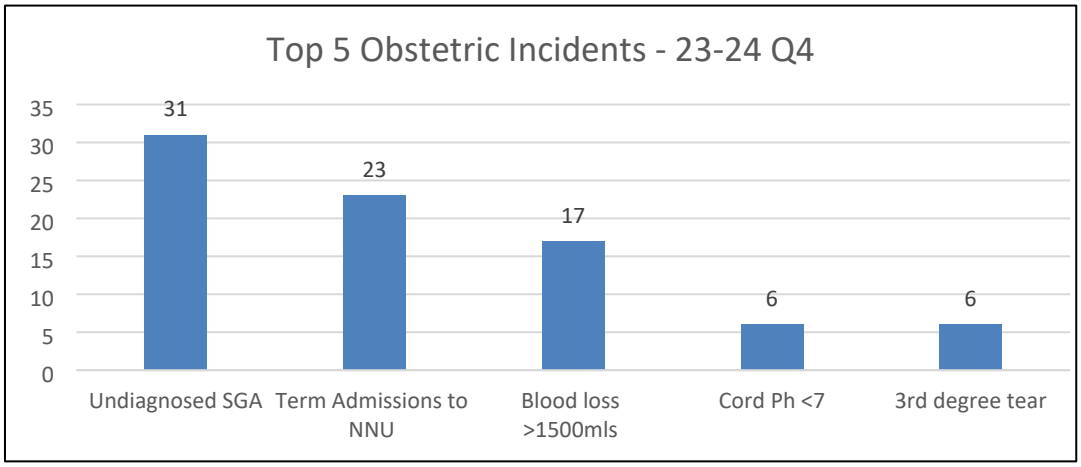
There were **2 moderate or above harm incidents**, with 1 StEIS reported by WWL at end of Q4 (both on StEIS register). Duty of Candour has been served in both cases.

WEB157774 Unplanned Transfer to Level 3 Unit (neonatal death). A detailed rapid review & timeline are in progress and staff statements underway. For escalation to LfPSE and recommend WWL StEIS report. (StEIS reported and Duty of Candour undertaken by Royal Oldham Hospital).
Coroner's case.

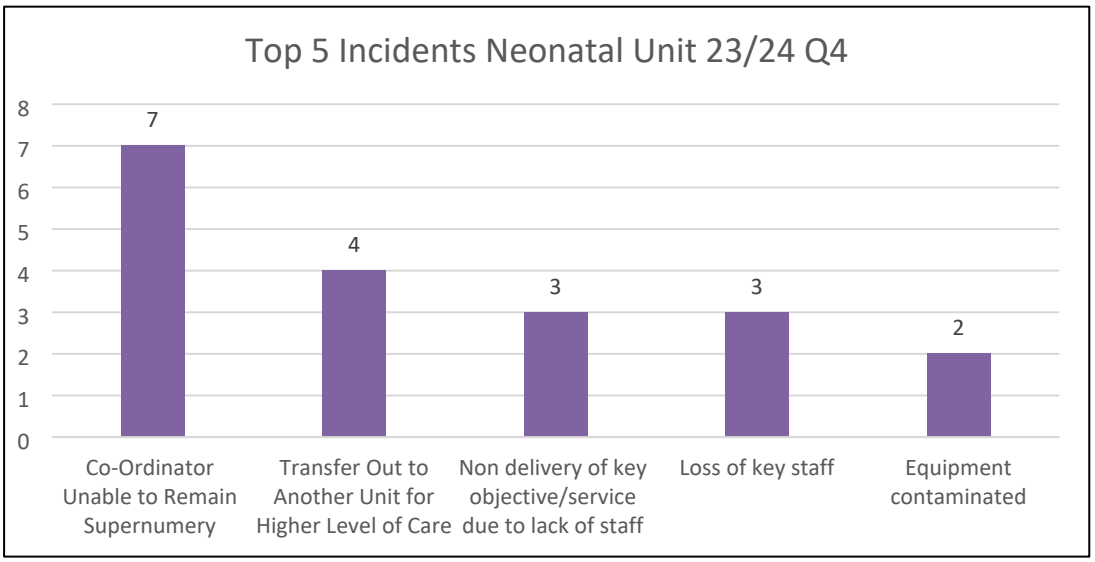
WEB156790 / StEIS 2024/2667 Delay in responding to call for assistance (incident date 14.2.2024) – Escalated to LfPSE. For PSII under PSIRF local priority category 'Sub-optimal care of deteriorating patient'. Immediate learning re oversight of unit, apnoea alarm inaudible from medication room. Duty of Candour served.

No exceptions

1.2 Top 5 Reported Incidents Obstetrics/Maternity– Q4



1.3 Top 5 Reported Incidents Neonatology – Q4



Undiagnosed SGA is the highest reported maternity incident in Q4. WWL remains in the top 10 Trusts in the country for diagnosis of SGA on scan. All scans with >10% discrepancy between estimated fetal weight and birth weight have been reviewed by the Sonography team and the images were of good quality and no learning has been found. The SBL team have strengthened training and now individual assessment of fundal height measurement is undertaken as part of mandatory training to ensure a standardised approach.

Work continues with ATAIN as the second highest reported maternity sub-category in Q4. New initiatives planned include a midwifery Transitional Care lead to strengthen collaborative working and oversight in the event that the neonatal nurse is called back to the neonatal unit due to staffing pressures. Transitional care documentation is under review to support robust care planning and handover between the 2 teams.

Staffing incidents were the highest reported neonatal sub-category.

No exceptions

1.4 Serious Incidents Q4

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

StEIS

Q4 has seen a decrease in StEIS reported incidents as compared to Q3.

1 Neonatology incident has been StEIS reported in Q4.

WEB156790 / StEIS 2024/2667 Delay in responding to call for assistance (incident date 14.2.2024) – Escalated to LfPSE. For PSII under PSIRF local priority category 'Sub-optimal care of deteriorating patient'. Immediate learning re oversight of unit, apnoea alarm inaudible from medication room. Duty of Candour served.

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

MNSI/NHSR

Q4 has seen a decrease in the number of cases referred to MNSI when compared to Q3.
0 incidents have been referred to MNSI of which 0 have been accepted for investigation.

No exceptions

1.5 MNSI overview Q4

January 2019- December 2023	Cases to date	
	Total number referrals	23
	Cases rejected	10
	Total investigations to date	13
	Total investigations completed	11
	Current active cases	2
	Exception reporting	**No exceptions**

1 case finalised in Q4

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

Advise, Resolve, Learn – MNSI / NHSR

MIS Year 5 reporting period 6.12.2022-7.12.2023

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

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

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

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

There have been no eligible cases for referral to NHS Resolution since 15.8.2023. CNST Yr.6 is due for publication on the 2nd April 2024 and assurance data will continue to be provided.

No Exceptions

1.7 Learning from completed investigations

In Q4, 5 investigations were approved at LfPSE. Action plans will be monitored via LfEG.

WEB number	Date	Incident	Learning
WEB151872 StEIS 2023/21628	Nov 2023	Massive PPH/hysterectomy	Confusion and lack of clarity re Obs 9 MOH Guideline & cut off for MoH protocol to be activated. Delay in transfusion of FFP due to confusion re MOH Pack System activation. No Consultant Haematologist oversight. Non availability of Vascular Surgical Skills/ Stepwise Arterial Ligation.

			Cell Salvage not available out of hours
WEB149717 StEIS 2023/21638	Sep 2023	Difficult maternal GA and prolonged neonatal resus	While 'high-risk' patients are identified in the safety huddles on delivery suite, MDT discussions are not held around anaesthetic options in emergency situations. Discussions are only held as an emergency is unfolding, which has the potential to limit shared decision-making between anaesthetic and obstetric staff around the optimal anaesthetic options, due to emerging time pressures.
WEB136351 StEIS 2023/2503	Dec 2022	Neonatal stroke (MNSI)	Women aiming for vaginal birth after Caesarean (VBAC) who attend in early labour should have plan of care which takes into account accumulative risk factors (discharged home with history of vaginal blood loss, tightenings and abnormal antenatal cardiotocography (CTG). Lack of robust system to alert obstetric midwifery team of Group B streptococcus (GBS) status when tests taken by GP. Obstetric review took place 30 minutes following escalation of pathological CTG. There was an opportunity to intubate the baby earlier. Adequate sedation when intubating neonate may have improved likelihood of success. Anti-seizure medication could have been commenced earlier when cerebral function monitoring (CFM) monitoring not available.

WEB139693 StEIS 2023/6632	Mar 2023	Therapeutically Cooled (MNSI)	Trust to ensure staff are supported to provide continuous monitoring. Trust to ensure enough pulse oximeters to allow simultaneous monitoring of maternal pulse and fetal heart rate. Staff to respond to audible and visual alarms on CTG machine.
WEB145544 StEIS 2023/13640	Jul 2023	Therapeutically Cooled (MNSI)	Trust to provide appropriate handover tools to support robust handover of risk during induction of labour (IOL) process. Wireless monitoring is needed to support continuous monitoring when women who are high risk need to mobilise. Hyperstimulation during IOL process needs to be recognised and acted upon.

1.8 Investigation progress – overview of open investigations

At the end of Q4, **6** serious incident investigations are open.

WEB number	Date	Incident	Progress	Stage	Plan
WEB145195 StEIS 2023/16382	Aug 2023	Neonatal death (22+6) (Joint PMRT)	Preliminary PMRT held	Awaiting Final PMRT	Await final grading.
WEB147679 StEIS 2023/18407	Aug 2023	HIE 2-3 (MNSI)	Final Report Received	Action Plan	Present at LfPSE in April.
WEB117402 StEIS 2023/20166	Oct 2021	Historic case. Meconium Aspirate. Changes on MRI possible HIE. Diagnosis of Cerebral Palsy. MNSI.	Final Report Received	Action Plan	Present at LfPSE in April.
PSIRF					
WEB156568 /WEB156556	Feb 24	Suspected co-sleeping death at home	RR presented at LfPSE	PMRT - Fact gathering	For joint PMRT with Royal Bolton Hospital.
WEB156790 StEIS 2024/2667	Feb 24	Delay in responding to call for assistance on the NNU	RR presented at LfPSE	PSII - Fact gathering	Present PSII at LfPSE in May.

WEB157774	Mar 24	Unplanned Neonatal Transfer to Level 3 Unit (Death).	Detailed RR & Timeline in progress	Statements	Escalate to LfPSE – for StEIS. Coroner's case.

Exception

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

1.9 Triangulating data slide – Claims, Incidents, Complaints

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

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

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

NHS Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Advise, Resolve, Learn

Themes Q4 2023-24

Fail to supervise- lack of oversight on NNU, lack of oversight and collaborative working TC/NNU.
Fail/delay treatment - Delay in responding to alarm, lack of follow up following discharge, inappropriate triage telephone assessment of woman with history of pre-term birth, poor documentation of Vitamin K.
Failed to warn – informed consent – Painful exam during IOL process, bruise on foot following heel prick test, poor communication re burial/cremation process.
Psychological damage – inadequate provision of pain relief, mother had to call out for help, lack of information around MOD for woman fearful of birth.

Complaints Q4 2023-24 (6 complaints in Q4 – main themes)

Clinical treatment - Perception membrane sweep undertaken, lack of adequate pain relief and the removal of Entonox during postnatal stay, lack of response to sounding alarm when baby in respiratory distress, anaesthesia which led to lasting numbness, retained placenta following C/S, lack of follow-up following discharge, lack of support around tongue-tie, treatment of high ketone levels.
Communication - Lack of information re MOD, not feeling heard, poor communication re cremation/burial pathway, no explanation of bruising on baby's foot.

Learning Q4 2023-24

Conversations re MOD should be documented at every point.
Apnoea alarms need to be audible.
Oversight of the wards should be always maintained.
Staff should be mindful of potential impact of VEs.
Systems and processes need review on TC .
Robust documentation is required re Vitamin K
Ensure history of pre-term labour is considered during Triage phone assessment.

Incidents Q4 2023-2024 (2 moderate or above harm incidents)

Delay in responding to call for assistance - 'Sub-optimal care of deteriorating patient'. Immediate learning re oversight of unit, apnoea alarm inaudible from medication room.
Unplanned Transfer to Level 3 Unit (neonatal death). Immediate learning re triage and transitional care systems and processes and poor documentation of vitamin K.

Actions Q4 2023-4

Matron to disseminate info re MOD conversations	By 31/5/2024 CL	
Source solution to inaudible apnoea alarms	By 31/07/2024 SN	
Team feedback re Vit K. Full investigation	By 31/07/2024 EB	
TC/NNU processes to be reviewed	By 01/12/2023 LB/SN	
Central surveillance to be maintained on NNU	By 01/04/2024 SN	

2. Patient Experience - MVP and Service-user Feedback

The Patient, Public and Staff Engagement (PPSE) Lead Midwife has now been appointed and in post since February 2024.

The role includes working in partnership with the WWL Patient Experience team, the MNVP, Dads Matter teams, and with Union representatives working towards the RCM Caring for You agenda. The PPSE midwife will also lead the Birth Thoughts service. Themes will be collated from positive and negative feedback in collaboration with all stakeholders to inform an action plan in order to improve our response to concerns as well as gain a better understanding of what we do well.

The PPSE midwife has already visited 21 women (and their families) on the Maternity Ward who have had emergency procedures during their birth. 20 (95%) have given positive feedback about the care they have received with 1 identifying some areas for improvement. Positive feedback was given for 10 individual members of staff which has been cascaded to each of them. Examples provided below.

Student midwife Katie was so cheerful, happy, calm, reassuring and just lovely.

As soon as I saw Hannah I felt in safe hands, the care she gave me was brilliant

My midwifery care was a positive experience, I even enjoyed the food it was very good!

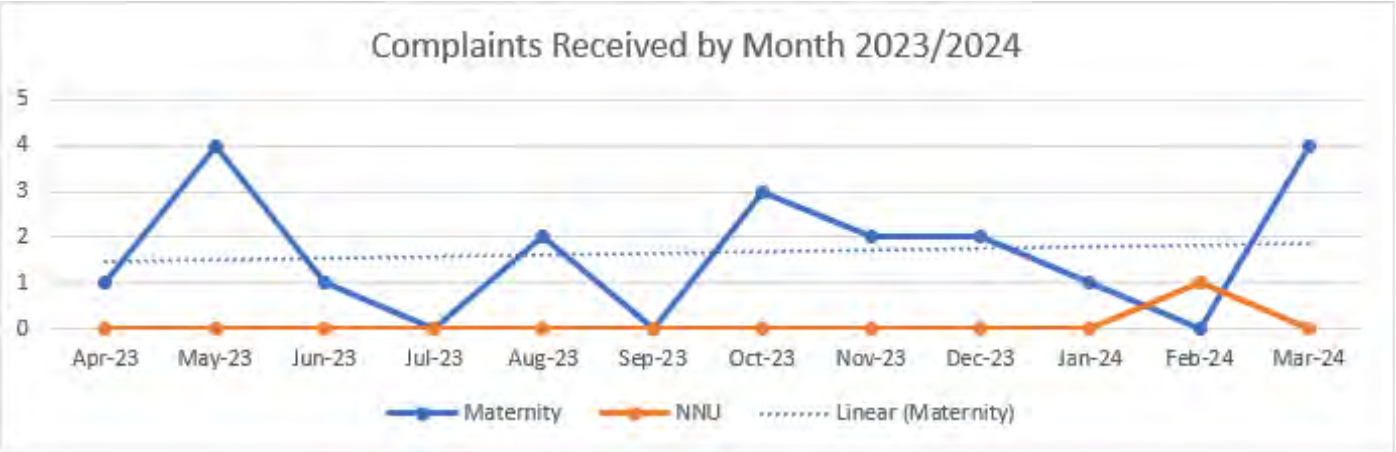
Everyone was lovely in Theatre and reassured me when I was frightened

I am glad I accepted a student midwife she was an asset, was normal, nothing was too much trouble. She was very honest with me about the induction and was just fab

Abbie was an absolutely amazing midwife. Her care and compassion for me and my baby during the induction process and throughout my labouring stage was next to none. She is an absolute credit to your team!

2.1 Complaints

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



In Q4, **5** formal complaints have been received for maternity services.

In Q4, 1 formal complaint has been received for the neonatal service and remains active. This is additionally being responded to via the PSII process, with the complainant's questions being feeding into the investigation.

Themes from complaints

Q4	Jan	Feb	Mar	Total
Clinical treatment	1	1	3	**5**
Communication	1	0	4	**5**
Trust Admin Processes	1	0	0	**1**
Values and Behaviours	1	0	0	**1**
Admissions & discharge	0	0	1	**1**

Clinical treatment:

1. Concerns around perception membrane sweep undertaken, lack of adequate pain relief and the removal of Entonox during postnatal stay.
2. Lack of response to sounding alarm when baby in respiratory distress.
3. Concerns raised around the use of anaesthesia, which lead to lasting numbness, and concerns raised around the possibility of retained placenta following a caesarean section.
4. Lack of follow-up following discharge and lack of support around tongue-tie.
5. Concerns over treatment of high ketone levels.

Communication:

1. Lack of explanation provided around maternal choice for mode of delivery and a lack of documentation to reflect concerns over pain relief received.
2. No explanations provided for bruising on baby's foot.
3. Referrals not made in a timely manner due to poor communication within the team.
4. Poor communication regarding cremation/burial of fetus.
5. Feeling unsupported and not listened to.

Trust Admin Processes:

1. Concerns over how a previous complaints investigation was handled.

Values and Behaviours:

1. Lack of empathy and support provided over the phone in Triage.

Admissions and Discharge:

1. Concerns over discharge being too soon.

Exceptions It is important to recognise that the number of complaints remains low, and the compliments received far outweigh concerns. However, an upward trend of complaints received has been noted over the rolling year in Maternity services. The number of formal complaints for the Neonatal services remains low. The introduction of the Patient, Public and Staff Engagement Midwife aims to improve our oversight and response to concerns and progress will continue to be monitored.

3. Risk register – Maternity and neonatal services

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

Under review	-	-	-	-
Awaiting approval	-	-	-	-
Approved	MAT	3772	Euroking System Error	20
	MAT	3604	Obstetrics and Gynaecology On-Call Availability Risk	15
	MAT	3802	Obstetrics/Gynaecology Tier 2 Staffing Shortages	12
	MAT	3616	Compliance with Maternity Incentivisation Scheme Year 5	12
	MAT	3605	Obstetricians and Gynaecologists on call rotas not allocating compensatory rest	12
	MAT	3362	Midwifery Staffing Shortages	12
	NEO	1977	Specialist AHP services should be available in all units for neurodevelopment and family integrated care	12
	MAT	3780	Maternity Ligature Risk	10
	MAT	3727	Euroking To PAS Error Risk	9
	NEO	1978	Access to a Neonatal Dietician competent in Neonatal nutrition	9
	MAT	3732	Entonox Risk	9
	MAT	3880	Daisy team future funding uncertain	9
	MAT	3756	Medical Devices Training	8
	MAT	3667	Emergency Evacuation from Maternity Birthing Pool	8
	MAT	2581	Sustainability of Maternity Services	8
	MAT	3669	Potential inability to undertake more than 1 emergency delivery at a time due to number of theatres available.	8
	MAT	1469	The risk of abduction from the maternity unit	8
	BOTH	3725	Junior Doctors Strike	6
	MAT	1758	Delivery suite coordinator should be supernumerary at all times.	6
	MAT	3400	Screening for GBS at 36 weeks gestation in women with a history of GBS (group B beta-haemolytic streptococcus) infection	6
	NEO	1975	BAPM staffing guidelines - Staff shortages on the Neonatal unit	6
	MAT	1469	The risk of abduction from the maternity unit	8
	MAT	2459	Transportation and supply of Entonox (Nitrous oxide 50% and oxygen 50%) by Community Midwives for use at Homebirths	4

At the end of Q4,

0 new risks **under review.**

0 new risks **awaiting approval**

1 risk **approved**
MAT 3880 Daisy Team future funding uncertain.

5 risks **closed**
MAT 140 Backflow of raw sewage
MAT 1037 CTG misinterpretation
MAT 3659 Insufficient number of Resuscitaires on Delivery Ward
MAT 3672 Lack of availability of NLS accredited training
NEO 2281 Significant number of staff without current accreditation for NLS course

2 risks proposed **for closure** at Divisional Risk Group in April 24
MAT 3616 Risk of non-compliance with CNST Yr. 5
MAT 2581 Sustainability of Maternity Services

MAT Risk 1469 reviewed following feedback from LMNS re lack of robust system to mitigate risk of abduction from maternity unit. New action added.

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

Exceptions - A number of risk actions are overdue.
- Several risks have been mitigated to target levels – to review for closure (risk tolerated).
- Several risks have not been progressed with scores remaining unchanged.

4. Ockenden 2 progress update

Q3 Update		Local Actions			N/A	Trust Corp Action	National/ regional Action
		Red	Amber	Green			
EA1	Workforce planning and sustainability	0	1	7			3
EA2	Safe staffing	0	0	9			1
EA3	Escalation and accountability	0	0	5			
EA4	Clinical governance-leadership	0	1	5		1	
EA5	Clinical governance – incident investigation and complaints	0	0	7			
EA6	Learning from maternal deaths	0	0	2			1
EA7	Multidisciplinary training	0	1	6			
EA8	Complex antenatal care	0	1	3			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	5	74	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.
Q4 has seen minimal progress against the 5 remaining actions.
MIAA Ockenden 2 audit in progress.

Exceptions - 5 actions remain, all are in progress. The outstanding actions were reviewed in March 24, progress updated and timeframe extended (now amber). All action leads have been asked to provide regular updates on their actions.

5. Maternity Incentive Scheme Year 5

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

On the 26th March 24, WWL were informed that they had met all 10 CNST Safety Actions for Year 5.

Year 6 of the Maternity Incentive Scheme will be published on 2 April 2024, and Trusts will be notified as soon as the updated guidance is made available.

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q3

	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU	TARGET
Oct -Dec 2023	578	44 (7.61%)	42 (7.26%)	**5 (11.36%)**	**4.5%**

In Q3, the total number of term admissions to the NNU was 7.61% of total term live births. This is an increase from Q2.

Unexpected term admissions to the NNU accounted for 7.26% of total term live births. This is an increase from Q2.

There is still work to be done with 5 (11.36%) potentially avoidable admissions.

Weekly MDT ATAIN meetings are led by the Quality and Safety Midwife and are scheduled to enable timely review of antenatal, intrapartum and postnatal care, identify themes and monitor the overarching ATAIN action plan.

Specialist midwives and team leaders are now part of this review process and provide a collaborative approach to enable improvement and service development specific to their area. A Neonatal and Obstetric Consultant now review all potentially avoidable admissions and are part of the working group to generate learning and actions to improve care. Several QI projects are underway.

<u>Learning from Potentially Avoidable Admissions in Q3</u>

Baby 1 - Baby was born at 38+4 in A & E by a normal vaginal delivery. There was no antenatal and intrapartum learning. The baby was attended following birth, by a paediatrician on A & E, there was a neonatal Resuscitaire in adult A & E but no O2 sats probe, baby was warm but grunting with no increased work of breathing and a decision was made to transfer the baby to the NNU at 23 minutes of age for observation. Baby was transferred back to mum on the postnatal ward at 5 hours having received no additional support.

Baby 2 - Baby was born at 39+3, baby was born via caesarean section due to maternal sepsis and prolonged rupture of membranes with a normal CTG. Baby was cared for appropriately on Transitional Care on IV antibiotics. There was a lack of documentation around the reason for admission, (documented as query needs an NG Feed). Baby had mucous, was slow to take a bottle feed on day 0, the blood sugars were stable, baby was clinically well, and other observations were normal. Baby did not have a feed chart in the notes. Baby did not receive additional feeds on the NNU and was transferred back to transitional care after 3 hours, baby could have continued to receive care on the transitional care unit.

Baby 3 - Baby was born at 40+5 by emergency caesarean section. The pregnancy was midwifery led, there was no antenatal or intrapartum learning. Baby required admission to the neonatal unit, at the point of admission baby was hypothermic T 35.5◦C, with a slow respiratory rate and blood glucose of 1.9 mmols. There was minimal documentation between birth and admission to the NNU at 5 hours old, no warm care bundle sticker. It is hard to establish the care provided to maintain normothermia at birth, and it is not clear how baby became cold, although the ambient temperature of Recovery was low. Baby was in cot at the time when hypothermia detected and measures to warm baby at this point were not taken.

Baby 4 - Baby was born at 39+4 and transferred from the postnatal ward, the pregnancy was midwifery led, and growth scans due to small fundal height measurement were normal, the glucose tolerance test was normal. Spontaneous labour and at 7cm dilated blood-stained liquor and an abnormal CTG was noted and episiotomy undertaken to expedite birth. The baby delivered normally. There was no antenatal or intrapartum learning. Apgar's were 9 and 10, cord gases were normal with 2 mins of delayed cord clamping. At 12 hours post birth the baby was slow to breastfeed, and baby's respiratory rate was 30. A plan was made by the SHO for regular feeds and a blood sugar, the midwife escalated concerns of noisy breathing to the paediatrician. The SHO admitted the baby for observation and a septic screen due to crackles and respirations of 39. The Neonatal consultant who reviewed the care concluded that care could have been supported on Transitional care at this time. It was noted this occurred during the doctors industrial action.

Baby 5 - Baby was born at 40 weeks by instrumental delivery following a routine MLC pregnancy and Intelligent intermittent auscultation in labour. CTG commenced due to an audible deceleration. Bradycardia noted on CTG and a second midwife performed ARM and applied FSE. Bradycardia continued. Baby was admitted due to low cord PH levels and a high base access due to an acute event where earlier escalation of a deteriorating heart rate and strengthened oversight of a senior midwife could have prevented a delay in delivery.

MIS Year 5 specific data		
Number of admissions to NNU that would have met TC admission criteria but were admitted to NNU due to staffing or capacity	Number of babies that were admitted to NNU because of their need for nasogastric tube feeding but would have been cared for on TC if NGT feeding was supported there	Number of babies that remained on NNU because of their need for nasogastric tube feeding but would have been cared for on TC if NGT feeding was supported there
0	1	0

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

	April 23	May 23	June 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
	Q1 23-24			Q2 23-24			Q3 23-24			Q4 23-24		
Total births	**214**	**215**	**213**	**183**	**234**	**205**	**211**	**221**	**197**	**199**	**194**	**213**
Total Stillbirths	**2**	**0**	**1**	**0**	**2**	**2**	**1**	**1**	**0**	**1**	**1**	**0**
Stillbirths adjusted for MTOP	2	0	0	0	2	2	1	0	0	1	1	0
Late fetal loss 22 – 23+6	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Neonatal Deaths	**1**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**1**	**1**	**0**

Early neonatal deaths (0-7 days)	1	0	0	0	1	1	0	0	1	1	1	0
Neonatal deaths adjusted for MTOP	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**0**
Maternal Deaths	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The NHS Long Term plan has set a target of reducing stillbirths and neonatal deaths by 50% by 2025. That would require England and Wales to reduce its stillbirth rate to 2.6 stillbirths per 1,000 births and the neonatal death rate to 1.5 neonatal deaths per 1,000 births.

7.1 Stillbirths

There were 2 stillbirths in Q4 at WWL.
There was also 1 stillbirth that occurred at another Trust following an in-utero transfer from WWL.
No immediate care or service delivery issues identified affecting the outcome. Await PMRT.

Data from stillbirths and neonatal deaths has been tabulated to allow the maternity team to identify emerging themes and trends.

2023	Type of stillbirth	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
Jan	Antenatal	33+1	White British	9	24	23.5	No	No	52.9	Yes	B, A
Jan	Antenatal	36+1	White British	2	28	36.5	No	GDM	0	No (known anomaly)	A, A
Mar	MTOP	25+6	White British	2	29	23.6	Yes	No	-	No	-
Mar	Antenatal	35+5	White British	1	32	45.7	Yes	No	5.5	Yes	B, B
Apr	Unknown	?29	White British	1	41	-	Yes	No	-	No	-
Apr	Antenatal	32+4	White British	1	34	34.4	No	No	36	Yes	B, B
Jun	MTOP	24+4	White British	1	33	46.6	No	No	76.7	No	-
Aug	Antenatal	35	White British	9	27	27.4	No	No	0.1	Yes	B, B
Aug	Antenatal	41	White British	2	27	37	No	No	31.7	No	A, A
Sep	Antenatal (twins)	26+5	Black African (speaks English)	2	29	33.2	No	No	4.5 0.0	No (MCDA twins)	A, A A, A
Oct	Antenatal	39+2	White British	4	29	33	No	Declined GTT	92.3	Yes	B, B
Nov	MTOP	35+6	Other Asian (speaks Farsi)	1	37	25.7	No	No	37.6	No	-
2024	Type of Stillbirth	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
Jan	Antenatal	26	White British	1	22	23.8	E-cig	No	4.3	No	
Feb	Antenatal	30	White British	2	35	30	No	GDM	0	No (known anomaly)	

Themes

100% of women who experienced a stillbirth in Q4 were White British.
100% of women who experience a stillbirth lived in the lower socio-economic deciles.

7.2 Neonatal Death

There were 2 neonatal deaths in Q4 at WWL. No care issues identified affecting outcome. Await PMRT. There was also 1 neonatal death which occurred at Royal Oldham Hospital following transfer from WWL on Day 5 of life. Coroner's case. Immediate learning identified regarding Triage and Transitional Care systems and processes, and Vitamin K documentation. For StEIS

2023	Type of NND	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
Jan	Early	18+5	White British	9	34	22.9	No	No	-	No	-
Feb	MTOP	21+1	White British	2	31	22.9	No	No	-	No	-
Apr	Early (Twin 1)	22	White other (speaks English)	2	27	22.4	No	No	-	Yes	A, A
Aug	MTOP	21+6	Black African (speaks English)	2	34	29	No	No	-	No	-
Sep	Early	20+6	Black African (speaks English)	3	34	32.8	No	No	-	No	-
Dec	Early	20+5	Asian Pakistani (speaks English)	9	27	36	No	No	-	No	-
2024	Type of NND	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
Jan	MTOP	20+6	Other Asian Philippines (speaks English)	1	41	20.55	No	No	-	No	NA
Feb	Early	20+0	Black African (speaks English)	3	41	30.1	No	No	-	No	NA

Themes

100% of women who experienced a neonatal death in Q4 were black/ethnic minority.
100% of women who experienced a neonatal death in Q4 were >40 years old
100% of women who experienced a neonatal death lived in the lower socio-economic deciles.

7.3 PMRT

In Q4, 4 cases were finalised at PMRT. Incidental learning was identified

- Ensure LWMH is given as per guidelines
- Triage telephone assessment document now strengthened to ensure appropriate information re fetal movements is obtained
- Ensure all missed appointments are documented on Euroking and pathway followed.
- Diabetes specialist midwife to be notified of all missed GTT appointments. New process commenced.

No exceptions

8. Saving Babies Lives (SBL)

Element		Compliancy/ Improvement Plan
Element 1- reducing smoking in pregnancy		Q4 - CO @ booking 96 %. CO @ 36 weeks 93 %. Meets SBL parameters. Quit date data needs improvement currently @45% minimum target is 50%. Regular teaching sessions re CO monitors are undertaken. Audit regularly undertaken.
Element 2- risk assessment and surveillance for fetal growth restriction		Audit completed and compliant within SBL parameter of 50%. SGA detection at WWL is 73%. Most babies at risk of FGR and SGA are detected within antenatal period. WWL is in the top 10 in the country for detection rates.
Element 3- Raising awareness of reduced fetal movements.		Audit shows Dawes Redman CTG 93% - above SBL parameter of 80%. Next working day scan is 74% which is below minimum of 80%. New facility in Triage commenced 14.03.2024. Two morning sessions now in place by midwife sonographer. Two Midwife Ultrasound Practitioners (MUPs) currently in training - complete in September 2024.
Element 4- Effective fetal monitoring during labour		All parameters for SBL are met and are above minimum targets.
Element 5- Preterm Births.		All optimisation/ SBL parameters are being met. Quick access preterm birth box utilised on Delivery Suite. Preterm birth clinic started in March 2024, dedicated access to consultant and transvaginal (TV) scanning. Trends are identified in audit and highlighted issues are addressed.
Element 6 – Diabetes in Pregnancy.		One stop clinic template implemented within SBL parameters. HbA1C @100% measurement above minimum target at 80%. All other parameters met.
Elements 1-6 - SBL training		89% doctors and midwives compliant with element modules. 11% non-compliant all contacted via e mail and face to face to address any ongoing issues with access, time allocation or learning challenges. Midwives 88% compliant, doctors 86% compliant. Grow 2.0 training commenced 34 members of staff trained in March 2024. 60% of clinic staff trained for digital rollout commencing April 2024. This is effective as commencement is wholly relied on in clinic until August 2024.

SBL Tool 'Soft Touch Point' completed in March 2024. Feedback from the action plan review identified no concerns. Deep dive on SBL data due in September/October (date TBA), next review will be assessed against the 'stretch ambition targets'.

No Exceptions

9. GMEC LMNS Ambition

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

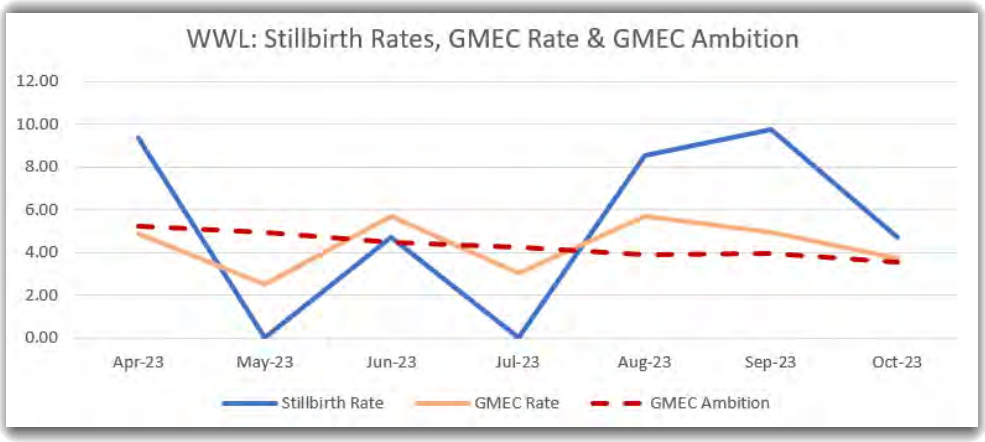
• Reduction in still births to a rate of 3.5 per 1000 registerable births in 2024/25

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

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

WWL will measure its progress against the GMEC LMNS ambition.

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



10. Mandatory Training Compliance Midwifery

	Number attended in Q4	Percentage of staff	Rolling percent
BLS	36	23%	87%
NLS	36	23%	87%
PROMPT	33	21%	82%

From September 23 the structure of mandatory training has changed. All Midwives will be allocated 4 maternity training sessions per year, consisting of PROMPT, full day fetal physiology, maternity safety day and specialist services update. This will ensure all elements of CNST, and core competencies are covered.

Exceptions
Q4 BLS/NLS compliance affected by short term sickness. PROMPT compliance affected by cancellation of January's training date due to the junior doctors strike.

10.1 Mandatory Training Compliance Other Specialities

	PROMPT	
	Number attended in Q4	Rolling percentage
Consultant Obstetrician	3	77%
Obstetric registrar	3	67%
Anaesthetist	5	80%
MSW	7	94%

Exceptions Q4 PROMPT compliance has been affected by the cancellation of January 24 session due to junior doctors strike. All obstetric doctors who require training have been contacted and dates booked. Trajectory for >90% compliance in June 2024.

10.2 Mandatory Fetal Physiology Training

	Fetal Physiology	
	Number attended in Q4	Rolling %
Midwives	27	94%
Obstetric Consultants	6	100%

Obstetric Registrars	4	91%
No exceptions		

11. UNICEF Baby Friendly Audit Report – Q4

Audit Programme: Random samples of mothers and clinical staff who support mothers are interviewed to elicit what standard of care is provided by the facility.
10 staff, 15 breastfeeding mothers and 12 bottle feeding mothers.

3/5 BFI standards met.
1/5 BFI standards partially met.
1/5 BFI standards non-compliant.

Areas for improvement
- 66% of mothers confirmed that they were aware of breastfeeding support available and how to access this.
- 83% of mothers confirmed that they had been supported with learning about making up feeds and that they had been supported with responsive bottle feeding however only 77% of mothers confirmed that they been advised to use first milk until their baby is a year old.

Additional quality questions

100% of mothers reported they received safe sleeping advice
80% of mothers reported they received written info or were referred to websites.

Have the staff been kind and considerate to you and your family?

All of the time	92%
Mostly	8%
Sometimes	0%

Thinking about the overall care from the service, how good do you think it has been?

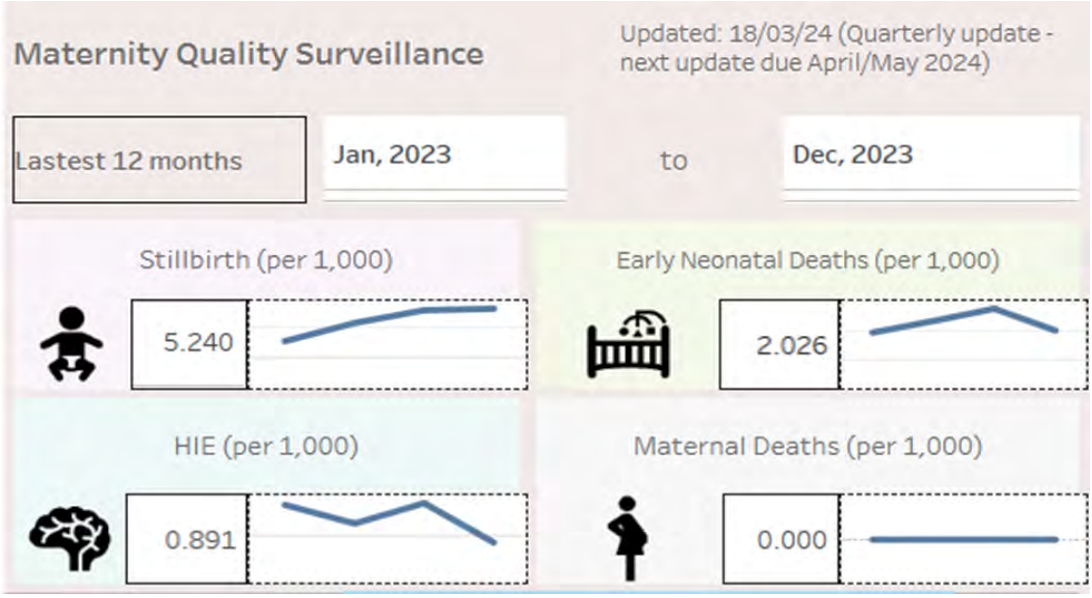
Very Happy	80%
Fairly Happy	20%
Unhappy	0%

12. Workforce / Safe staffing

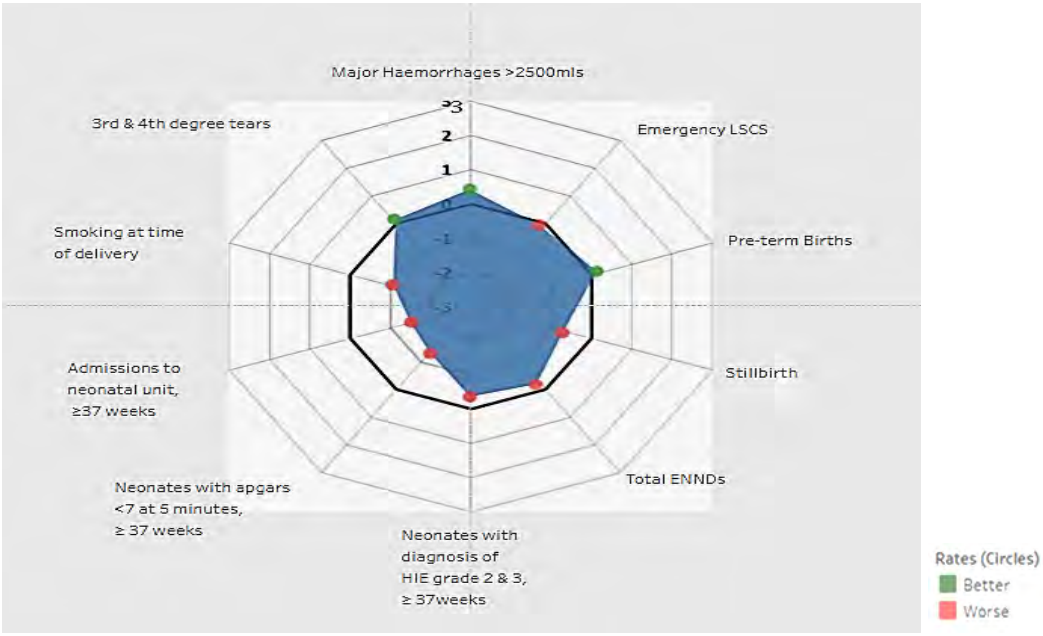
At the end of Q4 there were 5.31 WTE midwifery vacancies and 2 WTE MSW vacancies.

There is 1 WTE Band 5 neonatal nurse vacancy and 1.73 WTE HCA vacancies.

13. Maternity Quality Surveillance Dashboard. WWL Data Jan – Dec 23 Source Tableaux

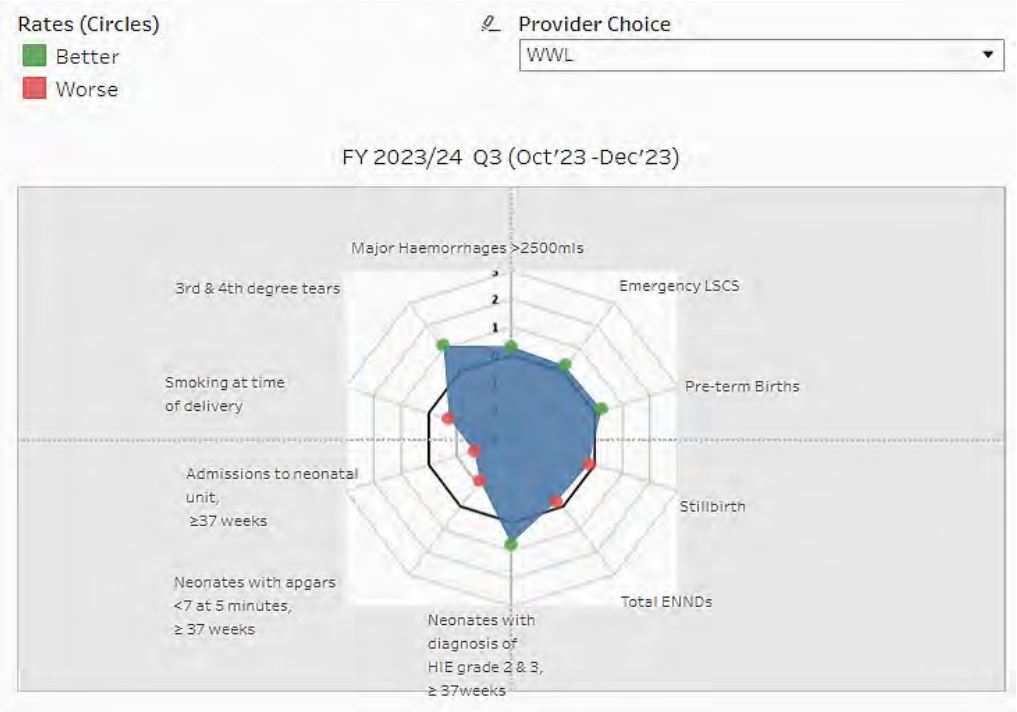


13.1 WWL data as compared to GMEC (Jan – Dec 23)



Between Jan and Dec 2023, WWL performed better than GMEC for rates of 3rd and 4th degree tears, major obstetric haemorrhage >2500mls, and pre-term births. This is an improvement on the previous rolling 12 month picture.

13.2 WWL Data compared to GMEC average – Q3 23/24 (latest data available) Source Tableaux



In Q3, WWL has performed better than the GMEC average in rates of 3rd and 4th degree tears, major haemorrhage >2.5 litres, emergency LSCS, and pre-term births and term babies with HIE grade 2 &3.

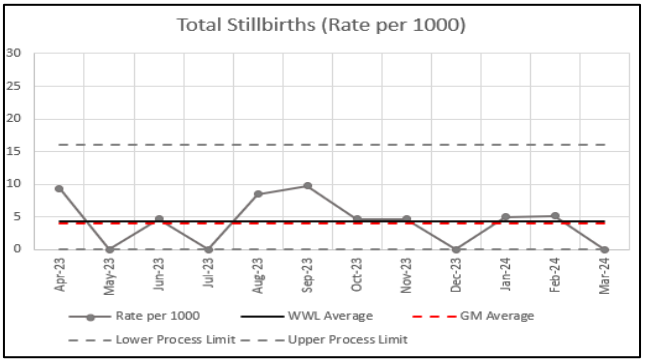
In Q3, WWL has performed worse than the GMEC average in rates of smoking at the time of delivery, term admissions to NNU, stillbirth, early neonatal death, neonates with Apgars <7 at 5 at term, and smoking at time of delivery.

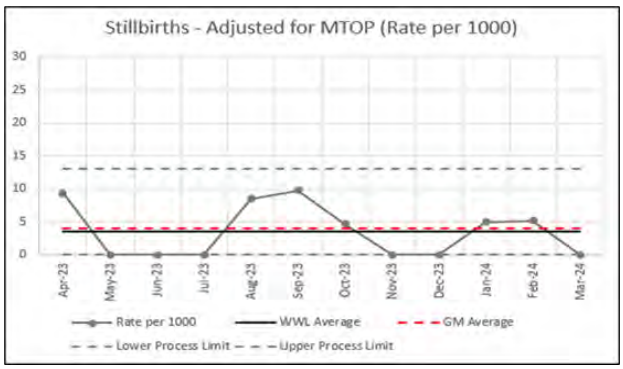
Analysis

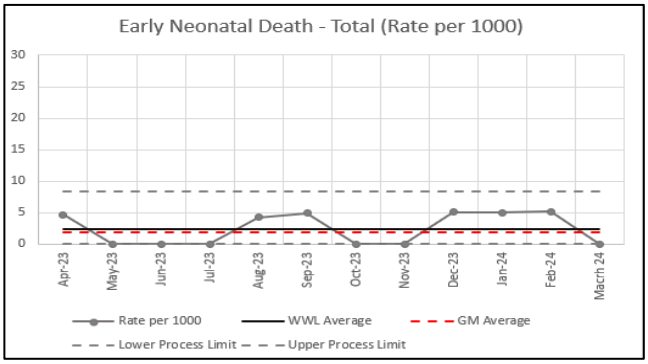
Reviews are undertaken in the Directorate in response to GMEC outlier data. In Q3 themed analyses were undertaken for Stillbirths, Early Neonatal Deaths, term babies diagnosed with HIE 2 and 3, Apgars <7 @5 at term, PPH >2500mls, 3rd and 4th degree tears and emergency Caesarean Section (see separate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

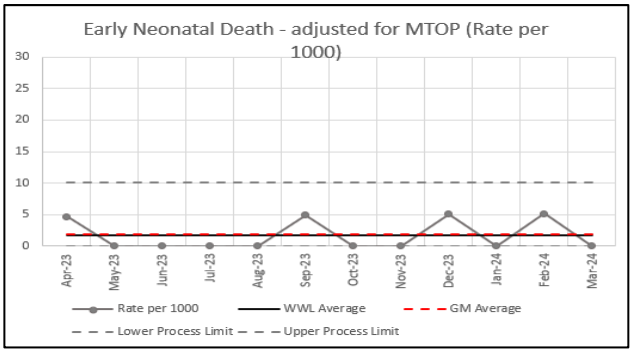
Looking at data over a period of time downward trends have been noted in several metrics at WWL which provides assurance of continuous improvement. Indeed, looking across 2023 WWL performed better than GMEC average for % age of 3rd and 4th degree tears, rate of PPH >2500mls and pre-term births.

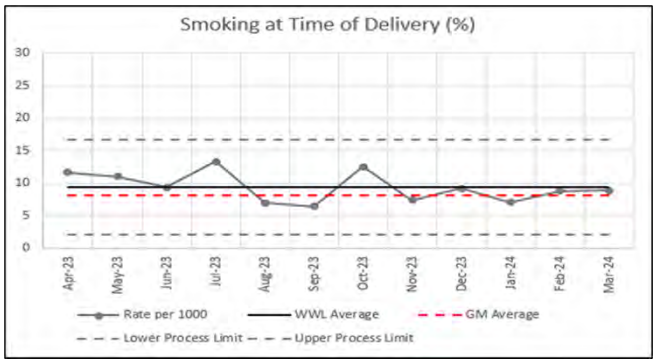
Q4 SPC charts below give assurance of continued improvement and QI work continues in all areas and themes and trends monitored. Outlier assurance data was provided to the LMNS for stillbirths and neonatal deaths in January and February and no concerns were identified through analysis of the cases. It is noted that rates of Apgar scores < 7 @ 5 at term have risen over Q4 and it is a recommendation of the report that in line with PSIRF a themed analysis is undertaken of all cases within Q4 with a view to identifying any learning.

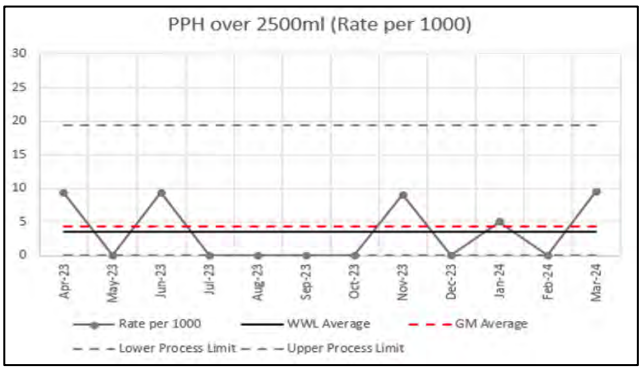

Total Stillbirths (Rate per 1000)
30
25
20
15
10
5
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit

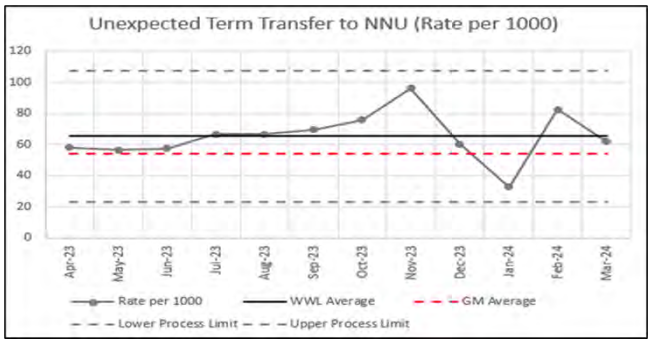

Stillbirths - Adjusted for MTOP (Rate per 1000)
30
25
20
15
10
5
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit

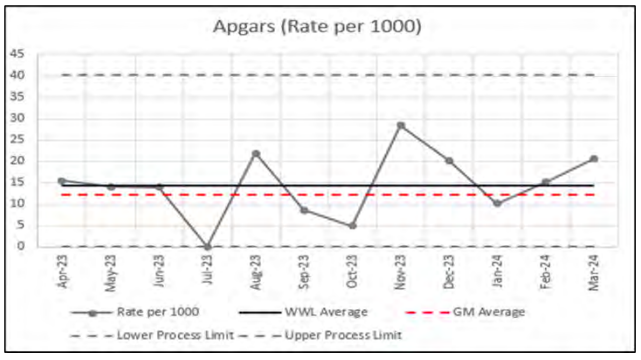

Early Neonatal Death - Total (Rate per 1000)
30
25
20
15
10
5
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Marcn-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit

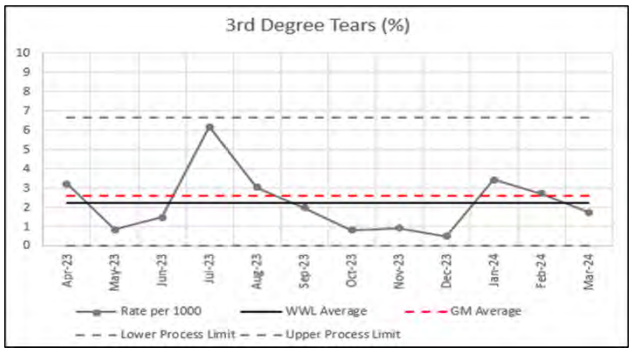

Early Neonatal Death - adjusted for MTOP (Rate per 1000)
30
25
20
15
10
5
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit

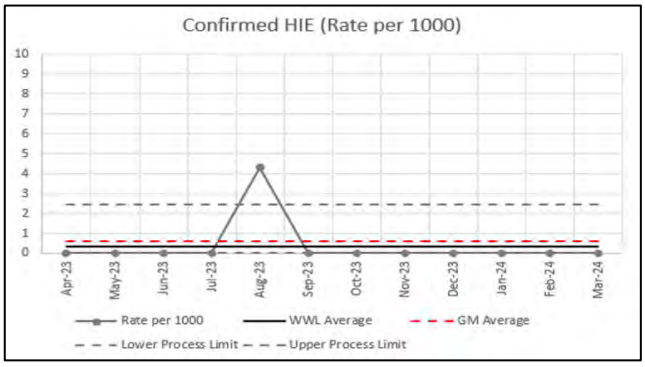

Smoking at Time of Delivery (%)
30
25
20
15
10
5
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit


PPH over 2500ml (Rate per 1000)
30
25
20
15
10
5
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit


Unexpected Term Transfer to NNU (Rate per 1000)
120
100
80
60
40
20
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit


Apgars (Rate per 1000)
45
40
35
30
25
20
15
10
5
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit


3rd Degree Tears (%)
10
9
8
7
6
5
4
3
2
1
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit


Confirmed HIE (Rate per 1000)
10
9
8
7
6
5
4
3
2
1
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Rate per 1000
WWL Average
GM Average
Lower Process Limit
Upper Process Limit

Summary

WWL has met all 10 of CNST Yr. 5 Safety Actions with 2 action plans in place. CNST Yr. 6 criteria is due for publication on the 2nd April 2024. SBL 'Soft Touch Point' was completed in March 2024 and the LMNS feedback from the action plan review has identified no concerns. The LMNS has set its ambition for 23-24 and 24-25 in relation to stillbirth and serious brain injury and WWL will monitor its progress against the ambition.

Q4 SPC charts give assurance of continued improvement and QI work continues in all areas and themes and trends monitored. Outlier assurance data was provided to the LMNS for stillbirths and neonatal deaths in January and February and no concerns were identified through analysis of the cases. It is noted that rates of Apgar scores < 7 @ 5 at term have risen over Q4 and it is a recommendation of the report that in line with PSIRF a themed analysis is undertaken of all cases within Q4 with a view to identifying any learning.

Maternity Perinatal Quality Surveillance Dashboard 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

		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Cardiotocograph (CTG) training and competency assessment	Midwives	10 (98.7 % compliant)	14 (98% compliant)	8 (96.3 % compliant)	5 (97 % compliant)		
	Consultants	1 (90% compliant)	1 (83% compliant)	2 (92.8% compliant)	2 (85.7% compliant)		
	Registrars	1 (86% compliant)	2 (100% compliant)	1 (88% compliant)	1 (90% 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)		
	MSW	0 (0%) (86% compliant) **PROMPT cancelled due to doctors strike**	4 (11%) (89% compliant)	4 (11%) (89% compliant)	3 (8.6%) (94% compliant)		
	Obstetric Consultants	0 (0%) (69% compliant) **PROMPT cancelled due to doctors strike**	1 (7.7%) (61.5% compliant)	2 (18%) (77% compliant)	1 (7.7%) (84% compliant)		
	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)		
	Anaesthetists	0 (0%) (88% compliant) **PROMPT cancelled due to doctors strike**	3 (15%) (90% compliant)	2 (15%) (80% compliant)	0 (15%) (88% compliant)		
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)		60	60	60	60		
1:1 care in labour		100%	100%	100%	99%		
Maternity Red Flags reported (>3)		0	3	5	5		

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Diverts: Number of occasions unit unable to accept admissions(>1)	0	0	0	1		
Supernumeray Shift Co-ordinator	100%	100%	100%	98%		
The number of incidents logged graded as moderate or above (>5)	0	1	1	2		
All cases eligible for referral to HSIB.	0	0	0	0		
Number of Datix submitted when shift co-ordinator not supernumerary*	0	0	0	1		
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		
Coroner Reg 28 made directly to Trust	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)		
Number of StEIS Reportable Incidents**	0	0 (1 NN)	0	0		
Number of Stillbirths	1	1	0	1		
Number of Early Neonatal Deaths ***	1	1	0	0		
Number of Maternal Deaths	0	0	0	0		

Maternity Perinatal Quality Surveillance Dashboard April 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

Exception report

Stillbirths	Progress in achievement of CNST 10	Maternity Red Flags reported
There was 1 stillbirth in April 2024 • 36+3 gestation primigravida Decile 2 Ethnic Origin - Caribbean non smoker • Attended with reduced fetal movements % no fetal heart was confirmed. The case will be reviewed through the PMRT process Initial Learning: Check Maternal Observations at each contact PIGF Testing Pathway - review as missed opportunity	Publication of CNST Year 6 Standards Review of all standards underway	5 validated Red Flags were reported on Birthrateplus app • Delayed or cancelled time critical activity – 1 • Coordinator unable to maintain supernumeracy status - NOT providing 1:1 Care - 1 • Delay in admission for induction and beginning the process - 3 • Further red flags not validated - 2 • Safety maintained at all times and no harm caused
Early Neonatal Deaths before 7 days	**1:1 care in labour**	**Staff Feedback from Frontline Champions & Walkabouts (Bi-Monthly)**
• There were no Early Neonatal Deaths in April	• One woman who was unable to receive 1:1 care due to high activity and acuity on the unit.	• The next Formal Walk around is scheduled for the Tuesday 9th July

Cardiotocograph (CTG) training	Practical Obstetric Multi-Professional Training (PROMPT)
Midwives = 5 (97% rolling compliance) Consultants = 2 (85.7% rolling compliance) Registrars = 1 (90% rolling compliance)	Midwives 11 attended (6.7%) rolling % 86.5% MSW 3 attended (8.6%) rolling 94% Obstetric Consultants 1 attended (7.7%) rolling % 84% Obstetric registrars 1 attended (7%) rolling % 84.6% (1 now on LTS) Anaesthetists 0 attended (15%) rolling % 88%

Feedback

Service User Voice Feedback	Staff Feedback from Frontline Champions & Walkabouts (Bi-Monthly)
Feedback from Patient All the staff were absolutely excellent and amazing. Can't thank you all enough. Can't remember all the names but I few that I can remember were. Molly, Chelsea, student midwife with Chelsea in delivery suite and Emma in discharge from maternity ward. They were brilliant!!!!	Formal Walkabout Kevin Parker-Evans, Chief Nurse Non Executive Director Francine Thorpe and Mary Moore has met with Maternity Staff on the 7th May 2024 . Postive feedback was received and they walked across neonatal and maternity unit. They engaged in conversation maternity staff and student midwives and received valuable feedback. As a result of feedback a rotating security camera has now been ordered for the triage waiting area.

DATA ANALYTICS & ASSURANCE

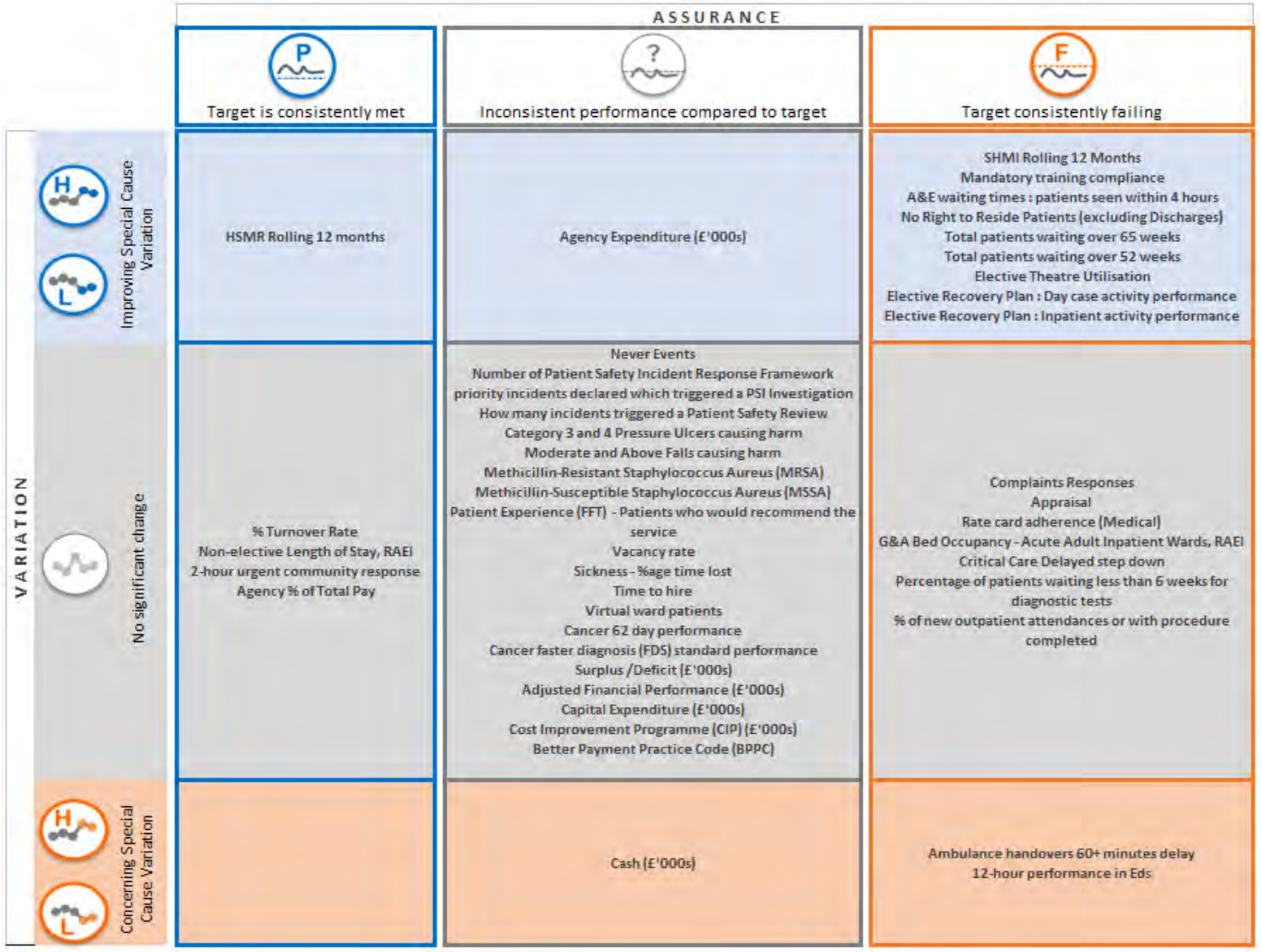
NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

M1 24/25 Integrated Performance Report For Board of Directors Meeting 5.6.24

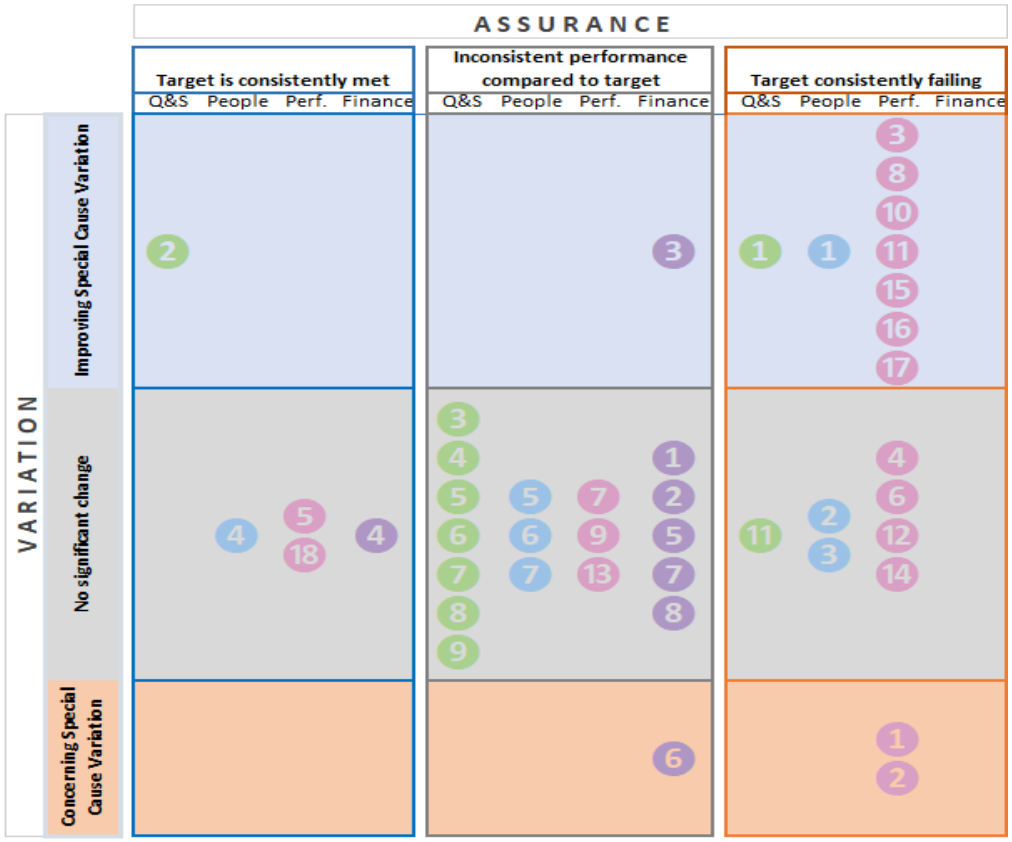
The WWL Way

Contents

Integrated Performance Report 24/25:
Trust Matrix : M1 April 24



Integrated Performance Report 24/25:
Trust Matrix : M1 April 24



KEY : Quality & Safety · People · Performance · Finance

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

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)

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

1. Surplus /Deficit (£'000s)
2. Adjusted Financial Performance (£'000s)
3. Agency Expenditure (£'000s)
4. Agency % of Total Pay
5. Capital Expenditure (£'000s)
6. Cash (£'000s)
7. Cost Improvement Programme (CIP) (£'000s)
8. Better Payment Practice Code (BPPC)

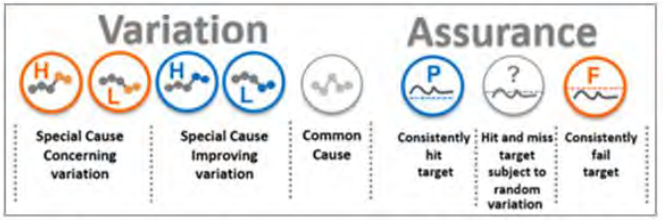
Integrated Performance Report 24/25:
Trust Holistic Narrative : M1 April 24

There has been continued improvement on the ED 4hour performance improving the quality of care our non-admitted ED Attendance. The No Criteria To Reside numbers and WWL's overall bed base numbers continue to make the reduction of 12 hour waits in the department problematic with there still being a reliance on premium spend staffing to support the utilisation of escalation capacity (AAA,DL and Corridor) seeing a continued spend with medicine and urgent care on escalation staffing contributing to the overall variation of the financial plan.

Integrated Performance Report 24/25:
Quality & Safety Overview: M1 April 24

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	SHMI Rolling 12 Months	Jan 24	104.66	100			111.61	109.08	114.14
2	HSMR Rolling 12 months	Feb 24	90.70	100			95.41	0.00	97.69
3	Never Events	Apr 24	0	0			0	0	1
4	Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI Investigation	Apr 24	9	4			4	0	12
5	How many incidents triggered a Patient Safety Review	Apr 24	45	33			36	15	57
6	Category 3 and 4 Pressure Ulcers causing harm	Apr 24	0	0			1	0	4
7	Moderate and Above Falls causing harm	Apr 24	5	0			1	0	5
8	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Apr 24	0	0			0	0	0
9	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Apr 24	1	0			1	0	6
10	WWL Clostridium Difficile (CDT)	Apr 24	1	5			1		
11	Complaints Responses	Apr 24	54.3%	90%			63.3%	37.2%	89.4%
12	Patient Experience (FFT) - Patients who would recommend the service	Apr 24	87.0%	86.7%			86.7%	79.0%	94.5%

Summary icons key:



Integrated Performance Report 24/25:
Quality & Safety Narrative : M1 April 24

In month 1 (April 2024), nine incidents were escalated as per our Patient Safety Incident Response Plan (PSIRP). Seven of these incidents triggered a PSII, whilst the remaining two prompted a thematic analysis. The PSIIs addressed three cases of suboptimal care of deteriorating patients and one case of treatment delays, all of which are local priorities, as well as two national priority incidents involving the unexpected death of a neonate. Additionally, an ad hoc PSII was commissioned for a pressure ulcer incident due to the significant harm involved and the substantial learning opportunities it presented.

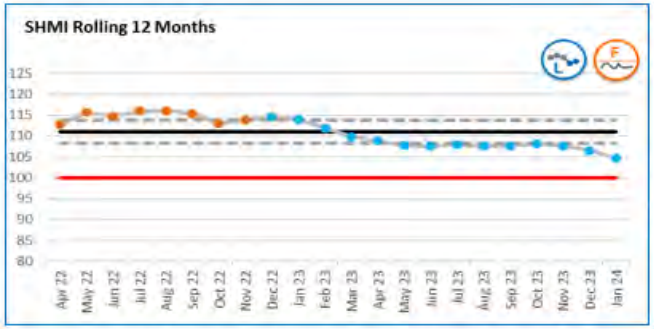
The Trust identified recurring themes, specifically related to alleged abuse of patients by staff and the management of deteriorating patients, thematic analysis of incidents reported over the past 12 months was subsequently commissioned.

Given the rise in incidents relating to deteriorating patients, we have decided to reinvigorate the task and finish group for this workstream, with outputs from this group being reported to Learning from Experience Group (LEG). An update on progress will be presented to LEG in June 2024.'

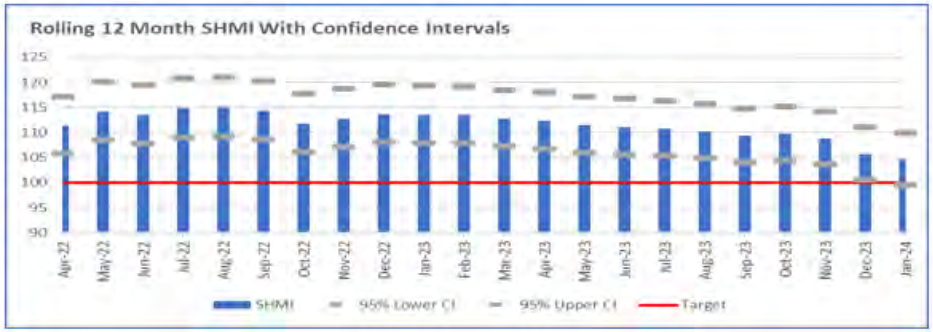
Complaints
There was another increase in the numbers of complaints received (24% within Q4 23/24). M1 saw a reduction in the response rates. There is improvement work underway with divisions to ensure compliance, in particular targeting older complaints. An increased effort has been made to de-escalate complaints by earlier discussions with complainants to understand their concerns and provide them with as much information as possible at that early stage. This has allowed us to de-escalate a number of complaints at this early stage the percentage of those concerns de-escalated is increasing.
Top 3 types of complaints remain Values and behaviours, communication and admissions & discharges. Complaints training continues to support the addressing of these issues.

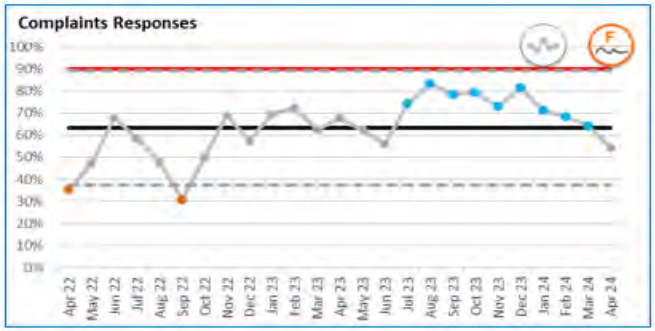
Integrated Performance Report 24/25:
Quality & Safety Insight Report: M1 April 24

Focus : Quality & Safety

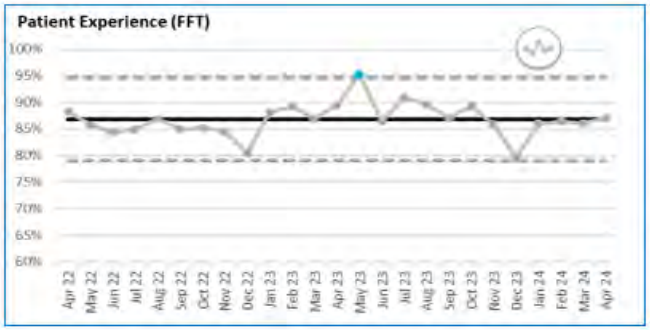


Apr-24
104.66
Variance Type
Special cause improving variation
Target
100.00
Target achievement
Metric is constantly failing the target





Apr-24
54.30%
Variance Type
Common cause variation
Target
85%
Target achievement
Metric is constantly failing the target



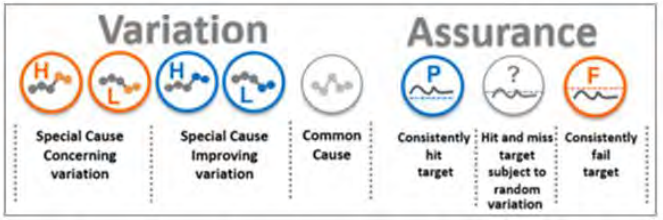
Apr-24
87.0%
Variance Type
Common cause variation
Target
Target achievement

Summary:	Actions:	Assurance:
1. & 2. 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 3. 4.	1. & 2. Continue Sepsis improvement plans to ensure that patients are appropriately managed 3. work with system partners to ensure appropriate discharge placements for patients 4.	1. & 2. SHMI is currently within national expected range 'funnel plot' and has been so for many months 3. 4.

Integrated Performance Report 24/25: People Overview: M1 April 24

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Mandatory training compliance	Apr 24	94.9%	95.0%	H	F	93.4%	91.9%	94.9%
2	Appraisal	Apr 24	80.4%	90.0%		F	79.1%	77.3%	80.8%
3	Rate card adherence (Medical)	Apr 24	67.3%	80.0%		F	51.2%	32.8%	69.5%
4	% Turnover Rate	Apr 24	8.9%	10.0%		P	9.0%	8.7%	9.2%
5	Vacancy rate	Apr 24	6.7%	5.0%		?	6.0%	4.9%	7.1%
6	Sickness - %age time lost	Apr 24	5.2%	5.0%		?	5.2%	4.5%	5.8%
7	Time to hire	Apr 24	53.6	65.0		?	57.7	46.6	68.7

Summary icons key:



Integrated Performance Report 24/25:
People Narrative: M1 April 24

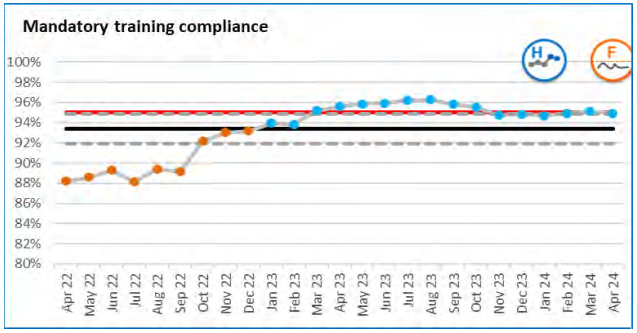
Sickness absence rate increased in April 2024 to 5.25% (in-month) and continues to remain above the Trust target of 5%. Short term absence remained static at 2.3% compared to March 2024, however, long-term absence increased to 2.9% compared to 2.9% in March 2024. As with previous months Stress/Anxiety/Depression accounted for the greatest proportion of absence (29%) and continues to be an area of focus for the Trust in understanding the support our staff require to enable them to stay well and in work.

Turnover remains below the Trust target of 10% at 8.9% and has reduced from the previous month. WWL consistently meets and exceeds the target in relation to this metric, and a stretch target has been considered and will be discussed further via People Committee. A total of 37 people left the Trust in April 2024, 10 of whom were not known why, 7 retired, 5 relocated and 4 achieved a promotion in another organisation.

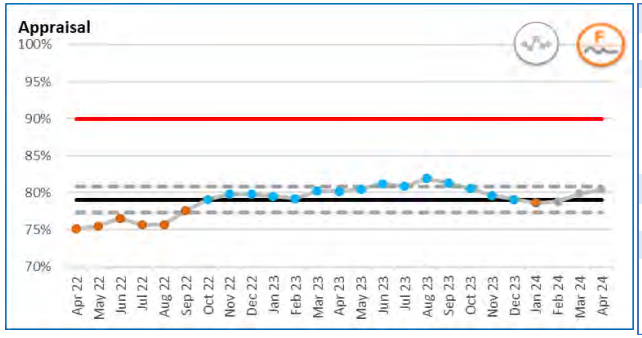
Time to hire increased in the from the previous month but at 53.6 days remained below the target of 65 days both at a Trust level and across all Divisions. The Trust has recently introduced Digital ID Checks which has had a significant impact on the efficiency of the recruitment process and demonstrates the need to ensure that further digital solutions are explored, which is in action through partnership working between HR and IM & T.

Integrated Performance Report 24/25: People Insight Report: M1 April 24

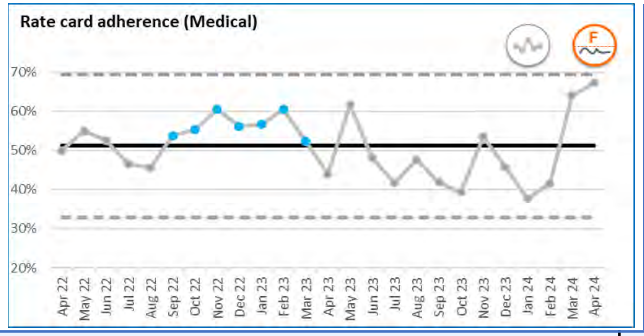
Focus : People



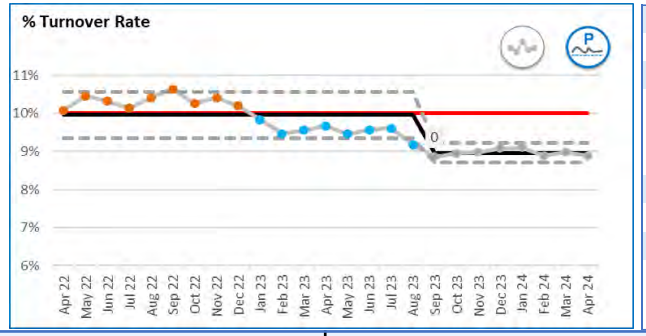
Apr-24
94.90%
Variance Type
Special cause improving variation
Target
95%
Target achievement
Metric is constantly failing the target



Apr-24
80.40%
Variance Type
Common cause variation, no significant change
Target
90%
Target achievement
Metric is constantly failing the target



Apr-24
67.30%
Variance Type
Common cause variation
Target
80%
Target achievement
Metric is constantly failing the target

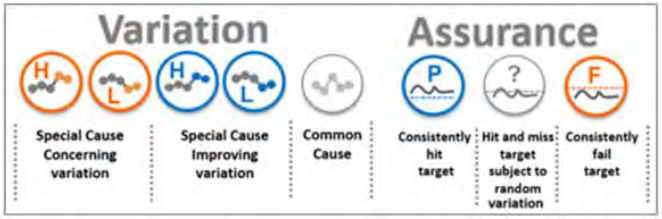


Apr-24
8.9%
Variance Type
Common cause variation
Target
10.0%
Target achievement
Metric is constantly achieving the target

Summary:	Actions:	Assurance:
1. Mandatory training continues to report just below target of 95% at 94.9%. Low reporting modules are Safeguarding Children L3 (79.9%), Safeguarding Vulnerable Adults (88%), Moving & Handling L2 (89.5%), IPC L2 (90%), Fire Safety L2 (92.4%), Prevent Clinical (92.5%), IG (93.3%) 2. Appraisal reported a small increase however continues to be below the target. Community Division reporting the highest compliance rate at 88%. 3. If A & E rates removed from rate card adherence compliance would sit at 91%. A & E rates under review. 4. Turnover consistently meets the target and is low compared to similar organisations.	1. Detailed compliance information shared with Divisions. Discussion at Divisional Assurance Meetings. Monthly escalation reports via ETM now in place. 2. New appraisal year due to be launched which provides a refreshed opportunity for improvements. Discussion at Divisional Assurance Meetings. 3. Weekly medical establishment control meetings are in place. Liaison (Medical Bank provider) attend monthly and support review. Systematically working through each rate card breach to review lessons learnt. 4. Amend target to agreed GM stretch target of 8.5% and devise	1. Executive Director oversight and scrutiny in place till targets met. Further oversight to be provided by new Wider Leadership Team meeting. 2. Oversight to be provided by new Wider Leadership Team Meeting. 3. Governance in place to monitor and take forward improvements. 4. The Trust benchmarks well when compared with other similar organisations. The associated action plan to push turnover down even further will be taken through the People Committee.

Integrated Performance Report 24/25: Performance Overview: M1 April 24

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Ambulance handovers 60+ minutes delay	Apr 24	434	0	H	F	236	54	418
2	12-hour performance in EDs	Apr 24	17.6%	10%	H	F	15.6%	12.6%	18.5%
3	A&E waiting times : patients seen within 4 hours	Apr 24	71.4%	76%	H	F	68.8%	65.3%	72.3%
4	G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI	Apr 24	99.4%	96%		?	97.9%	95.9%	99.9%
5	Non-elective Length of Stay, RAEI	Apr 24	4.11	4.68		P	4.09	3.54	4.64
6	Critical Care Delayed step down	Apr 24	16	0		F	15	1	30
7	Virtual ward patients	Mar 24	116.0%	80%		?	95.8%	75.2%	116.3%
8	No Right to Reside Patients (excluding Discharges)	Apr 24	115	50	L	F	136	117	154
9	Cancer 62 day performance	Mar 24	78.4%	75%		?	79.2%	67.8%	90.5%
10	Total patients waiting over 65 weeks	Apr 24	226	270	L	F	918	449	1387
11	Total patients waiting over 52 weeks	Apr 24	2573	2619		?	3025	2215	3836
12	Percentage of patients waiting less than 6 weeks for diagnostic tests	Apr 24	77.8%	95%		F	75.4%	64.0%	86.7%
13	Cancer faster diagnosis (FDS) standard performance	Mar 24	82.6%	77%		?	78.3%	70.1%	86.6%
14	% of new outpatient attendances or with procedure completed	Apr 24	44.5%	46%		F	43.7%	42.0%	45.5%
15	Elective Theatre Utilisation - Capped touchtime	Apr 24	81.3%	85%	H	F	77.9%	73.2%	82.6%
16	Elective Recovery Plan : Day case activity performance	Apr 24	100.4%	100%	H	F	52.1%	30.1%	74.0%
17	Elective Recovery Plan : Inpatient activity performance	Apr 24	97.3%	100%	H	F	46.9%	18.5%	75.2%
18	2-hour urgent community response	Mar 24	89.3%	70%		P	83.4%	73.4%	93.4%

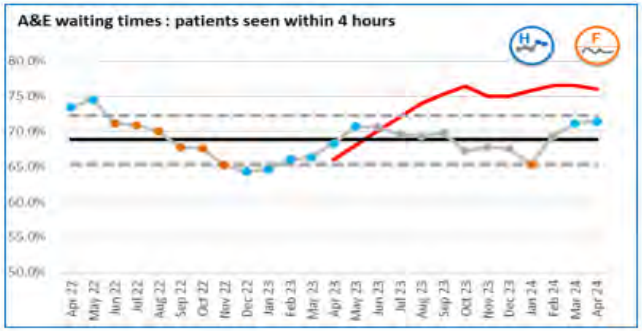


Integrated Performance Report 24/25: Performance Narrative : M1 April 24

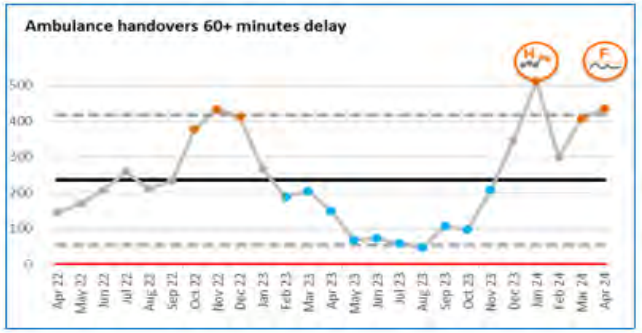
- 4-hour performance in April continued to improve, achieving 71.4%. Despite this, 12-hour waits, and ambulance delays continued as a pressure.
- WWL has the lowest bed base in GM by a significant margin, which is apparent in the 12-hour ED waits for admitted patients – on days with the highest performance, and no corridor care, 12-hour waits are 12% of total attendances as a minimum.
- Reducing ambulance handover delays is a priority – an action plan has been developed and will be monitored weekly at exec level.
- WWL had until May 2024 over-reported NRTR numbers and appeared as an outlier - the number of medically optimised patients had been reported in error which is significantly higher. Despite this correction, NRTR patients typically account for approximately 17-18% of the General and Acute Bed base.
- Patients waiting beyond both 65 and 52 weeks reduced and are ahead of trajectory. All specialties with the exception of gynaecology have plans to clear 65 weeks by the end of September – gynaecology plans are in progress and include potential mutual aid and the utilisation of a referral triage service, funded by GM.
- Cancer services continued to exceed both the 62-day performance target and the 28-day faster diagnosis standard.
- Elective theatre utilisation improved but is still below target of 85% - day case and elective activity delivered a combined 98% of the elective recovery target, with a slight over-delivery of day case activity and under-delivery of elective – all divisions under-achieved on the value of elective activity delivered by around £40k, although a benefit is expected once activity is fully coded.

Integrated Performance Report 24/25: Performance Insight Report: M1 April 24

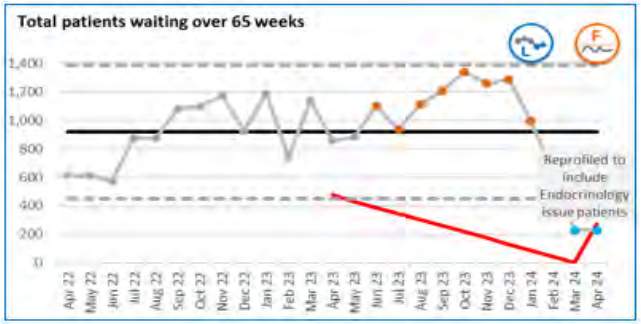
Focus : Performance



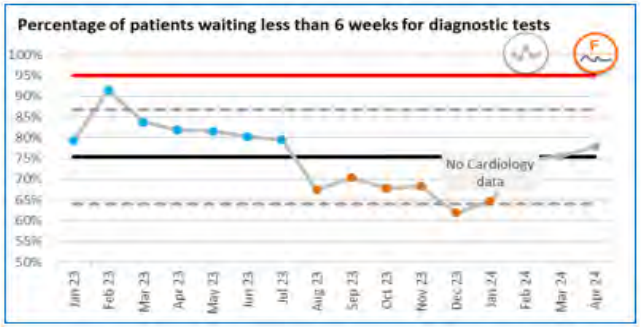
Apr-24
71.40%
Variance Type
Special cause improving variation
Target
76%
Target achievement
Metric is constantly failing the target



Apr-24
434
Variance Type
Concerning special cause variation
Target
0
Target achievement
Metric is constantly failing the target



Apr-24
226
Variance Type
Special cause improving variation
Target
270
Target achievement
Metric had constantly failed the target



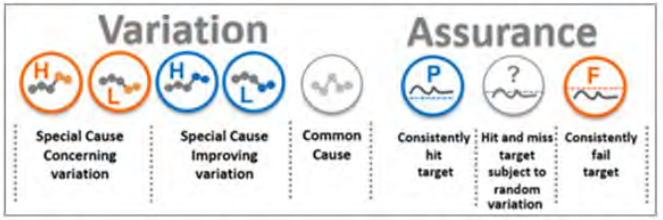
Apr-24
77.8%
Variance Type
Common cause variation
Target
99.0%
Target achievement
Metric is constantly failing the target

Summary:	Actions:	Assurance: A
1. A&E 4 hour performance improved but remains below target of 78% 2. Ambulance delays deteriorated in month 3. Improvement in patients waiitng over 65 weeks, and ahead of trajectory – gynae remains a risk 4. Diagnostic performance increased but is below target – driven by endoscopy and non obstetric ultrasound – on target to recover to 95% by year end	1. Increased streaming to UTC, social work colleagues resident on site and supporting ED 2. Clinically led ambulance handover action plan, weekly exec scrutiny 3. Exploration of mutual aid options with Bolton and also referral triage service 'Consultant Connect' - data suggests could reduce WL by 1/3 by returning appropriate patients to GPs with management plans negating need to be seen 4. LPV in progress to secure NOUS activity, endoscopy recovery plan in place and progressing well. Potential mutual aid offer for endoscopy from Bolton	1. Improving position, month on month – May performance currently 73.3% 2. Exec led weekly scrutiny 3. Micro management of waiting lists, improving position 4. Improving position, on target to achieve by year end

Integrated Performance Report 24/25: Finance Overview: M1 April 24

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Surplus /Deficit (£'000s)	Apr 24	-1817	-1274			-1059	-8161	6043
2	Adjusted Financial Performance (£'000s)	Apr 24	-1800	-1258			-606	-5878	4666
3	Agency Expenditure (£'000s)	Apr 24	746	689	L		943	492	1395
4	Agency % of Total Pay	Apr 24	2.4%	3.2%	L		2.6%	1.9%	3.4%
5	Capital Expenditure (£'000s)	Apr 24	1025	3474			2169	-3459	7796
6	Cash (£'000s)	Apr 24	22533	19088	L		30623	19663	41583
7	Cost Improvement Programme (CIP) (£'000s)	Apr 24	1882	2275			2085	-651	4821
8	Better Payment Practice Code (BPPC)	Apr 24	95.1%	95%			92.3%	84.7%	99.8%

Summary icons key:



Integrated Performance Report 24/25: Finance Narrative : M1 April 24

Surplus/Deficit: The Trust is reporting an actual deficit of £1.8m for month 1, April which is £0.5m adverse to plan. The key drivers for the adverse variance are non-delivery of CIP £0.4m and under performance against the elective recovery plan by £0.1m.

Adjusted Financial Performance: The adjusted financial performance is a surplus of £1.8m, which is £0.5m adverse to plan.

Agency Expenditure: Agency expenditure is £0.7m in month 1, which is comparable to previous months and favourable to plan by £0.3m.

Agency % of Total Pay: Agency expenditure equates to 2.5% of total pay expenditure, which is below the NHSE agency ceiling of 3.2% of total pay expenditure. The agency ceiling has reduced from 3.7% to 3.2% for the 2024/25 financial year.

Capital Expenditure: The Trust has agreed a capital plan with GM for the financial year 2024/25 of £21.0m, although there may be further changes due to ongoing discussion with NHSE. The plan consists of £9.3m operational CDEL, £8.2m PDC and £3.5m for lease expenditure (right of use assets). In month 1, expenditure of £1.0m has been incurred which is £2.4m below plan.

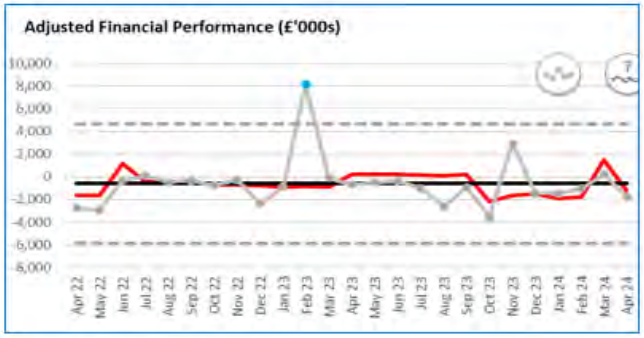
Cash: The Trust has a closing balance of £22.5m at the end of April which is £3.4m above plan. Cash has reduced by £2.4m from the previous month primarily due to capital payments. Based on the current cash run rate, external support would be required in quarter 2.

Cost Improvement Programme (CIP): The Trust has a planned CIP Target of £27.3m for 2024/25. The plan is £19.1m recurrent and £8.2m non recurrent delivery. In month 1, actual CIP of £1.9m was transacted, which is £0.4m below plan.

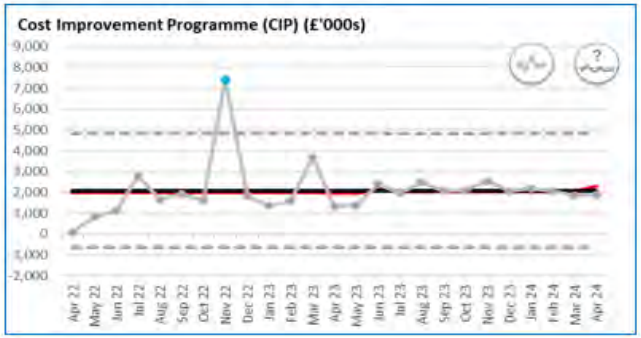
Better Payment Practice Code (BPPC): BPPC performance for April is 95.1% by volume and 93.1% by value, which is an improvement to previous months.

Integrated Performance Report 24/25: Finance Focus Page: M1 April 24

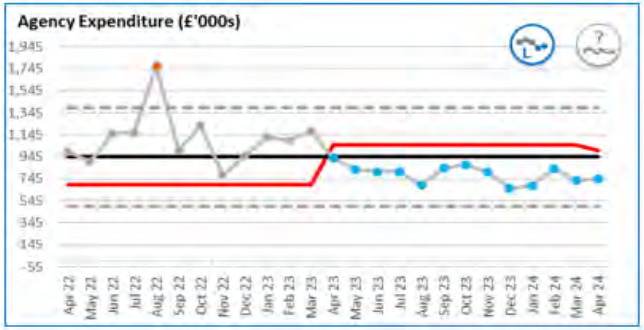
Focus : Finance



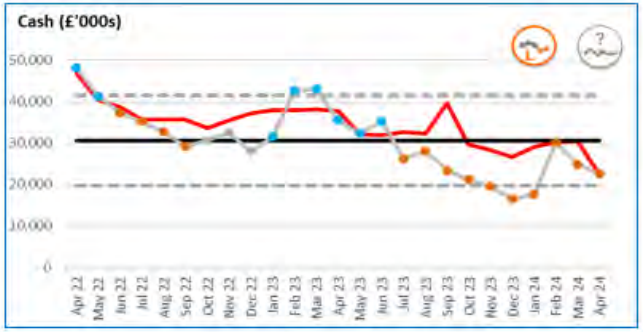
Apr-24
-1800
Variance Type
Common cause variation, no significant change
Target
-1258
Target achievement
Inconsistent performance compared to target



Apr-24
1882
Variance Type
Common cause variation, no significant change
Target
2275
Target achievement
Inconsistent performance compared to target



Apr-24
746
Variance Type
Improving special cause variation
Target
689
Target achievement
Inconsistent performance compared to target



Apr-24
22533
Variance Type
Concerning special cause variation
Target
19088
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
1. The revenue plan for 2024/25 is a deficit of £14.8m. At month 1, there was an actual deficit of £1.8m, an adverse variance of £0.5m to the planned deficit of £1.3m. This is due to CIP underperformance of £0.4m and elective activity underperformance of £0.1m. 2. For month 1, there is slippage of £0.4m against the CIP plan, with actual CIP of £1.9m transacted against the plan of £2.3m 3. Agency expenditure has shown special cause improvement since April 2023 and remains below the NHSE ceiling. 4. Cash is showing concerning special cause variation due to the downward trend. The cash balance at the end of April is £22.5m.	1. This financial year is year one of the three-year financial sustainability plan. Continued focus on delivery of financial position, with grip and control measures continuing from 2023/24. Activity plan to be recovered within the financial year. See 2. for CIP actions. 2. CIP slippage to be recovered within the financial year. Support from transformation and finance teams. 3. Agency controls to remain in place. All temporary spend to be monitored. 4. Cash management strategy in place with detailed cash forecasting. Application for cash support from NHSE withdrawn for quarter 1. Applications for cash support in quarter 2 are required to be submitted by 12 June.	1. Monthly divisional assurance meetings for all clinical divisions, Finance Improvement Group (FIG) and Finance and Performance Committee. Monthly provider oversight meeting with GM ICB (Ext.). 2. Monthly divisional assurance meetings for all clinical divisions, Finance Improvement Group (FIG) and Finance and Performance Committee. Monthly provider oversight meeting with GM ICB (Ext.). 3. Medical and Non-Medical Establishment Review Groups, Finance and Performance Committee. 4. Cash Management Group, Finance and Performance Committee. GM Capital and Cash Group (Ext.)

Agenda item: [28]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 12 (March 2024)
Presented to:	Board of Directors
On:	5th June 2024
Item purpose:	Information
Presented by:	Kelly Knowles, Operational Director of Finance
Prepared by:	Senior Finance Team
Contact details:	T: 01942 773736 E: Heather.Shelton@wwl.nhs.uk

Executive summary

Description	Performance Target	Performance	Explanation
Revenue financial plan	Achieve the financial plan for 2023/24.	Amber	The Trust has delivered the revenue position agreed with GM and NHSE for the 2023/24 financial year of a £10.4m deficit, **subject to final sign off by the Trust's external auditors, KPMG**. This is £3.9m adverse to the original plan of £6.5m deficit. At the year end, the Trust is reporting an actual technical deficit of £17.9m against the planned deficit of £6.7m, an adverse variance of £11.2m. The adjusted financial performance (used to measure system performance) is an actual deficit of £10.4m, which is £3.9m adverse to plan. The £10.4m deficit was the revised control total agreed with GM ICB and NHSE as part of the £180.0m deficit agreed as a system. GM has delivered the £180.0m deficit position, subject to external audit of provider and ICB annual accounts. Escalation expenditure of £9.7m has been incurred this year. The Trust has fully delivered the CIP target of £24.4m (a saving of c.5%), with £13.2m delivered recurrently. The Trust originally planned for non-recurrent balance sheet support of £8.9m within the 2032/24 plan. £13.1m has been released through a full review of payables, deferred income, and the annual leave accrual.

Activity	Achieve the elective activity plan for 2023/24.	Red	The Trust has underperformed against the full year elective activity target by £4.9m. This includes the notified target reduction from NHSE for industrial action in month 1-7 but instead of adjusting the target for the month 8-11 impact of industrial action additional income was provided through the ICB. The pressure relating to lost income because of Industrial action above the target reduction is £2.1m and this has been fully funded resulting in a full year under performance against the ERF target of £2.8m. As advised by GM ICB, we have excluded the over performance on unbundled activity (£2.9m) within our reported month 12 position.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Amber	The Trust has a closing balance of £24.9m which is £5.4m below plan. Cash has reduced by £5.2m from the previous month due primarily to capital payments made in the month. The variance to plan relates to the revenue deficit, and other timing differences. NHSE requires cash balances to be split between capital and revenue cash, closing cash balance is split: capital cash (£9.7m) and revenue cash (£15.2m). The operating cash days metric is 14 days at the end of March compared to 21 at the end of February, and 27 days at the beginning of the financial year. This metric reduces to 8 days when applied to the revenue cash balance only. The cash balance has declined during 2023/24 and cash support is expected to be required in 2024/25. A request for revenue cash support in Q1 of 2024/25 has been submitted and supported by NHSE and will now require HM Treasury approval. The Trust will be required to submit an updated cash forecast ahead of the draw down for May or June, which will reflect changes in the 2024/25 plan.

Capital expenditure (CDEL)	Achieve CDEL for 2023/24.	Green	The Trust has delivered its agreed capital plan with GM for the financial year 2023/24. There was a total investment in capital of £34.7m with £13.1m relating to operational CDEL, £15.9m PDC and £5.9m for right of use assets. The Trust received an additional increase in its CDEL allocation of £1.1m during March.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £24.4m, of which £19.7m is recurrent.	Green	The Trust has achieved the CIP target for 2023/24. This includes non-recurrent vacancy stretch of £4.7m. Achievement of this year's CIP target was difficult due to the challenges presented by escalation and industrial action. Of the amount delivered in year, £13.2m (54%) was recurrent.
Temporary expenditure	To remain within the agency ceiling set by NHSE and reduce bank expenditure.	Green	Agency expenditure in month 12 is £0.7m and £9.4m full year, which is 1.7% of the total pay bill for the full year (compared to the NHSE ceiling of 3.7%). Bank expenditure within the divisions was £2.6m in month 12 and £30.1m full year. Both bank and agency costs have reduced when compared to last year, £2.6m and £3.8m respectively.
Business conduct	Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days.	Red	BPPC performance for the year is 93.8% by volume and 92.5% by value, which is similar to previous months. As the performance is below the target of 95% a red RAG rating has been applied. An action plan is in place to improve the BPPC to the target of 95.0%.
Financial risk	Report the financial risks through the Board Assurance Framework.	Amber	Although the Trust has achieved its current year plan, significant risks remain to capital allocations, cash balances, activity levels, escalation levels, further industrial action and CIP delivery moving into 2024/25.

Link to strategy

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

Risks associated with this report and proposed mitigations.

The Trust has achieved its financial plans for revenue and capital for 2023/24 and the focus has now moved to 2024/25. The 2023/24 financial position was materially supported through non-recurrent measures. There remains an underlying structural deficit, which will be addressed through delivery of the financial sustainability plan over three years. The draft plan submission to NHSE in March was a revenue deficit of £13.1m. The planning round continues across the GM ICS with the support of PWC to ensure the final plans are challenging but achievable to support financial recovery of the ICS.

An application for cash support has been made for Q1 2024/25. Due to increased closing cash balances, providing the Trust achieves its financial plan for Q1, it is more likely that cash support will not be needed until Q2. The cash position is being closely monitored.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

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 month 12 Trust Finance Report was reviewed by ETM on 18th April 2024 and by the Finance and Performance Committee on 28th May 2024.

Recommendation(s)

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

Financial Performance

Key Messages

At the 2023/24 financial year end, the Trust has reported an actual technical deficit of £17.9m which is £11.2m adverse to plan. The adjusted financial performance is £10.4m deficit which is £3.9m adverse to the planned deficit of £6.5m.

In month, the Trust has reported a technical deficit of £7.2m, £8.7m adverse to plan. The adjusted financial performance is a surplus of £0.2m, which is £1.2m adverse to plan.

The position is subject to final sign off of the annual accounts by the Trust's external auditors.

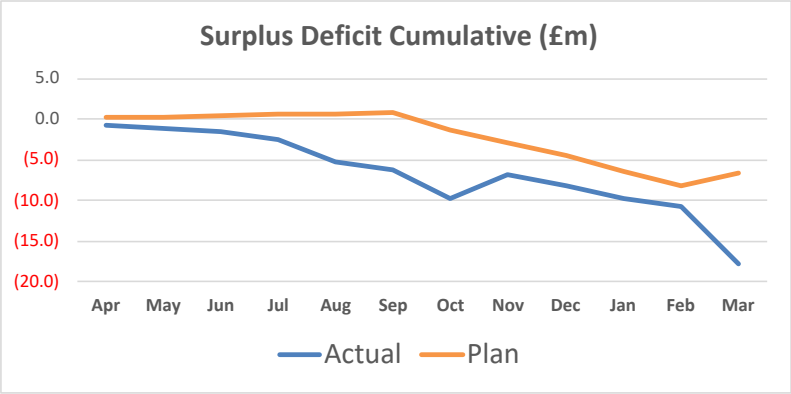
The Trust reported an actual technical deficit of £7.2m in month 12 (March 2024), which is an adverse variance of £8.7m to the plan. Within the month 12 position, there is balance sheet support of £1.4m in month, which includes £0.9m for the phased release of the annual leave accrual in quarter 4. The month 12 position is a technical deficit in month of £7.2m, which is £8.7m adverse to the original plan. The adjusted financial performance, used to measure system performance (which is net of technical adjustments) is a surplus of £0.2m, which is £1.2m adverse to plan.

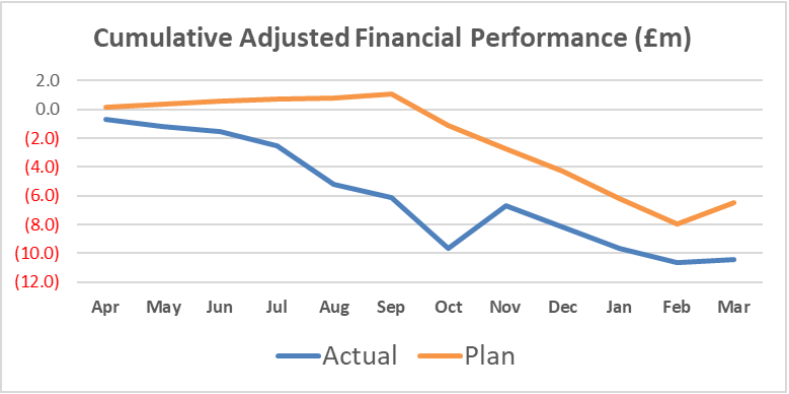
The GM ICS is expected to report a deficit of £180.0m for 2023/24, subject to audit.

The £10.4m deficit was the revised control total agreed with GM ICB and NHSE as part of the £180.0m deficit agreed as a system.

The ERF/API underperformance is £4.9m full year. This includes £2.1m of lost income due to industrial action that has been compensated within the additional £4.6m industrial action funding received by the Trust. Of this, £2.2m has been received in month 12. Therefore, the net underperformance is £2.8m.

Escalation expenditure of £9.7m above plan has been incurred during the year.





Key Financial Indicators

Key Financial Indicators	In Month (£000)			Full Year (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Financial Performance							
Income	60,067	42,016	18,051	523,101	506,768	16,332	506,768
Pay	(43,654)	(27,732)	(15,922)	(372,955)	(351,794)	(21,160)	(351,794)
Non Pay	(15,204)	(10,950)	(4,254)	(140,380)	(139,839)	(541)	(139,839)
Financing / Technical	(9,652)	(1,874)	(7,778)	(28,894)	(21,829)	(7,066)	(21,829)
Surplus / Deficit	(7,222)	1,459	(8,682)	(17,907)	(6,693)	(11,214)	(6,693)
Adjusted Financial Performance *	245	1,476	(1,231)	(10,395)	(6,500)	(3,895)	(6,500)
Memo Items							
CIP	1,838	2,041	(203)	24,410	24,404	6	24,404
Bank Expenditure	2,645	1,165	(1,480)	30,144	12,136	(18,008)	12,136
Agency Expenditure	729	1,049	320	9,493	13,799	4,306	12,593
Cash Balance	24,945	30,403	(5,458)	24,945	30,403	(5,458)	30,403
Capital Spend - CDEL	3,696	3,061	(635)	13,050	13,138	88	13,138
Capital Spend - PDC	3,785	2,067	(1,718)	15,756	15,756	0	15,756

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

Financial Performance

- Income is £18.0m favourable to plan in month and £16.3m favourable to full year plan. This includes £4.9m of ERF activity underperformance for the full year.
- Operating expenditure adverse to plan in month 12.

Temporary Spend

- Bank spend £2.6m in month and £30.1m ful year.
- Agency spend for the Trust is £0.7m in month and £9.5 full year. This is below the agency ceiling at 2.7% of total pay bill (ceiling 3.7%).

CIP

- £1.8m transacted in month, adverse to plan £0.2m
- £24.4m transacted full year, which is on plan.
- Split in month: Divisional £1.7m; Centralised £0.1m.

Cash

- £24.9m cash balance, decrease of £5.1m on last month due primarily to capital payments.
- £0.5m worse than plan.

Capital

- Capital spend of £7.5m is £2.4m more than plan in month.
- CDEL exependiture £3.7m is £0.7m more than plan in month.
- PDC expenditure £3.8m is £1.7m more than plan in month.

Divisional Performance

Medicine

- (£2.3m) Adverse to plan in month
- (£0.7m) Escalation costs
- (£0.5m) Stock adjustments
- (£0.5m) Drugs & clinical supplies
- (£0.2m) Nursing costs (Visas & 1:1 Care)
- (£0.4m) Smaller items

Surgery

- (£0.1m) Adverse to plan in month
- (£0.1m) Bank nursing costs (ward/theatres)

Specialist Services

- £0.1m favourable in month
- (£0.3m) Clinical Supplies
- £0.1m PAWS fees lower than expected
- £0.1m Vacancies
- £0.1m CDC slippage

Community

- On plan
- £0.3m Vacant posts
- (£0.3m) Temp spend (district nurses, Community Assessment Unit)

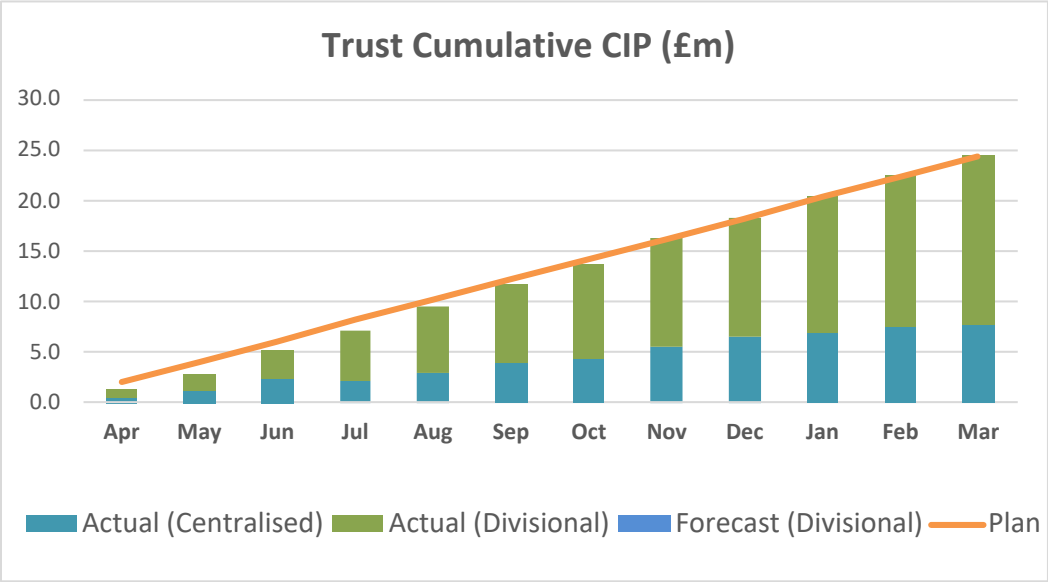
Estates & Facilities

- (£0.4m) Adverse to plan in month
- (£0.3m) Estates maintenance
- (£0.1m) Hotel costs - linen

Corporate Divisions

- £0.6m favourable in month
- £0.4m Nurse Director – Visas to clinical divisions
- £0.1m IM&T - Rev to Cap
- £0.1m – Med Dir – Education income

Cost Improvement Programme



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

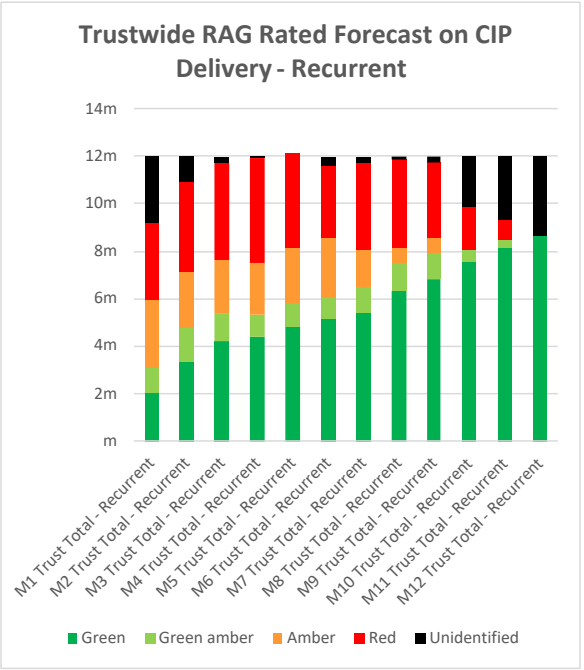
In year the Trust has delivered the £24.4m target. This is split by £16.7m divisional CIP and £7.7m Centralised CIP.

In month 12 actual CIP of £1.8m has been transacted which was £0.2m behind plan, with 15% (£0.2m) being transformational.

At year end, £8.6m has been transacted recurrently in year for divisional CIP, an increase of £0.5m since last month. The amount transacted recurrently comprises of £1.5m private patient income, £2.5m of non-pay savings, with the remainder being a combination of smaller schemes.

Transformational schemes are £2.3m of the full year value which includes income from private patients and an improvement in spend being driven through the Model Hospital/ National Cost Collection Index programme.

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



Forward Look

The planning round is nearing completion for the 2024/25 financial year. National planning guidance has been released now and is broadly in line with the draft guidance. The Trust has developed the 2024/25 plan in line with published guidance and aligned to the three year financial sustainability plan. Draft plans were approved at the Finance and Performance Committee on 26th March 2024 and Board on 3rd April 2024. Final revenue and capital plans are required to be submitted to GM ICB by 24th April 2024 and NHSE by 2nd May 2024.

The governments revised pay offer for consultants has now been accepted. SAS doctors in England have rejected the Government's offer on a new pay deal, with the BMA now set to consult members on the next steps. At the time of writing the junior doctors have not announced any further industrial action.

Agenda item: 28

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 1 (April 2024)
Presented to:	Board of Directors
On:	5th June 2024
Item purpose:	Information
Presented by:	Kelly Knowles, Operational Director of Finance
Prepared by:	Senior Finance Team
Contact details:	T: 01942 773736 E: Heather.Shelton@wwl.nhs.uk

Executive summary

Description	Performance Target	Performance	Explanation
Revenue financial plan	Achieve the financial plan for 2024/25	Red	The Trust is reporting an actual deficit of £1.8m for month 1, April which is £0.5m adverse to plan. The key drivers for the adverse variance are non-delivery of CIP £0.4m and temporary staffing costs in the clinical divisions during month 1. The plan for 2024/25 is a deficit of £14.8m and is year one of three for the financial sustainability plan to return to a break even position.
Activity	Achieve the elective activity plan for 2024/25.	Red	The Trust has underperformed against the internal elective recovery plan by £0.1m in month 1.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Amber	The Trust has a closing balance of £22.5m which is £3.4m above plan. Cash has reduced by £2.4m from the previous month primarily due to capital payments made in the month. The variance to plan relates to the revenue deficit, and other timing differences. Based on the current cash run rate, external support would be required in quarter 2.
Capital expenditure (CDEL)	Achieve CDEL for 2024/25.	Green	The Trust has agreed a capital plan with GM for the financial year 2024/25 of £21.0m. The plan consists of £9.3m operational CDEL, £8.2m PDC and £3.5m for lease expenditure (right of use assets). In month expenditure of £1.0m is £2.4m below plan. Of which £1.7m relates to lease remeasurements being lower than anticipated due to increases in the technical discount rate factor offsetting annual RPI increases.

Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red	In month 1, The Trust has delivered £1.9m CIP against the plan of £2.3m, therefore there is a gap of £0.4m. As at month 1 there is an unidentified gap of £5.0m in year and £4.5m recurrently. Work is ongoing with the Divisions to close the gap.
Temporary expenditure	To remain within the agency ceiling set by NHSE and reduce bank expenditure.	Amber	Agency expenditure is £0.8m in month 1, which is comparable to previous months and favourable to plan £0.3m. This is also £0.3m below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure. Bank expenditure was £2.2m in month 1, which has reduced £0.5m from month 12. Bank costs are driven largely by covering vacancies and 1:1 care.
Business conduct	Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days.	Amber	BPPC performance for April is 95.1% by volume and 93.1% by value, which is an improvement to previous months. As performance by value is below 95% but volume is above, an amber RAG rating has been applied. An action plan is in place to improve the BPPC to the target of 95.0%.
Financial risk	Report the financial risks through the Board Assurance Framework.	Amber	The financial environment for 2024/25 for both revenue and capital will be highly constrained and may impact on the ability of the Trust to deliver its strategic objectives. April has seen a £0.5m deficit to the financial plan, which will need to be recovered over the coming months if the Trust is to deliver its full year plan. The largest risks to the financial position in year are delivery of the elective activity plan, delivery of CIP, increase in escalation costs or temporary staffing expenditure, inflationary pressures, and industrial action (if not mitigated by further funding). If the recurrent CIP target is not met, this will impact the underlying position and the timescale of the financial sustainability plan.

Link to strategy

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

Risks associated with this report and proposed mitigations

There are risks within the 2024/25 revenue plan, the most material risks are:

- Delivery of the planned CIP of £27.3m. This includes the safe reduction in expenditure associated with escalation.
- Delivery of the activity plan to meet the planned levels of income.
- Management of other potential cost pressures in year, including industrial action for which there is no provision within the plan.

Further work is ongoing within the transformation programmes as well as the ICB and the locality to address escalation, and to identify further opportunities for CIP with a view to recover the deficit seen in April.

Due to increased closing cash balances, providing the Trust achieves its revenue plan it is assumed that cash support is needed in quarter 4. This is based on the CIP being fully cash releasing. However, the current cash run rate indicates cash support would be needed in quarter 2 or 3. Any support request will be submitted in accordance with the national timetable. The cash position is being closely monitored.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

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 month 1 finance report was reviewed by ETM on 16th May 2024 and by the Finance and Performance Committee on the 28th May 2024.

Recommendation(s)

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

Financial Performance

Key Messages

In month 1, The Trust has reported an actual deficit of £1.8m, which is £0.5m adverse to the plan.

The adjusted financial performance is £1.8m deficit which is £0.5m adverse to the planned deficit of £1.3m.

The Month 1 CIP delivered is £1.9m against the plan of £2.3m, which is a £0.4m underperformance. Within the delivery of £1.9m - 68% was non-recurrent transactional schemes

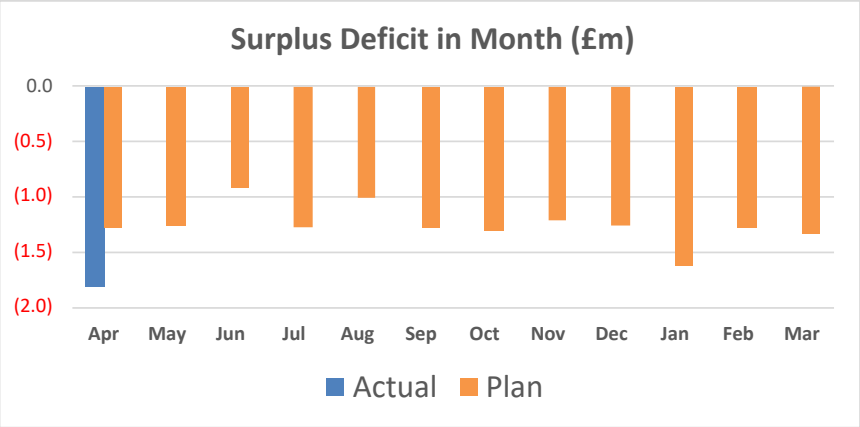
The Trust reported an actual deficit of £1.8m in month 1 (April 2024), which is an adverse variance of £0.5m to the planned deficit of £1.3m.

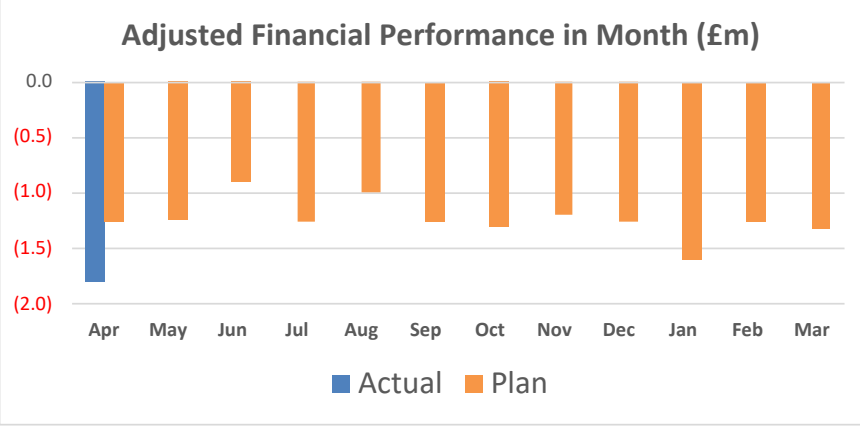
In month 1, the Trust income is £0.2m favourable to plan. The Trust has underperformed against the internal elective recovery activity plan by £0.1m in month 1, offset with some small positive income variances across the corporate areas.

Pay expenditure is £31.2m which is £0.6m adverse to plan due to temporary staffing costs in the clinical divisions, consultant pay award which is offset with income. The position includes 2% accrual for the assumed staff pay award in line with NHSE guidance, as this is within the commissioner contract uplift.

Non pay expenditure is £11.8m, which is £0.2m adverse to plan, primarily due to non-delivery of CIP.

The plan is relatively flat phased across the year. Working days phasing is applied to elective services, minor seasonality profiling for energy costs, and winter resilience measures in Surgery. Investments are phased in as per the business case (Theatre 11 and Endoscopy). CIP is evenly phased across the year.





Key Financial Indicators

Key Financial Indicators	In Month (£000)			Full Year (£000)
	Actual	Plan	Var	Plan
Financial Performance				
Income	43,020	42,860	160	519,105
Pay	(31,237)	(30,604)	(633)	(368,619)
Non Pay	(11,789)	(11,611)	(178)	(140,880)
Financing / Technical	(1,811)	(1,919)	108	(24,640)
Surplus / Deficit	(1,817)	(1,274)	(544)	(15,034)
Adjusted Financial Performance *	(1,800)	(1,258)	(543)	(14,841)
Memo Items				
CIP	1,882	2,275	(393)	27,300
Bank Expenditure	2,197	2,207	10	26,833
Agency Expenditure	746	689	(57)	11,796
Cash Balance	22,533	19,088	3,445	7,415
Capital Spend - CDEL	467	816	349	9,287
Capital Spend - Lease expenditure	0	1,721	1,721	3,535
Capital Spend - PDC	558	937	379	8,211
Total Capital Spend	**1,025**	**3,474**	**2,449**	**21,033**

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

Financial Performance

- Income is £0.2m favourable to plan in month.
- Operating expenditure adverse to plan in month 1.

Temporary Spend

- Bank spend £2.2m in month.
- Agency spend for the Trust is £0.7m in month. This is below the agency ceiling at 2.4% of total pay bill (ceiling 3.2%).

CIP

- £1.9m transacted in month, adverse to plan £0.4m.

Cash

- £22.5m cash balance, decrease of £2.4m on last month.
- £3.4m above plan.

Capital

- Capital spend of £1.0m, £3.5m behind the plan of £2.5m
- CDEL exependiture £0.5m; PDC expenditure £0.5m.

Divisional Performance

Medicine

- (£0.4m) Adverse to plan in month
- (£0.1m) CIP not delivered
- (£0.1m) Consultant vacant post cover
- (£0.1m) Nursing and medical bank
- (£0.1m) Smaller items

Surgery

- (£0.5m) Adverse to plan in month
- (£0.3m) CIP not delivered
- (£0.1m) Medical rota temp spend
- (£0.1m) Smaller items

Specialist Services

- (£0.2m) Adverse to plan in month
- (£0.3m) CIP not delivered
- (£0.2m) PAWS prior year adjustments
- £0.1m Private patient income
- £0.2m CDC slippage

Community

- (£0.1m) Adverse to plan in month
- £0.2m Vacant posts
- £0.1m CIP delivered
- (£0.1m) Non pay consumables
- (£0.3m) Temp spend (district nurses, Community Assessment Unit)

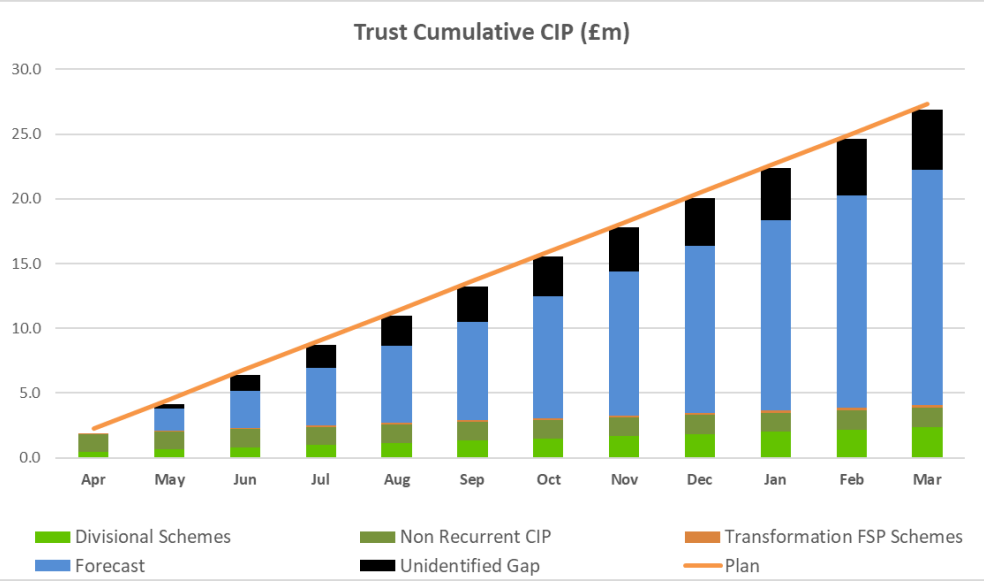
Estates & Facilities

- £0.1m Favourable to plan in month
- £0.1m Estates maintenance
- £0.1m Sustainability (Energy)
- (£0.1m) CIP not delivered

Corporate Divisions

- £0.3m Favourable in month
- £0.3m CIP Delivered

Cost Improvement Programme



The Trust has a planned CIP Target of £27.3m for 2024/25. The plan is £19.1m recurrent and £8.2m non recurrent delivery. The recurrent target is split £12.2m Divisional CIP and £6.9m Transformational CIP.

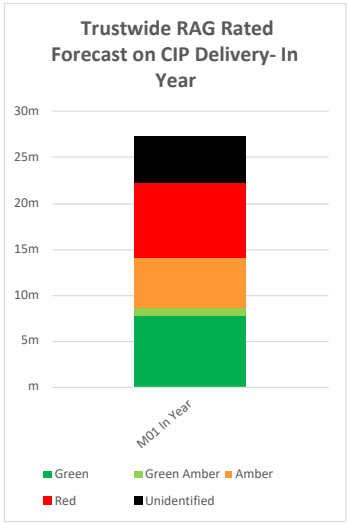
As at month 1, the Trust has identified £22.3m schemes in year (£5.0m gap) and £14.6m recurrently (£4.5m gap).

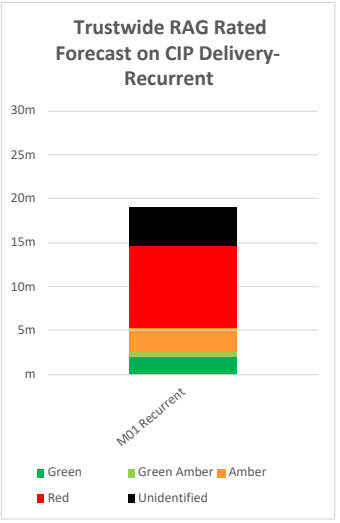
£1.9m has been delivered in month 1, which is £0.4m behind plan. This has been achieved through overperformance on non-recurrent vacancy factor.

As at month 1, the Trust has transacted £7.3m in year and £1.9m recurrently. This is predominantly made up of non-recurrent vacancy factor, community wheelchair scheme and non-pay challenges within divisions. Work is ongoing to progress the identified schemes.

Of the £22.3m identified in year, £8.1m (36%) are high risk schemes and are continually being reviewed with the aim to accelerate development of CIP plans, unblock current schemes and drive creativity and innovation with the teams.

The Trust has identified a number of mitigating items to address the unidentified gap, these are being reviewed to be aligned to the Divisions and existing Transformation Programmes.





Forward Look

The final revenue and capital plans for 2024/25 was approved by the Board of Directors on 1st May 2024, and submitted to NHSE on 2nd May 2024. The final system revenue plan was a £217m deficit, although there are discussions with NHSE in respect of a PFI adjustment which would improve the position by a further £20m to a deficit of £197m. Following a review meeting with the National Finance Director on 30th April 2024, a number of follow up actions were agreed:

- Review of elective activity ambition to try and deliver more activity.
- Review non pay growth areas.
- Provide a case on the return on investment of the major trauma centre costs of £26m.
- Consider what else is possible if we had national permission to progress.

The governments revised pay offer for consultants has now been accepted and will be processed in May 2024. SAS doctors in England have not agreed an improved pay offer with the government, with the BMA now set to plan to commence industrial action. At the time of writing the junior doctors have not announced any further industrial action. The plan assumes a 2.0% pay award for all staff groups in line with NHSE guidance; it is expected that this will be amended during the year as settlements are agreed.

The ICB will be taking the lead on oversight meetings for the 2024/25 financial year, taking over from PWC FPRM meetings. At the time of writing, further detail is awaited from ICB.

Maintaining grip and control is key to achieving a break-even position within the next three years. The measures introduced in 2023/24 will continue into 2024/25. It has been indicated that a system wide vacancy panel led by the ICB may be introduced within the near future.

GM ICB is developing a sustainability plan. The objective is to set out how the system will close the gap on finance, performance, quality, and population health over a three to five year period. The plan will demonstrate how the system will return to run rate balance by the end of 2025/26.

The finance team will be undertaking a refresh of finance reporting within quarter 1, with a particular focus on utilising SPC charts.

Agenda Item 29

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Freedom to Speak Up report to date
Presented to:	Board
On:	5th June 24
Item purpose:	Information and review
Presented by:	Freedom to Speak Up Guardian, WWL
Prepared by:	Selina Morgan
Contact details:	Selina.morgan@wwl.nhs.uk

Freedom To Speak Up Bi-annual Report,

March to 20th May 2024

Date: 20th May 2024

Subject: **Freedom to Speak Up**

Author: Selina Morgan - Freedom to Speak Up Guardian

Accountable Executive: Juliette Tait, Chief People Officer

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Board of Directors with an overview of the work of the Wrightington, Wigan and Leigh Teaching Hospital, NHS Foundation Trust (WWL) Freedom to Speak Up (FTSU) Guardian who was appointed by Manchester ICB and commenced in post at WWL on the 1st March 2024. The FTSU Guardian's activity and development is highlighted in this report covering the period from 1st March 2024 to 20th May 2024.

1.2 The FTSU Guardian has worked closely with communications team over the last two months with the ambition to raise awareness, raise the profile of Freedom to Speak up and contributing to the developing Speak Up culture at WWL including:

- FTSU Guardian provided introductory narrative and a photograph for the Intranet WWL Intranet - Freedom to Speak Up Service
- Design of an e-self referral form available on the Intranet and FTSU Guardian's e-mail signature. Freedom to Speak Up Contact Form. The purpose of this is to potentially raise the number of people speaking up, encourage a range of colleagues to use the service and increase ways people may wish to raise concerns, particularly those who want to remain anonymous.
- A FTSU poster is up in and around the hospital and available on request.
- Developed an EoI (Expression of Interest) form for staff wishing to become FTSU Champions available on the intranet page.
- The FTSU Guardian has undertaken staff induction.

2. BACKGROUND/ CONTEXT

2.1 The role of FTSU Guardians and the NGO were established in 2016 following events at Mid Staffordshire NHS Foundation Trust and the subsequent public inquiry by Sir Robert Francis QC. The aim of the review was to provide advice and recommendations to ensure that NHS staff would feel safe to raise concerns, confident that they would be listened to, and concerns acted on.

2.2 FTSU Guardians help protect patient safety and the quality of care, improve the experience of workers, and promote Speaking Up, listening and learning to make improvements. They do this by ensuring that workers are supported in speaking up and that issues raised are used as opportunities for learning and improvement. They work within their organisations with Executive leaders to help ensure that barriers to speaking up are addressed and a positive culture of speaking up is fostered.

3. OUTLINE OF FTSU GUARDIAN RESPONSIBILITIES

- Raise awareness of Freedom to Speak Up
- Thank the person for speaking up.
- Listen to the PSU (Person Speaking Up)
- Keep confidential records about concerns raised on the FTSU case Tracker.
- Support workers to speak up when they feel they are unable to do so by other routes.
- Encourage workers to go to line management in the first instance, however we know this is not always possible.
- Ensure workers are responded to, and make sure the person speaking up receives feedback on actions taken.
- Work proactively to support their organisation to tackle barriers to speaking up.
- It is important to note, no evidence is required for a FTSU Guardian to look into anything raised with them.

4. OUTLINE OF MANAGEMENT/ EXECUTIVE FTSU RESPONSIBILITIES

- WWL currently has 1 WTE FTSU Guardian who works impartially and independently and has been supported throughout the last 10 weeks by the Executive Lead for FTSU, Juliette Tait, Chief People Officer.
- Supported by the Non-Executive Lead who also supports the program.
- Meets regularly with the Chief Executive, Chair and Non-Executive Lead.
- Supported by the Lead Freedom to Speak Up Guardian of Manchester ICB who provides formal Line Management to the FTSU Guardian and regular 1:1s take place.

5. OUTLINE OF FTSU CHAMPION RESPONSIBILITIES

5.1 The FTSU Guardian at WWL developed an EoI (Expression of Interest) application form for all staff wishing to become FTSU Champions and advertised through regular communication routes. The Guardian is now supported by a network of 11 confirmed FTSU Champions.

5.2 The role of FTSU champions is voluntary and appointees carry out this important work alongside their substantive posts. Their role is to:

- Help raise awareness of FTSU by being visible and role modelling the values and behaviours associated with speaking up and listening up,
- Thank, provide signposting and support to individuals who need to raise concerns and to escalate matters accordingly.
- Champions do not manage cases.

5.3 The NGO role recommends a clear distinction between the roles of the Champion and Guardian and that "only FTSU Guardian's, having received National Guardian's Office training and registered on the NGO's public directory, should handle [speaking up] cases"

6. FTSU CHAMPION EXPANSION & DEVELOPMENT

6.1 During the summer of 2024, there will be an ongoing expansion of the FTSU Champion network as the FTSU role cannot be done in isolation. The FTSU Guardian is hoping to appoint a minimum of 20 FTSU Champions.

6.2 Champion Training was delivered on the 15th May 24 by the FTSU Guardian for WWL in partnership with Manchester ICB. Out of the 11 Champions, 8 managed to attend the training session and will receive certificates signed by Mary Fleming, Chief Executive and the Guardian in thanks and recognition of their commitment to support staff. Further Champion applications continue to be received and a second Training session will take place in approximately3 months' time.

7. CASES RAISED VIA FTSU.

7.1 During March 2024 to 20th May 2024, **23** concerns were reported to the FTSU Guardian during this period. There was a steady increase in the number of concerns raised via the FTSU Guardian in March, April saw less contacts and May so far has again seen a steady increase. The chart below shows the number per month to date:

FTSU Contacts 2024					
Month	FTSU SpeakUp Mailbox	FTSU anonymous e-Form	Other	Total per month	Closed
Mar-24	9	0	0	**9**	3
Apr-24	1	2	1	**4**	1
May-24	6	3	1	**10**	1
Total to date	**16**	**5**	**2**	**23**	**5**

7.2 Themes are reported in 'real time' via a drop-down box on the FTSU Guardian's tracker. Themes of concerns which have been raised via FTSU at WWL have included cultures, in particular:

- Leadership and Management
- Attitudes and behaviours/ poor communication - where staff feel uncomfortable to raise concerns with a line manager, concerns that could potentially impact on patient safety.
- Staffing levels,
- isolated concerns of environmental issues.

7.3 All concerns were escalated to the relevant senior leaders in that division. The FTSU Guardian will continue to meet with managers to discuss action plans for improvement.

7.4 It is important to note that there are many routes to speaking up at WWL and FTSU should be viewed as an alternative, particularly when the usual means of raising concerns have been exhausted or feel too challenging for an individual. The FTSU Guardian at WWL has received the following reasons from staff at WWL as being barriers to them raising concerns using the usual routes of escalation:

- Fear of detriment – examples have included worry about the consequences for their employment, fear of being treated differently, fear of bullying behaviours getting worse.
- Concerns were raised previously but there has been no satisfactory response or concerns are ongoing.

7.5 It is essential that managers and leaders respond to concerns with a growth mindset, one where concerns are welcomed and seen as an opportunity for learning and improvement. People who raise concerns should routinely be informed as to how the matter has been handled, while respecting confidentiality as required. The FTSU Guardian holds 'Check in' meetings with the PSU to update on feedback and planned actions received from management.

8 PROGRESS TO DATE

- Meetings held with Executive Directors
- Meetings held with Non-Executive Directors
- Developed FTSU Case tracker
- Developed FTSU Divisional tracker
- Developed Leaders response form

- Designed and disseminated posters across the main hospital and community sites
- Designed a Feedback questionnaire for staff who have used the FTSU route
- Engagement sessions held where Guardian presented to:
    - People Committee 2/04/24
    - Partnership Council 15/04/23
    - FAME Staff Network 16/04/23
    - Senior Division of Medicine, Nursing and AHP meeting 23/04/24
    - Audit Committee 2/05/24
    - Maternity/NNU Leaders meeting14/05/24
- Met with all potential FTSU Champions to explain the role
- Delivered FTSU Champion Training in partnership with Manchester ICB 15/05/24 and created a certificate for FTSU Champions signed by CEO, Mary Fleming
- Agreed with business intelligence colleagues to support the design of a mini FTSU Dashboard to support FTSU data reporting
- Ordered FTSU Champion lanyards to increase the visibility of FTSU.

9 FTSU FEEDBACK

9.1 The FTSU Guardian will request feedback from individuals after a case is closed. Individuals can now complete the questionnaire anonymously. The responses to one question; “Given your experience of speaking up, would you speak up again?” are required to be collected for the NGO.

9.2 As part of the feedback, FTSU Guardian asks responders to rate how satisfied they were with the service from the FTSU Guardian. The rating scale uses numbers from 0 (very unsatisfied) to 10 (very satisfied).

As at today there have been no responses received to the questionnaire, however, this would usually be reported via these Board reports for assurance.

10 FTSU POLICY AND GUIDANCE

10.1 Together with NHS England, the National Guardian’s Office has published its new and updated national Freedom to Speak Up Policy.

10.2 NHS England state that organisations should adopt this policy, WWL already has a FTSU Policy in place and this is in line with the national framework.

11 FTSU eLEARNING

11.1 ‘Speak Up’ eLearning is part of WWL’s Mandatory training. It’s 96.6% so well within target and has been for the past 12 months. We currently have a total of 241 non-compliant staff.

11.2 ‘Listen Up’ and ‘Follow Up’ eLearning is also available via the eLearning portal.These are not currently part of mandatory training but as a voluntary accreditation.

11.3 All 11 Champions have completed the Speak Up and Listen Up modules.

11.4 ‘Listen Up’ eLearning is also recommended to be completed by any person in a line management role. The purpose of this training is to focus on listening to concerns and understanding the barriers to speaking up.

11.5 'Follow Up' is the final eLearning module and completes the full package of training developed by HEE and the National Guardian's Office (NGO) – Speak Up, Listen Up & Follow Up. This final module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to, and action taken.

11.6 The National Guardian's Office expects that senior leaders (including executive and non-executive directors, lay members and governors) will complete all three modules 'Speak Up,' 'Listen Up' and 'Follow Up.'

11.7 The FTSU Gurdian is in communication with the WWL Learning and Development Manager, Jenny Heaton to add the Follow Up module on to the e-learning portal, and will issue a further communication about the ongoing plan to roll out the training

12 NEXT STEPS

- FTSU Guardian to continue to work with Communications Team
- Continue to build on a network of FTSU Champions across the organisation
- The FTSU Guardian will continue to undertake engagement events and programmes alongside the FTSU Champions to raise awareness of FTSU
- FTSU Management/ senior leader development sessions will be offered.
- FTSU Video clip for staff induction slot is under development
- The FTSU Policy will be reviewed and updated to be in line with national policy
- The FTSU Guardian will establish links with HR and Governance to establish processes that can triangulate themes coming from different routes to speaking up
- The Guardian will join the ICB community of practice for Freedom to Speak Up Champions across Greater Manchester to support them in their role, share best practice and pick up on common themes
- Continue with increasing visibility through attendance at Trust locations and other Staff Network meetings. These are scheduled to take place during May and June 2024.
- Continue engagement at both a regional and national level through attendance at networking meetings and appropriate conferences.
- Participate in MIAA Internal Audit in Quarter 4 to audit our processes so far.
- Freedom to Speak Up Month in October will provide another opportunity for the FTSU Guardian at WWL and Champions to raise awareness of how much we value speaking up at WWL. *The theme for Speak Up month is yet to be confirmed.*

13 RECOMMENDATIONS

- Trust Board are asked to note the contents of this report.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Assurance Framework (BAF)
Presented to:	The Board
On:	5 June 2024
Presented by:	Director of Corporate Affairs
Prepared by:	Head of Risk Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

The latest assessment of the trust's sixteen key strategic risks is presented here for approval by the Board.

Link to strategy

The risks identified within this report focus on the achievement of strategic objectives.

Risks associated with this report and proposed mitigations

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

Financial implications

There are four financial performance risks within this report.

Legal implications

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

People implications

There are three people risks within this report.

Wider implications

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

Recommendation(s)

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

1. Introduction

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

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

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

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

2. BAF Review

2.1 The latest assessment of the trust's sixteen key strategic risks is presented here for approval. The BAF is included in this report with detailed drill-down reports into all individual risks.

2.2 **Patients:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the Quality and Safety Committee Meeting on 13 May 2024. One risk has been closed since the last Board meeting in April 2024: Risk 3647 – Preferred Place of Death. The remaining three patient focussed risks have been carried over from the 2023/24 BAF and aligned with the 2024/25 corporate objectives and risk appetite statement.

2.3 **People:** Current risks were reviewed and updated in line with the 2023/24 corporate objectives prior to the People Committee Meeting on 2 April 2024. There are currently three open people focussed strategic risks, which will be reviewed and aligned with the 2024/25 corporate objectives for the next People Committee Meeting on 11 June 2024.

2.4 **Performance:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the F&P Committee meeting on 28 May 2024. Three finance focussed risks have been updated, and one new risk added, since the since the last Board meeting in April 2024: Risk 3998 – Cash Balance. The two performance focussed risks have been carried over from 2023/24 with the risk scores remaining the same. All risks have been updated in line with the 2024/25 annual corporate objectives and risk appetite statement.

2.5 **Partnership:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the Board meeting on 5 June 2024. There are currently four open partnership focussed strategic risks carried over from the 2023/24 BAF and aligned with the 2024/25 corporate objectives and risk appetite statement. The risk score for Risk 3299 –

University Teaching Hospital - University Hospital Association criteria has increased from 6 to 8 since the last Board meeting in April.

3. New Risks Recommended for Inclusion to the BAF

3.1 One new risks has been added to the BAF since the last Board meeting in April 2024.

- *Finance Risk ID 3998 – Cash Balance* was added to the BAF in May 2024.

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

4.1 One risk has been accepted and de-escalated from the BAF since the last Board meeting in April 2024.

- *Patient Risk ID 3647 – Preferred Place of Death* was closed in May 2024 as targets are being continually met and the related corporate objective for 2023/24 has been achieved.

5. Updates to the BAF document for 2024/25

- Current BAF risks have been mapped to the corporate objectives.
- A revised risk appetite statement for 2024/25 was approved by the Board in February 2024 and integrated into the BAF document.
- The risk scoring matrix 2023/24 was revised to include probability descriptors for time limited risks, such as the corporate annual objectives.
- Golden thread links have been extended to include system risks on the Wigan locality BAF, see appendix 1 for a summary of the identified locality system risks.
- An objective tracking indicator has been added to identify if the objective is 'on track' or 'off track' to be achieved by the target date.
- Three alarm bell assurance has been added to drive the process element of the BAF, as outlined in the GGI System Risk Case Study 2023.

6. Review Date

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

7. Recommendations

7.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

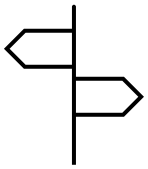
2024/25

The content of this report was last reviewed as follows:

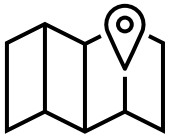
Board of Directors	April 2024
Quality and Safety Committee:	May 2024
Finance and Performance Committee:	May 2024
People Committee:	April 2024
Executive Team:	June 2024

> **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

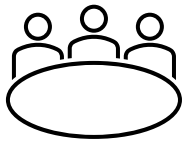


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

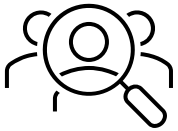


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

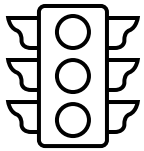
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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

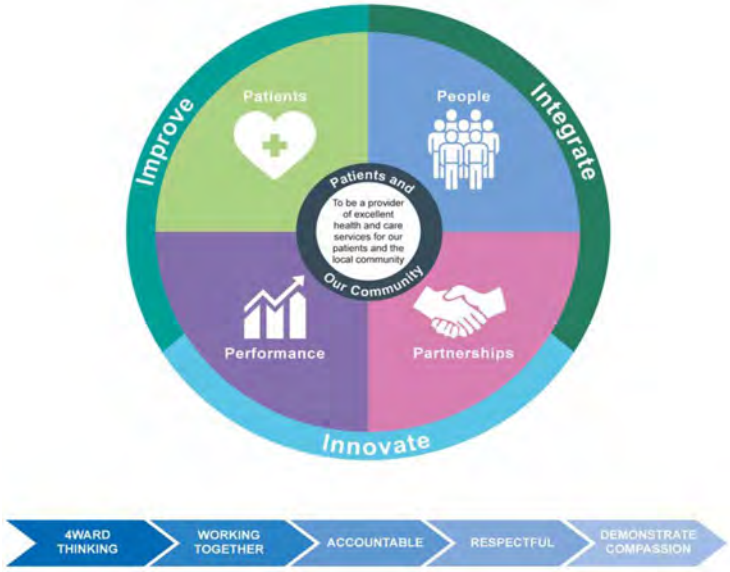
DIRECTOR LEADS

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



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…

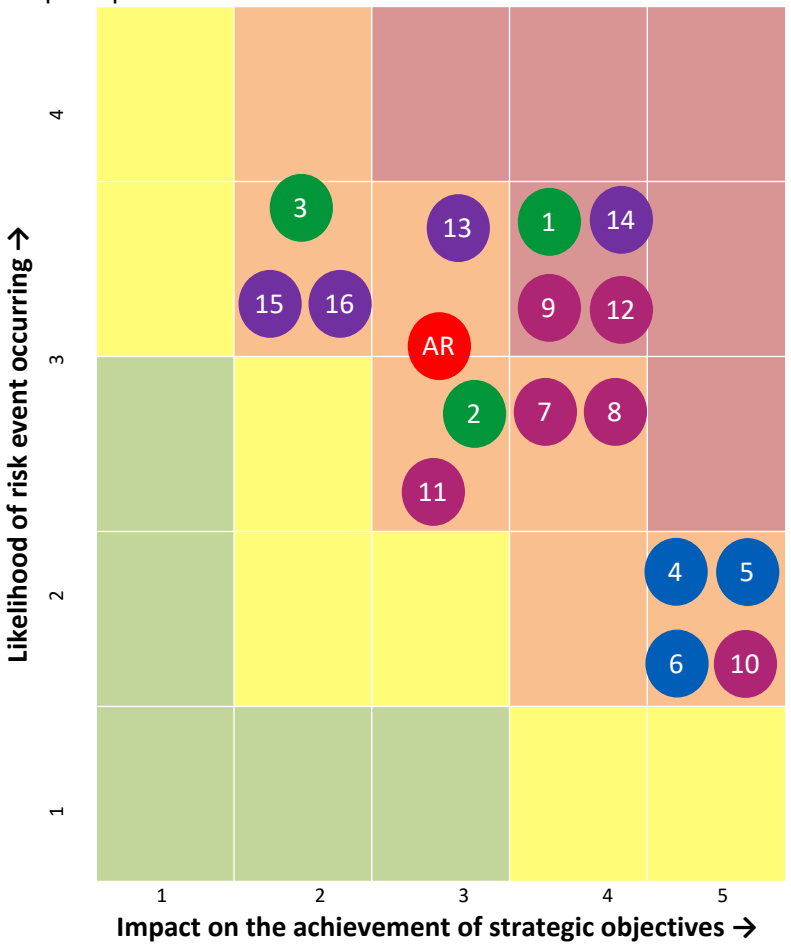
- improve the health and wellbeing of the population we serve
- develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable
- make progress towards becoming a Net Zero healthcare provider
- increase our research activities delivering 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

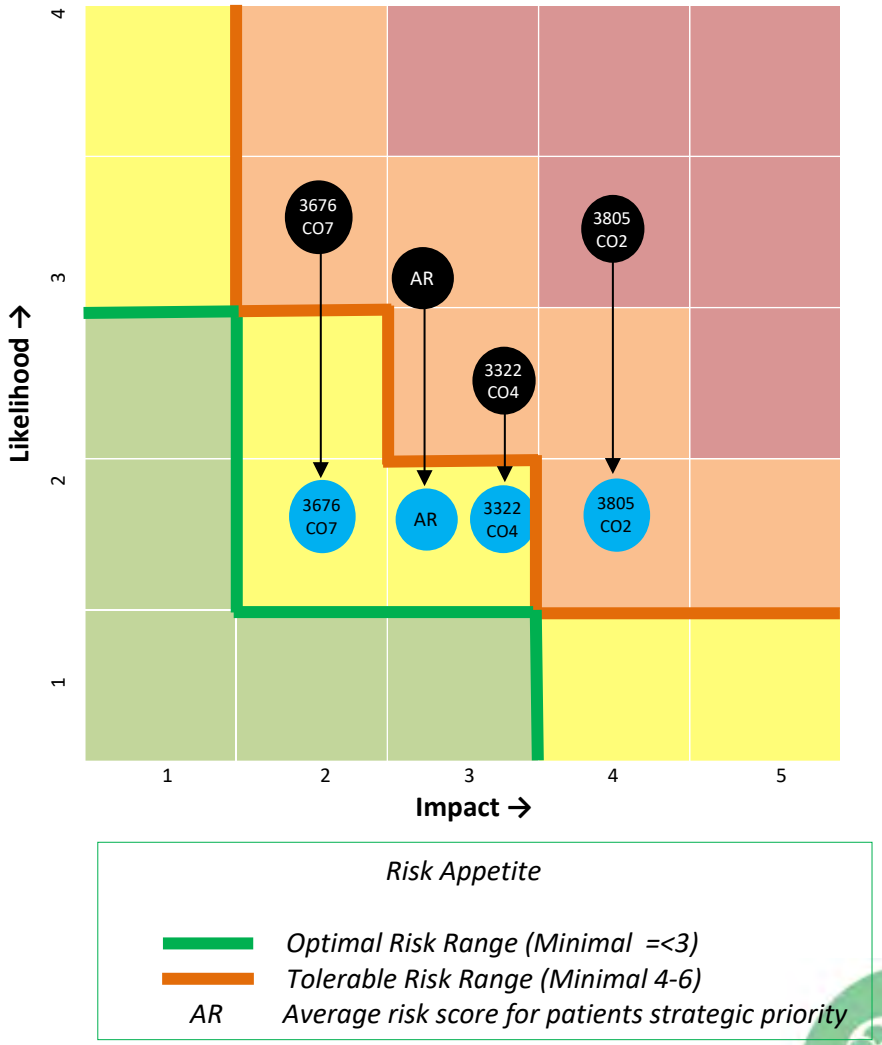
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

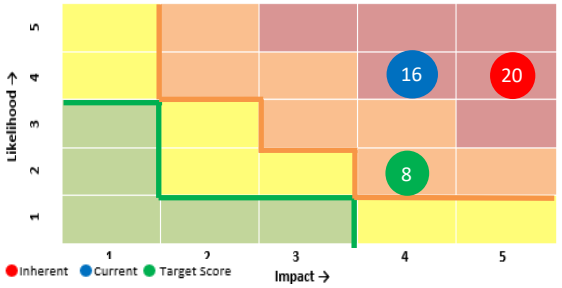
The following corporate objectives are aligned to the **patients** strategic priority:

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.	Awaiting year end data
CO3	To improve diabetes care for our paediatric population (up to age 19)	To improve the care of paediatric patients with type 1 diabetes up to age 19 focussing on 5 care processes.	No risk currently identified
CO4	To improve the delivery of harm-free care	Continue improvements Pressure Ulcer Reduction. System Wide improvement for reducing pressure ulcers.	Off Track for zero pressure ulcers
CO5	To promote a strong safety culture within the organisation	Continue to strengthen a patient safety culture through embedding Human Factor awareness. Continue to increase staff psychological safety.	On Track
CO6	To improve the quality of care for our patients	Continue and build upon the accreditation programme	On Track
CO7	Listening to our patients to improve their experience	Deliver timely and high quality responses to concerns raised by patients, friends and families.	Off Track

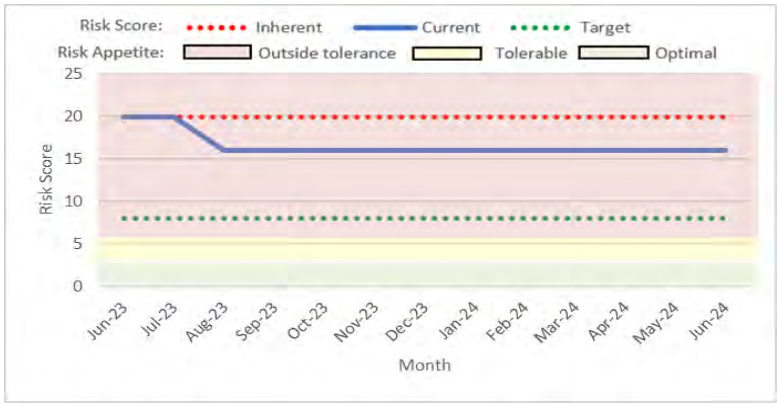
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



Corporate Objective: CO2 To improve the safety and quality of clinical services						**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**	LSR1: quality and safety of patient care
Date of last review	**8.05.24**		**Risk treatment**	Treat

Risk Score Timeline

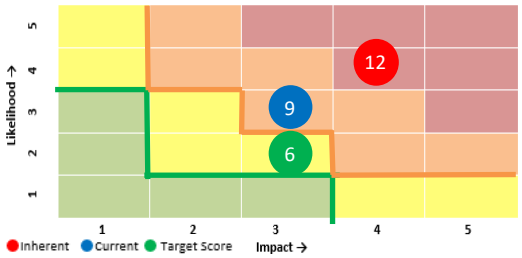


Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date By Whom
Threat: **(ID 3805)**	• Sepsis Nurse = High Visibility, Ward walk rounds. Recommenced by current Sepsis Lead Nurse. • Link Nursing in all wards and department have 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 • Appropriate Care Score objective may not be achieved due to the lack of data available from 2022/23. • Blood culture training is only currently available to ED staff. • HIS sepsis flags are currently over sensitive and do not differentiate between sepsis and a differential diagnosis. • Adult SOP being review by the community teams with new NICE guidance (issued Jan 24). • New Sepsis e-learning module under construction.	**2nd Line:** • Quality & Safety Committee Jan 2024 • Board Feb 2024 • ECC Red Flag Sepsis Audit recommenced – Jun 2023 • AQ Audit recommenced – Mar 2023	**2nd Line:** • Data for March 2024 will be available in April/May, therefore the end of year BAF from the Sepsis point of view may be later than the next Board meeting on 3rd April.	1. Sepsis E-Learning review to incorporate the new NICE Guidance and new policy information 2. Community SOP for Adults	July 2024 Sepsis Lead July 2024 Sepsis Lead

Corporate Objective: CO4 To improve the delivery of harm-free care

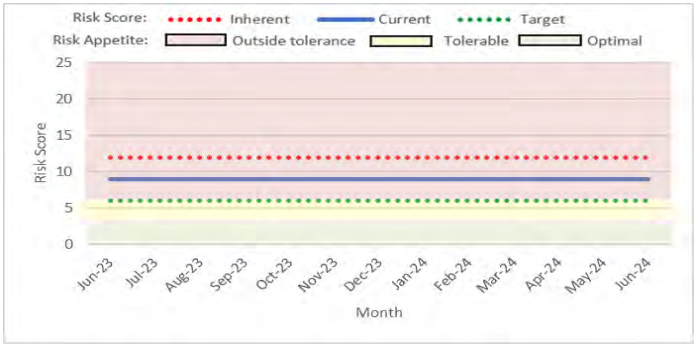
1 | 2 | 3 — **Overall Assurance level: Medium**

Principal risk	**Risk Title:**	**PR 2: Harm Free Care - Avoidable Pressure ulcers**
	Risk Statement	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.
Lead Committee	**Quality and Safety**	
Lead Director	**CN**	
Date risk opened	**19.10.21**	
Date of last review	**8.05.24**	



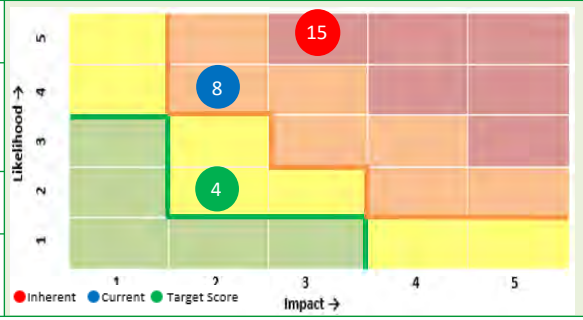
Risk Appetite	Minimal
Risk category	Safety, quality of services & patient experience.
Datix ID / Links	Threat (ID 3322) – LSR1: quality and safety of patient care
Risk treatment	Treat

Risk Score Timeline

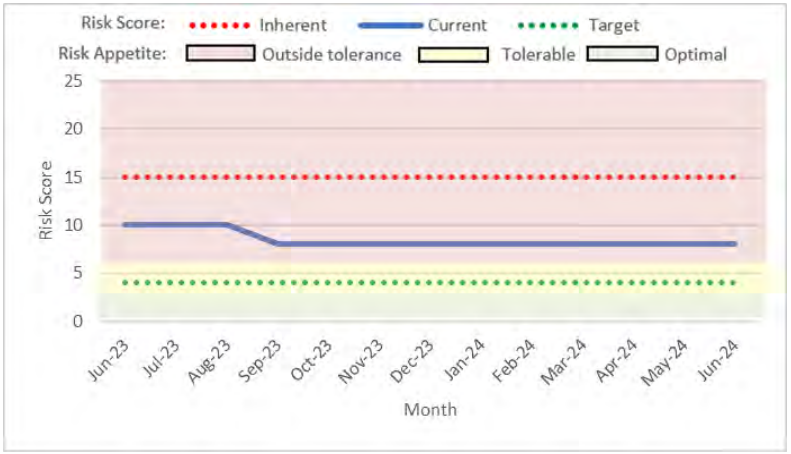


Existing controls	Gaps in existing controls	Assurances	Gaps	Risk Treatment	Due Date
• Pressure ulcer link nurses trained within all areas and extended to community care homes. • Human factors training to continue to be embedded within the organisation building on success of 2022/23. • Category 2/DTI Pressure Ulcer Review Panels (PURP) in place and aligned to PSIRF framework. • Category 3/4 & Unstageable Pressure ulcer panels Review Panels (PURP) in place. • Pressure ulcer policy and SOPs embedded. • PU prevention training in place and monitored via the Learning Hub. • Quarterly reports submitted to HFC group, Patient Safety group, NMAHP body and Q&S committee to provide assurance. • Data captured re incidence of moisture associated skin damage (MASD) • 2022/23 MIAA PU audit report evidenced substantial assurance and all actions required where completed by Q4. • ED improvement plan updated for 24/25 and monitored by PU steering group. • Use of AAR to create opportunities for learning across divisions. • First contact data now captured. • All ward leaders and matrons trained in PU verification. • Tissue viability team at full establishment and the team working differently. Corporate risk 3323 closed. • Differential diagnosis training in Q4 has resulted in a marked reduction in PU being stepped down at PURP.	• Staff being able to be released to undergo training. • Junior workforce. • Increased scrutiny in use of bank and agency staff. • Escalated areas continue beyond winter 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. • REPOSE overlay provision for the escalated areas in ED. • Beds owned by individual Divisions, whilst awaiting total bed management implementation. • Inconsistency in agreed staff ratios 1:8 in times of escalation reduced. • Delay in MASD pathway being update in line with GM MMG, awaiting confirmation and printing of final version. • Redeployment of staff into escalation areas without a robust induction • HIS freeze stalling required changes in care planning and terminology in relation to PU prevention and care.	**2nd Line:** • Quality & Safety Committee • May 2024 • Board April 2024	No gaps currently identified	• Continue the roll out of human factor training. • Total bed management project progressing. • Steering group to monitor through audit programme implementation of PURP action plans. • Commence the changes required in the category 3, 4 and unstageable panels to align to the Patient Safety Incident Response Framework (PSIRF framework). • Review the aSSKINg tool since its implementation across the Trust for improvements in reporting and releasing time to care. • Further progress with Business Intelligence; a dashboard to illustrate PU data at a glance. • TV service to explore further, the relationship between end-of-life skin changes (SCALE) and PU development in the community. • Incorporate omissions in complex wound care into the PURP process, to allow a forum for review and identifying learning and such learning will be monitored through the pressure ulcer prevention steering group. • 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. • Unstageable category to be 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. • Work with the local authority to launch the system wide pressure ulcer prevention policy. • 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.	PU steering group June 2024

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**	LSR1: quality and safety of patient care	
Date of last review	**8.05.24**		**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.	• There are currently no backlogs. • Requirement to source venues to run further training courses. • Despite training and good feedback from the session, staff are not coming back to us so that we can critic their work • Although there has been the introduction of the boxes, the Patient Relations and PALS team, have recommenced recording concerns when the patient relative have stipulated a record - patients/relatives are directed to Legal when all other resolutions have been explored (following the path of the patient and ringing round).	**2nd Line:** • Quality & Safety Committee May 2024 • Board April 2024 • Task and finish group set up so that divisions use functionalities within Datix.	• No gaps currently identified.	1. Further training for staff to be arranged.	July 2024 CN

People

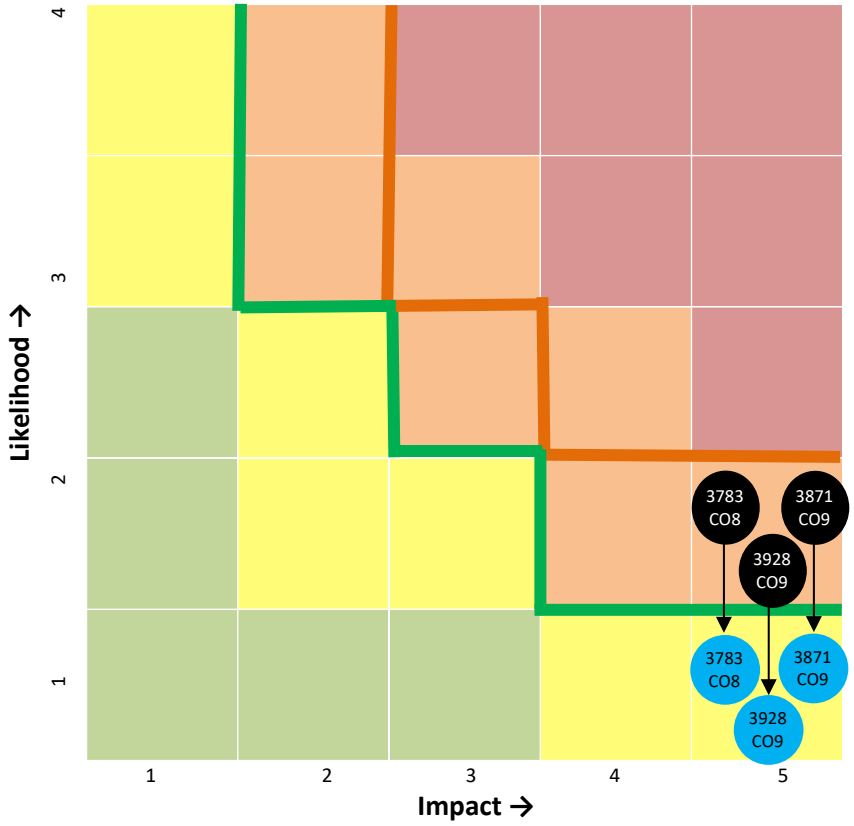
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

The following 2023/24 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.	As part of Our Family, Our Future, Our Focus cultural development we will: ✓ Continue to prioritise our staff voice. ✓ Co design our just and learning culture. ✓ Improve the quality of meaningful conversations with our people. ✓ Create an inclusive, person centred experience. ✓ Showcase how we are acting on concerns raised by staff and patients.	On Track
CO10	To develop system leadership capability whilst striving for true placed collaboration for the benefit of our people.	The WWL leadership community will baseline where we are now, map where we wish to be, and bridge the gap to focus our collective effort: We will regularly participate in leadership development events so that we: ✓ Continue to develop inclusive and compassionate leadership capability. ✓ Achieve higher levels of mutual trust and respect. ✓ Reduce demand by empowering our colleagues to improve the discharge & patient flow for our residents.	On Track

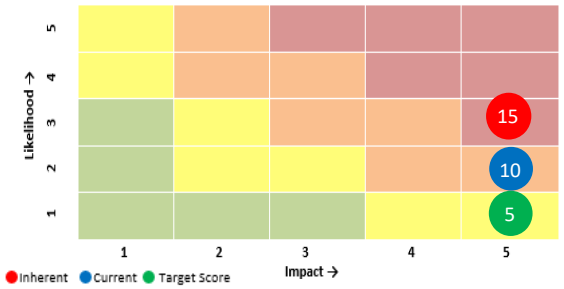
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for the people strategic risk:



Risk Appetite

Optimal Risk Range (Cautious = <6)
Tolerable Risk Range (Cautious = 8-10)

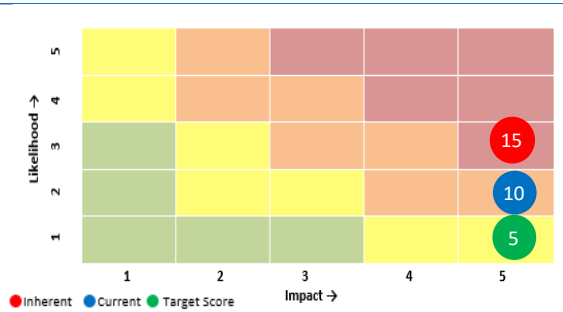
Corporate Objective: CO8 To enable better access to the right people, in the right place, in the right number, at the right time	1	2	3	**Overall Assurance Level**	**Medium**

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	**02.04.24**		**Risk treatment**	Treat

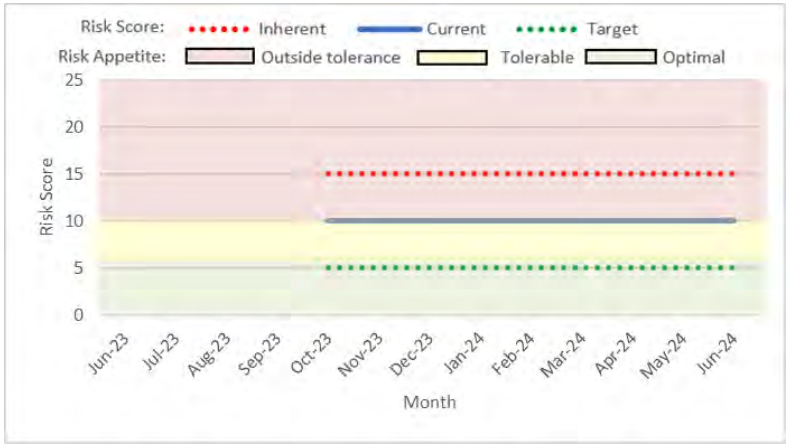
Risk Score Timeline

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** Linked risks to corporate risk register: **ID 3572** Industrial action **ID 3229** Staff absence wellbeing **ID 3227** Maintaining safe staffing levels	• Workforce planning 2023/24 • Empactis relaunch • Civility Programme (just & learning culture) • People Dashboard refresh • Newton Europe Commission (pending) • National Staff Survey (October 2023 go live) • Launched start of year events – new appraisal season and route plan appraisal approach. • 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:** • The sustainable workforce programme aims to implement robust trust wide workforce planning methodology and plans. • Empactis relaunch reports to Transformation Board monthly under sustainable workforce workstream • Civility Programme reports to Our Family, Our Future, Our Focus under the culture and leadership workstream. • Newton Europe Commission updates via ETM • Our Family, Our Future, Our Focus oversees National Staff Survey. • First start of year event 28th June. Assurance reporting regarding compliance and quality improvements will be to People Committee.	• Turnover reporting identifies that circa 25% of leavers, leave within the first 12 months of employment.	1. 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.	1. August 2024– D/CPO & AD for SE & W 2. June 2024 - CPO

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

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 5 : Staff Engagement**		
	Risk Statement:	There is a risk that we may not deliver the cultural development agenda objective, due to a lack of sufficient workforce awareness about EDI and we do not have substantive Workforce EDI resource, which may result in failure to deliver our strategy and statutory duties under the Equality Act.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.
Date risk opened	**02.11.23**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**02.04.24**		**Risk treatment**	Treat

Risk Score Timeline



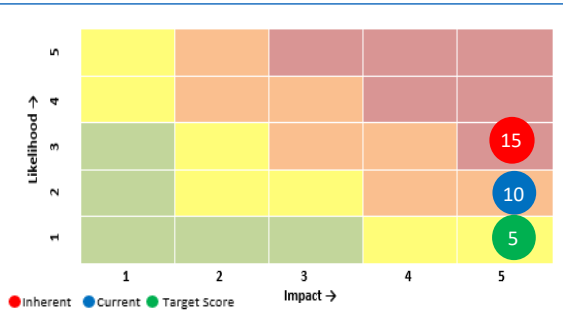
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3871**	• Actions contained within the 3 pillars of OFOFOF – Wellbeing; Culture & Leadership and associated governance framework • National Staff Survey • New Appraisal Framework "My Route Planner" • Understanding of data in WRES, WDES and Gender Pay Gap Report • NHSE EDI High Impact Improvement Targets • Board Development Workshop focussing on EDI 14.3.24 Workshop took place January 2024.	• EDI resource temporarily funded until November 2024. • People Strategy, which will align and coordinate activity under development.	• OFOFOF meetings established and continue to drive forward positive activity. • Culture & Engagement Programme launched. • Turnover of staff, and staff engagement actively monitored at Divisional Assurance and RAPID meetings. • Recruitment and retention standing agenda item for People Committee to enable high level monitoring and assurance. • WWL achieved highest Staff Engagement score in 2022 National Staff Survey, and highest response rate in Greater Manchester. • Staff network established. • EDI Steering Group first meeting scheduled for 22.4.24	• Data linked to protected characteristics signifies lower staff experience for black, Asian and minority ethnic staff and Disabled staff. • Further information required to support organisation review NHSE EDI Objectives.	1. Develop business case for substantive EDI funding 2. Develop WRES Action Plan with engagement of FAME Network 3. Develop WDES Action Plan with engagement of Disability Staff Network. 4. Implementation of EDI High Impact Objectives.	1. August 2024 (AD SE & W) 2. August 2024 (EDI Lead) 3. August 2024 (EDI Lead) 4. August 2024 (CPO, EDI Lead)

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

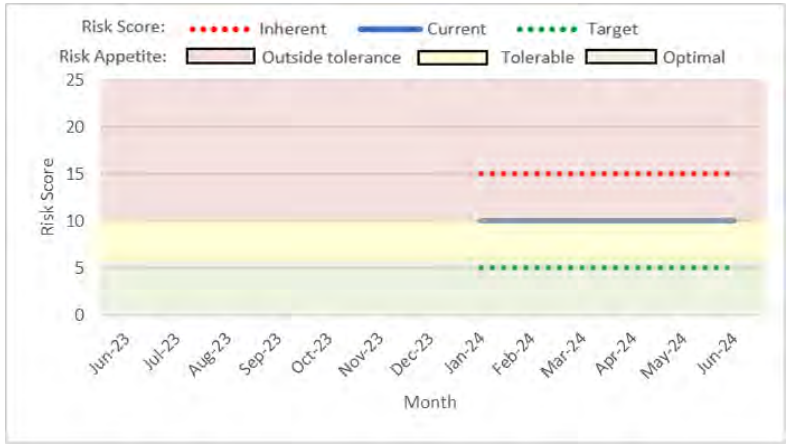
1 | 2 | 3

Overall Assurance Level **Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 6 : Internationally Educated Nurses**
	Risk Statement:	There is a risk that we will not retain this valued workforce. Feedback received highlights that colleagues who have been educated internationally have a negative work experience. The Trust has taken significant steps to fill ongoing qualified nursing gaps through the recruitment of over 450 internationally educated nurses.

Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.
Date risk opened	**31.01.24**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**02.04.24**		**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 3928**	• Pastoral Support post within the Nursing Professional Practice Team. • Mechanisms in place to enable feedback.	• No qualified IEN support available and pastoral support currently funded until March 2025. • Lack of recruitment strategy to fully embed IEN within existing nursing vacancies.	• Feedback shared with Board colleagues ensuring full understanding of experience of IEN. • Interim Chief Nurse recently recruited has experience of successfully supporting the IEN workforce. • Enhanced EDI Support being arranged for Ward Leaders, Matrons and other senior nursing colleagues. • New IEN Improvement Group to be established.	• Actions are very early in implementation and it is difficult to measure and see success at this stage.	1. Request funding to support Senior IEN to work within Professional Practice Team. 2. Establish Chief Nurse led IEN Improvement Group, reporting into newly established EDI Steering Group. 3. Increase visibility of senior leaders to IEN workforce. 4. Establish full action plan with improvement actions required.	1. June 2024 (CPO/CFO) 2. June 2024 (CN) 3. June 2024 (CN) 4. June 2024 (CN/CPO)

Performance

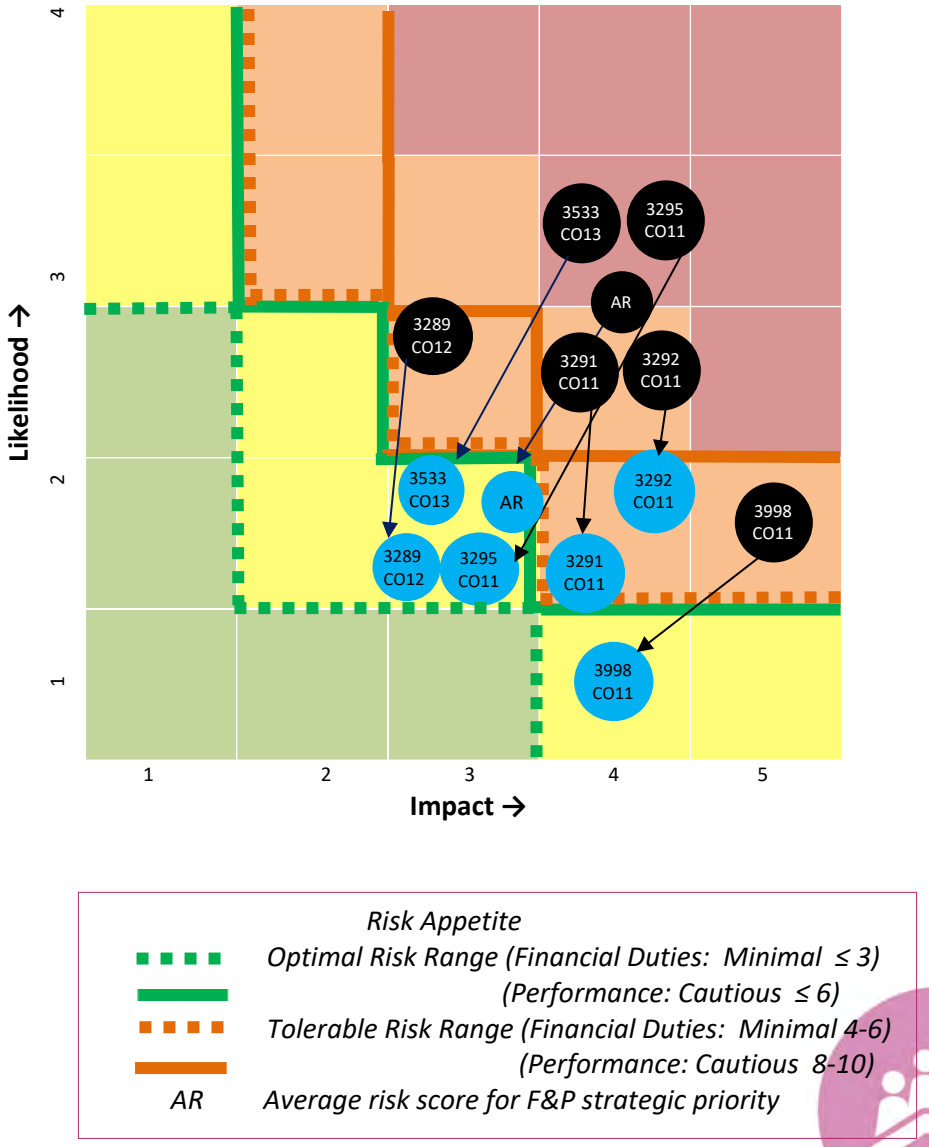
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

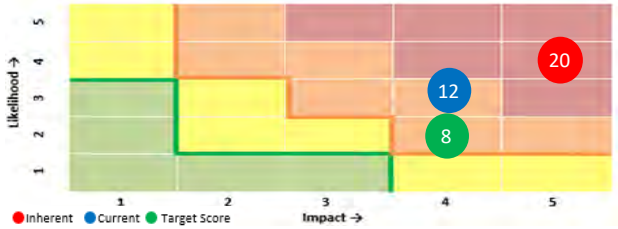
The following objectives are aligned to the **performance** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	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

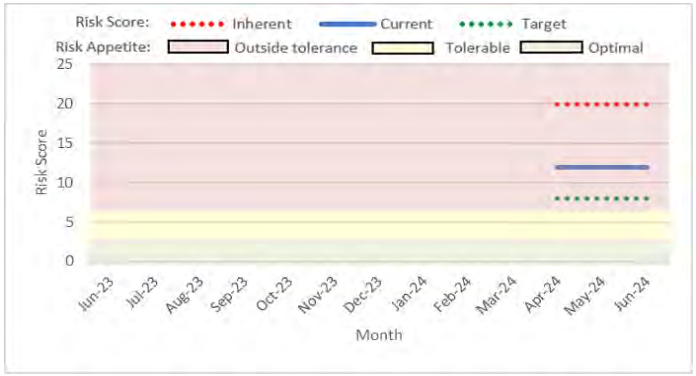
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



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

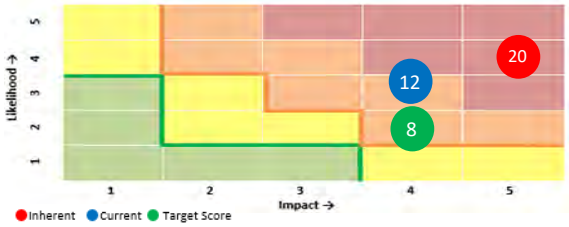
Principal risk	**Risk Title:**	**PR 7: Financial Performance: Failure to meet the agreed I&E position**		
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties. This includes ERF, CIP (see PR2), further impact of industrial 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	**28.05.24**		**Risk treatment**	Treat

Risk Score Timeline

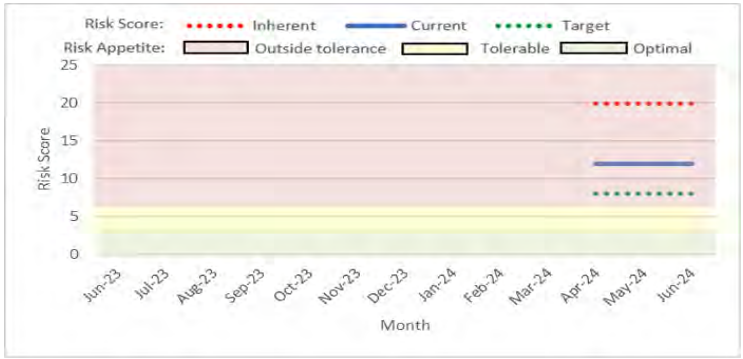


Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
• Final plan signed off by Board and submitted to NHSE – 2nd May 24. • Draft and final plans scrutinised through monthly FPRM meetings with GM ICB, NHSE and PWC. • PWC led planning oversight process on behalf of GM ICB during Q4 2023/24 with significant scrutiny on assumptions (Ext) • Final plan is reflective of year 1 of the approved WWL Financial Sustainability Plan (FSP). • FSP was developed during 2023/24 and had F&P and Board Approval. • All divisions accepted budgets in April 24. • CIP target agreed with programme for delivery and actions. • Robust forecasting including scenario planning for worst, most likely and best case will continue from quarter 2. • Executive oversight and challenge of CIP & Financial performance through Divisional Assurance Meetings, Financial Improvement Group, Transformation Board. • Establishment control groups established for non medical and medical staffing with scrutiny and rigour over agency spend in line with national agency controls. • Stringent business case criteria to ensure only business critical investments are approved. • Full review of financial position by locality partners. • GM standardised financial controls implemented in 2023/24 remain in place across WWL. • ERF baseline of 103.6% is in line with NHSE guidance – based on 2023/24 baseline before adjustments for industrial action. • Activity plans based on theoretical maximum capacity have been approved by divisions and submitted to NHSE on 2nd May 24. • ERF plan submitted in excess of baseline to include activity associated with NHSE approved developments • Revenue plan includes income in line with GM ICB contract offer excluding the growth on ERF for developments noted above • Improvement Director with operational portfolio continues to work with the Trust • Finance Improvement Group meeting monthly, chaired by Chief Executive • Monthly Provider Oversight Meetings established from May 24 (Ext) • GM Controls in place for new expenditure above £100k not within plan (STAR process) (Ext) • All headcount increases are required to be taken through an Exec led QIA process	• NHSE have not confirmed acceptance of the final GM ICS revenue plan (control total discussions ongoing) • GM system single recovery plan not yet fully developed (Ext) • FSP to be refreshed quarterly throughout 23024.25 to ensure the 3 year trajectory for recovery is achievable • Pay awards not yet confirmed (other than consultants) and could lead to industrial action with no confirmed financial arrangements agreed (Ext) • No medium to long term resource confirmation or financial planning (Ext)	**1st Line:** Monthly Divisional Assurance meetings for all clinical divisions and Finance Improvement Group (FIG) **2nd Line:** Finance & Performance Committee May 24. **External:** Monthly Provider Oversight Meeting with GM ICB (Ext) May 24	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Ongoing review of existing grip and control measures 2. Organisational wide communication of the financial position, challenges and controls 2. GM System infrastructure established to support delivery of I&E position (Ext).	Q2 / CFO Throughout 2024/25/ CFO Q2 24/ CFO

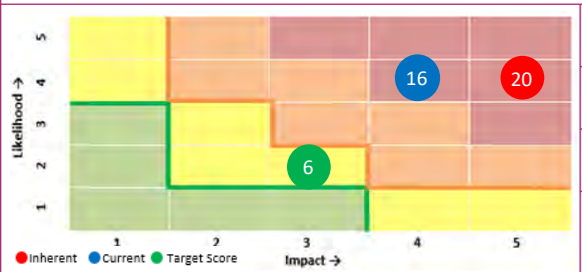
Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

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	**28.05.24**		**Risk treatment**	Treat

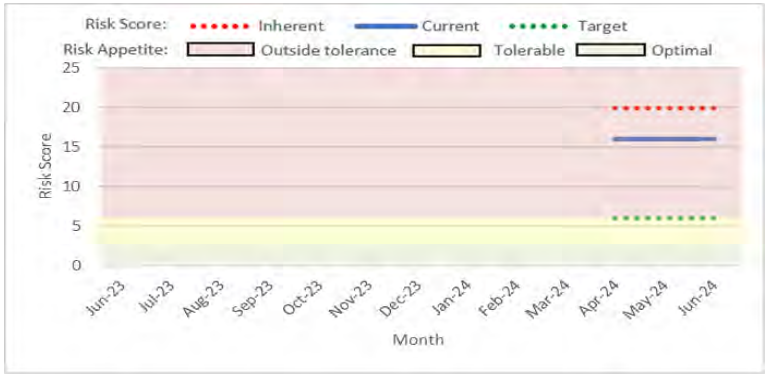
Risk Score Timeline



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	• Limited mechanisms to facilitate delivery of system wide savings.	**1st Line:** Monthly Divisional Assurance meetings for applicable divisions and monthly finance improvement group (FIG) **2nd Line:** Finance & Performance Committee May 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

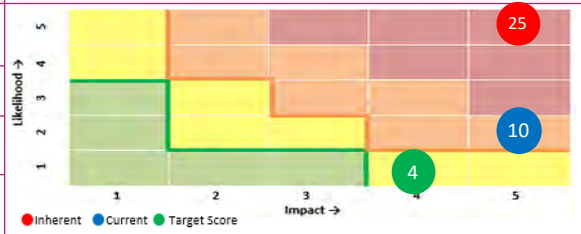
Corporate Objective: C11 Deliver our financial plan, providing value for money services					1	2	3	**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 9: Capital Funding**							
	Risk Statement:	There is a risk that there is 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**			**Linked system risks**	LSR6 Financial plans				
Date of last review	**28.05.24**			**Risk treatment**	Treat				

Risk Score Timeline

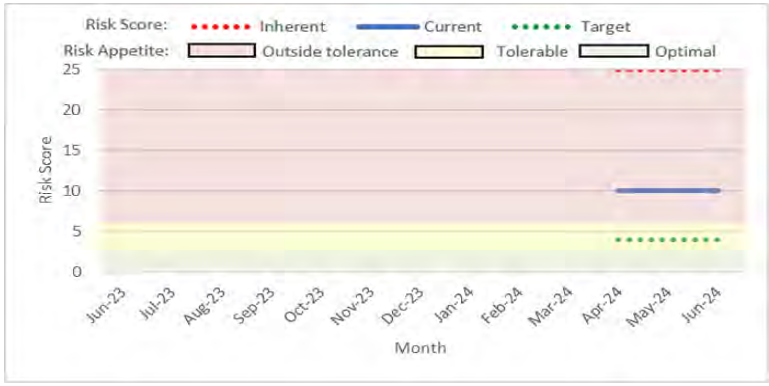


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3295)**	• Lobbying via Greater Manchester for additional capital into the national process. (Ext). • Capital priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified within plan. • 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.	• Impact of inflation in terms of project costs and timescales. WWL capital plan currently £0.7m overcommitted against CDEL envelope. GM CDEL plan currently overcommitted by £42.5m (Pennine transaction £42.5m; 5% planning over commitment £7.4m) – discussions ongoing with NHSE (Ext) Potential reallocation of CDEL between providers for 2024/25 following GM prioritisation. GM lease plan (IFRS16) overcommitted against envelope. Further work required on five year forward view to refine plan. System capital allocations from 2025/26 onwards not confirmed.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - May 2024 **External:** GM Capital and Cash Group	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring of Capital spend in line with trajectory. 2. Development of capital reporting through the refreshed DFM App. 3. Discussions ongoing between GM ICB and NHSE national team to confirm whether additional CDEL will be made available to cover GM overcommitment (Ext)	Throughout 2024/25 CFO Q1 2024/25 CFO Q1 2024/25 GM ICB (Ext)

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

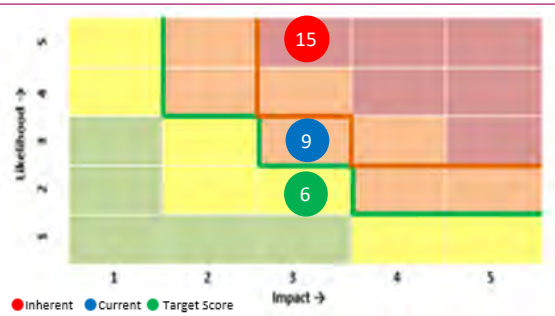
Principal risk	**Risk Title:**	**PR 10: Cash Balance**		
	Risk Statement:	There is a risk a that the Trust may have insufficient cash balance to meet normal business activities on a day-to-day basis, due to cash balances potentially becoming too low, resulting in the need to request additional support, financial obligations not being met, or the capital programme being restricted.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal
Lead Director	**CFO**		**Risk category**	Financial Duties
Date opened	**20.05.24**		**Threat: System Risk:**	**ID 3998** LSR6 Financial plans
Date of last review	**28.05.24**		**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 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) • See PR 2 for additional controls to ensure that CIP delivery is cash releasing.	• Awaiting clarification on whether the GM deficit plan will be cash backed if revised control total agreed.	**1st Line:** Cash management Group **2nd Line:** Finance & Performance Committee May 2024 **External:** GM Capital and Cash Group	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring and forecasting of the cash balance 2. Application to NHSE in advance of each quarter if cash support may be required	Throughout 2024/25 CFO Throughout 2024/25 CFO

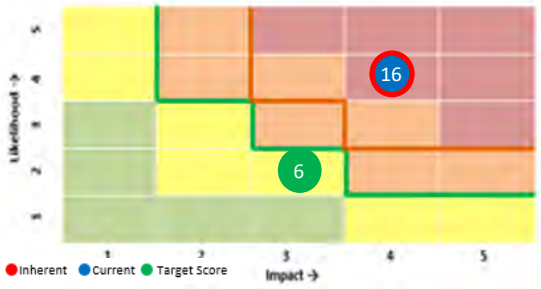
Corporate Objective: **CO12** To minimise harm to patients through delivery of our elective recovery plan	1	2	3	**Overall Assurance level**	**Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 11: Elective services**		
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting in a reduction in demand and insufficient diagnostic capacity to deliver elective waiting times, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious
Lead Director	**COO**		**Risk category**	Performance Targets
Date risk opened	**19.10.21**		**Linked system risks**	LSR8: Statutory duties including the NHS Constitutional targets
Date of last review	**28.05.24**		**Risk treatment**	Treat

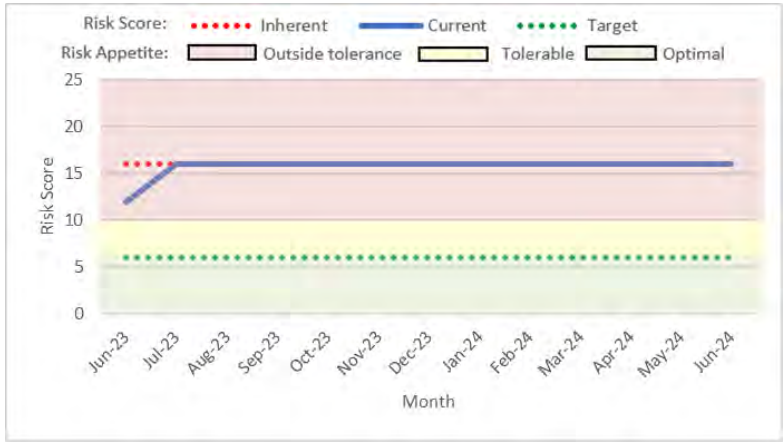
Risk Score Timeline

Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: (ID 3289) Linked risks on corporate risk register: **3572** Industrial action **3718** Elective Recovery	• On track to eliminate waits over 65 weeks, except for Gynaecology patients. Exploring options for mutual aid. • Bi weekly meetings with ICB. • Continue to exceed the trajectory for the cancer faster diagnosis standard. • Implementation of Community Diagnostic Centres which will provide more capacity without waiting list initiatives. • Monitor through divisional assurance meetings with clear escalation protocols to exec team meetings and F&P Committee - developed into an app. • Transformation Plan - elective productivity and capacity aims to increase diagnostics and support delivery of electives and develop elective capacity. • Providing mutual support from GM and region for high volume low complexity plus orthopaedic work. • Digital validation of waiting lists.	• No new dates for Industrial action announced, but no resolution provided. • Demand for patients on cancer pathways exceeds capacity and impacts on delivery of non-cancer elective work. • Diagnostic capacity insufficient to deliver elective waiting times in some modalities. • Follow up waiting list is increasing. • Increase productivity to meet organisational targets • Impact of Estates issues on elective activity.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – May 2024 • Elective activity and efficiency board chaired by CFO.	•No gaps in assurance currently identified.	1. Revised endocrine clinic templates agreed. 2. Exploring mutual aid and insourcing options for Gynaecology. 3. GM pilot of external referral management.	June 2024 June 2024 June 2024

Corporate Objective: CO13 Improve the responsiveness of urgent and emergency care	1	2	3	**Overall Assurance level**	**Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 12: Urgent and Emergency Care**			
	Risk Statement:	There is a risk to urgent and emergency care delivery as we are consistently operating above 92% occupancy levels, due to insufficient capacity and bed base in comparison to Acute Trust's across Gm and nationally, resulting in longer waits, delayed ambulance handovers, reduced patient flow and more scrutiny through NHS England.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious	
Lead Director	**COO**		**Risk category**	Performance / Hospital Demand, Capacity and Flow	
Date risk opened	**05.09.22**		**Linked system risks**	LSR8: Statutory duties including the NHS Constitutional targets	
Date of last review	**28.05.24**		**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 • WWL's Multi agency Discharge Event (MADE) took place 11th to 17th March. • Flagged to the system that WWL bed base per population is considerably lower than the rest of GM. • Delay in ambulance handovers within 60 minutes has increased due insufficient capacity. • No right to reside recording has been reviewed in line with national guidance which will result in a reduction in number reported. • Hospital Discharge and Flow Programme led by COO. • The urgent and emergency care transformation board supports system wide change. • Full capacity protocol. • Working on an action plan in anticipation of CQC report.	• Insufficient capacity with over 100% occupancy rate. • Corridor care in spells rather than consistent, but is still occurring. • Work required further upstream regarding higher acuity of patients in borough. • IMC bed capacity reduced in Nov 2023 and is continuing to impact on pathway 2 discharges.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – May 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

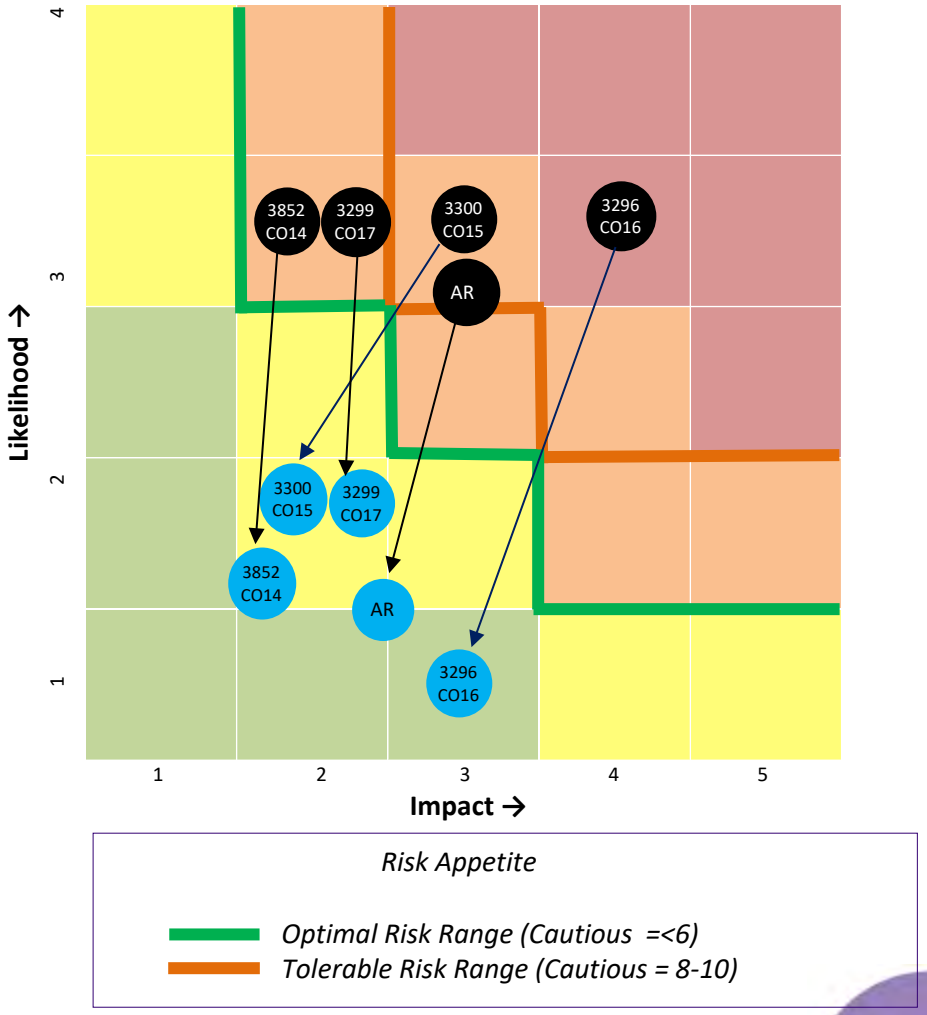
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

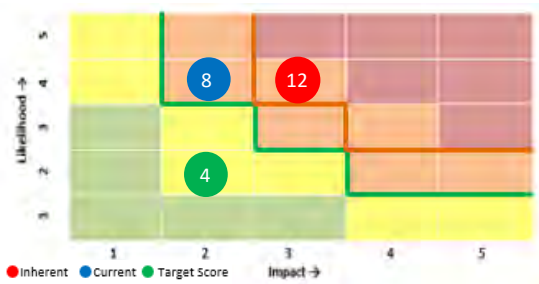
The following objectives are aligned to the **partnerships** strategic priority:

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

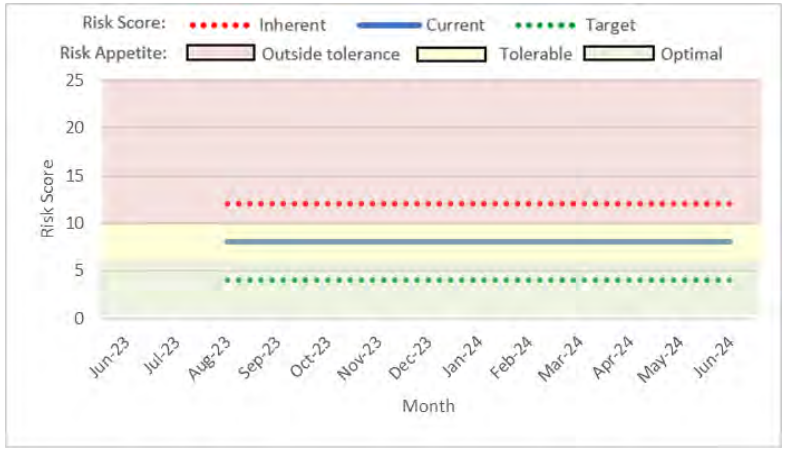
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



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

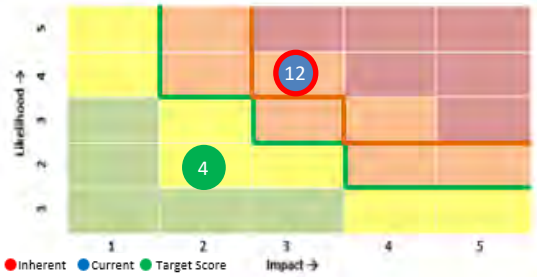
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 13: Supporting widening access to employment for local residents**			
	Risk Statement:	There is a risk that access to funding for support initiatives which support widening access to employment for local residents 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**	LSR6 Financial plans	
Date of last review	**03.04.24**		**Risk treatment**	Treat	

Risk Score Timeline

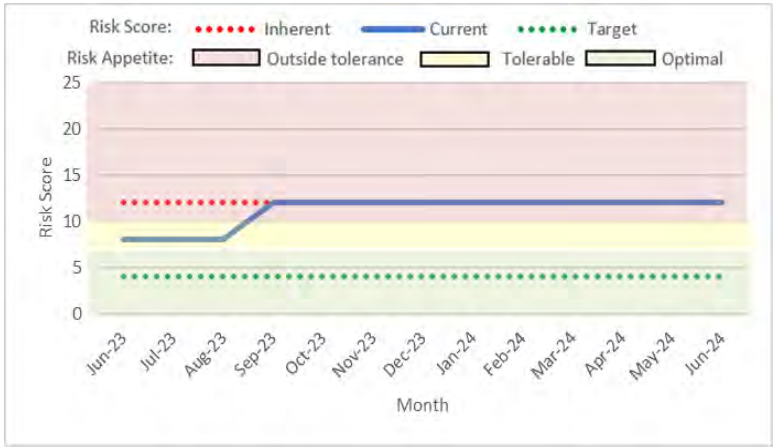


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3852**	• Progress reviewed through Anchor Institution Steering Group.	•Recurrent funding to support ongoing development and delivery of widening access to employment schemes.	**2nd Line:** • Bimonthly Anchor Institution Steering Group • Biannual report to Trust Board	•None currently identified	1. Wigan and Leigh College have agreed to support a non-recurrent role to support our Talent4Care programme. 2. Review current and potential widening access to employment schemes through the Anchor Institution Steering Group 3. Consider development of approach to business cases which take into account quantifiable social benefits.	March 2025 - DSP

Corporate Objective: **CO15** To develop effective partnerships within the new statutory environment	1	2	3	**Overall Assurance level**	**Medium**

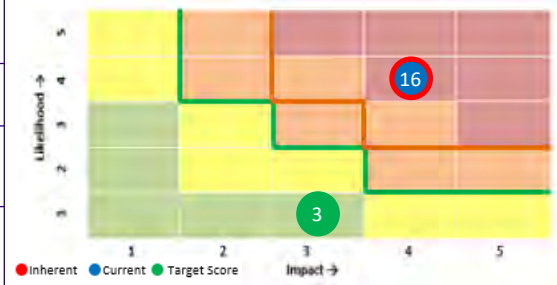
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 14: Partnership working - CCG changes**			
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.			
Lead Committee	**Board of Directors**		**Risk Appetite**	Cautious	
Lead Director	**DSP**		**Risk category**	Strategy	
Date risk opened	**19.10.21**		**Linked risks**	LSR7 - system leadership	
Date of last review	**03.04.24**		**Risk treatment**	Treat	

Risk Score Timeline

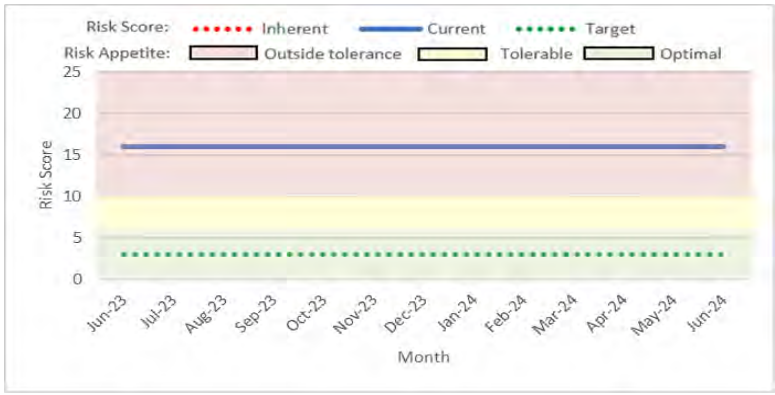


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3300**	• Locality meeting structures in place to support lasting corporate knowledge.	Despite bringing people from the ICB and other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

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

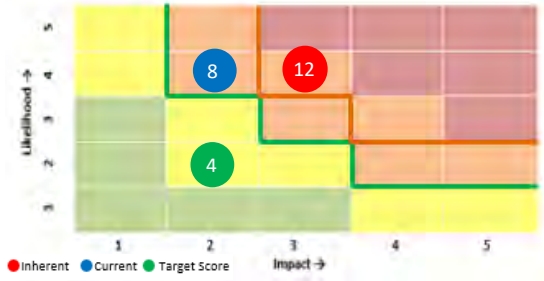
Principal risk	**Risk Title:**	**PR 15: Estate Strategy - net carbon zero requirements**		
	Risk Statement:	There is a risk that the Trust will not meet its net zero commitments and Climate Change will have an impact on the Trust delivering services, that cannot be mitigated.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious
Lead Director	**DSP**		**Risk category**	Sustainability /Net Zero
Date risk opened	**19.10.21**		**Linked system risks**	LSR9 – Drive innovation
Date of last review	**21.05.24**		**Risk treatment**	Treat

Risk Score Timeline

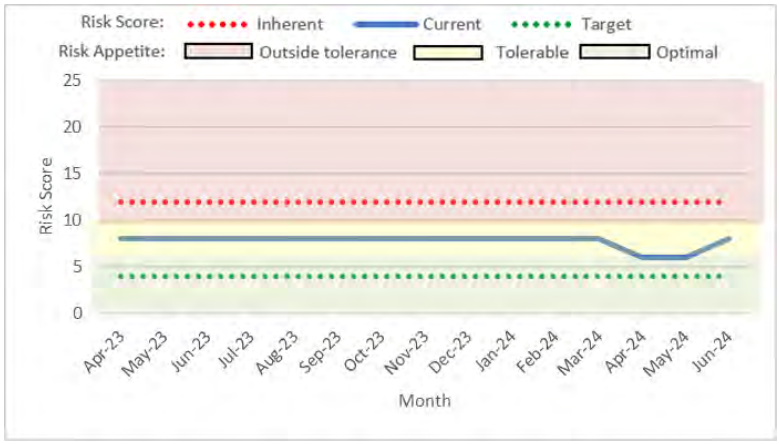


Strategic Opportunity /Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3296**	• Sustainability Manager in post. • Band 7 Energy Manager approved. • Climate Change Adaptation Plan is in development. • Heat Decarbonisation Plan has been 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 in times of sickness. The sustainability manager is also acting as energy manager which takes up the majority of the working week. • Climate Change Adaptation Plan (in development) • Sustainability Impact Assessment (developed not integrated into QIA) • Capital funds required to fund adaptation measures. • Sustainability Assurance Framework • Lack of functioning sub meters to monitor energy use • Struggling to recruit B7 energy manager. Exploring options to go out as an apprenticeship post • Our carbon footprint is increasing and investment into sustainability has been reduced this year.	• Bimonthly Finance & Performance Committee AAA reporting • Bimonthly Greener WWL Steering Group • Annual Sustainability report • Annual Carbon Footprint • Response plans for business continuity, critical and major incidents • Annual self-assessment against the NHS EPRR framework	• EPRR Self assessments reflecting climate change risk assessments (in development)	1. Climate change adaptation plan to be produced, approved, and implemented. 2. Complete carbon footprint assessment annually. 3. Map annual progress towards net zero against net zero trajectory 4. Net Zero Investment Plan and Climate Change Adaptation Plan to be integrated into Capital planning. 5. Climate Change Adaptation to be incorporated into Estates Strategy and site masterplans. 6. Heat Decarbonisation strategy to be integrated into Estates Strategy and site masterplans. 7. Sustainable Travel Plan to be produced and incorporated into Estates strategy and site masterplans. 8. Incorporate Sustainability Impact Assessment into Quality Improvement Assessment 9. Further develop governance structures to ensure all areas captured.	March 2025 / DSP

Corporate Objective: **CO17** To increase research capacity and capability at WWL in collaboration with EHU with a plan to make progress towards	1	2	3	**Overall Assurance level**	**Medium**

Principal risk	**Risk Title:**	**PR 16: University Teaching Hospital - University Hospital Association criteria**		
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to uncertainty regarding achieving the required core number of university Principal Investigators, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.		
Lead Committee	**Board of Directors**		**Risk Appetite**	Cautious
Lead Director	**MD**		**Risk category**	Strategy
Date risk opened	**19.10.21**		**Linked system risks**	LSR9 – Drive innovation
Date of last review	**22.05.24**		**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 14 individuals) with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. •We are achieving the criteria of a 2 year average of £200k/annum Research Capacity Funding awarded by end of March 2026. (An extension grant has been awarded to the NIHR funded SOFF trial which raises the NIHR grant income profile over the next 2 years.)	**2nd Line:** • Board of Directors – June 2024	• None currently identified.	The key actions for increasing University employed research Principal Investigators. Current status: Target – 14. 4 clinical academics in place, therefore 10 appointments required in final 2 years to achieve target of April 2026 for UHA application. ✓ 4 substantive EHU clinicians with Honorary Consultant status in WWL ✓ 2 (in progress) substantive EHU Clinical Academics offered Honorary Clinical Contracts with WWL ✓ 1 (in progress) agreement to appoint EHU Clinical Academic in Infectious Diseases. If the 3 in progress are confirmed within 2024/25, there remains 7 to achieve in final year 2025/26.	AR/AW March 2025

Appendix 1: Summary of Wigan Locality Strategic Risk Register Risks

Risk Reference	Risk Description
LSR1	Maintain and improve the quality and safety of patient care
LSR2	Failure to plan effectively for a pandemic situation or other significant business interruption event including digital resilience
LSR3	Failure to improve population health and care outcomes and to reduce health inequalities
LSR4	Failure to implement and manage effectively the systems, processes, and culture which enhances our reputation with our communities and stakeholders
LSR5	Failure to support and develop our workforce
LSR6	Achieving our financial plans and to maintain financial balance
LSR7	Discharging our system leadership responsibilities and supporting the effective integration of the locality's health and care system
LSR8	Statutory duties including the NHS Constitutional targets
LSR9	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:	2024/25 Corporate Objectives
Presented to:	Trust Board
On:	5th June 2024
Presented by:	Richard Mundon, Director of Strategy & Planning
Prepared by:	Dan Smith, Head of Strategic Projects
Contact details:	dan.smith@wwl.nhs.uk

Executive summary

A draft of the 2024/25 Corporate Objectives was presented to Board in April 2024 which incorporated previous feedback; to ensure a more consistent approach to measurement with more specific KPIs and inclusion of improvement of sepsis care to build on the work underway in 23/24.

The Final Corporate Objectives for 2024/25 are provided at Appendix 1.

Executive leads have further developed their Corporate Objectives for 2024/25 to incorporate the feedback and to include national targets from the NHSE Planning Guidance for 2024/25 which was delayed this year and issued on 27th March 2024. One minor change from the Guidance was the improvement of A&E waiting times to 78% in less than 4 hours (previously 76%), corporate objective 13.

Approval of Corporate Objectives was provided by ETM on 21 March 2024, with a change of focus for Corporate Objective 3 requested. The draft objectives have been discussed at the relevant Board Subcommittees.

Corporate Objective 3 still focuses on Improving Diabetes Care, but now targets improvements in diabetes care for our paediatric population, up to age 19.

Link to strategy

Our Corporate Objectives, alongside the Corporate and Divisional Business Plans for 2024/25 will be key delivery mechanisms for Our Strategy 2030. Each Corporate Objective identifies whether it responds to Improve, Integrate, or Innovate; three pillars of Our Strategy 2030.

Risks associated with this report and proposed mitigations

Many of the Corporate Objectives mitigate an identified corporate risk, which is regularly reported against within the Board Assurance Framework report.

Financial implications

Corporate Objective 11 directly relates to financial performance.

The WWL Way

Legal implications

None.

People implications

Corporate Objectives 8-10 directly relate to people-focused aims.

Wider implications

None.

Recommendation(s)

Board are requested to:

- sign off the corporate objectives for 2024/25 contained within Appendix 1.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Appendix 1

2024/25 Corporate Objectives

The WWL Way

Key Messages

WWL strives to be an outstanding organisation with a kind, compassionate and learning culture and strong partnerships within the locality and regionally.

Patient Safety &|Quality Improvement	Our priority remains on delivery safe patient care in the face of significant demand pressures and the requirement to deliver financial improvements. Key to this is developing our safety culture; listening to our patients when concerns are raised and learning from incidents. Our quality improvement priorities are: reducing pressure ulcers; sepsis care; paediatric diabetes care; and supporting people to be safely cared for at home, through working with partners and using technology.
Urgent and Emergency Care	It is critical that we improve the urgent and emergency care pathway, to reduce demand at the front door; manage patients effectively and efficiently through our hospital; and improve discharge, working with our partners to support patients within their own homes wherever possible.
People & Inclusivity	We will not tolerate discrimination. We want to have an inclusive and representative workforce that allows all staff to flourish, listening to each other and turning understanding into positive actions.
Financial Sustainability	Reducing the money we spend on delivering our services, without adversely impacting on safety or quality is important to ensure the sustainability of the services we provide. We all have a role in reducing unnecessary spend and using the resources we have as productively as possible.
Shaping our future	Whilst the challenges of today are significant, we will continue to develop our ability to meet the challenges of the future; through developing our digital and research capabilities and working as an Anchor Institution, with our partners across Wigan, to improve the health and wellbeing of the population we serve.

Areas of focus for 2024/25

Patients

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate

1	**To improve the safety and quality of clinical services**	• To enhance patient care through digital transformation	• Identify top 4 care homes with high admissions to hospital
			• Reduce admission for these patients through use of digital technology
			  • Virtual monitoring
			  • Phone line to SDEC
			  • Virtual team outreach
			• Enhancing patient experience by avoiding A&E
			• Relieve pressure on A&E
			• Delivering care closer to home.
				Medical Director	Q&S Committee	✓		✓

2	**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.	• Improvement in proportion of patients with suspected sepsis having blood culture to over 50% by the end of March 2025 • Improvement in proportion of patients with suspected sepsis having serum lactate to over 95% by the end of March 2025 • Antibiotics within one hour to over 95% by the end of March 2025 • Improvement in Appropriate Care Score for Sepsis patients to 60% by March 2025 as per Advancing Quality annual report.	Medical Director	Q&S Committee	✓		

Areas of focus for 2024/25

Patients

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
3	**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.	• Improve mean HbA1c from 68.8 to 66.6mMol/Mol • Improve cholesterol check in patients 12 years and over by 25% (baseline is 76%, target 95%) • Improve foot check in patients 12 years and over by 10% (baseline is 85%, target 93.5%) • Improve creatinine check for all patients to 99% baseline is 95%. • Improve Urinary Albumin check in patients 12 years and over by 15% (baseline is 83.3%, target 95%)	Medical Director	Paediatric Diabetes MDT Q&S Committee Wigan borough Diabetes Programme board Wigan borough Integrated Delivery Board Wigan Borough HWP System Board	✓	✓	✓

Areas of focus for 2024/25

Patients

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
4	**To improve the delivery of harm-free care**	• Continue improvements Pressure Ulcer Reduction • System wide improvement for reducing pressure ulcers	• Zero Hospital Acquired Category 3 , 4 and Unstageable pressures ulcers developed or worsened • Zero Community Acquired Category 3, 4 and unstageable pressure ulcers developed or worsened for patients on the District Nursing Caseload • Reduce both Hospital and Community acquired Category 2 Pressure Ulcers by 10% • Reduce the number of falls with moderate and above harm by 25%	Chief Nurse	Q&S Committee	✓	✓	
5	**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	• A total of 950 clinical staff to have completed human factors training by end of March 2025 • Fully embed PSIRF	Chief Nurse & Medical Director	Q&S Committee	✓		

Areas of focus for 2024/25

Patients

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
6	**To improve the quality of care for our patients**	• Continue and build upon the accreditation programme	• By March 2025: • 'Going for gold'. Increase the number of gold wards by 100% • 100% Increase in Platinum wards • All wards and Departments to have had full ASPIRE review • ASPIRE Assurance Group Commenced and established.	Chief Nurse	Q&S Committee	✓		✓
7	**Listening to our patients to improve their experience**	• Deliver timely and high-quality responses to concerns raised by patients, friends and families	• 90 % of complaints responded within our agreed time frame • 5% improvement on in-house inpatient survey on involved in care • 75% reduction in complaints related to loss of patient property • 5% improvement in patients recommending WWL as a place to receive care. • Evidence our learning from thematic complaints feedback and reduce complaints in the top 3 themes by 10% • 100% Increase in the recording and cross organisational use of plaudits	Chief Nurse	Q&S Committee	✓		

Areas of focus for 2024/25
People

People		To ensure wellbeing and motivation at work and to minimise workplace stress.						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
8	**To enable better access to care by having 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.	• Reduction in long term vacancies. • Reduction in bank and agency spend. • Increased Apprenticeship Levy Spend. • Workforce Plan signed off by Trust Board and in place.	Chief People Officer	People Committee	✓		

Areas of focus for 2024/25
People

People		To ensure wellbeing and motivation at work and to minimise workplace stress.						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
9	**To ensure we improve experience at work by actively listening to our people, and turning understanding 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.	• Analysis of Exit Questionnaires. • Board Action Plan developed. • Improved National Annual Staff Survey Results. • Improved Quarterly Staff Survey Results. • Increased Apprenticeship Levy Spend. • Increased contacts with the Freedom to Speak Up Guardian. • Introduction of new Exit Questionnaire Scheme. • Introduction of Stay and Grow Conversations. • Level 3 e-Rostering attainments. • Local Recognition Scheme in place. • Modern and accessible Flexible Working Policy. • Reduced absence rates. • Reduced turnover rates. • Reduction in bank and agency spend. • Reduction in long term vacancies. • Service Recognition Scheme running efficiently. • Workforce Plan signed off by Trust Board and in place. • All 10 commitments as outlined in the NHS Sexual Safety Charter are met.	Chief People Officer	People Committee	✓	✓	✓

Areas of focus for 2024/25
People

People		To ensure wellbeing and motivation at work and to minimise workplace stress.						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
10	**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	• EDI Steering Group established and in place. • Improved staff survey results within the Annual Staff Survey from staff with a protected characteristic. • Improved retention of nurses who have been engaged via GTEC. • Improved WRES Metrics • Improved WDES Metrics • Gender pay gap reduction. • Positive attendance at Staff Network meetings	Chief People Officer	People Committee	✓	✓	

Areas of focus for 2024/25
Performance

Performance		Our ambition is to consistently deliver efficient, effective and equitable patient care						
Purpose of the Objective		Scope and focus of objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
11	**To deliver our financial plan, providing value for money services**	• Delivery of the agreed revenue and capital 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.	• Delivery of agreed I&E position in view of an ICB approved plan • Ensure maximum revenue received under the contracting arrangement including Elective Aligned Payment Incentive. • Delivery of the efficiency plan. • Delivery of the prioritised capital investments in year within the CDEL allocation as agreed with the ICB. • The cash balance is sufficient to fund ongoing revenue commitments and planned capital investments. • Engage and communicate within the organisation to promote the Importance of sound financial management. • Delivery of financial transformation in line with strategic financial plan providing value for money services to our population	Chief Finance Officer	Integrated performance report through Finance and Performance Committee	✓	✓	✓

Areas of focus for 2024/25
Performance

Performance		Our ambition is to consistently deliver efficient, effective and equitable patient care						
Purpose of the Objective		Scope and focus of objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
12	**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.	• Eliminate waits of over 65 weeks for elective care by end of April 2024 and 52 weeks by March 2025. • Deliver the system specific activity targets (agreed through the operational planning process) • Consistently maintain the % of cancer patients seen within 62 days at >70% • Consistently maintain the cancer faster diagnosis standard of >77%	Chief Operating Officer	Integrated performance report through Finance and Performance Committee	✓	✓	✓

Areas of focus for 2024/25
Performance

Performance		Our ambition is to consistently deliver efficient, effective and equitable patient care						
Purpose of the Objective		Scope and focus of objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
13	**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.	• Improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025 • Achieve 100% of ambulance handovers within 30 minutes • Reduce adult general and acute (G&A) bed occupancy to 96% by March 2025, acknowledging the system wide challenges in this area. • Aspire that NCTR occupancy will be below 15% of the bed base. • Consistently meet or exceed the 70% 2-hour urgent community response standard	Chief Operating Officer	Integrated performance report through Finance and Performance Committee	✓	✓	✓

Areas of focus for 2024/25
Partnerships

Partnerships		To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
14	**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	• Increasing the % of influenceable non-pay spend made locally • Increase the number of Wigan residents employed by WWL through further development of our Education and Skills Partnership • Ensure a focus on health inequalities in our performance reporting, taking action to reduce inequalities where they are identified • Specific metrics on delivery of programmes to reduce health inequalities to be updated when IDB programme clearer.	Director of Strategy and Planning	Six monthly report to Trust Board	✓	✓	

Areas of focus for 2024/25
Partnerships

Partnerships		To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
15	**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.	• Specific metrics to be developed • Established system transformation programme addressing urgent and emergency care following Newton Diagnostic delivering agreed measurable improvements	Director of Strategy and Planning	Six monthly report to Trust Board		✓	
16	**To make progress towards becoming a Net Zero healthcare provider**	• Implementation of priority actions following completion of carbon footprint analyst and heat decarbonisation plan.	• Specific measurables to be refined based on deliverables for 2024/25 (likely to include quantified carbon savings from models of care and from investment in LED lighting)	Director of Strategy and Planning	Six monthly report to Trust Board	✓		

Areas of focus for 2024/25
Partnerships

Partnerships		To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
17	**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.	• Increase in the: number of research studies active across more clinical areas, in WWL and in partnership with Primary Care; and the number of participants recruited to research studies. • Increase in number of commercial trials and achieving a minimum of 80% delivered to the Site's agreed target number of participants in the time allocated (national KPI = *delivery to Time and Target*). • Staff (especially non-medical) applying to external research training and fellowship opportunities; and the number of clinical staff engaged in research as Principal Investigators, Associate Principal Investigators, and Chief Investigators. • New NIHR grant submissions, grant successes, and successful delivery of active NIHR funded projects (thereby maintaining or increasing the Research Capacity Funding attracted to the Trust). • Tracked steady progress towards achieving 6% of the clinical workforce employed as Clinical Academics (achieving 14 by March 2026)	Director of Strategy and Planning	Trust Research Committee	✓	✓	✓

Title of report:	Directors' declarations of interest
Presented to:	Board of Directors
On:	5 June 2024
Presented by:	Consent agenda
Prepared by:	Deputy Company Secretary
Contact details:	E: nina.guymer@wwl.nhs.uk

Executive summary

The attached table shows the various interests declared by directors for the financial year 2023/24. Directors are asked to review this table and to advise of any additional interests that need to be declared. It is important to note that interests of spouses and cohabiting partners should also be declared.

Link to strategy

There is no direct link to the organisational strategy.

Risks associated with this report and proposed mitigations

The content of this report is intended to mitigate against inappropriate procurement or other decisions being taken, by ensuring that the board is aware of each director's interests.

Financial implications

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

Legal implications

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

People implications

There are no people implications to highlight.

Wider implications

There are no wider implications to highlight.

Recommendation(s)

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

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

EXECUTIVE DIRECTORS	
Name	**Declared interests**
ARYA, Sanjay	Clinical private practice, Beaumont Hospital and WWL. Undergraduate Clinical Lead in Cardiology, Edge Hill University. Contracted to act as Principle Investigator for Triage Heart Failure Study Medtronic Company (in association with Manchester Foundation Trust). Honorary position on the Advisory Panel at Bolton University Medical School. Director and Chair of the Hospital Doctors' Forum, British International Doctors' Association (CRN: 01396082) Director, Highbank Grange (Bolton) Residents Association Limited (CRN: 04300183) Spouse is General Practitioner in Bolton
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) Director (Chair) and trustee, Cidari Education Limited (CRN: 08822760), now ended. Independent Person for Bolton Council Tutor and examiner for the Chartered Governance Institute UK and Ireland Swimming Coach at David Lloyd Chorley, now ended. 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)
WANNELL, Claire	Nil declaration

DIRECTORS DURING FY2023/24NO LONGER IN POST	
Name	**Declared interests**
BOUSTEAD, Tracy	Nil declaration
ELLIOT, Steven	Nil declaration
HANKIN, Terence	Nil declaration
NICHOLLS, Silas	Chair, North West NHS Leadership Academy Partner works for Liverpool University Hospitals NHS FT
TINDALE, Rabina	Nil declaration

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Standing Financial Instructions
Presented to:	The Board of Directors
On:	5th June 2024
Item purpose:	For information and adoption of the outlined changes to the Standing Financial Instructions
Presented by:	Tabitha Gardner Chief Finance Officer
Prepared by:	Shirley Martland – Associate Director of Financial Services and Payroll
Contact details:	T: 01942 773786

Executive summary

The purpose of this paper is to notify the Board of Directors (the Board) of changes made to the Trust's Standing Financial Instructions (SFIs) and Budgetary Control and Delegation Arrangements and to recommend that these changes, which were approved by Audit Committee at their meeting of the 2nd May, are adopted by the Trust.

Link to strategy and corporate objectives

None.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications with this report.

Legal implications

There are no direct legal implications in this report.

People implications

None.

Equality, diversity and inclusion implications

None.

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

The changes made to the SFI's were approved by Audit Committee on 2nd May 2024.

Recommendation(s)

It is recommended that the Board of Directors adopt the changes made to the SFI's.

Report

1 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.

A review of the SFI's is undertaken each September with any changes being notified at the next appropriate Audit Committee meeting. Two changes have arisen prior to the annual review and the SFI's have been updated to reflect these changes which are detailed below.

2 Changes

2.1 Research and Development Sponsorships

Following an internal audit review of Research and Development Sponsorships, Mersey Internal Audit Agency (MIAA) have identified a medium risk around the signing of research contracts and have made a recommendation to update the SFI's to include reference to the approval and signing of research contracts.

The SFIs have been updated to reflect the recommendation made by MIAA, and the following changes have been made:

Non-commissioner related contracts *(page 33)*

Amended from:

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) is in place and has been signed by both parties. SLAs 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.
Plus, in all circumstances:
(c) Director of Operations and Performance (or nominated deputy)
(d) Chief Finance Officer (or nominated deputy)
(e) Either: Chief Nurse, or Medical Director (or nominated deputies)

To:

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 other 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)

Added – SFI 10.9 *(page 34)*

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 and 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.

2.2 Changes to Executive Team Meetings

The Executive Team (ET) have agreed to establish a new group which will come into effect from June 2024. This group, the Wider Leadership Team will replace ET as the decision-making body for business cases and the SFI's have been updated to reflect this change as follows.

SFI 23. Business case process *(page 55)*

Amended from:

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).				

To:

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.

3 Recommendation

It is recommended that the Board of Directors adopt the changes made to the SFI's.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

Approved by the Board of Directors: 1st February 2023
Review date: September 2023

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, DFM.

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 balanced score card;

(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 7.71

(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 contracts established by the Crown Commercial Service (CCS), NHS Supply Chain (NHSSC), Shared Business Service Collaborative Procurement Service (SBS) Health Trust Europe (HTE) or another applicable organisation with appropriate frameworks, for the procurement of goods and services unless the Chief Executive or nominated officers deem it inappropriate.

SFI 7.21 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 7.22 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 7.23 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 7.24 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 7.25 The Trust has adopted an “e-tendering” system to issue and receive all tenders electronically.

SFI 7.26 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 7.27 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

SFI 7.28 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 7.29 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 7.30 All tenders must be issued and managed via the Trust’s, or other approved, electronic tendering systems e.g. Crown Commercial Services. No hard copy tenders will be accepted.

SFI 7.31 Electronic tenders will be held and locked electronically until the allocated time and date for opening.

Opening tenders

SFI 7.32 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 7.33 A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

Admissibility of tenders

SFI 7.34 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 7.35 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 7.36 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 7.37 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 7.38 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 7.39 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 7.40 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 7.41 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 7.42 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 7.43 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 7.44 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 7.45 All Tenders should be treated as confidential and should be retained for inspection.

Acceptance of tenders

SFI 7.46 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 7.47 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 7.48 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 7.49 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 7.50 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 7.51 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 7.52 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 7.53 All tenders should be treated as confidential and should be retained for inspection.

Signing of contracts

SFI 7.54 In all instances, the Trust's Procurement Team must be engaged in the tender procurement process prior to an official order being raised.

SFI 7.55 SFI 7.54 to SFI 7.58 refers specifically to circumstances where a contract needs to be signed (see DHSC guidance document available on the www.gov.uk website).

SFI 7.56 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 7.57 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

Fair and adequate competition

SFI 7.58 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 7.59 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 7.60 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 7.61 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 7.62 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 7.63 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 7.64 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 7.54.

SFI 7.65 In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

Private finance for capital procurement

SFI 7.66 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 7.67 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 7.68 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 7.69 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 7.70 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 7.71 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 7.72 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 7.73 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 7.74 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 7.75 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 7.76 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 7.77 The evaluation team shall make recommendations to the Board.

SFI 7.78 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 7.79 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 the Workforce Expenditure Panel.

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 Director of Workforce 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 Director of Workforce.

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)	≤ £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

3.	**Bad debts and claims abandoned**		
(a)	Private patients		
(b)	Overseas visitors		
(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	≤ £10,000 Legal Services Department ≤ £50,000 Chief Nurse	Not applicable

(c) Personal injury claims involving negligence where legal advice is obtained and relevant guidance has been applied (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	> £50,000 Audit Committee and Board of Directors	
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 2011.

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 2011; 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's Expenditure Guidance policy 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's Fundraising and Income Guidance policy 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 SPONSORHSIP 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 an appointed NHS Innovation Hub as its IP expert company to give advice and assistance in the protection, management and commercial opportunities of IP initiatives.

Staff obligations

SFI 21.11 All employees, including those covered by the Intellectual Property Policy, have an obligation to inform the Trust's R&D manager 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 Research and Development Manager 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 8 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 Should the Trust approve, it may also be necessary to seek NHSE's approval.

SFI 23.7 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**