Board of Directors - Public Meeting

Wed 06 August 2025, 13:30 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

14. Declarations of Interest

Information *Rhona Bradley*

Verbal item

14.1. Register of directors' interests

Information *Rhona Bradley*

14.1. Directors DoIs - Aug 2025.pdf (3 pages)

15. Minutes of the previous meeting

Approval *Rhona Bradley*

15. Minutes_Board of Directors - Public Meeting _040625.pdf (6 pages)

16. Action Log

Discussion *Rhona Bradley*

16. Public Board Action Log 2025.pdf (1 pages)

17. Patient Story

Information *Kevin Parker-Evans*

17. EDI Patient Story April 25V1.1.pdf (8 pages)

18. Chair's comments

Information *Rhona Bradley*

19. Chief Executive's report

Information *Mary Fleming*

19. APPROVED CEO Board Report_August 2025.pdf (5 pages)

20. Committee chairs' reports

Information *Non Executive Directors*

20.1. Quality and Safety

Information *Mary Moore*

20.1. AAA Q&S July.pdf (2 pages)

20.2. Finance and Performance

Information *Julie Gill*

20.2. F&P AAA - Jul 2025.pdf (2 pages)

20.3. People Committee

Information *Mark Wilkinson*

20.3. People Committee - Jun 2025 AAA.pdf (2 pages)

20.4. Research Committee

Information *Clare Austin*

20.4. AAA - Research - Jun 2025.pdf (2 pages)

21. Integrated performance report

Information *Richard Mundon*

21. Board of Directors IPR M3 2526.pdf (4 pages)
21a. IPR_M3_2526.pdf (25 pages)

22. Board Assurance Framework

Information *Steve Parsons*

22. BAF Report Board August 2025 v2.pdf (23 pages)

23. Finance report

Information *Tabitha Gardner*

23. Board Cover Sheet - Finance Report M3.pdf (2 pages)
23a. Trust Finance Report 25-26 June Month 3 Board.pdf (16 pages)

24. The NHS 10-Year plan

Information *Mary Fleming/Richard Mundon*

25. Safe nursing staffing biannual report

Information *Kevin Parker-Evans*

25. Bi Annual Safe Nurse Staffing Review March 2025.pdf (35 pages)

26. Maternity

26.1. Maternity Biannual staffing report

26.1. Maternity 1st Biannual Staffing Report July 2025 v2.pdf (22 pages)

26.2. CNST Board update

26.2. CNST BOARD REPORT UPDATE - July 20025.pdf (16 pages)

27. Freedom to Speak Up Guardian's report

Information

27. FTSU Annual Report 2024-25 for Board 060825 v2.0.pdf (9 pages)

28. Reflections on equality, diversity and inclusion

Discussion *Rhona Bradley*

Verbal item

Consent Agenda

29. Maternity Dashboard Reports and Dashboard

Information

- 29. Maternity Dashboard Report - June 25 final.pdf (11 pages)
- 29a. Maternity Dashboard - June 2025.pdf (3 pages)
- 29b. Perinatal Exception Report - June 2025.pdf (1 pages)
- 29c. Perinatal Dashboard - June 2025.pdf (2 pages)

29.1. CQC Picker Action plan

- 29.1. Picker CQC - Action Plan 2024 (Updated 4th July 25).pdf (3 pages)

30. Annual Summary of Deaths

Information

- 30. Deaths Audit Summary 2024 (003).pdf (9 pages)

31. Agenda item not used.

32. Green Plan

Approval

33. Date, time and venue of the next meeting

Information

01 October 2025, 1.15pm, Trust Headquarters

Agenda item: 14.1

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Directors' declarations of interest
Presented to:	Board of Directors
On:	6 August 2025
Purpose:	Information
Prepared by:	Head of Corporate Governance and Deputy Company Secretary E: nina.guymer@wwl.nhs.uk

NON-EXECUTIVE DIRECTORS	
Name	**Declared interests**
AUSTIN, Claire	Employed by Edge Hill University as Pro-Vice-Chancellor and Dean of the Faculty of Health and Social Care and medicine
BRADLEY, Rhona	Trustee, Addiction Dependency Solutions charity Governor, Learning Training Employment (LTE) Group Non-Executive Director, Home Group Housing Association Spouse is The Rt Hon Lord Bradley of Withington
GILL, Julie	Nil declaration
HOLDEN, Simon	Chairman of Governors, Pear Tree Academy School Director, Simon Holden Associates Limited (CRN: 09546681) Non-Executive Director, LocatED Property Ltd (No: 10385637)
JONES, Mark	Nil declaration
MOORE, Mary	Nil declaration
WILKINSON, Mark	Non-Executive Director and Vice Chair, Bolton At Home Ltd Non-Executive Director, Mastercall Healthcare Governor, Edge Hill University Director and shareholder, Fairway Consulting Services Ltd (CRN: 13767002) Wife employed by Lancashire County Council public health department

	Son works for Mersey and West Lancs NHS FT
THORPE, Francine	Independent Chair, Salford Safeguarding Adults Board

EXECUTIVE DIRECTORS	
Name	**Declared interests**
ARYA, Sanjay	Clinical private practice, Beaumont Hospital and WWL. Undergraduate Clinical Lead in Cardiology, Edge Hill University. Honorary position on the Advisory Panel at Bolton University Medical School (non-remunerated) Director, High Bank Grange (Bolton) Residents Association Limited (CRN: 04300183) (non-remunerated) Spouse is General Practitioner in Bolton Medical Director, Centre for Remediation, Support and Training (CRST) at Bolton University (voluntary) Executive Committee member, British International Doctors Association (UK) (non-remunerated) Lay Governor, Wigan & Leigh College (non-remunerated)
BRENNAN, Sarah	Nil declaration
TAIT, Juliette	Nil declaration
FLEMING, Mary	Nil declaration
GARDNER, Tabitha	Governor, Aspiring Learners Academy Trust Spouse is Director at Manchester University NHS FT
MILLER, Anne-Marie	Spouse is director of Railway Children Charity and Railway Children Trading Company Limited
MUNDON, Richard	Daughter works as Charitable Funds Manager at WWL.
PARKER-EVANS, Kevin	Spouse is Head of Safeguarding and Designated Adult safeguarding nurse for NHS Greater Manchester (Stockport Locality) Honorary Senior Clinical Lecturer at Edge Hill University

PARSONS, Steven	Self employed as a Football Referee Shareholder, BT Group Shareholder, Lloyds Bank Group Shareholder, Fuller, Smith and Turner PLC (family shares, arises from previous employment) Member, Nationwide Building Society Member, Newcastle Building Society (through merger with Manchester Building Society) Member, Co-Op Group Committee member, East Cheshire Harriers and Tameside Athletics Club Member, Campaign for Real Ale

Board of Directors - Public Meeting

Wednesday 4 June 2025, 13:45 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Attendees

Board members

Mark Jones (Chair), Sanjay Arya (Medical Director), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Sarah Brennan (Chief Operating Officer), Mary Fleming (Chief Executive), Simon Holden (Non-Executive Director), Tabitha Gardner (Chief Finance Officer), Richard Mundon (Deputy Chief Executive), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Kevin Parker-Evans (Chief Nurse), Juliette Tait (Chief People Officer), Francine Thorpe (Non-Executive Director), Mark Wilkinson (Non-Executive Director)

Absent: Julie Gill (Non-Executive Director), Mary Moore (Non-Executive Director)

In attendance

Nina Guymer (Head of Corporate Gov & Deputy Company Secretary), Steve Parsons (Director of Corporate Governance)

Meeting minutes

52. Declarations of Interest

Information

Mark Jones

The register was noted.

52.1. Register of directors' interests

Information

Mark Jones

18.1. Directors DoIs - Jun 2025.pdf

53. Minutes of the previous meeting

Approval

Mark Jones

The minutes of the previous meeting held on 2 April 2025 were **AGREED** as a true an accurate record.

19. Minutes_Board of Directors - Public Meeting _020425 (1).pdf

54. Action Log

Discussion

Mark Jones

21.3/25 - People Committee AAA

It was confirmed that the People and Culture Strategy had been shared with the full Board and therefore **AGREED** that the action could be closed.

193/4/24 - People Committee AAA

It was noted that board members would be encouraged to speak up on an ongoing basis and would have the opportunity to discuss any concerns as and when the FTSU report is brought to meetings. It was therefore **AGREED** that the action could be closed.

194/24 - WRES/WDES

The Chief People Officer advised that an item for discussion around health inequalities has been scheduled for the July 2025 board workshop, which would encompass ED&I. It was therefore **AGREED** that the action could be closed.

20. Public Board Action Log 2025.pdf

55. Staff Story

Information

A video was shared during the meeting, following some negative feedback which had been received by the Board around 12 months previously, around the staff experience and perception of the Global Majority Nurse staff group. It saw three Global Majority Nurses providing positive stories about their ability to progress and contribute to transform services within the organisation, affirming how, as a staff group, they have been much better supported since their concerns were heard by the executive team.

56. Chief Executive's report

Information

Mary Fleming

The Chief Executive wished to offer her formal thanks to her team for the work done in 2024/25 and what was achieved by the Trust.

She highlighted that the regional team have put WWL in to tier 2 for elective referral to treatment times, being slightly lower than the national average in terms of compliance. She added that WWL have offered much mutual aid to other providers and that there has been a commitment to support trusts which are able to demonstrate that they have suffered a detriment as a result of offering mutual aid. WWL is undertaking an analysis to determine if this is the case and if so, the matter will be raised at system level.

23. CEO Board Report_May 2025 v2.pdf

57. Integrated performance report

Information

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

Patients

The Board noted the report and were invited to raise queries in respect of each pillar.

In response to a query from the Chair, the Chief Nurse advised that single step breaches result predominantly from the Intensive Care Unit and that root-cause analyses are being carried out in each case to allow learning to be identified and cases to reduce. Digital support is now being used to inform rostering and decisions on skill mixed, based on data inputted by staff three times per day around patient acuity. He noted a £120k reduction in temporary spend and that the digital solution has supported that.

Mrs F Thorpe was pleased to see the reduction in the number and frequency of patients moves around the hospital, highlighting that the more a patient moves, the worse their outcomes are, since continuity of care is disrupted. It was noted that this had been a point of learning identified through a harm review.

Lady R Bradley asked whether there is any sign that corridor care is reducing.

The Chief Operating Officer advised that this is the case, with only two days of corridor care during the previous week, when there had also been a flood on one site. A trend for discharges in place of the use of corridor beds was highlighted and the Board were advised that there seems to be an understanding amongst colleagues now that the hospital must focus on ways of ensuring that it has less patients, rather than more staff.

Mrs R Bradley asked what progress had been made with winter plans, which are now beginning to be written for each division.

The Chief Operating Officer advised that actions have already begun and that there has been a culture change and an appetite to work differently, citing again the increase in discharges and the intention to minimise corridor care in winter.

People

Prof C Austin asked if there is an equality issue with the fact that pay is withheld for medical staff not having undertaken satisfactory job planning.

Performance

Mr S Holden asked what is being done to increase virtual ward attendances.

The Chief Operating Officer advised that work is ongoing with the community division to increase utilisation of the ward where appropriate. Discussion are also ongoing with Bolton NHS FT around use of this type of service.

The Board received and noted the report.

24. Board of Directors IPR M1 2526.pdf
24a. Board of Directors IPR M1 2526.pdf

58. Finance report Month 12 and Month 1

Information

Tabitha Gardner

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

Mr S Holden expressed a concern that the Trust may require cash in Q2, which is a period when many staff are on leave for the summer school break.

Mrs F Thorpe noted that recurrent CIP often requires changes in operational practice and asked if any significant blockers have been identified which have prevented schemes being taken forwards.

The Chief Finance Officer and Director of Communications explained that one issue can be that staff do not come forwards with ideas for change. They emphasised the importance of engaging with staff, supporting them to be part of a solution and then set out several avenues developed by WWL for this kind of engagement and feedback.

More widely, the Chief Executive set out three areas of key focus which WWL is unable to progress alone, being locality estates; locality community based services; the pace of the Provider Collaborative's progress and digital solutions.

Mr M Wilkinson asked if there is a view on the shortfall in terms of the transformation programmes, along side the CIP shortfall.

The Deputy Chief Executive advised that the 5 programmes for transformation have now been set out with each to be monitored by the most relevant assurance committee.

The Chief Finance Officer advised that the gap is mainly in the surgery and specialist services divisions. The team running the Getting It Right First Time (GIRFT) programme - a national NHS England programme designed to improve the treatment and care of patients - continues to work with the specialist services division and there is a possibility for savings and efficiencies resulting from that work. The surgery division however may not have the opportunity to make the gains that they have projected within the current year. She was keen to ensure that WWL measures performance against the constitutional standards overall and ensure that the financial position is aligned to this.

The Board received and noted the report.

25b. Board Cover Sheet - Trust Finance Report Apr 2025.pdf
25. Board Cover Sheet - Trust Finance Report March 2025.pdf
25c. Trust Finance Report 25-26 April Month 1 Board.pdf
25a. Trust Finance Report 24-25 March Month 12 Board.pdf

59. Committee chairs' reports

Information

Non Executive Directors

The non-executive director chairs of the Board's committees presented their respective reports.

59.1. Quality and Safety

Information

Francine Thorpe

The Chief Executive asked if the Quality and Safety Committee ever discusses staff and the effect of the requirement to reduce the organisation's number of whole time equivalent posts

Mrs F Thorpe explained that, although for the most part, this is not the Committee's remit, where appropriate, consideration is given to staffing. She provided the example that a report from the maternity team had previously identified issues which it determined would be resolved by recruiting additional staff, whilst the Committee had been supportive of the proposal, it was not within the Committee's purview to approve this and it was therefore suggested that a business case be produced an progressed through the appropriate governance route.

26.1. AAA QSmay25.pdf

59.2. Finance and Performance

Information

The Chief Finance Officer wished to highlight that the Committee had endorsed the start of phase 2 of the Better Lives Programme, reminding the Board that this would deepen and expand the transformation of care delivery across the borough through improvements in acute flow and length of stay; working under a ' One Wigan' community model and strengthening system-wide coordination.

Lady R Bradley commented on upcoming government reforms and pending budgets being released across the public sector which may impact on the progression of the programme.

26.2. AAA - FP - May 2025.pdf

59.3. People Committee

Information

Mark Wilkinson

26.3. People Committee - Apr 2025 AAA.pdf

59.4. Audit Committee

Information

Simon Holden

The Board noted the Committee's

26.4. AAA - Audit Committee - 8 May 2025.pdf

59.5. Research Committee

Information

Clare Austin

Prof C Austin noted that the report would be provided at the next meeting although wished to alert the board around:

- Ring fencing time to research, which is still a struggle for colleagues involved in research and;
- A letter received from NHSE the previous day, recognising the importance of the Board having oversight of research delivery and income, noting:
    - Key vibility of research activity and income, including scrutiny of performance metrics related to the UK Clinical Research Delivery (UKCRD) programme.
    - That reductions in headcount or recruitment freezes should not impact research work, especially where posts are funded from external sources such as grants or commercial contracts;
    - That cost-saving measures at provider level should not imply reductions in research staffing;
    - The importance of use of research income for its intended purpose, including recruitment to research and development posts.

The Board received and noted the reports.

60. National Staff Survey update

Information

Juliette Tait

The Chief People Officer provided an update on feedback received taken both from the staff survey and following its completion, through executive listening events. She highlighted several key themes identified mainly from conversations with staff:

- Staff want recognition for good work
- Staff want to be communicated with
- Staff want to feel part of the WWL team and work together effectively
- Staff want to be involved in the change going on around them
- The better enabled staff are to provide excellent patient care, the more job satisfaction they have and the happier they are at work

The Board noted that this would be discussed more fully at the upcoming People Committee meeting and were pleased to see the positive progress made thus far.

61. Chair's closing remark

Information

Mark Jones

The outgoing Chair, Mr M Jones, reflected on his career within the healthcare sector and his time at WWL. He explained that him along with many others have long held a belief that funding for heath services is not in the right place and that this, along with the operating model, needs to shift from hospital sites out in to the community to support the local healthcare offer. He explained however that he has always seen WWL as a great exemplar of partnership working and locality investment and was proud of the progress made in this regard throughout his tenure. He wished to acknowledge the success of the Board during his tenure, he noted that there had been several new recruits and he felt that transitions had been seamless and working relationships flourished on an ongoing basis, regardless of these changes.

The Board expressed thanks to Mr M Jones for his work as Chair and wished him all the best for his retirement.

Consent Agenda

62. Maternity Dashboard Reports

Information

The Chief Executive took good assurance from the reports provided and asked how WWL is going above and beyond to ensure that it is providing the best care for women.

The Chief Nurse advised that the service's next step will be to have undertaken a peer review which is being planned with Bolton NHS FT.

- 31a. Maternity Dashboard - Feb 25.pdf
- 31b. May 25 Neonatal Dashboard.pdf
- 31. Maternity Dashboard report April 25.pdf
- 31d. - Wrightington Leigh and Wigan Maternity Letter 2025-05 Baby Friendly Gold progress monitoring.pdf
- 31c. Perinatal Quality Surveillance Q4 24-25 Jan-Mar 25 (For June Board).pdf
- 31e. Baby Friendly Gold report Wrightington Leigh and Wigan 2025-04.pdf

63. Fit and proper persons annual report

Information

- 30 F&PP annual report.pdf

64. Date, time and venue of the next meeting

Information

6 August 2025, 1.15pm, Trust Headquarters

Action log: July 2025

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Feb 2025	24/25	Safe Nurse Staffing Bi-annual review	Provide assurance on the staffing of escalated areas for the People Committee.	K Parker Evans	Referred to People Committee	The Committee Chair suggested that Board oversight is required here and that this should be monitored through the regular reports to the Board (per the report on the agenda).
02 Jul 2025	76/25	Green Plan	Re-Submit the finalised Green Plan for the consent agenda	R Mundon	06 Aug 2025	

EDI Patient Story

Kevin Parker-Evans– Chief Nurse

Meeting Date: 06 August 2025

Sarah's Story

- For confidentiality reasons, patient will be referred to as Sarah.
- Sarah has a chronic pain condition and requires reasonable adjustments.
- Sarah wanted to speak with WWL's Disability Officer following telephone conversation with Consultant Secretary – Did not want to raise a complaint, just wanted to share her experience.
- Sarah had Ophthalmology OPD Appointment on 17/03/25 at Leigh. She contacted secretary prior to request reasonable adjustments because of her condition – Required bed to lie down on in consultation room / head support equipment. Staff Member dismissive of her disabilities – could not understand why patient could not sit or stand for eye appointment. Inferred that she would be unable to have her eye test! Sarah left feeling her disability her fault!
- Sarah then contacted the Nursing Team directly at Leigh OPD – the nurse was extremely accommodating and assured Sarah that a bed would be made available in the consultation room and head support equipment would be provided. Sarah felt reassured that her reasonable adjustments would be accommodated. She felt less anxious and more supported.

Sarah's Story

- Sarah agreed to let me contact her after her appointment to discuss her patient experience. Informed me Consultant Secretary had since, been back in contact with her to discuss reasonable adjustments for appointment.
- Sarah attended appointment with two friends – Overall Good Experience
- On arrival needed wheelchair – one was sourced, but difficulty manoeuvring it to Area 1.
- Nurse greeted her quite quickly, took to side room (no bed in room as requested) but one was ready for her in the room next door, which she was to visit next.
- She laid down on bed. Support Head equipment used. Eye test adjusted to meet her needs.
- Given prescription – When 'handing in' at Peak Community Pharmacy at Leigh Infirmary was told had to wait 15/20 mins for this. Difficult when suffer with chronic pain and need to readjust / move.
- At home had difficulty due to condition squeezing medication. Phoned hospital pharmacy, they posted out aid to Sarah, designed to assist patients with motor skills difficulties.

Questions Asked

- Can wheelchairs be made easier to use / Have instructions on the best way to use?
- Can prescriptions be sent to the GP for them to deliver?
- Do patients have to use hospital pharmacies?
- Why was the prescription aid not offered with the prescription?
- Can pharmacy waiting times for patients with conditions such as chronic pain be reduced?
- How can we raise staff awareness about patient's reasonable adjustments?
- How can we alert staff to patient needs?

Lessons Learned

Can wheelchairs be made easier to use / Have instructions on the best way to use?

Project currently being undertaken by Estates Team

- 2 Wheelchair Models recently trialled by hospital staff with patients 24/03/25 – 13/04/25
- 3 Lived Experience Partners invited to be involved in project
- Meetings held to discuss Wheelchair Stations etc.

Lessons Learned

Can prescriptions be sent to the GP for them to deliver? Do patients have to use hospital pharmacies?

Pharmacy Team currently in discussions with a company to support this for patients.

Concept:

- Patients would state their regular chemist, their prescribed item(s) would be sent directly to the regular pharmacy for the patient to collect at their convenience / be delivered.

- This has also been raised by patients and their relatives who receive regular prescriptions from WWL.

- **Outcome: Improved patient experience**

  Patients do not have to travel to collect / Not all patients drive, reliant on public transport or relatives and friends / some patients live a distance away / travel costs.

Lessons Learned

Why could the prescription aid be sent out to patient at home, but not the prescription?

Pharmacy Service at Leigh – Provided by Peak Community Pharmacy (independent to WWL) / May offer different services to WWL. It is possible that the aid was delivered out of courtesy to the patient.

Can pharmacy waiting times for patients with conditions such as chronic pain be reduced?

Can be difficult to separate the needs of all patients – WWL has have young, elderly, terminally ill patients, all presenting to the pharmacy triage area and all having their own needs to be met. WWL do offer the time in which they will likely be waiting, to give them the opportunity to go for a drink and then come back.

At present waiting times are around 20 minutes. This may seem extreme; however, prescriptions go through several checks before being presented for dispensing:

- **Clinical check** (Is it safe? / Is the dose correct? / Are alternatives available?)
- **Dispensing** (label generated & sent to robot to dispense (robot will be dispensing upwards of 100 items at same time) / label then attached)
- **Accuracy Check** (Is prescription and item(s) correct? / Are sundries required?
- **Final Check** (Patient called and counselled / advised).

Lessons Learned

How can we raise staff awareness about patient's reasonable adjustments?

How can we alert staff to patient needs?

Being reviewed in Reasonable Adjustment Digital Flag Workstream

- **Recording & Alerting**
- **Patient and Staff Awareness**
- **Actioning Requests**
- **Training**

Regular EDI Update Slot at Divisional PEEG Meetings requested

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	06 August 2025
Item purpose:	Information
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy and corporate objectives

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with this report.

Equality, diversity, and inclusion (EDI) implications

There are no EDI implications in this report.

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

N/A

Recommendation(s)

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

Introduction

As we navigate through a transformative period in healthcare, this report provides a snapshot of the national context we are working within, and our unwavering commitment to innovation, collaboration, and excellence in patient care. Significant changes have taken place since we last met which include the recent publication of the 10 Year Plan, the NHS Oversight Framework, and ongoing work to implement the future Integrated Care Board (ICB) Blueprint.

10 Year Plan

In July, the Government launched the 10 Year Health Plan for England, setting a bold new direction for the NHS. This plan aims to guarantee the future of the NHS, shaped by the experiences and expectations of the public, patients, partners, and the health and care workforce. The plan includes three major shifts: from hospital to community, analogue to digital, and treatment to prevention. These changes will help us provide personalised care, empower patients, and ensure the best of the NHS is available to all. For staff, the plan aims to make the NHS the best place to work by setting new standards for flexible and modern employment, expanding training opportunities, and reducing unnecessary administrative burdens.

NHS Oversight Framework

The recent publication of the NHS Oversight Framework marks a significant shift in the strategic landscape for healthcare providers. This framework aims to provide a consistent and transparent approach to assessing the performance of Integrated Care Boards (ICBs) and NHS Providers, ensuring public accountability and establishing a foundation for improvement. For WWL, this means increased scrutiny and support to enhance performance, with a focus on accountability, collaboration with other providers, and addressing local community needs. The framework also presents opportunities for greater autonomy and strategic development, aligning with WWL's ongoing efforts to improve health outcomes and reduce inequalities within the Wigan locality.

ICB Blueprint

Under the NHS Reforms, it is the intention that ICBs will be significantly reduced in size. Nationally, the number of ICBs will be reduced by 50%, with Greater Manchester aiming for a 39% reduction. A national ICB blueprint has been released, defining reformed ICBs as "strategic commissioners". This means ICBs will focus on understanding the needs of the population, setting system goals, planning, agreeing on transformation priorities, contracting, overall assurance and oversight, and quality improvement. Some functions, like GP IT and medicines management, will be moved out of the ICB. We will continue to have 10 integrated Place Partnerships in Greater Manchester, supported by a partnership agreement. ICBs will set the accountability framework for Place performance and effectiveness, while Places (e.g. Wigan) will be responsible for developing local priorities and plans, ensuring integrated delivery, and aligning resources and incentives.

Investments

Our brand-new Endoscopy extension at the Royal Albert Edward Infirmary in Wigan welcomed its first patients in July. This state-of-the-art facility boasts three advanced endoscopy rooms and a new patient recovery area. This development will provide patient benefits, including improved privacy

and dignity for our patients, greater choice, more timely appointments, and enhanced care for gastrointestinal cancers. Additionally, our Endoscopy service at the Wigan site now meets the physical infrastructure requirements of the Joint Advisory Group accreditation, which is crucial for supporting the delivery of the Bowel Cancer Screening Programme both locally and regionally. Our Endoscopy service at Leigh was formally JAG accredited this month.

We also unveiled a new, state-of-the-art 3T Magnetic Resonance Imaging (MRI) scanner as part of a major upgrade to Wrightington Hospital. The new unit, located near Wrightington's newest theatres, includes two units housing the scanner and support services, as well as an updated waiting area and reception. This cutting-edge technology will not only support research at Wrightington, ensuring the development and performance of advanced techniques, but also allow the Trust to collaborate with clinical research and industry partners nationwide as well as supporting local radiology services across the North-West.

BetterLives – Transforming Care, Promoting Independence

In July, over 90 delegates from WWL, Wigan Council, and the Greater Manchester ICB gathered at Wigan Town Hall for a BetterLives Engagement Event. The day was a fantastic opportunity to highlight the impact of the programme so far, and to influence its future direction. It was a powerful reminder of the strength of our system when we collaborate, and the potential of the BetterLives programme to improve health and care for residents of the Wigan Borough. Big impacts have already been made, as reported in the previous Board Report; our focus now is to sustain these improvements and successfully move into phase two which focuses on intermediate care, reducing the reliance on in-demand hospital beds and providing care elsewhere. It will also look at reducing discharge delays and helping people who leave hospital find the most independent outcomes, to help reduce repeat admissions.

Industrial Action

Safe services across our sites were able to be maintained throughout the most recent period of Industrial Action by Resident Doctors (previously Junior Doctors). Most planned elective services went ahead as planned, as well as protected services in urgent and emergency care, cancer care and maternity. We appreciate that Resident Doctors taking strike action puts immense pressure on our staff and can affect the patients we work with, and I would like to thank everyone at WWL for their continued support and hard work during this five-day strike action.

Finance

In the first quarter of the year, the Trust reported a deficit of £2.5 million, which is £1.0 million worse than planned. We have experienced delays in delivering our Cost Improvement Programme (CIP), with £5.6 million delivered in the quarter against a target of £7.9 million, and 70% of this delivery is non-recurrent. This limits our ability to reduce the underlying deficit sustainably and places increased pressure on the remainder of the year to identify and implement recurrent savings. Recovery of the CIP position is therefore critical and will require a strengthened focus on recurrent delivery, acceleration of divisional recovery plans, and robust oversight through the Financial Improvement Group. In parallel, safely reducing the overall Whole Time Equivalent position remains a key priority, with actions focused on tight vacancy management, controlling temporary staffing, and aligning workforce plans with financial recovery objectives. On a more positive note, income is slightly ahead of plan, underpinned by strong elective activity performance. This reflects both

increased throughput and improved case mix, particularly in high-value specialties. Sustaining this level of activity will be key to maintaining financial resilience in the coming months, especially as we work to close the gap on recurrent savings delivery.

Recognition of Our People and Services

This month, we celebrated the high-quality medical education within WWL, recognizing the achievements of our doctors and students and their contributions to medical education. I attended the ceremony at our Medical Education Building alongside student doctors, FY1 and FY2, as well as colleagues from several divisions and family members of the student doctors. A total of 16 awards were presented on the day.

I would also like to congratulate Gideon Abegmafle, a Global Majority Practice Development Nurse and Chief Nursing Officer Fellow, who was awarded Nurse of The Year at the Caribbean and African Health Network (CAHN) Black Healthcare Awards. Since the National Health Service was established in July 1948, people of Black, Caribbean, and African heritage have played a fundamental role in the delivery of its care. We are incredibly proud of Gideon and the work being done at WWL to create a more diverse and inclusive nursing workforce.

Additionally, we were thrilled to announce last month that WWL has been shortlisted in six categories in this year's Nursing Times Awards. All shortlisted teams will present their award-worthy projects to a prestigious judging panel in September, and I look forward to updating you on the outcomes following the awards ceremony in October.

Finally, our very own Chief Medical Officer and Consultant Cardiologist, Professor Sanjay Arya, has been presented with his OBE (Officer of the Order of the British Empire) medal by King Charles at Windsor Castle. Accompanied by his family, Professor Arya was honoured for his services to Black and Minority Ethnic Doctors and Healthcare in North-West England (Greater Manchester).

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	9 July 2025
Chair:	Mary Moore

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

ALERT

- **Blood culture compliance in sepsis pathway**
  The Committee alerts the Board to continued underperformance in blood culture collection as part of the sepsis bundle. Despite improvements in other metrics, this remains a stubborn gap. A joint quality improvement project with Bolton NHS FT is being explored, and targeted education is underway. As actual numbers are low there is work ongoing with AQuA to progress a more representative metric.
- **Specialist services division update**
  Workforce in ultrasound and radiology remain high risk (20 / 16 respectively) with potential breaches of national guidance. This appears to be driven by inconsistent pay rates across GM. Mitigations are in place with Mutual aid, progressing a joint appointment with Edge Hill and a shared post with Bolton NHS FT. However, the risks remain as scored, currently.

ASSURE

- **Specialist services division update**
  The Committee was assured by the division's governance maturity, proactive risk management, and innovative work on ambulatory pathways. Notably, a new same-day discharge model in orthopaedics has significantly reduced length of stay and improved patient flow. Receiving Best Tariff payments for Fractured Neck of Femur remain low at 24% for April 2025. This pathway is impacted by pressure and flow issues with work from RAEI being undertaken in Wrightington. This should show an improvement following the 'My Recovery' work, GIRFT and the implementation of a new pathway.
- **Metastatic cancer patient experience project (staff story)**
  The Committee was assured by the Trust's leadership in capturing the lived experience of patients with metastatic cancer. The findings have informed a GM-wide strategy and are being used locally to improve pathways and communication. The project was commended for its compassionate and transparent approach. This work will inform future work on Better Lives and the NHS 10YP shift from hospital to community.
- **Complaints and patient experience reports**
  The Committee was assured by improvements in complaints handling, particularly in the

medicine division, and the integration of patient voice into learning. The use of infographics and Healthwatch engagement was noted as good practice

- **Quality impact assessments (QIA)**
  The Committee was assured that all service changes undergo rigorous quality impact assessment (QIA) scrutiny. Of 44 initial QIAs reviewed, three were escalated for full assessment, with two ultimately rejected due to potential negative impacts on quality or safety.

ADVISE

- **Neck of femur pathway and best practice tariff**
  The Committee advises that the Trust is currently in the bottom quartile nationally for time-to-ward metrics for fractured neck of femur patients, impacting both patient outcomes and financial reimbursement. The division is working to reinstate dedicated beds and improve flow, supported by the Trust's "Right Patient, Right Ward" objective
- **Maternity culture programme**
  The Committee advises that a bespoke organisational development programme is underway in maternity and child health, following a concerning staff survey. While midwifery engagement has been strong, medical engagement remains limited. A follow-up plan is in place, and the Committee will continue to monitor progress.
- **Deteriorating patient workstreams**
  The Committee advises that improvement work is progressing across several domains including oxygen prescribing, fluid balance, and GCS monitoring. Martha's Rule has been successfully implemented across inpatient areas, with plans to adapt it for A&E and maternity.
- **Microbiology**
  WWL has hired one microbiologist, shortly to take up post, with another waiting to be interviewed.
- **Complaints and patient experience reports Healthwatch Wigan and Leigh ED Capturing Experience Report highlighted:**
  People in ED were there for a large wide range of reasons and symptoms, over 80% of people had been directed to ED by a clinician and roughly 70% of the people thought there was no alternative to them presenting at ED. Work is ongoing to understand the profession of referring clinicians to inform Trust wide programmes of work.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

See alert point 2.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	29 July 2025
Chair:	Julie Gill

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

ALERT

Gastroenterology performance

The Committee alerts the Board to significant underperformance in gastroenterology, which accounts for half of the Trust's financial variance. A back-to-core business case has been developed, but recovery is not expected before September.

12-Hour Waits in ED

The Committee alerts the Board to continued breaches of the 12-hour wait target in ED. Immediate actions have been taken, including reconfiguration of the department and improved discharge processes.

CIP (Cost Improvement Programme) delivery and financial risk

The Committee alerts the Board that the Trust is £2.3m behind on CIP delivery. Weekly divisional huddles and escalations are in place, but the risk to financial sustainability remains high. WWL is 65 WTEs above plan, which is directly impacting the delivery of CIP.

Cash position and deficit support funding

The Committee alerts the Board that the Trust's cash position is deteriorating, with a forecast year-end balance of £1.5m. This is contingent on full delivery of CIP and receipt of deficit support funding, which is not guaranteed.

ASSURE

Solar panel investment

The Committee was assured that the £2.1m sustainability award for solar panel installation is on track for completion by year-end. This will deliver a £300k recurrent CIP and reduce the Trust's carbon footprint.

Pharmacy robot and Endoscopy Reprocessing Unit

The Committee was assured that replacement of the pharmacy robot and endoscopy reprocessing equipment is essential and fully funded. These investments will maintain operational efficiency and patient safety.

Centrus Financial System transition

The Committee was assured that transitioning from Oracle to Centrus will align the Trust with the GM-wide approach, improve procurement controls, and deliver annual savings of £50–100k 1.

Transformation Programme governance

The Committee was assured that transformation programmes are being actively managed, with clear SROs, financial targets, and oversight mechanisms. A workshop will be held to align capital investments with strategic priorities

Preparation for winter pressures

This was noted to be on track with many actions completed or in train.

ADVISE

Capital Business Cases (funded by public dividend capital) – in-principle approval

The Committee advises the Board that a suite of capital business cases has been approved in principle, subject to a follow-up workshop being held with members. This session will explore the strategic alignment, financial implications, and interdependencies of the proposals, particularly in relation to the 10-Year Plan and estate strategy.

Call Before Convey Scheme

The Committee advises that early results from the "Call Before Convey" scheme, aimed at reducing unnecessary hospital admissions via community-based triage, are promising. Further data and evaluation will be brought forward in future reports.

Elective recovery and tier 2 oversight

The Committee advises that elective recovery performance is improving, with positive feedback from Tier 2 oversight. Continued use of the independent sector and mutual aid is helping to reduce 65-week breaches.

Transformation programme reporting

The Committee advises that a new reporting structure for corporate transformation programmes has been agreed. Highlight reports for elective productivity and commercial opportunities will be brought to future meetings, with other programmes reporting to relevant committees

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

The Committee wished to highlight to the Board the need to ensure that financial risks on the Board Assurance Framework are appropriately scored (particularly income and investment, efficiency and cash – these are now contained within one risk).

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	10 June 2025
Chair:	Mr M Wilkinson

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

ALERT

- The Committee wished to alert the Board of an NHS England requirement to receive assurance on the correct application of the NHS Job Evaluation system. It was confirmed that a task and finish group would be established in relation to this and the Committee would receive a formal position report at our August meeting. The NHS Job Evaluation process is the tool to ensure equal pay. Consideration of medical staff job plan compliance highlighted the need for improvement and the Committee sought further assurance via an update at a future meeting.

ASSURE

- The learning needs analysis was well received and noted the alignment of training spend with trust priorities and personal development plans, indicating that the allocation of training monies is well-informed by organisational needs.
- The Committee approved the EDS (Equality Delivery System) Report for publication on the Trust website, this report illustrated that WWL is on track in terms of EDS compliance and although there is room to improve, particularly in relation to the Inclusive Leadership domain, the Committee was comfortable with the trajectory outlined and the actions outlined to address the inclusive leadership domain.
- The national statutory and mandatory training programme report confirmed that the Trust is on track with scheme of work as outlined by NHS England. The Trust has implemented all recommended actions within the due dates so far, and will take steps to review the locally mandated training courses by February 2026 as outlined in the programme of work. This will be reported back to the Committee before the final submission.
- The evidence of planning to improve engagement in the next National Staff Survey was received by way of assurance. The Committee requested a further update at the next meeting in terms of the range of actions taking place at a Divisional level.

ADVISE

- The Committee noted upcoming improvements to the appraisal strategy utilising a continuous improvement approach and that a subsequent internal audit will be undertaken to provide insight on how effective this has been.

- Retention (particularly the 20% turnover in the first year) and sickness absence were noted as challenges in the divisional report provided by community services. Pleasingly, the report highlighted the positive results from the staff survey.
- A more general update will be provided to the Committee in terms of sickness absence, following further queries raised on review of the workforce dashboard.
- The freedom to speak up annual report was received and noted.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- No risks were identified and the Committee was pleased to note no outstanding reports or recommendations in respect of internal audits.

Agenda item:

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Research Committee
Date of meeting:	3 July 2025
Chair:	Clare Austin

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

ALERT
▪ The committee raised several times throughout the meeting the matter of clinicians not having time to do research (including attending research related meetings). This has been highlighted as a concern previously and a need for additional support here was identified. ▪ The committee were advised of a letter that has been received from NHSE NHS England » Board oversight and staffing of NHS clinical trials which discusses Board visibility and recruitment to research posts. It was noted that the Research Committee provide an effective way for the Board to discharge its research responsibilities.
ASSURE
▪ The 3-year work plan associated with the research assurance framework is on track. ▪ There has been a positive increase in the number of patients recruited to NIHR trials, exceeding the target in Q4 of 2024/25 ▪ The Wigan Health and Care forum has good attendance from different stakeholders.
ADVISE
▪ The Committee thanks Prof. A Watts for his work as Clinical Director for Research and welcomed Prof. P Monga as the new Clinical Director for research ▪ The committee heard Ms V Lyle's research story around the virtual fracture clinic, the positive impact this is having on the patient journey. ▪ Discussions took place around the expectations for the involvement of ACPs AMPs and AHP's consultants in research, which is incorporated into their job descriptions and how this can be incorporated into their revalidation process, setting out WWL's expectations an linking it to the 4 pillars. ▪ Prof. S Arya to work with colleagues to allocate time for individuals to support commercial trials into their job plans to work towards allocating time for commercial trials in job plan ▪ The committee effectiveness was reviewed, with members of the committee agreeing that they would prefer the review to take place in a different format to ensure transparency and psychological safety when reviewing the committee ▪ ED&I reflections for the meeting noted that there is continued growth within the PPI group, the waiting lists that will be lower due to the virtual fracture clinic, the clinic will also support accessibility for patients and reduce travel for some as there will be less duplication.

They further noted that there are 72 subscribed members to the Wigan Health and Care forum and the focus of the forum being health inequalities across the borough.

- It was noted that the Research Strategy expired in 2026, and there is a plan to refresh this year through the committee and to develop a new associated workplan.
- Enhance WWL's research visibility on LinkedIn by focusing on high-quality content.
- The research team are working with Ms A Lowe, the WWL consultant in public health, who works with the Trust and the Local Authority.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- No significant risks were noted.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	M3 25/26 Integrated Performance Report
Presented to:	Board of Directors Meeting
On:	6th August 2025
Item purpose:	Information
Presented by:	Deputy Chief Executive
Prepared by:	Principal Data Analyst, Data Analytics and Assurance
Contact details:	BIPerformanceReport@wwl.nhs.uk

Executive summary

The latest month, for M3 June 25 update of the Trust's Integrated Performance Report (IPR) is presented to the Board of Directors.

The metrics within the report have been updated to reflect priorities for 25/26. Each of the metrics has been evaluated to a Data Quality Assessment Framework with results shown in the report.

We are pleased to report that, for the second month running, there have been no never events - a significant achievement that underlines our commitment to safe care. Our key mortality metrics illustrate an encouraging picture. The Summary Hospital-level Mortality Indicator (SHMI) has improved again, reaching 102.5 and remaining within the expected range, whilst the Hospital Standardised Mortality Ratio (HSMR) remains stable and well below the 100 index at 94.8.

The number of patient safety incidents triggering an investigation has dropped to just one, below our internal threshold and reflective of our safety interventions. While there has been a slight increase in incidents requiring patient safety review, these numbers remain comfortably beneath our threshold, indicating a strong culture of continuous improvement.

Our performance regarding category 2 Hospital-Acquired Pressure Ulcers (HAPUs) continues on a positive trajectory, with a notable decrease from 38 to 25 in Month 3, reflecting our focused efforts in this area. For the past 24 months, there have been no community-acquired pressure ulcers attributable to an act or omissions in care. However, we acknowledge the development of one category 3 HAPU related to care provided by our organisation. This has prompted further reflection and action, reinforcing our commitment to learning and prevention. June also saw the successful hosting of a Trust-wide learning event, bringing together system partners to share insights and collaborate on addressing Borough-wide challenges.

Four out of six infection metrics saw some deterioration this month. We continue to prioritise robust surveillance and mandatory monthly reporting of all healthcare-associated infections (HCAIs). Each case is thoroughly reviewed through our internal process, ensuring that learning, best practice, and emerging trends are quickly disseminated across the Trust. It is also important to note that there is no published NHS England threshold for MSSA, which guides our interpretation of this metric.
We are encouraged by the improvement in complaint response times, with Month 3 seeing a rise to 77.1%. While this is still below our standard, our ongoing emphasis through fortnightly meetings and 'lightning learning' sessions is generating momentum. There has also been a continued reduction in complaints requiring further review after final response, indicating an improvement in the quality of replies. The volume of complaints increased this month from 70 to 74, mainly within the Medicine Division, reflecting the ongoing challenge of patient waits in the Emergency Department - a key area for our ongoing attention.

Staff appraisal rates have continued their upward trend, moving from 81.8% to 83.1%. Although we have not yet achieved our 90% standard, focused divisional action plans and assurance meetings are supporting this positive direction. The updated appraisal process for 2025/26 now fully embeds our new Trust values. Further enhancements are under development, informed by valuable feedback from the 2024 National Staff Survey.

Sickness absence is up slightly in Month 2, from 5.6% to 5.9%, remaining above our target of 5%. This remains an area of focus, with supportive management and health initiatives in place to address underlying causes.

Workforce turnover remains relatively stable at 8.6%, just above our target of 8.5% and notably below peer averages within Greater Manchester. Encouragingly, most staff exiting the organisation is due to retirement or promotion, highlighting our role in career progression and lifelong learning.
Vacancy rates have increased for the third consecutive month, reaching 4.3%, partially a result of the continuation of the vacancy hold into July. The highest rates are seen within Allied Health Professionals at 7.2%. A targeted initiative, led by our Chief AHP, is now underway to address this challenge.

Our whole-time equivalent (WTE) workforce in Month 3 stands at 6931.5, representing a reduction of 29.7 WTE compared to last month, but still 65 WTE above the Trust plan. Divisions are refining their workforce plans as cost improvement programmes are developed and transacted, with the Mutually Agreed Resignation Scheme (MARS) expected to have further impact going forward. Oversight remains rigorous through our Divisional Performance meetings and governance forums.
Price cap compliance improved in Month 3 to 24.4%, a notable step forward though still below the 60% target. As the number of non-compliant individuals reduces, the remaining cases are increasingly concentrated in critical roles that are hard to fill, making further rapid progress a challenge but not surmountable.

Emergency Department (ED) flow remains a significant focus. Month 3 saw a slight increase in 4-hour wait performance, reaching 71.7% against a 76% standard, reflecting ongoing operational pressures. The proportion of patients spending over 12 hours in the ED also rose to 18.3% (standard: 10%). We have robust action plans in place to address both metrics, including enhanced partnership working and targeted process improvements.

Ambulance handover times remained strong, with an average of 32 minutes in May against a target of 38 minutes. The proportion of patients not meeting criteria to reside dropped to 30.7%, a reduction from Month 2, though we acknowledge that this remains significantly above the 12.5% target. Collaborative work between our Community React Team and the Community Admissions Avoidance Team (CAAT) is having a positive impact on ED pressures, and the urgent 2-hour response target continues to be achieved. The Call to Convey project, in partnership with Northwest Ambulance Service, is successfully reducing ED conveyance rates, further alleviating unscheduled care pressures.

The 31-day cancer performance for May was 91.49%; we recognise this has dipped from the Month 1 position of 94.9% and remains just below the 96% target. There were also minor decreases in the 28-day and 62-day cancer performance metrics (76.3% and 76.5% respectively). Challenges around capacity and pathways in colorectal and breast services have contributed to these outcomes, and focused improvement work is actively underway.

Our radiology teams continue to prioritise safety and service continuity, even as we navigate significant clinical risks in non-obstetric and obstetric ultrasound provision. Currently, 40% of patients are waiting more than six weeks for routine appointments, a variance from the 5% interim target. However, we are taking decisive action, with mitigation plans in place to increase staffing and reduce backlogs.

Notably, the wait times for MR scans have begun to show incremental improvement, with clear expectations for recovery by the end of September 2025. The team is prioritising reductions in complex examination backlogs and will next focus on high-complexity, low-volume cases, which is anticipated to accelerate progress.

Financially, Month 3 reflects an adverse variance in the revenue plan of £0.3m and £1.0m year to date, a deterioration from Month 2. This is primarily due to underperformance on our cost improvement programme (CIP), which, though now fully identified, is £2.5m below plan year to date. In response, we have strengthened escalation and management oversight to support delivery of the CIP. Elective activity levels remain positive, maintaining last month's improvement. Importantly, non-delivery of CIP impacts cash reserves, which closed Month 3 at £11.6m—a decrease of £3.8m since May. Notably, Bank expenditure remains controlled, running 13% lower than the 2024/25 average baseline.

Link to strategy and corporate objectives

This report provides the agreed key metrics and analysis that underpin delivery of our strategy and corporate objectives and aligned to national indicators.

Risks associated with this report and proposed mitigations

There are no risks currently associated with the report.

Financial implications

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

Legal implications

None currently identified.

People implications

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

Equality, diversity and inclusion implications

None currently identified.

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

IPR Executive meeting 28.7.25, ETM 31.7.25.

Recommendation(s)

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

Report

Please see the attached M3 25/26 IPR report.

Appendices

None.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

25/26 Integrated Performance Report

Meeting presented to:

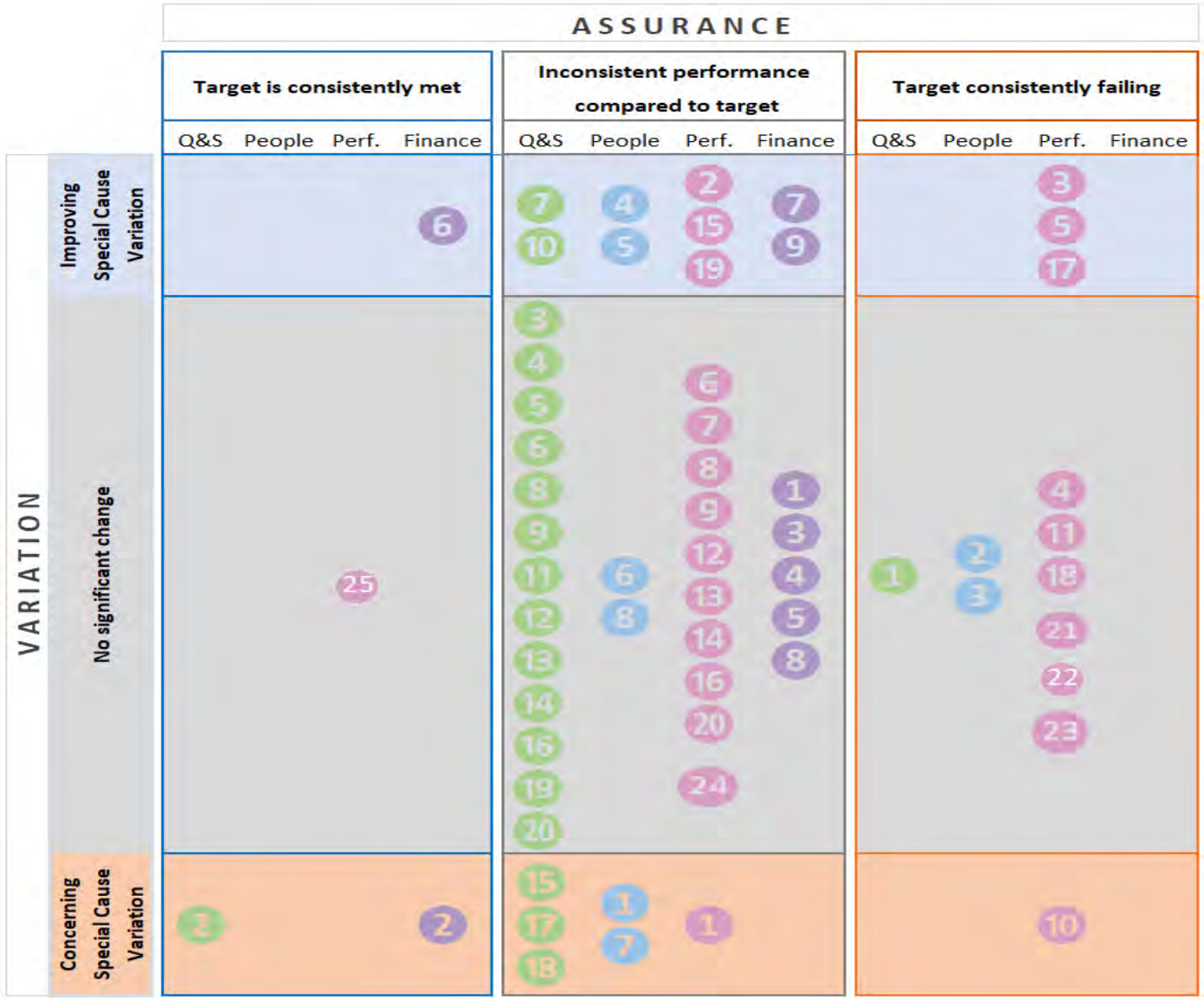
Board of Directors : 06/08/25

Contents

Trust Matrix : M3 25/26

VARIATION	ASSURANCE: Target is consistently met (P)	Inconsistent performance compared to target (?)	Target consistently failing (F)
Improving Special Cause Variation (H / L)	Agency Expenditure (£m)	Methicillin-Resistant Staphylococcus Aureus (MRSA) % Turnover Rate Vacancy Rate RTT Waiting List Percentage of Patients Waiting Over 52 Weeks for Community Services Overnight Total General and Acute Beds and the Number of Which are Occupied Bank Expenditure (£m) Better Payment Practice Code (BPPC)	SHMI Rolling 12 Months Percentage of Patients Waiting Over One Year Total Patients Waiting Over 65 Weeks Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours
No significant change	Urgent Community Response (UCR) Referrals	Never Events Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation How Many Incidents Triggered a Patient Safety Review 25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions or Lapses in Care To reduce the total number of falls per 1000 bed days Methicillin-Susceptible Staphylococcus Aureus (MSSA) WWL Clostridium Difficile (CDT) Escherichia Coli (E.coli) Klebsiella Species Reduction in the Number of Patients who Transfer Between Wards More Than 5 Times Complaints Responses Patient Experience (FFT) - Patients who Would Recommend the Service Number of Whole Time Equivalent Posts Time to Hire Percentage of Patients Treated Within 18 Weeks Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks Cancer 31 Day Treatment Standard Performance Percentage of Patients Treated for Cancer Within 62 Days of Referral Elective Theatre Utilisation - Capped Touchtime Elective Recovery Plan : Day Case Activity Performance Elective Recovery Plan : Inpatient Activity Performance Average Time to Ambulance Handover Virtual Ward Occupancy Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days Adjusted Financial Performance (£m) - Variance to Plan API Income (£m) - Variance to Plan Total Cost Improvement Programme (CIP) (£m) - Variance to Plan Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan Capital Expenditure (£m) - Variance to Plan	Appraisal Price Cap Compliance Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under Outpatient New : Follow-up Ratio Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days Average Number of Days Between Planned and Actual Discharge Date Percentage of Patients who do not Meet the Criteria to Reside
Concerning Special Cause Variation (H / L)	HSMR Rolling 12 Months Cash (£m)	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care Reduction in Category 2 and DTI HAPU and CAPU Overall Pseudomonas Aeruginosa Mixed Sex Accomodation Breaches - Non Clinically Justified Reduction in the Number of Complaints Mandatory Training Compliance Sickness - Percentage Time Lost (%) Total Patients Waiting for First Attendance	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test

Trust Matrix : M3 25/26



	Q&S-1
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 PSI Investigation
5	How Many Incidents Triggered a Patient Safety Review
6	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care
7	Reduction in Category 2 and DTI HAPU and CAPU Overall
8	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care
9	To reduce the total number of falls per 1000 bed days
	Q&S-2
10	Methicillin-Resistant Staphylococcus Aureus (MRSA)
11	Methicillin-Susceptible Staphylococcus Aureus (MSSA)
12	WWL Clostridium Difficile (CDT)
13	Escherichia Coli (E.coli)
14	Klebsiella Species
15	Pseudomonas Aeruginosa
16	Reduction in the Number of Patients who Transfer Between Wards More Than 5 Times
17	Mixed Sex Accomodation Breaches - Non Clinically Justified
18	Reduction in the Number of Complaints
19	Complaints Responses
20	Patient Experience (FFT) - Patients who Would Recommend the Service
	People
1	Mandatory Training Compliance
2	Appraisal
3	Price Cap Compliance
4	% Turnover Rate
5	Vacancy Rate
6	Number of Whole Time Equivalent Posts
7	Sickness - Percentage Time Lost (%)
8	Time to Hire

	Elective Care
1	Total Patients Waiting for First Attendance
2	RTT Waiting List
3	Percentage of Patients Waiting Over One Year
4	Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under
5	Total Patients Waiting Over 65 Weeks
6	Percentage of Patients Treated Within 18 Weeks
7	Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks
8	Cancer 31 Day Treatment Standard Performance
9	Percentage of Patients Treated for Cancer Within 62 Days of Referral
10	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test
11	Outpatient New : Follow-up Ratio
12	Elective Theatre Utilisation - Capped Touchtime
13	Elective Recovery Plan : Day Case Activity Performance
14	Elective Recovery Plan : Inpatient Activity Performance
15	Percentage of Patients Waiting Over 52 Weeks for Community Services
	Urgent & Emergency Care
16	Average Time to Ambulance Handover
17	Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours
18	Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department
19	Overnight Total General and Acute Beds and the Number of Which are Occupied
20	Virtual Ward Occupancy
21	Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days
22	Average Number of Days Between Planned and Actual Discharge Date
23	Percentage of Patients who do not Meet the Criteria to Reside
24	Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days
25	Urgent Community Response (UCR) Referrals
	Finance
1	Adjusted Financial Performance (£m)
2	Cash (£m)
3	API income (£m)
4	Total Cost Improvement Programme (CIP) (£m)
5	Recurrent Cost Improvement Programme (CIP) (£m)
6	Agency Expenditure (£m)
7	Bank Expenditure (£m)
8	Capital Expenditure (£m)
9	Better Payment Practice Code (BPPC)

Trust Holistic Narrative : M3 25/26 Page 1 of 2

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Trust Holistic Narrative : M3 25/26 Page 2 of 2

Our whole-time equivalent (WTE) workforce in Month 3 stands at 6931.5, representing a reduction of 29.7 WTE compared to last month, but still 65 WTE above the Trust plan. Divisions are refining their workforce plans as cost improvement programmes are developed and transacted, with the Mutually Agreed Resignation Scheme (MARS) expected to have further impact going forward. Oversight remains rigorous through our Divisional Performance meetings and governance forums.

Price cap compliance improved in Month 3 to 24.4%, a notable step forward though still below the 60% target. As the number of non-compliant individuals reduces, the remaining cases are increasingly concentrated in critical roles that are hard to fill, making further rapid progress a challenge but not surmountable.

Emergency Department (ED) flow remains a significant focus. Month 3 saw a slight increase in 4-hour wait performance, reaching 71.7% against a 76% standard, reflecting ongoing operational pressures. The proportion of patients spending over 12 hours in the ED also rose to 18.3% (standard: 10%). We have robust action plans in place to address both metrics, including enhanced partnership working and targeted process improvements.

Ambulance handover times remained strong, with an average of 32 minutes in May against a target of 38 minutes. The proportion of patients not meeting criteria to reside dropped to 30.7%, a reduction from Month 2, though we acknowledge that this remains significantly above the 12.5% target. Collaborative work between our Community React Team and the Community Admissions Avoidance Team (CAAT) is having a positive impact on ED pressures, and the urgent 2-hour response target continues to be achieved. The Call to Convey project, in partnership with North West Ambulance Service, is successfully reducing ED conveyance rates, further alleviating unscheduled care pressures.

The 31-day cancer performance for May was 91.49%; we recognise this has dipped from the Month 1 position of 94.9% and remains just below the 96% target. There were also minor decreases in the 28-day and 62-day cancer performance metrics (76.3% and 76.5% respectively). Challenges around capacity and pathways in colorectal and breast services have contributed to these outcomes, and focused improvement work is actively underway.

Our radiology teams continue to prioritise safety and service continuity, even as we navigate significant clinical risks in non-obstetric and obstetric ultrasound provision. Currently, 40% of patients are waiting more than six weeks for routine appointments, a variance from the 5% interim target. However, we are taking decisive action, with mitigation plans in place to increase staffing and reduce backlogs.

Notably, the wait times for MR scans have begun to show incremental improvement, with clear expectations for recovery by the end of September 2025. The team is prioritising reductions in complex examination backlogs and will next focus on high-complexity, low-volume cases, which is anticipated to accelerate progress.

Financially, Month 3 reflects an adverse variance in the revenue plan of £0.3m and £1.0m year to date, a deterioration from Month 2. This is primarily due to underperformance on our cost improvement programme (CIP), which, though now fully identified, is £2.5m below plan year to date. In response, we have strengthened escalation and management oversight to support delivery of the CIP. Elective activity levels remain positive, maintaining last month's improvement. Importantly, non-delivery of CIP impacts cash reserves, which closed Month 3 at £11.6m—a decrease of £3.8m since May. Notably, Bank expenditure remains controlled, running 13% lower than the 2024/25 average baseline.

Using Statistical Process Control (SPC) Charts

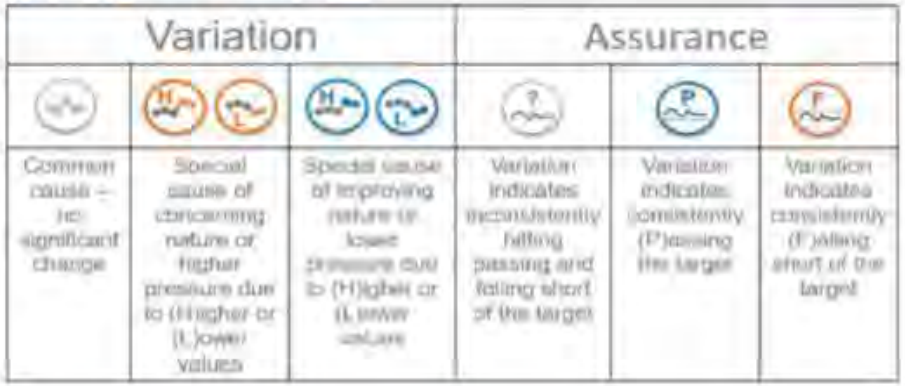
Statistical Process Control (SPC) is a method for viewing data over time to highlight variation. This methodology has long been associated with Quality Improvement and enables us to understand where variation is normal and also where variation is different and requires further actions. This is known as special cause variation.

SPC Charts have upper and lower process limits. Approximately 99% of data points will fall between these two control limits. If a target is outside of the control limits, it is unlikely that it will be achieved without a change in practice.

Icons are used on our SPC charts for ease of interpretation. As well as these icons giving an indication of whether variation is normal or not, there are also icons providing an indication of assurance in terms of performance targets.

SPC charts aren't always appropriate for all metrics and where this is the case, alternative charts will be used showing trends over time, including any applicable targets.

NHS England's SPC Icons



Understanding the rules of SPC

There are a number of rules that help us interpret SPC charts. These rules indicate something that would not happen through natural variation:

- A single data point outside of the process limit
- Consecutive data points above or below the mean
- Six consecutive points increasing or decreasing
- Two out of three points close to the process limit – an early warning

These rules indicate *special cause variation*.

Data Quality Assessment Framework Overview

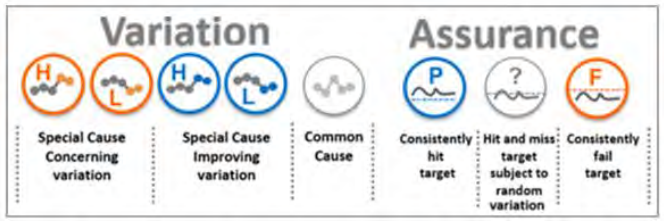
Each of the metrics within the IPR have been assessed to the scoring framework outlined below.
We assess the Sign off and Review process, whether the data is Timely and Complete and assess the Process and System around the data. We score this as per the table below and include an assessment on each of the summary pages in the report.

Component	Subcomponent	Checkpoint	Rationale	Score	Subcomponent RAG Rating	Component RAG Rating
Sign off and Review	Sign Off	Metric definition been agreed and sense checked by the report producer	This will assess the level to which the definition has been agreed and how widely sense checked.	1	1	≤ 3 = Red 3 = Amber 4 - 6 = Green
		Metric definition been agreed and sense checked by a senior leader in the DAA team		2	2	
		Metric definition been agreed and sense checked by clinical and/or operational SRO		3	3	
	Review	Metric is outside of the review period	This will assess the timeliness of the data. Some data will only be made available in arrears (eg SHMI, HSMR, cancer) - should thosetheir review period be agreed differently?	1	1	
		Metric is within one month of the review period		2	2	
		Metric is within the review period		3	3	
Timely and Complete	Timely	Major changes to reported data at the next snapshot	Changes above 10% tolerance expected to previously reported data.	1	1	≤ 2 = Red 3-4 = Amber 5 - 6 = Green
		Minor changes to the reported data at the next snapshot	Less than 10% tolerance changes expected to previously reported data.	2	2	
		No changes to the reported data at the next snapshot	No changes made to previously reported data.	3	3	
	Complete	More than 10% of values in reported data are missing	More than 10% of values in reported data are expected to be missing	1	1	
		Less than 10% of values in reported data are missing	Less than 10% of values in reported data are expected to be missing	2	2	
		No missing values in reported data	No missing values in reported data	3	3	
Process and System	Process	There are no validity checks performed on reported data	There are no validity checks performed on reported data	1	1	≤ 2 = Red 3-4 = Amber 5 - 6 = Green
		Data is processed following business logic rules which have not yet been assessed by the DAA assurance process, or have not met the Silver standard	Data is processed following business logic rules. However, these rules have either not yet been assessed using the DAA assurance process, or have not met the Silver or Gold Standard. The review must have been completed within the last 3 years	2	2	
		Data is processed following business logic rules which have been assessed by the DAA assurance process and have been awarded Silver or Gold standard	Data is processed following business logic rules. These rules have been assessed using the DAA assurance process, and have met the Silver or Gold Standard within the last 3 years	3	3	
	System	Data is collected outside of a proper digital system e.g. spreadsheet or manual report	Data is recorded outside of a recognised digital system	1	1	
		Data is split over multiple digital systems or recorded data is not structured	Data is split over multiple digital systems or recorded data is not structured	2	2	
		A digital system is used to record structured data	A digital system is used to record structured data	3	3	

Quality & Safety Overview 1 of 2: M3 25/26

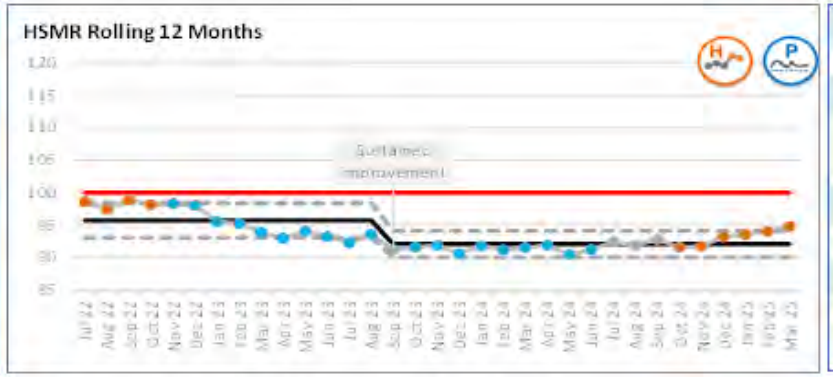
	KPI	Latest month	Measure	Threshold	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	SHMI Rolling 12 Months	Feb 25	102.52	100	L	F	104.70	103.36	106.04	S	T	P
2	HSMR Rolling 12 Months	Mar 25	94.80	100	H	P	92.09	90.05	94.13	S	T	P
3	Never Events	Jun 25	0	0		?	0	0	2	S	T	P
4	Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation	Jun 25	1	4		?	2	0	8	S	T	P
5	How Many Incidents Triggered a Patient Safety Review	Jun 25	23	33		?	26	0	52	S	T	P
6	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care	Jun 25	1	0		?	1	0	3	S	T	P
7	Reduction in Category 2 and DTI HAPU and CAPU Overall	Jun 25	36	34	H	?	29	9	50	S	T	P
8	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care	Jun 25	1.0	0.5		?	0.7	0.0	2.6	S	T	P
9	To reduce the total number of falls per 1000 bed days	Jun 25	6.8	6.1		?	7.0	4.3	9.8	S	T	P

Summary icons key:

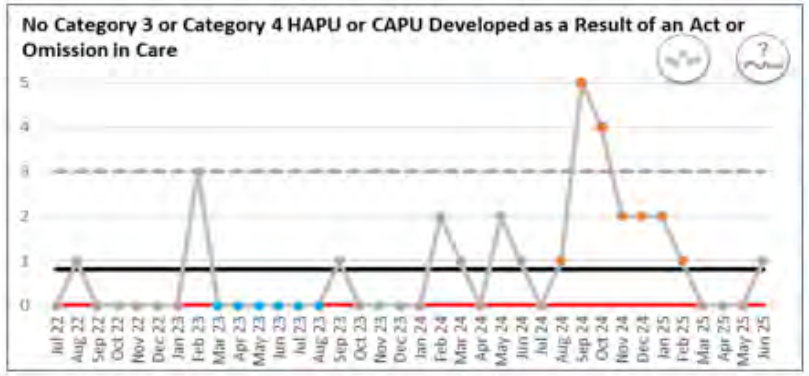


Quality & Safety Insight Report 1 of 2: M3 25/26

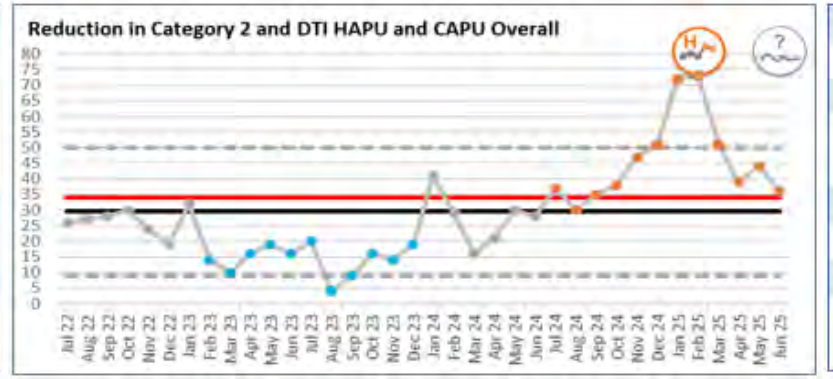
Feb-25
103
Variance Type
Special cause improving variation points
Threshold
100
Target achievement
Metric is consistantly missing the target/ threshold



Mar-25
95
Variance Type
Special cause concerning variation points
Threshold
100
Target achievement
Metric is consistantly achieving the target/ threshold



Jun-25
1
Variance Type
Common Cause Variation
Threshold
0
Target achievement
Inconsistent performance compared to threshold/ target



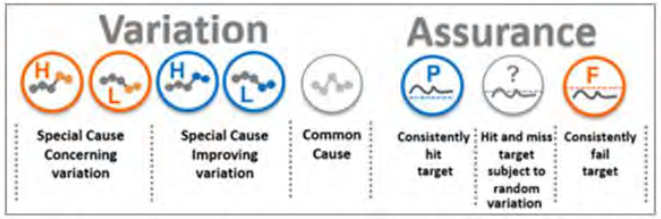
Jun-25
36
Variance Type
Special cause concerning variation points
Threshold
34
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1 & 2 SHMI / HSMR : Monthly and quarterly mortality review groups continue to review any areas of SHMI that are alerting and seek assurances that these are being managed appropriately. **3. Pressure ulcers, omissions in care:** There was 1 category 3 HAPU in June that developed as a result of an omission or act of care. **4. Pressure Ulcers :** The number of cat 2 and 3 pressure ulcers has increased overall during month 3, but there is continued downward trend in terms of them developing due to acts or omissions in care; both community and in hospital.	**1 & 2 SHMI / HSMR :** Continue improvement plans to ensure that patients are appropriately managed. Continue to work with system partners to ensure appropriate discharge placements for patients **3. Pressure ulcers, omissions in care:** Focused work in progress following deep dives on Aspull, ASU and ED. **4. Pressure Ulcers :** Embed learning from the system wide learning event held in June to inform a review of borough wide pressure ulcer policy.	**1 & 2 SHMI / HSMR :** SHMI is currently within national expected range 'funnel plot' and has been so for many months. Both SHMI and HSMR are continuing to fall and are now better than some other similar sized GM Trusts **3. Pressure ulcers, omissions in care**: Continued scrutiny of all pressure ulcers reported to identify learning opportunities . **4. Pressure Ulcers :** Pressure ulcer plan reviewed with a re-focus on new learning identified through learning events and reviews, monitored by Harm Free Care Group.

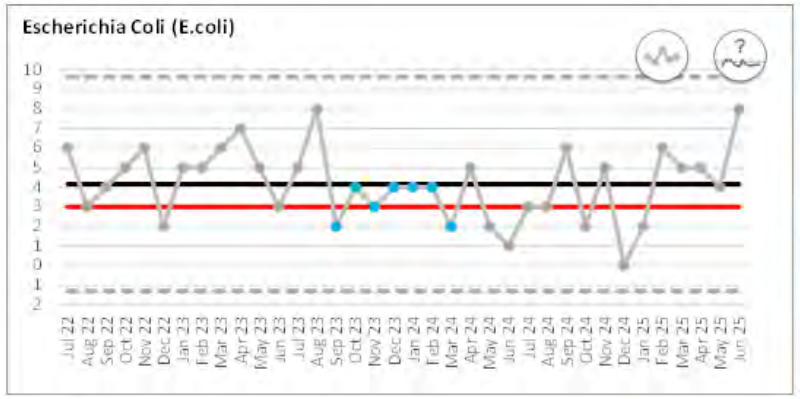
Quality & Safety Overview 2 of 2: M3 25/26

	KPI	Latest month	Measure	Threshold	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
10	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Jun 25	0	0	L	?	0	0	0	S	T	P
11	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Jun 25	3	0		?	1	0	5	S	T	P
12	WWL Clostridium Difficile (CDT)	Jun 25	7	5		?	6	0	17	S	T	P
13	Escherichia Coli (E.coli)	Jun 25	8	3		?	4	0	10	S	T	P
14	Klebsiella Species	Jun 25	1	1		?	1	0	4	S	T	P
15	Pseudomonas Aeruginosa	Jun 25	2	0	H	?	0	0	2	S	T	P
16	Reduction in the Number of Patients who Transfer Between Wards More Than 5 Times	Jun 25	5	8		?	7	0	14	S	T	P
17	Mixed Sex Accomodation Breaches - Non Clinically Justified	Jun 25	18	19	H	?	14	2	25	S	T	P
18	Reduction in the Number of Complaints	Jun 25	74	40	H	?	42	19	66	S	T	P
19	Complaints Responses	Jun 25	77.1%	90.0%		?	66.9%	42.8%	91.0%	S	T	P
20	Patient Experience (FFT) - Patients who Would Recommend the Service	Jun 25	88.5%	90.0%		?	87.2%	81.0%	93.5%	S	T	P

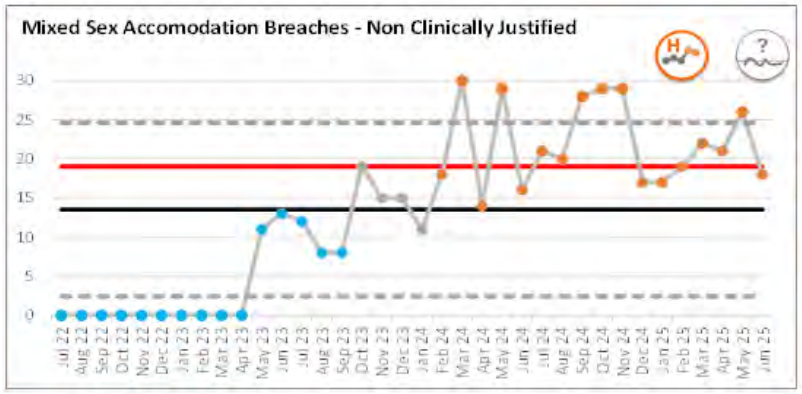
Summary icons key:



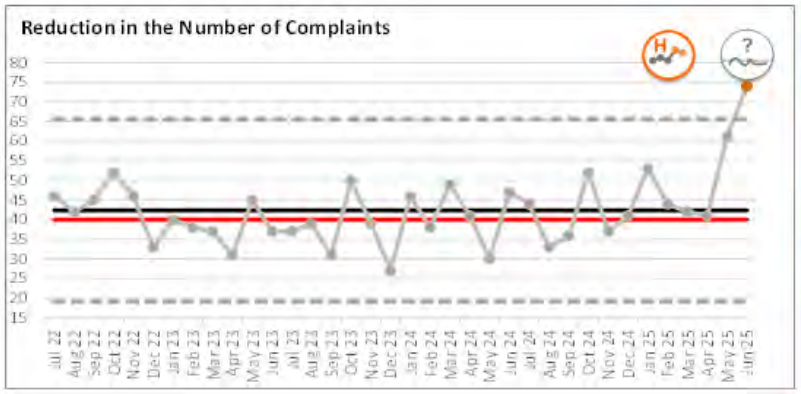
Quality & Safety Insight Report 2 of 2: M3 25/26



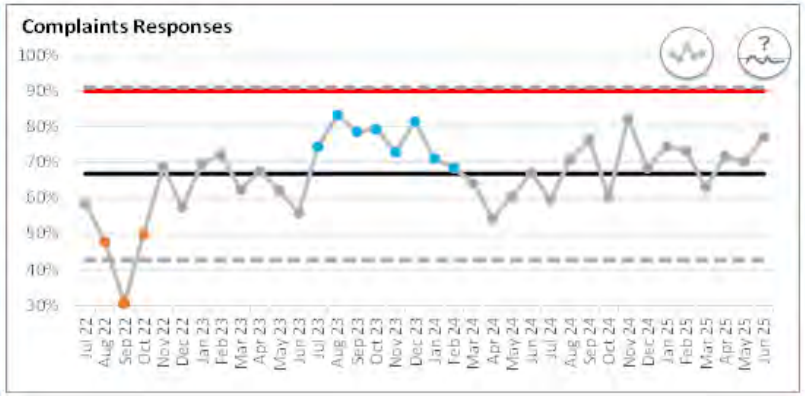
Jun-25
8
Variance Type
Common cause variation
Threshold
3
Target achievement
Inconsistent performance compared to threshold/ target



Jun-25
18
Variance Type
Special cause concerning variation
Threshold
19
Target achievement
Inconsistent performance compared to threshold/ target



Jun-25
74
Variance Type
Special cause concerning variation
Threshold
40
Target achievement
Inconsistent performance compared to threshold/ target



Jun-25
77.14%
Variance Type
Common cause variation
Threshold
90%
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. **E.Coli** - there was an increase in month 2. **Mixed Sex accommodation –** there was a decrease in June 3. **Complaints** - The current response rate is not at the level required, although an improvement from previous month. 4. **Complaints** – there was an increase in June and this will be reviewed further	1. **E.Coli -** whilst there is an increase, every incident is currently under a review in line with national guidance, causation themes are being identified to inform local remedial action plans. 2. **Mixed sex accommodation –** there was a slight decrease in the numbers and is reviewed at bed meetings 3. **Complaints -** Lightning learning and focussed education to empower frontline teams to manage concerns better and work towards reducing the number of complaints made 4. Further review of increase and any themes and trends	1. All incident themes are reported through Infection Control Groups. 2. Mixed Sex accommodation is reviewed at bed meetings 3. **Complaints :** There has been a continued reduction in 'second bites' those complainants who return to us following their final responses 4. All complaints are reviewed at LFPSE weekly meetings, divisional group meetings and Corporate Patient Experience Group

Quality & Safety Narrative: M3 25/26

SHMI / HSMR
The Trust most up to date SHMI from Jan 2025 is 103.27 which is a reduction from last month and still well within the 'funnel plot' for expected range. Alerting groups are reviewed within the monthly and quarterly mortality groups in order to ensure plans are in place for any areas of concern.

Incidents
In month 3 (June 2025), the Trust escalated 1 incidents as a PSII. This incident involved a delay in the management of a patient presenting with chest pains confirmed to have suffered aa non ST-Elevation Myocardial Infarction. Key issues identified included an abnormal ECG recorded by NWAS but not action on presentation to ED, repeat ECG not completed for 3 hours. This has idented a possible recurring theme of delayed ECGs in patients presenting with chest pains. In light of these, a thematic review has been commissioned to review the issues and identify remedial actions.

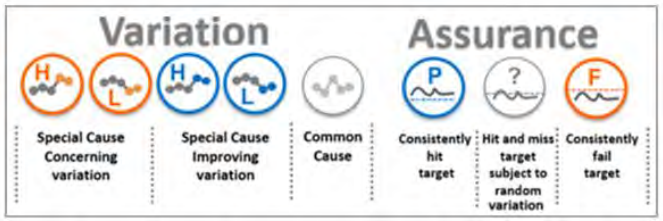
Complaints
We improved our complaints response rate to 77.1% in June 2025. Complaints fortnight meetings continue with the Executive Chief Nurse and Divisional Directors of Nursing to provide support and scrutiny. Lightning learning and support from the Patient Relations Team is continuing to support and empower all staff to manage concerns. Complaints and incidents are reviewed weekly within the Learning from Patient Safety Events Group and any that are linked are noted here to ensure that there is cross working to support patients who have made a complaint that are also linked to adverse events.

Holistic Summary
Learning from incidents and complaints is reviewed within the weekly LFPSE meeting, the theme of possible delays in ECGs has been escalated as a Thematic review, being medically led.

Our People Overview : M3 25/26

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	Mandatory Training Compliance	Jun 25	92.2%	95.0%	L	?	94.9%	93.8%	95.9%	S	T	P
2	Appraisal	Jun 25	83.1%	90.0%		F	81.9%	80.6%	83.2%	S	T	P
3	Price Cap Compliance	Jun 25	24.4%	60.0%		F	30.3%	17.4%	43.1%	S	T	P
4	% Turnover Rate	Jun 25	8.6%	8.5%	L	?	8.7%	8.4%	9.0%	S	T	P
5	Vacancy Rate	Jun 25	4.3%	5.0%	L	?	5.9%	4.9%	6.9%	S	T	P
6	Number of Whole Time Equivalent Posts - Variance to plan	Jun 25	-64.99	0.00		?	-86.04	-213.68	41.60	S	T	P
7	Sickness - Percentage Time Lost (%)	Jun 25	5.9%	5.0%	H	?	5.5%	4.8%	6.2%	S	T	P
8	Time to Hire	Jun 25	55.9	65.0		?	57.6	46.4	68.8	S	T	P

Summary icons key:



Our People Narrative : M3 25/26

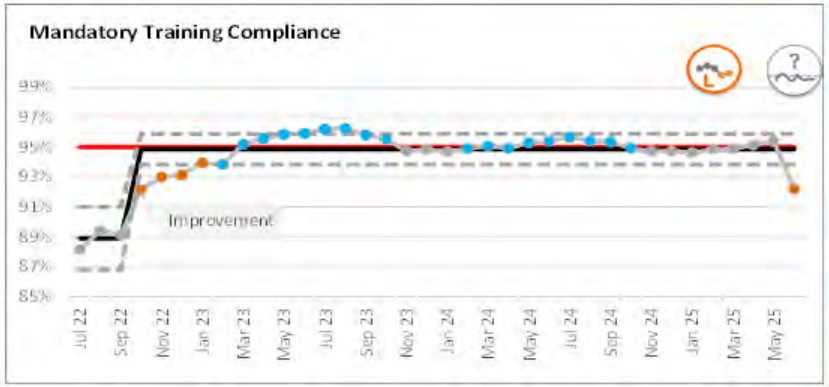
Appraisals – As of June 2025 (M3), appraisal compliance has improved to 83.1%, up from 81.8% in May. While progress continues, the rate remains below the Trust's 95% target. All divisions remain under close scrutiny through Divisional Performance Reviews, with progress monitored against local action plans. Further emphasis is being placed on leadership accountability and consistent appraisal quality to support cultural transformation.

Price cap compliance – the overall Price cap compliance has improved to 24.4%, this was driven mainly from the improvement to the Non-Medical price cap compliance to 100% exceeding the national target set at 80%, whilst the medical price cap compliance has declined to 0.25%, significantly below the national target of 60%, as per previous month this continues to be driven by medical agency locum shifts exceeding NHSE price caps. Key drivers continue to include high-cost medical locum shifts and difficulty sourcing compliant agency staff. The Medical Vacancy Control Group continues to oversee agency usage, with enhanced efforts to convert long-term locums to bank contracts, re-negotiate agency rates, and implement the agency tiering framework to drive up compliance.

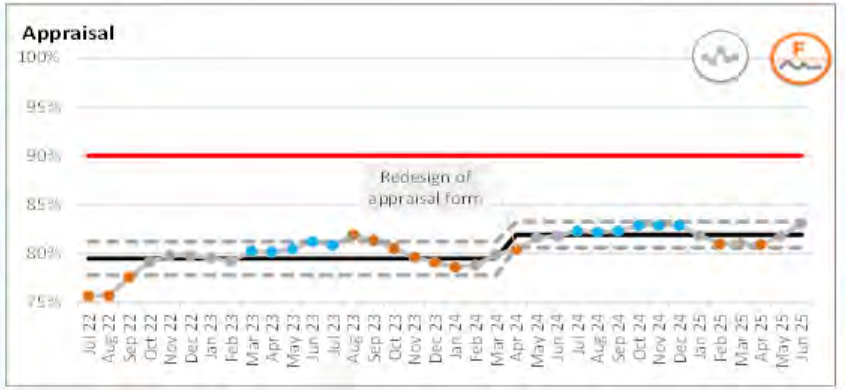
Vacancy Rate – The Trust-wide vacancy rate has increased slightly to 4.3%, though remains below the 5% target. The highest vacancy rates remain in AHP (7.2%%), Additional Clinical Services (6.4%), and Admin & Clerical (6.1%). Nursing & Midwifery (1.5%), Estates & Ancillary (3.1%) and Medical & Dental (4.4%) report the lowest rates. The recruitment hold introduced in June will continue in July. A robust Quality Impact Assessment (QIA) process is in place to ensure any impacts on patient safety and service continuity are fully considered.

WTE – Total workforce in June was 6,931.5 WTE, a reduction of 29.7 WTE from May. Despite the fall, workforce levels remain 65 WTE above plan. Substantive decreased (−7.1 WTE) but remains 82.6 WTE above plan. Bank usage fell significantly (−24.8 WTE), now 6.9 WTE below plan, reflecting tighter control or reduced internal availability. Agency usage increased marginally (+2.2 WTE) but remains below plan (−10.8 WTE), indicating continued cost containment.

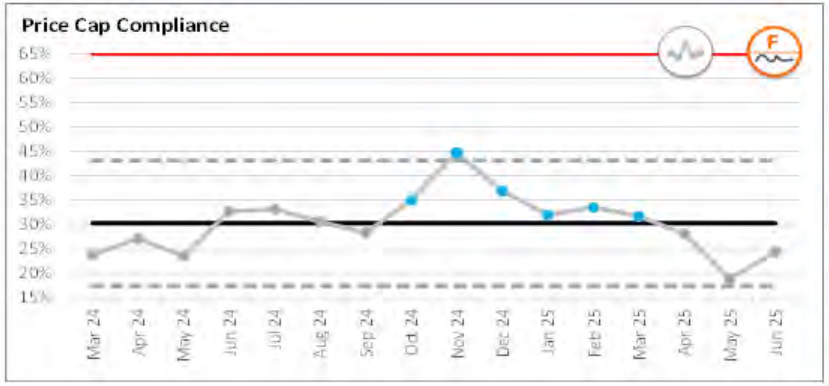
Our People Insight Report : M3 Month Year



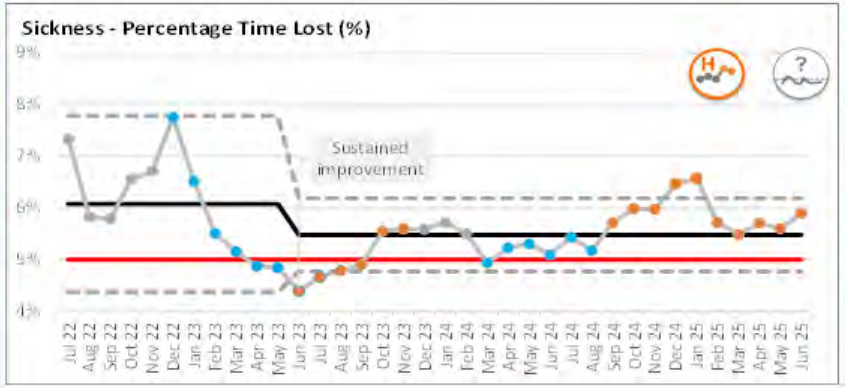
Jun-25
92.2%
Variance Type
Special cause concerning variation
Target
95%
Target achievement
Inconsistent performance compared to threshold/ target



Jun-25
83.1%
Variance Type
Common cause variation
Target
90%
Target achievement
Metric is consistently missing the threshold/ target



Jun-25
24.4%
Variance Type
Special cause improving variation
Target
60%
Target achievement
Metric is consistently missing the threshold/ target



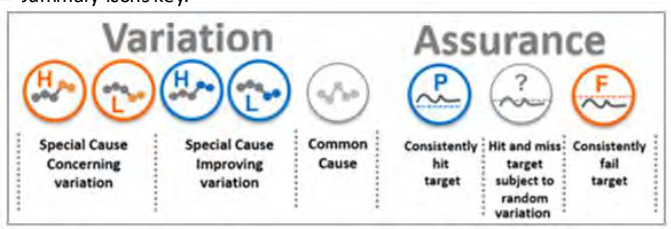
Jun-25
5.9%
Variance Type
Special cause improving variation
Target
5.0%
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. At 83.1% and despite improvement from last month, appraisal rates continue to remain below the target of 90% 2. Price cap compliance is significantly below the target, predominantly due to medical agency locums, and has not achieved it at any point in the previous 12 months, however non-medical price cap compliance remains strong and continues to axed the national target of 80%. 3. Vacancy rate remains below the Trust target due to continued grip and control and low turnover in addition to the recruitment hold introduced in June and continues to be in place in July. 4. With continued grip and control measures in place, including recruitment hold since June, the total workforce WTE in June was 65WTE above the planned workforce, whilst substantive staff in post was also above plan, both bank and agency were below the plan	1. Continued monitoring of appraisal completion rates through monthly Divisional Performance . Divisions have plans in place to improve compliance 2. Scrutiny of shifts above agency cap through Executive Medical Vacancy Control meeting, chaired by the Medical Director. Actions ongoing to recruit to posts substantively to reduce use of agency, renegotiate rates and to introduce agency tiering 3. Vacancy rate : Continued grip and control of vacancies through Executive Vacancy Control Panel. Hold on recruitment introduced in June 25 and continues in July 2025. QIA process in place to ensure no untoward impact on quality and safety 4. Divisions continue to refine and enact workforce plans to bring about reductions. Continued scrutiny of bank and agency usage	1. Data containing outstanding appraisals sent to divisions on a monthly basis and accessible through the Learning Hub. Oversight of progress in working through plans to increased compliance through Divisional Performance Meetings, Wider Leadership Team and People Committee 2. Medical Price cap compliance monitored through Executive Medical Control Group, Wider Leadership Team and People Committee 3. Vacancy rate – oversight though Divisional Performance Meetings, Wider Leadership Team and People Committee 4. WTE reported and monitored through Divisional Performance meetings, Finance Improvement Group, Wider Leadership Team and People Committee

Our Performance Overview – Elective Care : M3 25/26

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	Total Patients Waiting for First Attendance	Jun 25	39747	30751	H	?	33181	29725	36636	S	T	P
2	RTT Waiting List	Jun 25	49396	52503	L	?	52460	50841	54078	S	T	P
3	Percentage of Patients Waiting Over One Year	Jun 25	3.3%	1.0%	L	F	4.4%	2.3%	6.5%	S	T	P
4	Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under	Jun 25	0.5%	0.3%		F	0.7%	0.4%	1.0%	S	T	P
5	Total Patients Waiting Over 65 Weeks	Jun 25	66	0	L	F	264	3	525	S	T	P
6	Percentage of Patients Treated Within 18 Weeks	Jun 25	63.0%	65.0%		?	61.0%	56.2%	65.8%	S	T	P
7	Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks	May 25	76.3%	80.0%		?	81.2%	74.2%	88.2%	S	T	P
8	Cancer 31 Day Treatment Standard Performance	May 25	91.5%	96.0%		?	92.5%	85.0%	99.9%	S	T	P
9	Percentage of Patients Treated for Cancer Within 62 Days of Referral	May 25	76.2%	75.0%		?	78.6%	68.4%	88.7%	S	T	P
10	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test	Jun 25	30.4%	5.0%	H	F	19.8%	12.6%	27.0%	S	T	P
11	Outpatient New : Follow-up Ratio	Jun 25	2.13	2.00		F	2.24	2.04	2.44	S	T	P
12	Elective Theatre Utilisation - Capped Touchtime	Jun 25	79.0%	85.0%		?	70.5%	55.3%	85.7%	S	T	P
13	Elective Recovery Plan : Day Case Activity Performance	Jun 25	95.4%	100.0%		?	97.1%	83.8%	110.4%	S	T	P
14	Elective Recovery Plan : Inpatient Activity Performance	Jun 25	90.6%	100.0%		?	100.7%	79.4%	122.0%	S	T	P
15	Percentage of Patients Waiting Over 52 Weeks for Community Services	Jun 25	0.5%	0.0%	H	?	0.1%	0.0%	0.1%	S	T	P

Summary icons key:



Our Performance Elective Care Narrative : M3 25/26

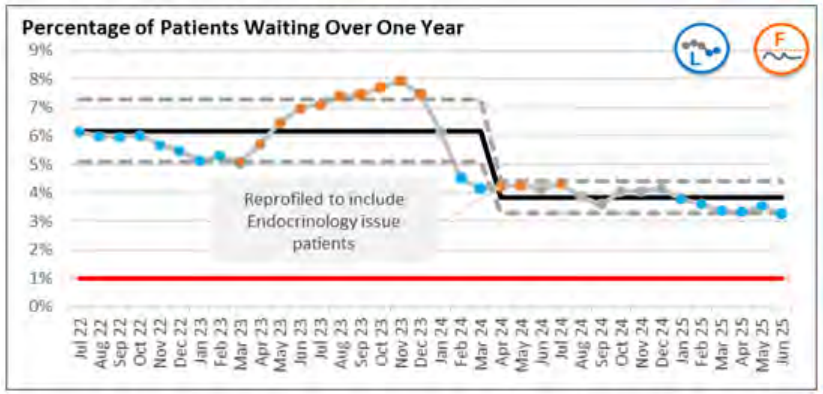
RTT Waiting List: As of June 2025, the RTT (Referral To Treatment) Waiting List stands at 49,396 which is within the target, this is an improved position from previous months. The percentage of patients waiting over 52 weeks reached 3.3% in June 2025, above the end of March 2026 1.0% target. This is being actively managed to reach the target with support of the independent sector to facilitate removal of some of the longest waiting patients over 52 weeks also maximizing the use of elective capacity to increase productivity. The first patients are expected to transfer to the independent sector in July 2025.

The 31-day cancer performance for May was 91.49%, this is a decrease from the M1 reported position of 94.9% and remains below the 96% target. There were also decreases in the 28 day and 62 performance targets. (76.3% and 76.5% respectively). Capacity/Pathway issues in colo rectal and breast services have contributed to the decrease in performance. Diagnostic capacity issues in breast imaging are not forecasted to improve until September 2025.

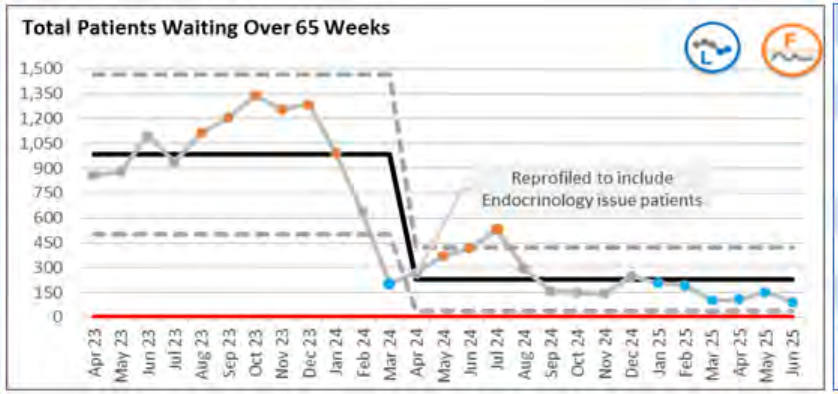
Radiology performance remains challenging across several modalities with significant clinical risks evident in the provision of non-obstetric and obstetric ultrasound. 40% of patients are waiting more than 6-weeks for routine appointments which is at a significant variance to the 5% interim target. Mitigations are being implemented to increase staffing levels to maintain essential services and to reduce backlog volumes.

The number of patients waiting more than 6-weeks for MR scanning has started to incrementally decrease and is expected to recover by the end of September 2025. The service is currently focusing on reducing the complex examinations from the backlog and then will prioritise a large cohort of low-volume, high-complexity examinations which will accelerate backlog reduction. DEXA backlogs are proving more challenging to reduce but improvement is anticipated due to increase in capacity in weekend availability.

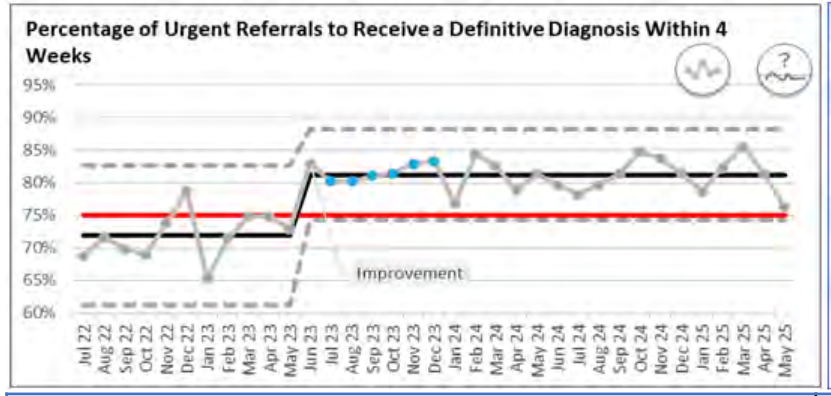
Our Performance Insight Report : Elective Care M3 25/26



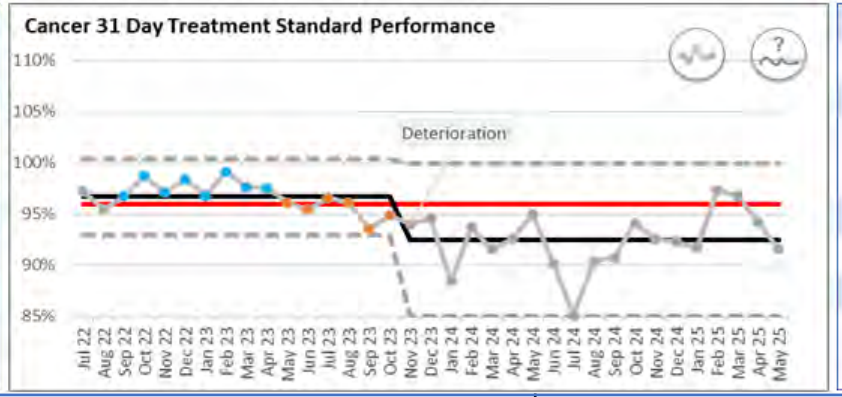
Jun-25
3.27%
Variance Type
No target/ threshold
Target
0
Target achievement
Metric is consistently missing the threshold/ target



Jun-25
95
Variance Type
No target/ threshold
Target
0
Target achievement
Metric is consistently missing the threshold/ target



May-25
76.31%
Variance Type
Common cause variation
Target
75%
Target achievement
Inconsistent performance compared to threshold/ target



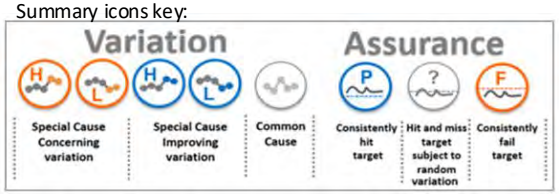
May-25
91.55%
Variance Type
Common cause variation
Target
96%
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. The number of patients waiting over one year is falling and is now at the lower process limit 2. The number of 65-week capacity breaches has decreased from the previous month. Pressure areas remain as plastics/dermatology along with endocrinology, ENT, Gyn and General Surgery. 3. Significant deterioration due to constraints in NOUS, endoscopy and echocardiography. Staffing shortages amplified by national pay control measures. 4. Deteriorating position	1. Continue to focus on reduces the waits through a combination of internal capacity and seeking support from the independent sector for the pressured specialties 2. Continue to focus on reduces the waits through a combination of internal capacity and seeking support from the independent sector for the pressured specialties 3. Recovery planning, risk management, mutual aid, external resource 4. recovery action plan and governance arrangements for Cancer care are being reviewed	1. Weekly PTL/ long waits week mtg with COO to go through each service area. 2. Weekly PTL/ long waits week mtg with COO to go through each service area. 3. System level monitoring. Trust assurance via Divisional Assurance Meeting 4. GM cancer alliance

Our Performance Overview – Urgent & Emergency Care: M3 25/26

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
16	Average Time to Ambulance Handover	Jun 25	00:32:40	00:38:00			00:40:56	00:18:27	01:03:26	S	T	P
17	Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours	Jun 25	71.7%	76.0%	H	F	69.2%	65.8%	72.7%	S	T	P
18	Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department	Jun 25	18.3%	10.0%		F	19.7%	16.5%	22.9%	S	T	P
19	Overnight Total General and Acute Beds and the Number of Which are Occupied	Jun 25	91.1%	96.0%	L		94.3%	91.7%	96.8%	S	T	P
20	Virtual Ward Occupancy	Jun 25	74.2%	80.0%			72.7%	44.0%	101.5%	S	T	P
21	Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days	Jun 25	1799	1439		F	1919	1644	2193	S	T	P
22	Average Number of Days Between Planned and Actual Discharge Date (Excludes patients discharged on discharge ready date)	Jun 25	7.6	0.0		F	6.7	4.9	8.5	S	T	P
23	Percentage of Patients who do not Meet the Criteria to Reside	Jun 25	30.7%	12.5%		F	27.8%	21.8%	33.8%	S	T	P
24	Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days	Jun 25	1370	1560			1432	1175	1689	S	T	P
25	Urgent Community Response (UCR) Referrals	Jun 25	84.9%	70.0%		P	81.5%	71.1%	92.0%	S	T	P

Summary icons key:



Our Performance Urgent & Emergency Care Narrative: M3 25/26

The NWAS average handover time slightly increased in June to 32 minutes, this is an increase from the reported 31 minutes in May. This remains below the target of 38 minutes and remains a significant improvement from April (47 minutes).

There has been a slight decrease in 4-hour performance, in June 71.6% of Emergency Department (ED) attendances were admitted, transferred, or discharged within 4 hours. In May performance was 72.2%.

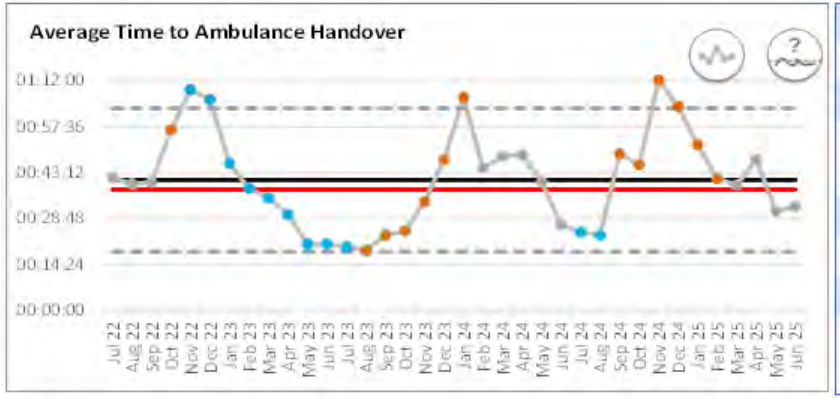
The percentage of patients waiting over 12 hours in the emergency department (ED) has increased, in June the reported figure was 18.3%. In May the position was 17.98%, This figure remains significantly above the 10% target. A specific focus for the Division is to significantly reduce the number of patients waiting more than 12 hours in the department, then subsequently discharged.

Despite marginal improvements in the target, flow throughout the Emergency department (ED) remains challenging. The Division continue to work collaboratively with system partners to improve performance. In addition, the ED Improvement plan is supporting key improvement metrics outlined in the Urgent and Emergency care plan published by NHS England in June.

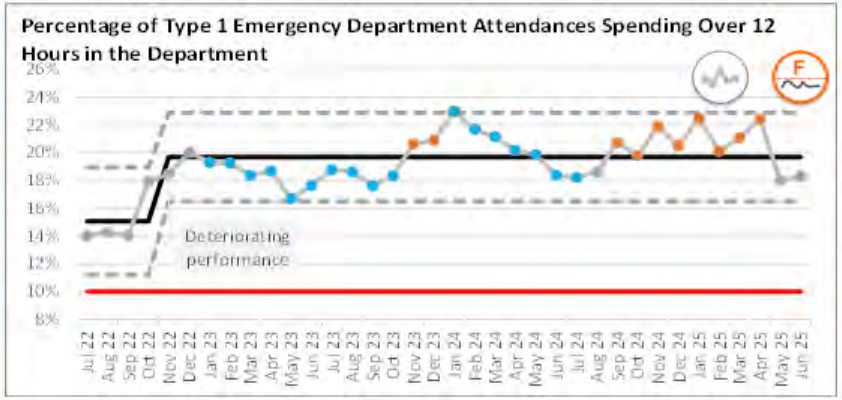
The community react team has been supporting the Community Admissions Avoidance Team (CAAT) practitioner at the front door which is impacting positively on pressure in ED. At the same time, the urgent 2-hour response times target has been achieved

Call to convey is underway in collaboration with NWAS and the project is delivering a reduction in conveyances to ED contributing to a reduction in UEC pressure.

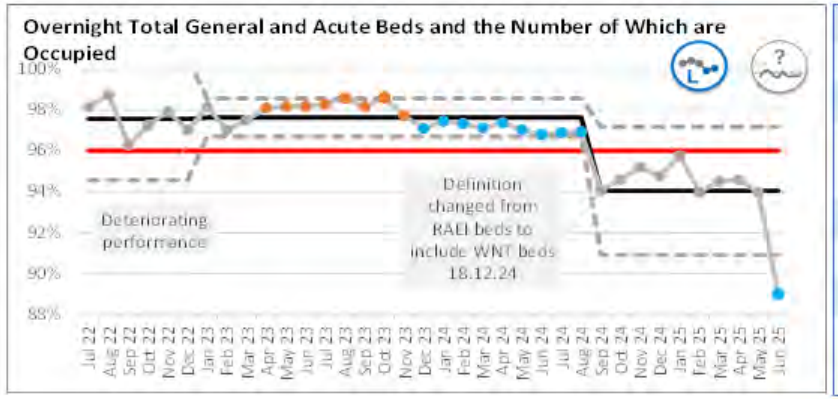
Our Performance Insight Report : Urgent & Emergency Care M3 25/26



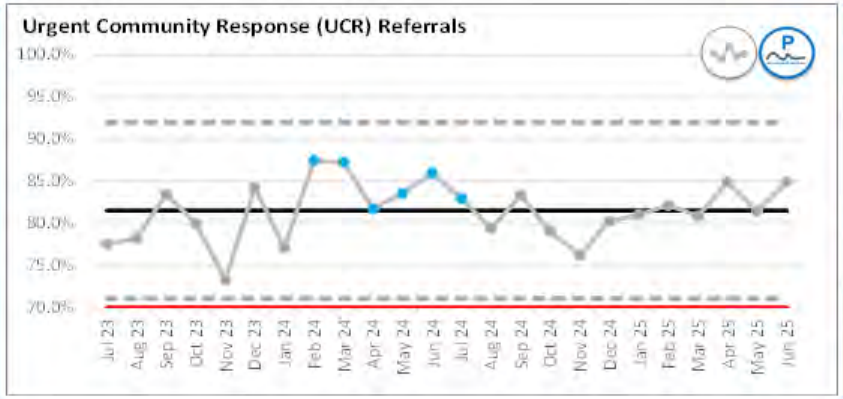
Jun-25
00:32:40
Variance Type
Commmon cause variation
Target
00:38:00
Target achievement
Inconsistent performance compared to threshold/ target



Jun-25
18.32%
Variance Type
Commmon cause variation
Target
10.0%
Target achievement
Metric is consistently missing the threshold/ target



Jun-25
89.01%
Variance Type
Special cause improving variation
Target
96.0%
Target achievement
Inconsistent performance compared to threshold/ target



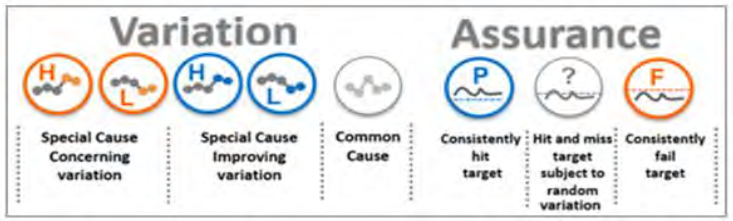
Jun-25
84.92%
Variance Type
Commmon cause variation
Target
70.0%
Target achievement
Metric is consistently meeting the threshold/ target

Summary:	Actions:	Assurance:
1. Flow in the Emergency Department (ED) remains challenging, there was a small increase in the ambulance handover times in June, however this remains below the 38-minute target, 2. There was a slight decrease in the 4-hour performance target. 3. In June there was a slight increase in the number of patients waiting over 12 hours in the Emergency department (ED) for admission or discharge.	1. UEC improvement plan to include key performance metrics and recovery trajectories, will be monitored and reviewed on a weekly basis by the medical, nursing and performance team. 2. Additional actions to urgently address number of patients awaiting more than 12 hours in the Emergency Department (ED). These include expanding the use of an appointment system to offer patients an appointment in the UTC/SDEC the following day, aiming to reduce the number of patients waiting in the department overnight,. 3. Specific focus on the number of patients waiting more than 12 hours in the department and subsequently discharged home.	1. Daily performance review with operational, nursing and medical teams. 2. Daily review of overnight performance against the 4-hour and 12-hour standards. 3. Weekly ED Assurance meetings

Our Finance Performance Overview : M3 25/26

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	Adjusted Financial Performance (£m) - Variance to Plan	Jun 25	-0.3	0.0			0.3	-4.2	4.8	S	T	P
2	Cash (£m)	Jun 25	11.7	11.5	L	P	23.4	12.5	34.3	S	T	P
3	API Income (£m) - Variance to Plan	Jun 25	0.1	0.0			-0.3	-1.5	0.9	S	T	P
4	Total Cost Improvement Programme (CIP) (£m) - Variance to Plan	Jun 25	-1.3	0.0			0.5	-1.7	2.7	S	T	P
5	Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan	Jun 25	-1.4	0.0			-0.6	-1.6	0.3	S	T	P
6	Agency Expenditure (£m)	Jun 25	0.7	2.2	L	P	0.9	0.5	1.3	S	T	P
7	Bank Expenditure (£m)	Jun 25	1.2	3.4	L		2.4	1.7	3.1	S	T	P
8	Capital Expenditure (£m) - Variance to Plan	Jun 25	-1.0	0.0			1.3	-3.0	5.5	S	T	P
9	Better Payment Practice Code (BPPC)	Jun 25	96.0%	95.0%	H		93.4%	88.2%	98.7%	S	T	P

Summary icons key:

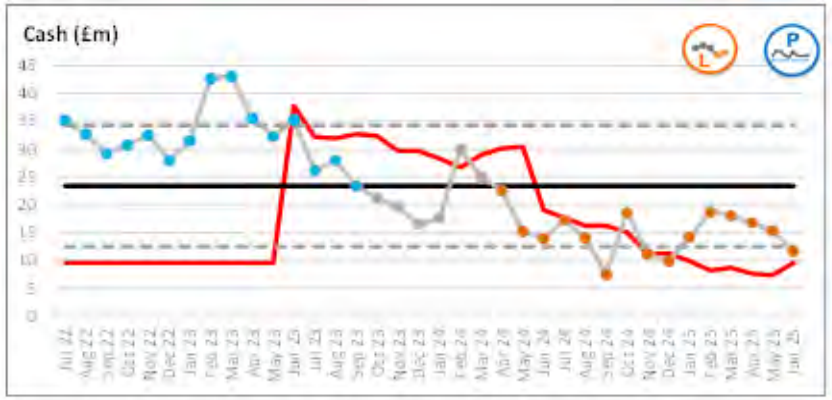


The finance slides in the IPR should be viewed alongside the monthly finance report for wider context

Our Finance Performance Narrative : M3 25/26

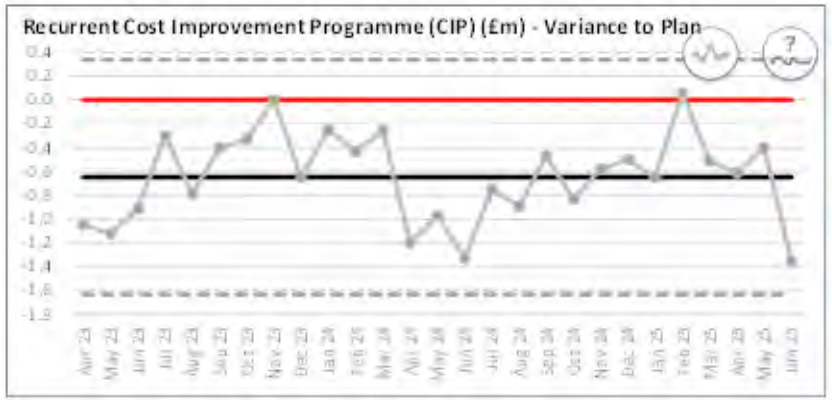
Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Red		At the end of quarter 1, there is an actual deficit of £2.5m, which is £1.0m adverse to plan. Our month 3 position is £0.3m worse than plan in month. The month 3 position includes two one-off benefits totalling £0.6m associated with items related to last financial year which are now concluded. Without these benefits, our position would have been £0.9m adverse to plan in month.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		Closing cash at the end of June was £11.6m, decrease of £3.8m from May. The cash plan is based on delivery of the revenue and efficiency plans and remains challenging for 2025/26.
API Income	Achieve the elective activity plan for 2025/26.	Amber		Divisional elective API performance has maintained the improvement seen last month. In month 3 we are £0.1m favourable to the internal elective API plan, and £0.4m behind year to date.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Red		Total CIP delivered in Month 3 is £2.1m, which is £1.3m below plan: £0.8m is recurrent (36%) and £1.3m is non-recurrent (64%). The recurrent YTD delivery is £2.3m behind plan. As at month 3, The recurrent plan is fully identified however there is significant risk to this. In month 3, all divisions are significantly behind plan.
	Deliver Recurrent CIP of £23.0m	Red		
Agency expenditure	30% reduction in agency spend.	Red		In month 3, agency expenditure was £0.7m, £0.2m above the plan of £0.4m. Agency spend YTD is showing a decrease of 3% relative to the NHSE baseline (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.
Bank expenditure	10% reduction in bank spend	Amber		Our bank plan reflects the NHSE planning requirement to reduce expenditure by 10% on the month 8 2024/25 forecast outturn, plus a further £2.0m stretch associated with the difficult decisions. YTD, bank expenditure has reduced by 13% on the 2024/25 average baseline and therefore exceeds the expected planning reduction.
Capital expenditure	Achieve capital plan for 2025/26.	Amber		Capital expenditure in month 3 is £3.8m which is £1.0m behind plan. This Is due to the delay of a property lease renewal, now expected within Q2.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Green		BPPC performance in-month performance was 96.0% by volume and 98.1% by value, YTD performance was 95.6% by volume and 98.2% by value

Our Finance Performance Insight Report : M3 25/26

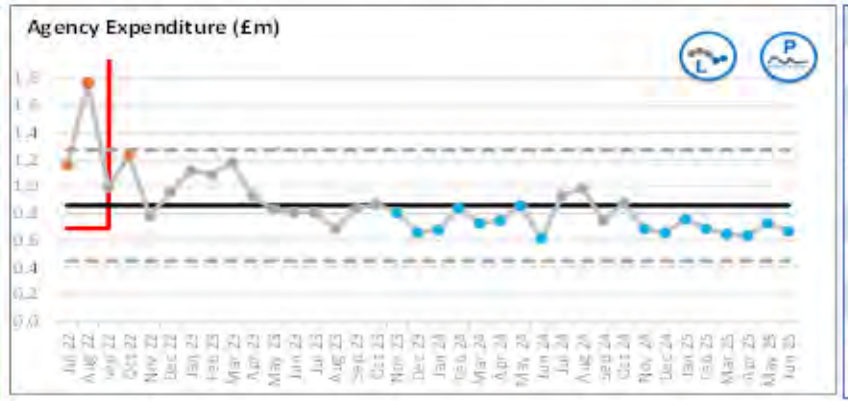


Jun-25
11.7
Variance Type
Special cause concerning variation
Target
11.5
Target achievement
Metric is consistently meeting the threshold/ target

Jun-25
0.1
Variance Type
Common cause variation
Target
0.0
Target achievement
Inconsistent performance compared to threshold/ target



Jun-25
-1.4
Variance Type
Common cause variation
Target
0.0
Target achievement
Inconsistent performance compared to threshold/ target



Jun-25
0.7
Variance Type
Special cause improving variation
Target
2.2
Target achievement
Metric is consistently meeting the threshold/ target

Summary:	Actions:	Assurance:
1. Closing cash at the end of June was £11.6m, decrease of £3.8m from May. The cash plan is based on delivery of the revenue and efficiency plans and remains challenging. 2. Divisional elective API performance has maintained the improvement seen last month. In month 3 we are £0.1m favourable to the internal elective API plan, and £0.4m behind year to date. 3. Year to date, recurrent CIP delivered is £1.7m against a plan of £4.0m, 30% of the total year to date delivery. The plan phasing increased from Month 3. 4. In month 3, agency spend was £0.7m, £0.2m above the plan of £0.4m. Agency spend YTD is showing a decrease of 3% relative to the NHSE baseline (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.	1. Cash is being closely monitored. Based on the current run rate, the forecast indicates that cash support may be required in Q3, assuming continued receipt of DSF. 2. The underperformance in month 1 is expected to be recovered over the remainder of the financial year. 3. The mitigation plans proposed through Divisional Highlight reports will be scoped financially with relevant PID and QIAs completed. Further intervention will be put in place for Divisions who consistently under-perform through executive "Huddles". 4. Agency expenditure continues to be closely monitored with grip and control measures in place. Temporary spend reduction links to CIP delivery.	1. Cash Management Group, Finance and Performance Committee. 2. Divisional Assurance Meetings, Finance Improvement Group, Executive Team Meeting, Finance and Performance Committee 3. CIP Huddles to be arranged following M2 Divisional Assurance Meetings (CFO/ Deputy CEO led) 4. Executive Pay Control Group, Divisional Assurance Meetings, Finance Improvement Group, Finance and Performance Committee

Title of report:	Board Assurance Framework (BAF) 2025/26
Presented to:	Board of Directors
On:	6 August 2025
Purpose:	Information
Presented by:	Director of Corporate Governance
Prepared by:	Head of Risk Director of Corporate Governance
Contact details:	E: John.harrop@wwl.nhs.uk steven.parsons@wwl.nhs.uk

Executive summary

The trust's key strategic risks to the achievement of the annual corporate objectives 2025/26 are presented here for the committee's review and approval. The BAF format and content will have a full review for the Board meeting in October 2025.

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 is one strategic financial performance risk identified within this report.

Legal implications

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

People implications

There is one strategic people risk identified within this report.

Wider implications

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

Recommendation(s)

The Board of Directors 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.

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 trust's key strategic risks to the achievement of the annual corporate objectives 2025/26 are presented here for the committee's review and approval. The BAF is included in this report with detailed drill-down reports into all individual risks.

3. New Risks Recommended for Inclusion to the BAF

The risks have been refreshed and aligned to the annual corporate objectives 2025/26.

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

The number of risks on the BAF has reduced from 16 to 8, aligning with the annual corporate objectives 2025/26. There will be a full review of the BAF format and strategic risks in the October 2025 BAF report.

5. Review Date

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

6. Recommendations

6.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Board assurance framework

2025/26

The content of this report was last reviewed as follows:

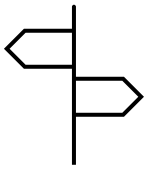
Board of Directors	June 2025
Quality and Safety Committee:	July 2025
Finance and Performance Committee:	July 2025
People Committee:	June 2025
Executive Team:	July 2025

“ **assurance** (/əˈʃɔːrəns/) *noun*

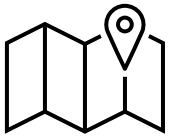
The process by which a board of directors gains confidence in the organisation's governance, risk management, and internal control frameworks. It involves evaluating the effectiveness of these frameworks and identifying areas that need improvement to ensure the organisation achieves its objectives. ”

Definition in the context of the Orange Book (HM Treasury’s guidance on risk management).

How the Board Assurance Framework fits in

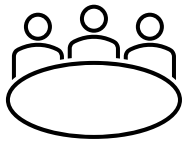


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

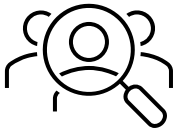


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

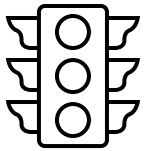
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have 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 Governance
COO:	Chief Operating Officer	DCE:	Deputy Chief Executive Chief Officer for Strategy, Partnerships and Digital
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 linking the corporate risk register, the BAF and the system risk register, which 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 functions which provide independent assurance and external assurance. Overall assurance level for each risk is summarised as high, medium or low.
Gaps in assurance:	Areas where there is limited or no assurance that procedures and processes 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 Board and its Sub Committees which will monitor completion of the required actions and progress with delivery of the allocated objectives
Objective Tracking BRAG rating:	Completed/Business as Usual on Track Delayed Problematic

Our approach at a glance

Our strategy 2030

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

25/26 Corporate Objectives

Strategic Ambition

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

- To improve the quality of care for our patients and residents
- To ensure that our residents and patients have the best possible experience of our care
- To promote early detection and intervention, preventing avoidable ill-health

25/26 Corporate Objective

Strategic Ambition

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

Make WWL a great place to work and ensure that our staff feel valued

25/26 Corporate Objectives

Strategic Ambition

To consistently deliver efficient, effective and equitable patient care

- Foster a sustainable, efficient and productive financial environment
- Drive improvements in our overall performance, placing patients at the centre of everything we do. Take our opportunities to be outstanding
- Optimise delivery of our elective and non-elective services

25/26 Corporate Objective

Strategic Ambition

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

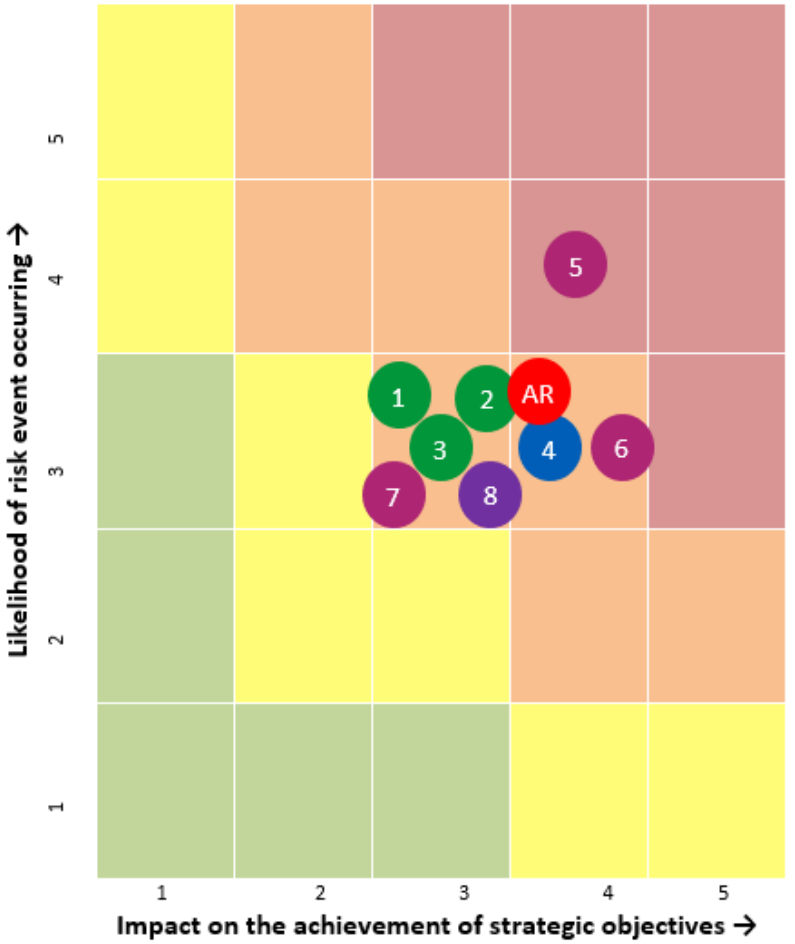
To further strengthen existing partnerships and develop new ones to complement and support our NHS services and research activities

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	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Data and information management	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Governance and regulatory standards	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Staff capacity and capability	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Staff Engagement	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Staff wellbeing and safety	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Estates and Facilities	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Financial Duties	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Performance Targets	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Hospital Demand, Capacity and Flow	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Sustainability / Net Zero	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Technology	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Adverse publicity	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Contracts and demands	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Strategy	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Transformation	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager

The heat map below shows the distribution of all 8 strategic principal risks based on their current scores:



Green: patients | Blue: people | Pink: performance | Purple: performance | Red: average risk score

Patients

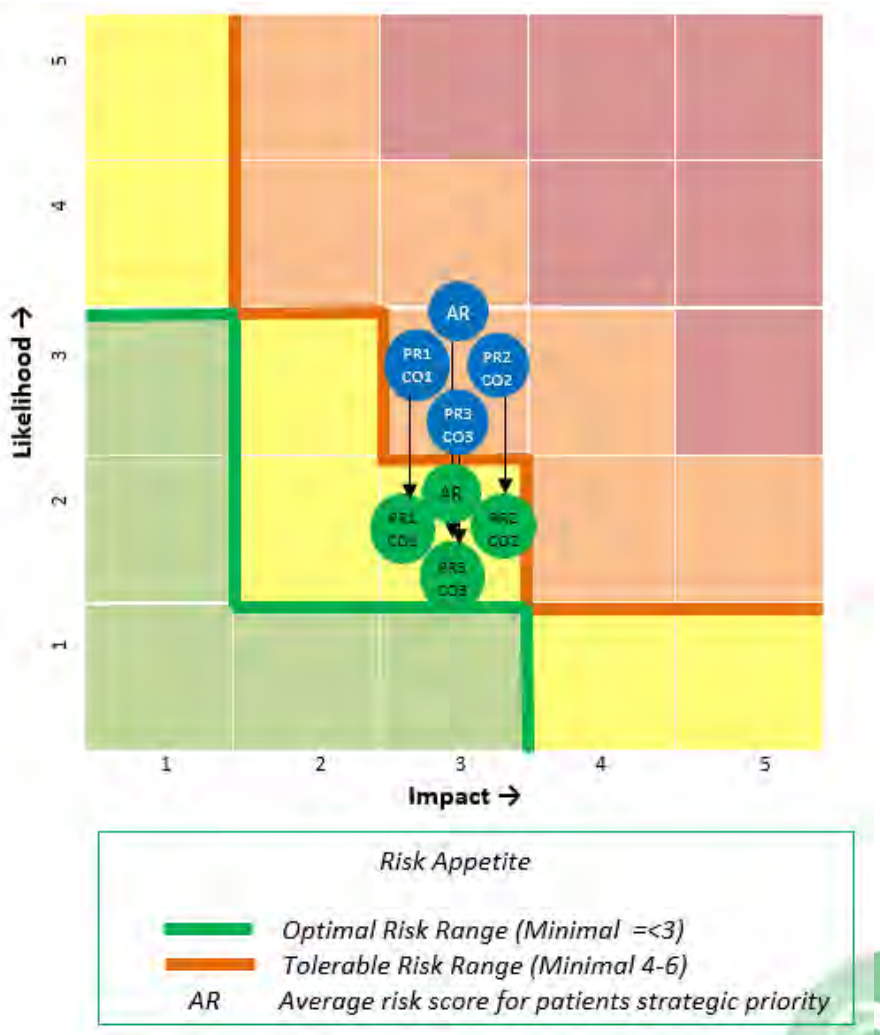
To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

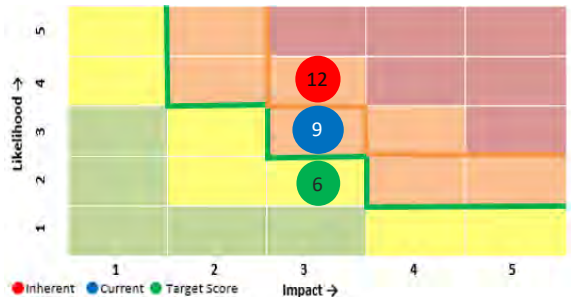
The following corporate objectives are aligned to the **patients** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Tracking BRAG rating
CO1	To improve the quality of care for our patients and residents.	• Right patient, right ward, right professional, right time for 80% of patients with heart attack, stroke, acute abdomen or fractured neck of femur to reduce harm and mortality. • Fundamentals of care • Harm free Care (agree key priority areas) • Ensuring no unnecessary interventions	• Increase in the % of staff who recommend WWL as a place to be treated • Reduced patient delays • Reduction in harms • Increase in compliments / decrease in complaints
CO2	To ensure that our residents and patients have the best possible experience of care.	• Putting patients and residents at the heart of decision making; about their own care and about design of services • Developing a culture among our teams which gives patients the power • Support patients to manage their own care, particularly making use of digital approaches (e.g. patient initiated follow ups, digital apps, self-booking) • Clear, accurate patient communication • Review our estates through the eyes of our patients and residents • Develop a deeper understanding of patient experience by making it easier for them to provide feedback, e.g. provide digitally enabled feedback via QR codes.	• Lived Experience integral to decision making and service improvement • Increase in the % of patients who would recommend WWL as a place to be treated • Increase in compliments / decrease in complaints
CO3	To promote early detection and intervention, preventing avoidable ill-health.	• Redesigning community services across Wigan around the needs of communities and reducing duplication (working in partnership with primary care, social care, mental health, voluntary sector, WWL community services) • Focus on prevention, with specialties using data and working with primary care to support identification of inequality in outcomes and opportunities to intervene earlier • Alignment of health promotion opportunities with our services	• Reduction in avoidable admissions.

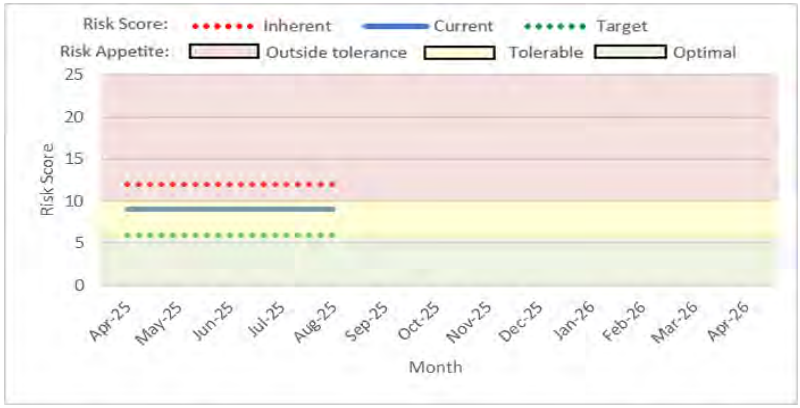
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for these risks:



Corporate Objective: CO1 To improve the quality of care for our patients and residents																Overall Assurance level	Medium
Linked Objectives:	**CO1**	✓	**CO2**	✓	**CO3**	✓	**CO4**	✓	**CO5**	✓	**CO6**	✓	**CO7**	✓	**CO8**	✓	

Principal risk	**Risk Title:**	**PR 1: Quality of Care**		
	Risk Statement:	There is a risk that quality of care across the Trust may deteriorate, due to resource limitations restricting our ability to improve, resulting in increased patient delays, incidents of avoidable harm, reputational damage and an increase in complaints.		
Lead Committee	**Quality and Safety**		**Risk Appetite**	Cautious
Lead Director	**MD / CN**		**Risk category**	Safety, quality of services & patient exp.
Date risk opened	**30.07.25**		**Linked system risks**	-
Date of last review	**30.07.25**		**Proximity / Treatment**	12 months Treat

Risk Score Timeline



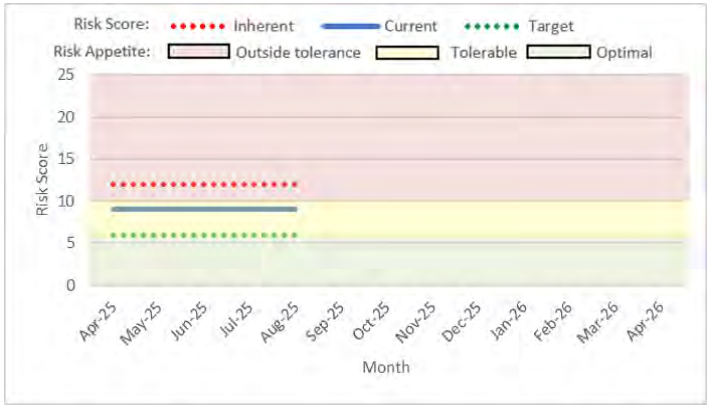
Opportunity, Threat / Linked corporate risks	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date By Whom
Threat	• The trust has made good progress in transitioning to the new Patient Safety Incident Response Framework. • Incident response and investigation policies, procedures and processes in place. • National Safety Standards for invasive procedures (NATSIPS) and local safety standards (LOCSIPS) in place. • The Ward accreditation system ASPIRE Quarter 4 report provides assurance that significant progress has been made. • Safe Medical Staffing report provided assurance that appropriate levels for the majority of shifts across acute medicine and Same Day Emergency Care (SDEC) during the period October 2024 to February 2024.	• Areas for improvement with National Safety Standards for invasive procedures (NATSIPS) and local safety standards (LOCSIPS) identified.	**1st Line:** • Divisional PSG - monthly **2nd Line:** • SAFEty Meeting – Daily • Learning From Patient Safety Events (LFPSE) meeting -weekly • Trust Patient Safety Group (PSG) – monthly • Quality & Safety Committee – bi-monthly • Patient Safety Incident Response - quarterly • Report received for National Safety Standards for invasive procedures (NATSIPS) and local safety standards (LOCSIPS) • Monthly Falls Panel meeting • Resuscitation Group • Safe Medical Staffing Report	**2nd Line:** • Areas for improvement with National Safety Standards for invasive procedures (NATSIPS) and local safety standards (LOCSIPS identified.	• Further assurance to be provided regarding National Safety Standards for invasive procedures (NATSIPS) and local safety standards (LOCSIPS. Action plan to be progressed.	March 2026 Task and Finish Group

3322 Harm Free Care – Avoidable Pressure Ulcers – risk score 9	• A more robust approach to manage the learning from Hospital Acquired Pressure Ulcers (HAPU) has been undertaken with a Trust wide rapid action review which has seen an impact. • Metrics for all harm free care have been reviewed.	Harm Free Care Report highlighted that there has been an overall Trust increase in patients acquiring skin damage from pressure ulcers in 2024/25 compared to 2023/24.	**2nd Line:** • Harm Free Care Report - quarterly	**2nd Line:** Metrics for all harm free care in Harm Free Care report to correlate harms to direct omissions in care moving forward.	Bi-monthly Harm Free Care reports to Quality & Safety (Q&S) Committee to track progress with action plan.	March 2026 CNO
3805 Sepsis Recognition, Screening & Management - 16	• Improved compliance with Sepsis-6 Care Bundle • Progress made against the Advancing Quality metrics for sepsis.	Some challenges to sustaining improvements against some of the measures.	**2nd Line:** • Sepsis Group • Infection Prevention & Control (IPC) Report and BAF - quarterly • Divisional Assurance Reports • Bi-annual safe staffing report	No gaps in assurances currently identified.	Actions are ongoing to address the issued identified in the Advancing Quality (AQ) metrics for sepsis.	March 2026 CNO
	• External review of the Trust's provision for learning disability, autism or identify as neuro-diverse report received with some areas of good practice highlighted. • Maternity reports regularly track inequalities data and can evidence actions being taken to provide appropriate support.	Twelve recommendations for improvement noted.	**External:** Review of the Trust's provision for patients with a learning disability, autism or identify as neuro-diverse received – May 2025. Oversee by Learning Disability/Autism and Neurodiversity Effectiveness Group.	No gaps in assurances currently identified.	Action plan to be progressed.	March 2026 Learning Disability/Autism and Neurodiversity Effectiveness Group

Corporate Objective: CO2 To ensure that our patients and residents have the best possible experience of our care																Overall Assurance level	Medium
Linked Objective:	CO1	✓	CO2	✓	CO3	✓	CO4	✓	CO5	✓	CO6	✓	CO7	✓	CO8	✓	

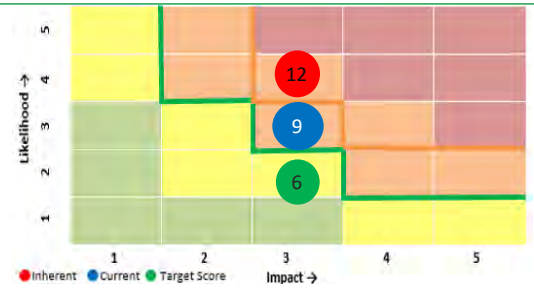
Principal risk	**Risk Title:**	**PR 2: Patient Experience**			
	Risk Statement :	There is a risk that residents and patients may have a negative experience of our care, due poor management of periods of excessive demand, delays in treatment, poor information flows to and from patients and other partners, poor attitudes displayed to patients, not learning from incidents and complaints, resulting in an increase in complaints and a reduction in patients who would recommend WWL as a place to be treated.			
Lead Committee	**Q&S**		**Appetite**	Cautious	
Lead Director	**MD / CN**		**Risk**	Safety, quality of services & patient exp	
Date risk opened	**30.07.25**		**Linked system**	No linked risks	
Date of last review	**30.07.25**		**Proximity / Treatment**	12 months Treat	

Risk Score Timeline

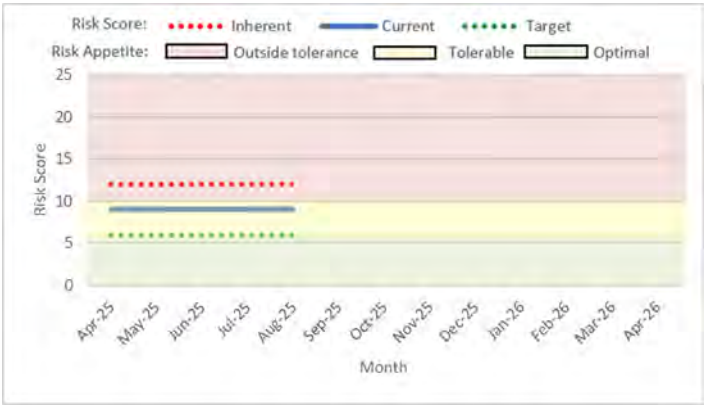


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances	Gap in assurances	Risk Treatment	Due Date
Threat (ID 3322)	• Patient Stories shared at Quality & Safety Committee to share and learn from patient experiences of using WWL services. • Excellent performance in complaints response times and targeted work on de-escalation to resolve patient experience issues. • Complaints Standard Operating Procedure (SOP) in place with defined roles, processes and timescales. • Positive feedback from patients and relatives about the introduction of open visiting.	• No gaps currently identified.	**1st Line:** • Divisional Patient Safety Group - monthly **2nd Line:** • Trust Patient Safety Group – monthly Quality & Safety Committee - monthly Complaints report – quarterly Patient Experience and Engagement Group – quarterly	No gaps in assurance currently identified	• The proposed establishment of a Lived Experience Group for people with neurodiversity and the recruitment of Lived Experience Partners who are receiving training from Advancing Quality Alliance (AQUA). • Further assurance required in relation to managing 'overheating incidents' and mitigating any potential risk to patients is still required.	Bi-monthly MD/ CN Bi-monthly MD/ CN

Corporate Objective: CO3 To promote early detection and intervention, preventing avoidable ill-health																Overall Assurance level	Medium
Linked Objectives:	CO1	✓	CO2	✓	CO3	✓	CO4	✓	CO5	✓	CO6	✓	CO7	✓	CO8	✓	

Principal risk	**Risk Title:**	**PR 3: Early Detection and intervention, preventing avoidable ill-health**		
	Risk Statement	There is a risk that there may be avoidable admissions to the Trust's services, due to ineffective engagement with Primary Care and Local Authority through 'place' and external policies that do not support preventing avoidable ill health, resulting in avoidable ill-health.		
Lead Committee	**Quality and Safety**		**Risk Appetite**	Cautious
Lead Director	**MD / CN**		**Risk**	Safety, quality of services &
Date risk opened	**30.07.25**		**Linked system**	No linked risks
Date of last review	**30.07.25**		**Proximity / Treatment**	12 months Treat

Risk Score Timeline



	Existing controls	Gaps in existing controls	Assurances	Gap in assurances	Risk Treatment	Due Date
Threat: **Datix ID 3676**	• Actions being piloted to address themes within the Lost to Follow Up Group • Improvement in some of the measures used to track progress with diabetes care for our paediatric population.	• Lost to follow up patients.	**1st Line:** • Divisional Patient Safety Group - monthly **2nd Line:** • Learning From Patient Safety Events (LFPSE) meeting -weekly • meeting -weekly Trust Patient Safety Group (PSG) – monthly • Quality & Safety Committee - monthly • Lost to follow up Group • Deteriorating Patient Group • Learning from Deaths Report – quarterly / annual **3rd Line:** Mersey Internal Audit Agency (MIAA) Ockenden 2 significant assurance report. **External:** Care Quality Commission (CQC) Picker survey places maternity in top five nationally	No gaps currently identified.	1. Quality & Safety Committee to receive regular reports from the Lost to Follow up group to monitor progress.	March 2026 MD /CN

People

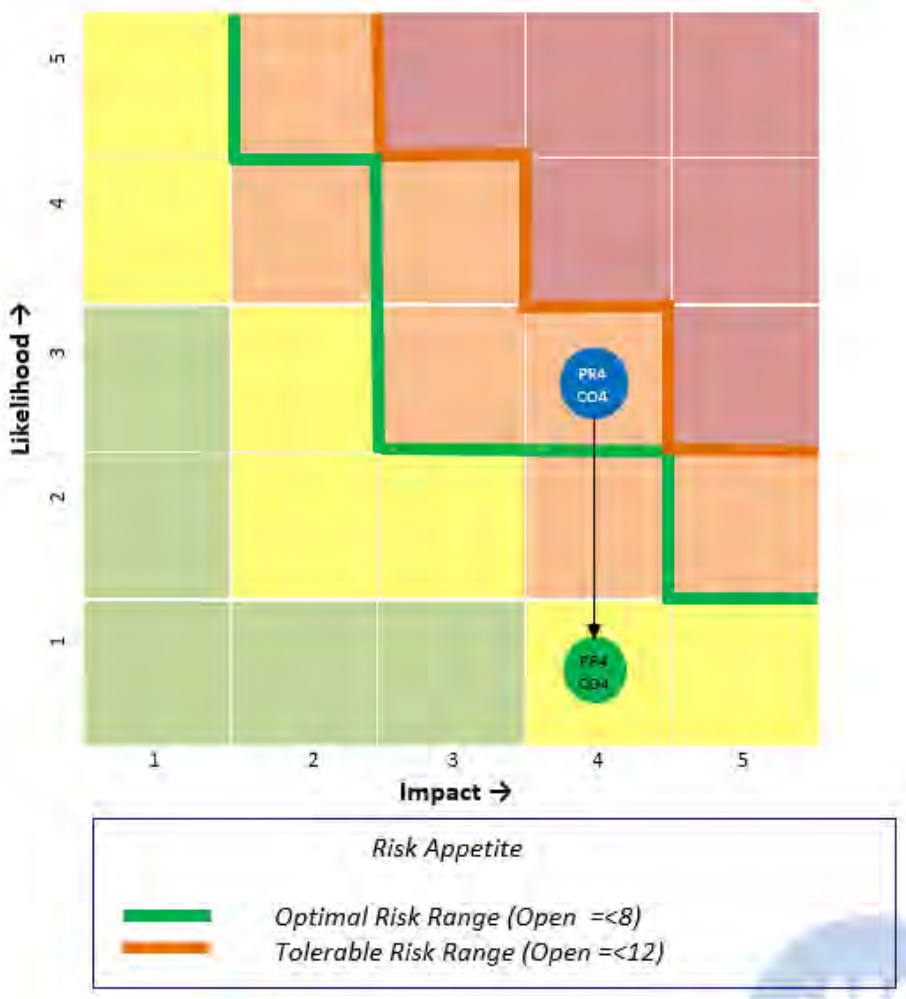
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

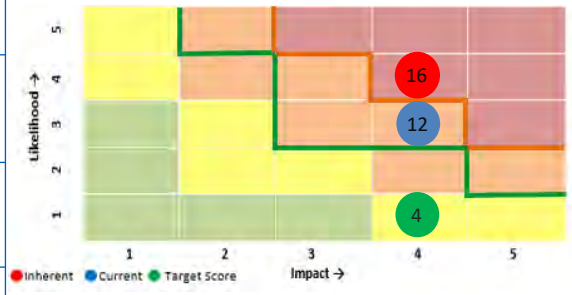
The following corporate objectives are aligned to the **people** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Tracking BRAG rating
CO4	Make WWL a great place to work and ensure that our staff feel valued	• Well-developed compassionate and brilliant leaders • Visible leaders who listen to feedback and act upon it • Ensure clear wellbeing offer is present • Provide opportunity for our staff to be recognised for the great work they do • Work with Wigan Locality partners to ensure we are supporting people into employment • Empower out staff to be creative and innovative to enable improvement • Prioritise recruitment into hard to fill roles • Support our staff to speak up • Ensure equality, diversity and inclusion exists for all and raise the voice of minority groups • Develop a financially sustainable workforce plan that meets the transformation needs both relevant to WWL and that of the NHS Plan.	● Reduced sickness absence ● Continued low turnover ● Essential bank use only and no agency ● Improved engagement with Staff Survey ● Improved Staff Survey results ● Improved WRES/WDES ● Increased representation across Bands 8 and above

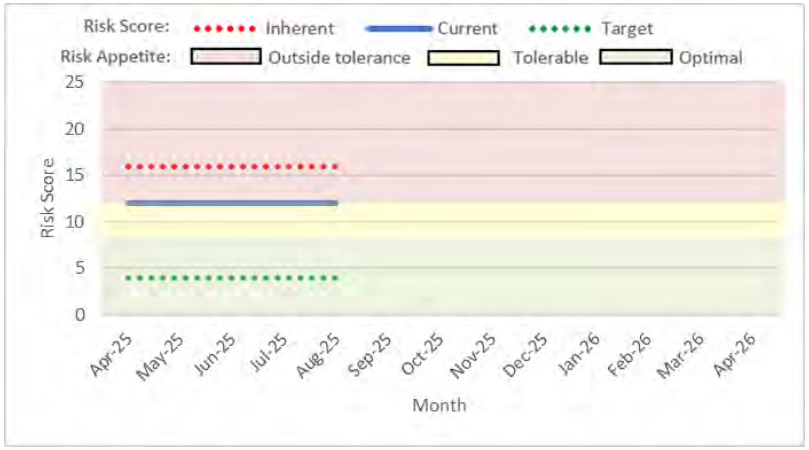
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for these risks:



Corporate Objective: CO4 Make WWL a great place to work and ensure that our staff feel valued																**Overall Assurance Level**	**Medium**
Linked Objectives:	CO1	✓	CO2	✓	CO3	✓	CO4	✓	CO5	✓	CO6	✓	CO7	✓	CO8	✓	

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 a financially sustainable workforce plan. In 2025/26 WWL is required to reduce headcount by c200. This will be managed with compassion and in line with Trust policy however there is a risk that these actions will negatively impact on staff wellbeing and motivation.		
Lead Committee	**People**		**Risk Appetite**	Open
Lead Director	**CPO**		**Risk category**	Staff Capacity & Capability, Staff Engagement Staff Wellbeing.
Date risk opened	**30.07.25**		**Linked system risks**	Datix ID 3783 LSR5: support and develop workforce
Date of last review	**30.07.25**		**Proximity / Treatment**	12 months Treat

Risk Score Timeline



Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
• Target agreed with all service leads. • Divisionally led high level workforce plans have been submitted • Transformation schemes are developed which are organisational wide and led by Senior Responsible Officers. • Every workforce reduction / change scheme is underpinned by a QIA • Continued core focus on key workforce metrics at Divisional Performance Reviews • Wider Leadership Team receives monthly data on key workforce metrics, including sickness; turnover; appraisal completion • Continued delivery of the commitments made in the WWL People & Culture Strategy • Bank and agency reduction plans have been submitted • Monthly workforce performance data submitted through the Greater Manchester and NHS England via PWR • Vacancy Control Panel established • Quarterly pulse survey is run across the organisation with results considered at Wider Leadership Team • National Staff Survey will enable us to make a sense check of temperature of staff feeling • Regular executive led listening events are run across the organisation • Communities of Inclusion established for underrepresented groups • Monthly forums held for "hard to reach" groups e.g. healthcare support staff, global majority nurses • We LEAD programme launched on 1st April 2025.	• Not all Divisions have fully worked up schemes of work • Potential industrial action	**2nd Line:** • Establishment Control Group (Medical and Non-Medical) • LNC • Workforce Partnership Forums • People Committee • GM Financial Sustainability Programme • Industrial Action Planning Group • Monthly Divisional Performance Review Slides • Monthly People Dashboard reported at WLT	• Substantive workforce numbers remain largely static.	• Support for Divisional leaders and Corporate Directors in relation to the implementation of workforce plans.	Throughout 2025/26 CPO

Performance

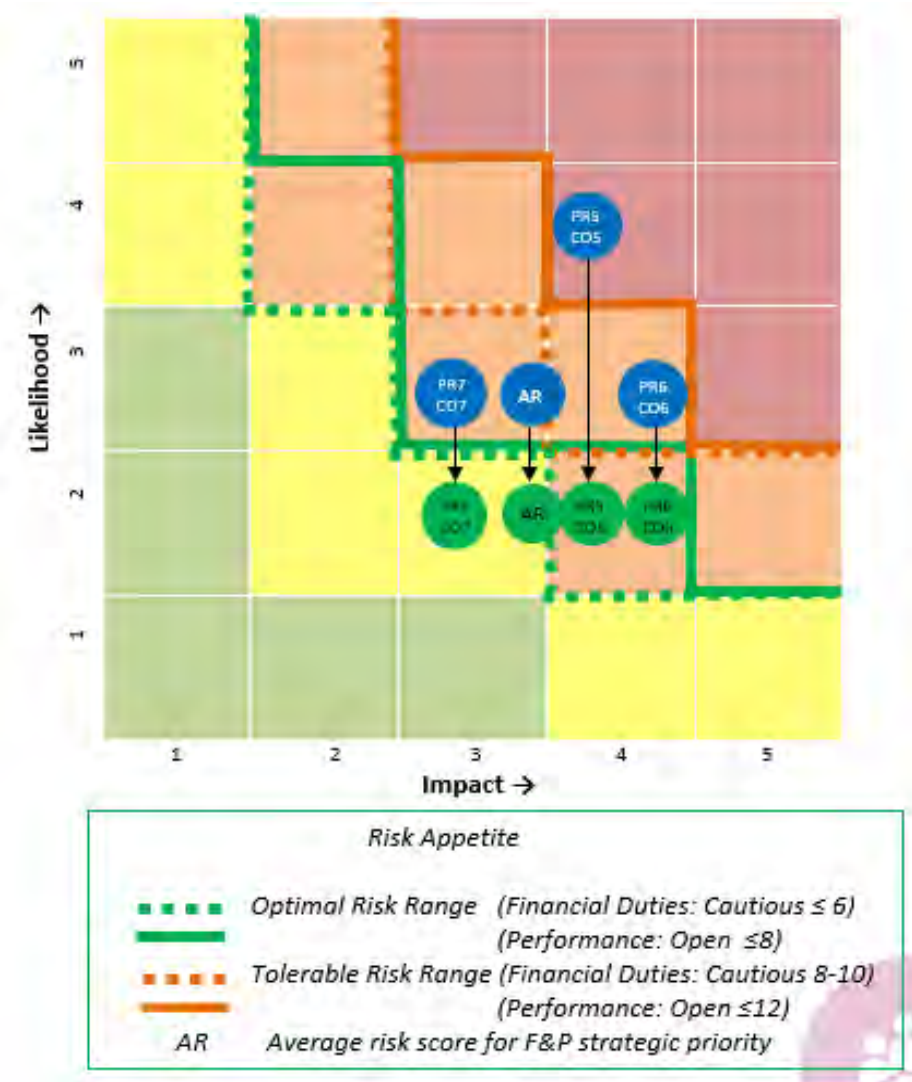
To consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

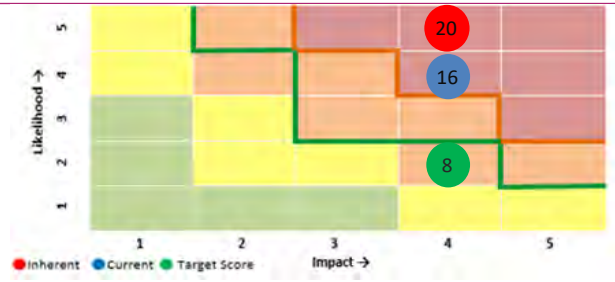
The following objectives are aligned to the **performance** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Tracking BRAG rating
CO5	Foster a sustainable, efficient and productive financial environment	• Delivery of financial statutory duties • Transform and innovate to achieve sustainable improvement and to manage within our resources • Enhance productivity across all areas through implementing best practices, leveraging technology and streamlining processes to improve outcomes	●Revenue position in line with plan ●Capital position in line with plan ●Cash position in line with plan and liquidity improving ●Cash releasing CIP delivered including planned reductions in our workforce ●Underlying financial position improving ●Demonstrable improvements in productivity metrics
CO6	Drive improvement in our overall performance, placing patients at the centre of everything we do. Take our opportunities to be outstanding.	• Embed doing the basics brilliantly as our standard • Continue improving integration across our divisions and with external organisations • Ensure that WWL is the preferred place of treatment for our patients, where appropriate • Ensure relevant dashboard information is available to ward leaders to influence quality of care delivery • Utilise staff surveys and patient feedback to drive improvements • External projection of good news stories • Active targeting of income opportunities (i.e. repatriation from private providers)	● 80% of patients would choose WWL as their first choice for any future treatment ● Demonstrable change implemented in response to feedback mechanisms
CO7	Optimise delivery of our elective and non-elective services	• Implementation of the Better Lives programme and work with the wider system to keep patients out of acute settings where suitable to release pressure on UEC services and rationalise demand for elective services to those who truly need them. • Improve UEC flow to positively impact staff morale and patient experience • Optimise the usage of our Elective Hubs to improve waiting list performance. Opportunity to further increase the acuity threshold at Leigh through innovation (e.g. use of telemedicine) • Leverage the status of our Elective Hubs as GM assets	●Improved 4-hour and 12-hour A&E performance ●Improved discharge / NCTR performance ●Reduced usage of escalation areas ●Higher utilisation of elective hub sites – minimal fallow theatre lists ●Further increased range of procedures deemed as 'suitable for Leigh' ●Any spare elective hub capacity is offered to / used for mutual aid to support GM peers

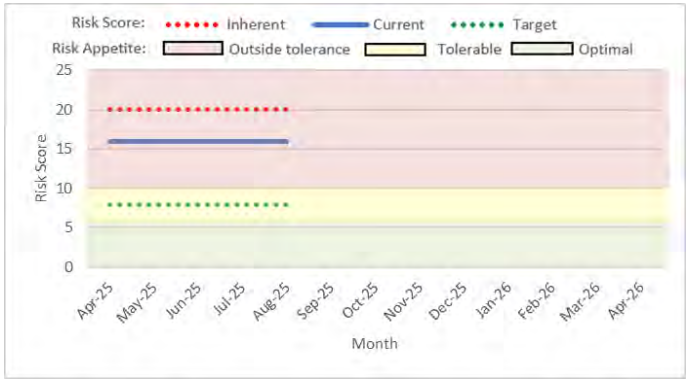
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for these risks:



Corporate Objective: CO5 Foster a sustainable, efficient and productive financial environment																Overall Assurance level	High
Linked Objectives:	CO1	✓	CO2	✓	CO3	✓	CO4	✓	CO5	✓	CO6	✓	CO7	✓	CO8	✓	

Principal risk	Risk Title:	PR 5: Delivery of the Financial Recover Strategy		
	Risk Statement:	There is a risk that the Trust may fail to deliver the Financial Recovery Strategy, due to issues with the revenue, capital and cash position, failure to deliver CIP and issues with productivity metrics and the underlying financial position, resulting in breaches in financial statutory duties.		
Lead Committee	Finance & Performance		Risk Appetite	Cautious
Lead Director	CFO		Risk category	Financial Duties
Date opened	30.07.25		Threat: System risk	LSR6 Financial plans
Date of last review	30.07.25		Proximity / Treatment	12 months Treat

Risk Score Timeline

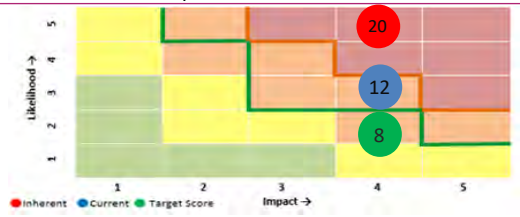


Strategic Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
ID 3292 Financial Performance: Failure to meet the agreed I&E position	• Final plan signed off by Board and submitted to NHSE – April 25. • Draft and final plans scrutinised through monthly Provider Oversight meetings with GM ICB. (Ext) • Draft and final plans discussed through Executive Team Meetings, Board Away Days and Board meetings including risks to delivery, consequences of a deficit plan and difficult decisions. • Planning process co-ordinated through internal planning group with representation from strategy and planning, workforce and finance • External scrutiny of approach and assumptions within the draft plan took place through NHSE commissioned consultancy (Seagry) during Mar 25 (Ext) • 2025/26 is year 2 of the WWL Financial Sustainability Plan (FSP). • GM agreed allocation of deficit funding of £8.9m, included within 2025/26 plan. • CIP target agreed with programme for delivery and actions. • Executive oversight and challenge of CIP & Financial performance through Divisional Performance Review Meetings, Financial Improvement Group, Transformation Board. • Establishment control groups ongoing for non medical and medical staffing with scrutiny and rigour over agency spend in line with national agency controls. • Discretionary non-pay controls ongoing for specific categories of spend. • Stringent business case criteria remains to ensure only business critical investments are approved. • Revenue plan includes income in line with GM ICB contract offer with the exception of ERF above the notified cap (£7.9m) • Finance Improvement Group meeting monthly, chaired by Chief Finance Officer and attended by Chief Executive • Monthly Provider Oversight Meetings ongoing (Ext) • GM Controls remain 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 • GM vacancy control panel established (Ext) • 2025/26 contract signed in line with planned activity and income • Deficit Support Funding (DSF) confirmed for Q2 and isn't subject to clawback • Scenario Modelling - Year-end forecasts include worst, mid, and best-case scenarios, reported through the Trust Finance Report from M3	• Divisions to accept budgets through the finance hub during May 2025 • Robust forecasting including scenario planning for worst, most likely and best case not yet underway • Final business rules not yet confirmed relating to deficit funding • DSF now needs to be earned for Q3 and Q4 based on specific criteria • No confirmation on support for IA costs	**1st Line:** Monthly Performance Review meetings for all clinical divisions and Finance Improvement Group (FIG) **2nd Line:** Finance & Performance Committee July 2025. **External:** Monthly Provider Oversight Meeting with GM ICB (Ext)	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	Organisational wide communication of the financial position, challenges and controls	Throughout 2025/26 CFO

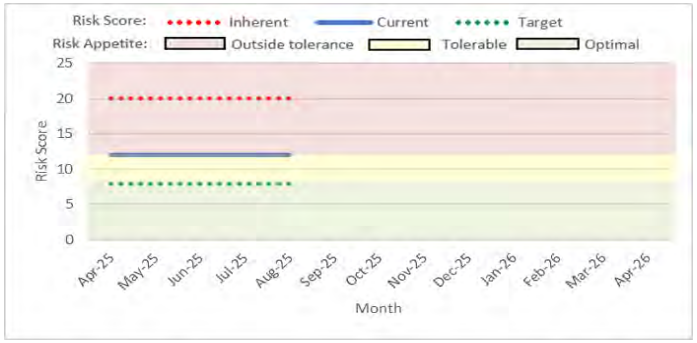
Strategic Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
Threat ID 3291 Financial Sustainability: Efficiency targets	• Robust CIP divisional delivery approach and governance. • Monitored via Divisional CIP groups, reporting through Divisional Performance Review 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. • CIP plan for 2025/26 was developed through review of NHSE productivity packs, local priorities aligned to national themes (Transformation schemes), Exec led opportunities and core divisional CIP • CIP Handbook providing guidance and oversight processes • Previous MIAA review 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) • Clinical leadership ongoing reviewing benchmarking opportunities for quality improvements through model hospital and GIRFT and reported through CAB, ETM and Divisional Assurance Meetings. • System savings group ongoing across Wigan locality, chaired by Deputy Place Based Lead • Finance Improvement Group meeting monthly with agreed workplan • Established QIA process led by Chief Nurse and Medical Director • Cross divisional CIP group ongoing and chaired by Divisional Director of Ops for Community Services • GM Sustainability Plan endorsed by NHS GM Board to ensure appropriate management of finances and use of resources across GM (Ext) • Weekly CIP risk categorisation reported to NHSE (Ext) • CIP oversight through monthly Provider Oversight Meetings with the GM ICB (Ext) • Weekly huddles established with divisions to drive achievement	• Limited mechanisms to facilitate delivery of system wide savings. • Limited PMO resource internally to support delivery of CIP plans	**1st Line:** Monthly Divisional Performance Review meetings and monthly finance improvement group (FIG) **2nd Line:** Finance & Performance Committee July 2025	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	Monthly updates on CIP presented to Executive Team, with regular updates to Divisional Teams.	Throughout 2025/26 CFO/COO
Threat ID 3295 Capital Funding	• Capital priorities agreed by Executive Team & Trust Board throughout the planning round with final plan approved. • 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 Resource Allocation Group (CRAG) ongoing to support development of ongoing capital strategy, collaboration and prioritisation of capital spend. (Ext) • Programme Boards established for major capital schemes. • 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 balances 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. • Leases and operational CDEL plan is combined from 2025/26 • WWL capital plan is within operational CDEL envelope including a 5% planning tolerance to be managed locally during 2025/26. • 10 year infrastructure plan completed and submitted to GM in 2024/25. • GM CDEL plan balanced (Ext) • GM ICB has supported £9.7m of WWL schemes against national capital programmes (PDC) included within the 2025/26 plan	PDC Business cases supported by NHSE and reviewed by ETM and WLT to be approved by Board August 25.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - July 2025	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	Close monitoring of Capital spend in line with trajectory.	Throughout 2025/26 CFO

Strategic Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
Threat ID 3998 Cash Balance	• 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. • Internal cash management group established and strategy being reviewed in line with national changes to cash support. • Opening cash balance higher than plan due to receipts of cash during Q4 of 2024/25. • Cash forecast reviewed with no support required in Q1 of 2025/26 • 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 through Finance Advisory Committee and individual discussions with the ICB (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 8 for additional controls to ensure that CIP delivery is cash releasing. • Ongoing treasury management processes • CUF change notified July 25 to account for pay award cash impact (Ext) • Cash management mitigations have been developed for implementation if required to ensure the minimum cash balance is maintained (deferring creditor payments, invoicing upfront, management of the capital programme)	• NHSE process paused for providers requesting cash support in April • GM Cash Group to be re-established (Ext.) • DSF now needs to be earned for Q3 and Q4 based on specific criteria • Development of a memorandum of understanding between the ICB and GM providers which sets out a staged approach to cash flow mitigations to preserve cash availability in 2025/26 (Ext)	**1st Line:** Cash management Group **2nd Line:** Finance & Performance Committee July 2025	• 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	Throughout 2025/26 CFO

Corporate Objective: **CO6** Drive improvement in our overall performance, placing patients at the centre of everything we do. Take our opportunities to be outstanding.																**Overall Assurance level**	**High**
Linked Objectives:	**CO1**	✓	**CO2**	✓	**CO3**	✓	**CO4**	✓	**CO5**	✓	**CO6**	✓	**CO7**	✓	**CO8**	✓	

Principal risk	**Risk Title:**	**PR 6: Performance**		
	Risk Statement:	There is a risk that performance will not improve, due to lack of capacity to drive improvement, limited resourcing requiring priority decisions, failure to take patient priorities and views into account when reaching decisions on improvement and use of legacy IT systems with potential for cyber-attacks, resulting in poor performance, adverse publicity, business continuity disruptions and patients not choosing WWL as their first choice for any future treatment.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Open
Lead Director	**COO**		**Risk category**	Financial Duties
Date opened	**30.07.25**		**Threat:** **System Risk:**	**ID 3291** LSR6 Financial plans
Date of last review	**30.07.25**		Proximity / Treatment	12 months Treat

Risk Score Timeline

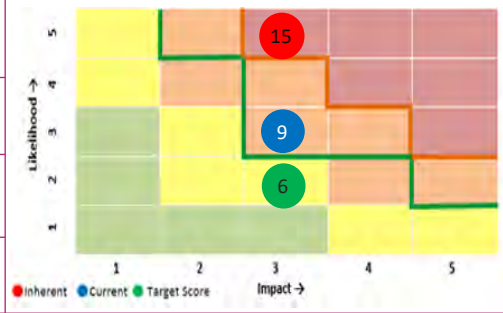


Strategic Opportunity / Threat	Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat	• Workforce reduction strategy aligned at WWL's financial sustainability plan and fully involves the divisional management. • Workforce reduction plan is robust. • The Better Lives funding has been approved for phase 2b which is non-recurrent until November 2025. • 2025/26 final transformation plan has been received, with the divisions involved in its design and delivery.	• The Better Lives funding is due to conclude in the 2025/26 financial year, presenting a risk for future social care funding and its impact upon health.	**1st Line:** Monthly Divisional Performance Review meetings and monthly finance improvement group (FIG) **2nd Line:** Finance & Performance Committee July 2025 People Committee June 2025	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Workforce reduction plan to be monitored though the People Committee and the Board of Directors meeting.	Throughout 2025/26 CFO/COO
4226 Cyber-attack: Health and social care - 9	• Funding secured for data back ups software, renewing the virtual desktop infrastructure, virtualisation platform, endpoint management software and network asset management software.	The reasonable worst-case scenario would involve catastrophic systemic service disruption due to ransomware moving quickly across the health and care IT estate. Systems would become inaccessible and organisations would move to offline services.	**1st Line:** Digital Divisional Quality Meeting - monthly	• No gaps currently identified	No further action currently identified.	

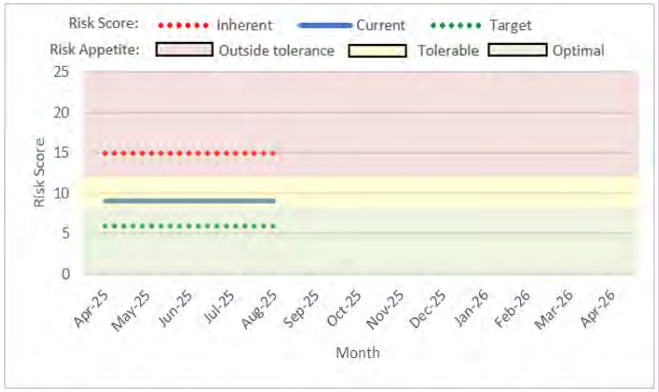
Strategic Opportunity / Threat	Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom

Corporate Objective: CO7 Optimise delivery of our elective and non-elective services

Linked Objectives:	CO1	✓	CO2	✓	CO3	✓	CO4	✓	CO5	✓	CO6	✓	CO7	✓	CO8	✓	Overall Assurance level	Medium

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 7: Delivery of our elective and non-elective services**		
	Risk Statement:	There is a risk that demand for elective and non-elective services may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting improved UEC flow, insufficient diagnostic capacity to deliver elective waiting times, poor management of winter demand with partners and ICB not delivering elective work to Wrightington, resulting in missed A&E performance targets, reduced discharge/NCTR performance, increased usage of escalation areas, underutilisation of elective hubs and a negative impact on staff morale and patient experience.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Open
Lead Director	**COO / CFO**		**Risk category**	Performance Targets
Date risk opened	**30.07.25**		**Linked system risks**	LSR8: Statutory duties including the NHS Constitutional targets
Date of last review	**30.07.25**		Proximity / Treatment	12 months 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)	• The Trust has been placed into tier two of the elective recovery programme. • Mutual aid has been offered by WWL.	• Challenges in Gastro. ENT, General surgery, dermatology and plastics. • Mutual aid has impacted upon the backlog for WWL's delivery.	**2nd Line:** • Elective activity and efficiency board chaired by CFO.	•No gaps in assurance currently identified.	1. Winter plan to be implemented	October 2025 COO/CFO
	• The performance against the 4-hour standards has remained static and there are still significant challenges with the performance of patients waiting 12-hours or more in the Emergency Department. • Ambulance handover time is improving	• The number of 'no criteria to reside' patients within the Trust affects flow around the hospital.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – May 2025	No gaps in assurance currently identified.	2. Progress Discharge and Flow Programme	March 2026 COO/CFO

Partnerships

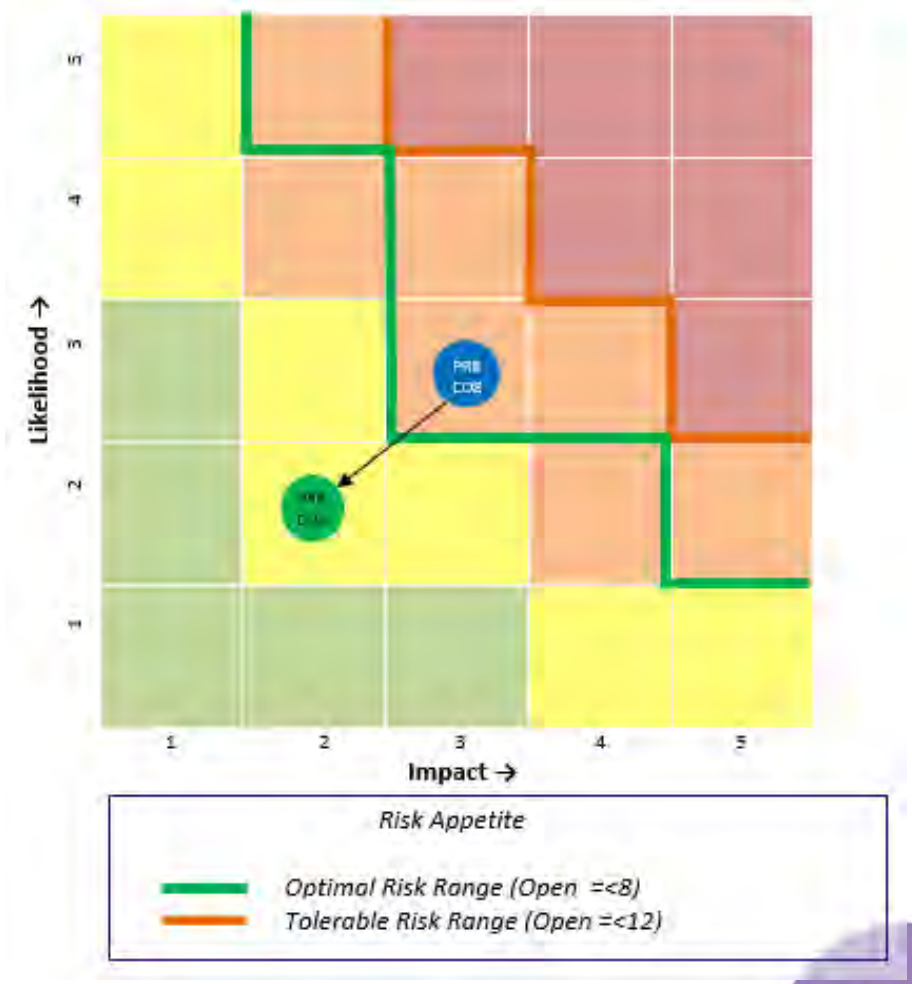
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

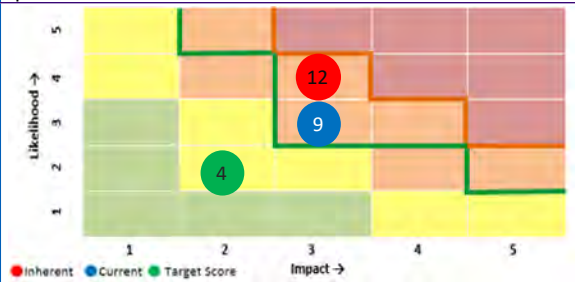
The following objectives are aligned to the **partnerships** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Tracking BRAG rating
CO8	To further strengthen existing partnerships and develop new ones to complement and support our NHS services and research activities	• Shared ownership across organisations in Wigan to solve tricky system issues. • Development of a workforce without organisational barriers across the locality. • Working with primary care to develop shared specialist care (including advice and guidance, shared care, special interest) • Focus on new and existing partners within Wigan, across GM and with neighbouring ICBs • Our Commercial Opportunities programme will seek to identify and support income generation for the Trust via the development of private patient and corporate opportunities while maintaining our commitment to patient care	• Clear patient pathways across organisations • Joint Work programmes • Locality teams and members • Increase in commercial and research income • More partnerships • An improved surplus position for commercial income (£1m for 25/26) that positively supports the Trust's overall financial position.

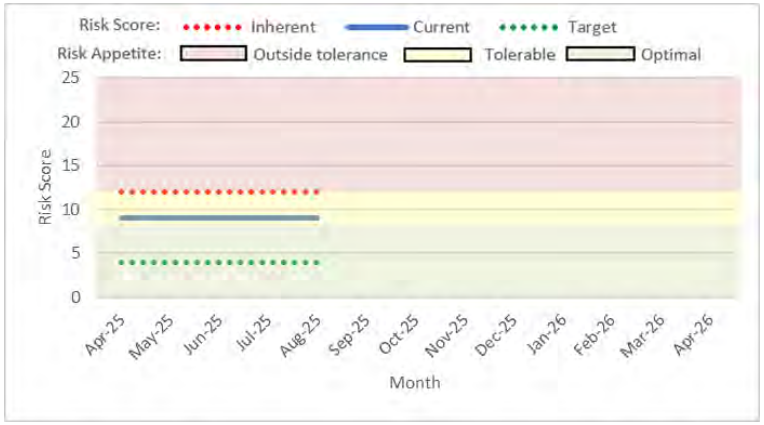
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for these risks:



Corporate Objective: **CO8** To further strengthen existing partnerships and develop new ones, to complement and support our NHS services and research activities.																**Overall Assurance level**	**Medium**
Linked Objectives:	**CO1**	✓	**CO2**	✓	**CO3**	✓	**CO4**	✓	**CO5**	✓	**CO6**	✓	**CO7**	✓	**CO8**	✓	

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR8: Partnership working**		
	Risk Statement:	There is a risk that working more closely with local health and care partners may not fully deliver the required benefits, due to instability at ICB and NHSE/DHSC, lack of engagement from relevant local authorities, not being able to meet the requirements to have University Hospital status, resulting in resulting in unclear patient pathways, uncertainty regarding partnership working, negative impact on commercial and research income and the Trust's overall financial position.		
Lead Committee	**Board of Directors**		**Risk Appetite**	Open
Lead Director	**DCE**		**Risk category**	Strategy
Date risk opened	**30.07.25**		**Linked risks**	SR7 - system leadership
Date of last review	**30.07.25**		**Proximity / Treatment**	12 months 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**	• Wigan and Leigh College have funded a role for 12 months to support our Talent4Care programme. • Locality meeting structures in place to support lasting corporate knowledge. • Development of locality UEC transformation programme. • 5 colleagues confirmed as meeting the substantive employment to EHU. • We are achieving the criteria of a 2 year average of £200k/annum Research Capacity Funding awarded by end of March 2026. • 5 clinical academics in place.	• 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. • Target is for 13 clinical academics by April 2026	**2nd Line:** • Board of Directors – bi-monthly • Research Committee – quarterly • **External:** System Board meetings – monthly Anchor Institution Steering Group.	Uncertainty around ICB changes, in particular responsibilities and resources held centrally in GM versus those delegated to localities.	1. Attendance at System Board meetings with Partners. 2. 8 appointments required in final 1.5 years to achieve target for UHA application.	Monthly DCE April 2026 DCE

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Financial reporting month 3 – Trust Finance Report
Presented to:	Board of Directors
On:	6th August 2025
Item purpose:	Information
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Senior finance team
Contact details:	heather.shelton@wwl.nhs.uk

Executive summary

At the end of quarter 1, there is an actual deficit of £2.5m, which is £1.0m adverse to plan. Our month 3 position is £0.3m worse than plan in month. The month 3 position includes two one-off benefits totalling £0.6m, which are associated with items related to last financial year which are now concluded. Without these benefits, our position would have been £0.9m adverse to plan in month. External scrutiny on the deliverability of our position will continue.

Recurrent CIP delivery is a significant concern, with in month slippage of £1.3m and the year to date slippage increasing to £2.3m. There was an increase in our CIP plan phasing from month 3, as the plan was lower in month 1 and 2 to facilitate time for CIP plans to be developed and implemented. We need to recover the CIP slippage and deliver the plan in full to achieve our 2025/26 financial plan.

Divisional elective API performance has maintained the improvement seen last month. This is £0.1m favourable in month due to over performance in Specialist Services. Surgery were breakeven to plan in month and Medicine continue to underperform in Gastroenterology, £0.1m adverse in month. Year to date underperformance is £0.4m adverse which we are currently forecasting to recover.

The cash balance as at 30th June 2025 is £11.7m, which is a decrease of £3.6m from last month. Cash is continuing to decline due to our deficit position, linked to the slippage on CIP delivery and static run rate. Operating cash days has reduced to 7 days.

Workforce in June is at 6,931 WTE, which is a decrease of 30 WTE on last month. However, the gap to the workforce plan is growing with the June position being 65 WTE above the plan of 6,866

WTE. Pay expenditure is £1.0m adverse to plan in month which is associated with the CIP underperformance.

Full year forecast scenarios have been completed. The mid-case scenario reflects an unmitigated forecast of £7.7m for the 2025/26 full year financial position, which reflects the level of risk associated with delivery of our breakeven financial plan. Mitigations of £7.7m have been identified which mean our forecast will reflect delivery of plan.

The underlying position will be refreshed every quarter. At the end of quarter 1, the extrapolated underlying run rate is a deficit of £21.3m. This is an improvement of £4.5m on the exit run rate from 2024/25 and is on trajectory with the planned improvement required for 2025/26.

Link to strategy

There are no direct links to strategy.

Risks associated with this report and proposed mitigations

There are no additional direct risks.

Financial implications

There are no direct financial implications as 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 EDI implications in this report.

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

ETM reviewed the finance flash metrics on 3rd July 2025 and the full year forecast on 17th July 2025. The full report was presented to the Financial Improvement Group on 28th July 2025 and the Finance and Performance Committee on 29th July 2025.

Wider implications

There are no wider implications of this report.

Recommendation(s)

The Board is asked to note the month 3 financial position.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Trust Finance Report

Month 3 – June 2025

Contents

Statistical Process Chart (SPC) Key

Key Financial Messages

At the end of quarter 1, there is an actual deficit of £2.5m, which is £1.0m adverse to plan. Our month 3 position is £0.3m worse than plan in month. The month 3 position includes two one-off benefits totalling £0.6m, which are associated with items related to last financial year which are now concluded. Without these benefits, our position would have been £0.9m adverse to plan in month. External scrutiny on the deliverability of our position will continue.

Recurrent CIP delivery is a significant concern, with in month slippage of £1.3m and the year to date slippage increasing to £2.3m. There was an increase in our CIP plan phasing from month 3, as the plan was lower in month 1 and 2 to facilitate time for CIP plans to be developed and implemented. We need to recover the CIP slippage and deliver the plan in full to achieve our 2025/26 financial plan.

Divisional elective API performance has maintained the improvement seen last month. This is £0.1m favourable in month due to over performance in Specialist Services. Surgery were breakeven to plan in month and Medicine continue to underperform in Gastroenterology, £0.1m adverse in month. Year to date underperformance is £0.4m adverse which we are currently forecasting to recover.

The cash balance as at 30th June 2025 is £11.6m, which is a decrease of £3.8m from last month. Cash is continuing to decline due to our deficit position, linked to the slippage on CIP delivery and static run rate. Operating cash days has reduced to 8 days.

Workforce in June is 6,931 WTE, which is a decrease of 30 WTE on last month. However, the gap to the workforce plan is growing with the June position being 65 WTE above the plan of 6,866 WTE. Pay expenditure is £1.0m adverse to plan in month which is associated with the CIP underperformance.

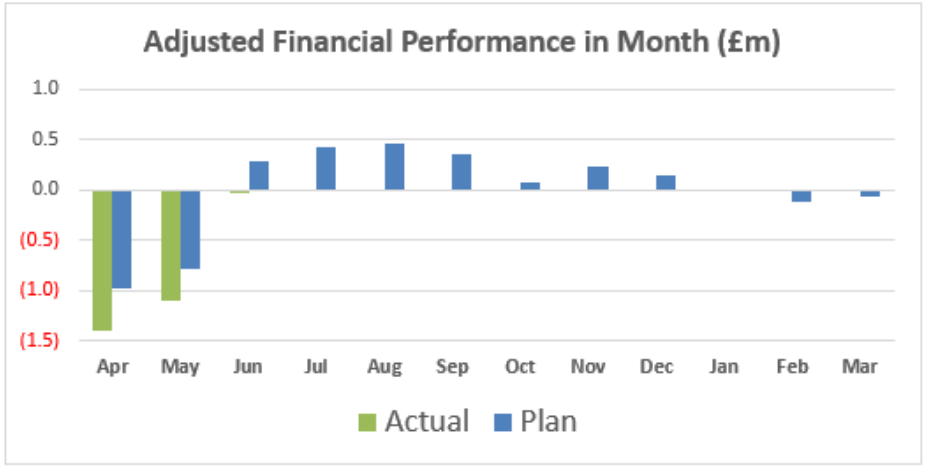
Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Red		At the end of quarter 1, there is an actual deficit of £2.5m, which is £1.0m adverse to plan. Our month 3 position is £0.3m worse than plan in month. The month 3 position includes two one-off benefits totalling £0.6m associated with items related to last financial year which are now concluded. Without these benefits, our position would have been £0.9m adverse to plan in month.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		Closing cash at the end of June was £11.6m, decrease of £3.8m from May. The cash plan is based on delivery of the revenue and efficiency plans and remains challenging for 2025/26.
API Income	Achieve the elective activity plan for 2025/26.	Amber		Divisional elective API performance has maintained the improvement seen last month. In month 3 we are £0.1m favourable to the internal elective API plan, and £0.4m behind year to date.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Red		Total CIP delivered in Month 3 is £2.1m, which is £1.3m below plan: £0.8m is recurrent (36%) and £1.3m is non-recurrent (64%). The recurrent YTD delivery is £2.3m behind plan. As at month 3, The recurrent plan is fully identified however there is significant risk to this. In month 3, all divisions are significantly behind plan.
	Deliver Recurrent CIP of £23.0m	Red		
Agency expenditure	30% reduction in agency spend.	Red		In month 3, agency expenditure was £0.7m, £0.2m above the plan of £0.4m. Agency spend YTD is showing a decrease of 3% relative to the NHSE baseline (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.
Bank expenditure	10% reduction in bank spend	Amber		Our bank plan reflects the NHSE planning requirement to reduce expenditure by 10% on the month 8 2024/25 forecast outturn, plus a further £2.0m stretch associated with the difficult decisions. YTD, bank expenditure has reduced by 13% on the 2024/25 average baseline and therefore exceeds the expected planning reduction.
Capital expenditure	Achieve capital plan for 2025/26.	Amber		Capital expenditure in month 3 is £3.8m which is £1.0m behind plan. This Is due to the delay of a property lease renewal, now expected within Q2.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Green		BPPC performance in-month performance was 96.0% by volume and 98.1% by value, YTD performance was 95.6% by volume and 98.2% by value

Financial Performance

Headlines

- In month, we are **£0.3m adverse to plan.** Year to date, the actual deficit is £2.5m, which is **£1.0m adverse to plan.** The month 3 position includes £0.6m of non-recurrent items which do not impact our underlying run rate.
- The CIP plan per month increases from month 3, as per the agreed financial plan. Month 3 has a planned surplus of £0.3m, including a CIP target of £3.4m.
- Income is £48.2m in month, **£0.9m favourable to plan** and this includes a £0.4m one-off benefit due to the settlement of the prior year CDC income with GM ICB. Divisional elective income is above plan for the second consecutive month.
- Pay is £33.4m in month, **£1.0m adverse to plan** in month. This is driven by CIP slippage with most of the CIP plan increase from month 3 within pay. The CIP variance on pay is £1.4m adverse in month and £2.5m adverse year to date. There is a £0.2m one-off benefit within pay associated with release of an accrual for a payroll correction on incremental points following arrears being processed.
- Non pay is £14.3m in month**, £0.3m adverse to plan**. Year to date, non pay is **£0.3m favourable to plan.**
- Excluding the non-recurrent deficit funding, the deficit is £0.8m in month and £4.7m year to date. Deficit funding has been confirmed for the GM system for Q2, but further assessment will be undertaken by NHSE for Q3 and Q4, with metrics currently in development.



Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	48,169	47,267	902	142,231	141,661	570	569,326
Pay	(33,429)	(32,464)	(965)	(101,106)	(98,913)	(2,192)	(391,663)
Non Pay	(14,315)	(13,990)	(325)	(42,306)	(42,648)	342	(171,256)
Financing / Technical	(469)	(552)	83	(1,395)	(1,655)	260	(6,621)
Surplus / Deficit	(44)	261	(305)	(2,576)	(1,556)	(1,020)	(213)
Adjusted Financial Performance (AFP)	(40)	279	(319)	(2,535)	(1,502)	(1,033)	0
Memo							
Deficit support funding	(741)	(741)	0	(2,223)	(2,223)	0	(8,893)
AFP excluding deficit support funding	(781)	279	(1,060)	(4,759)	(1,502)	(3,256)	(8,893)

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

Income

Division	In Month (£000)			Year to Date (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	502	422	80	999	1,259	(260)
Surgery	264	216	48	862	646	216
Specialist Services	1,488	1,593	(105)	4,603	4,754	(151)
Community Services	626	672	(46)	1,917	2,005	(88)
Non Divisional Income	44,193	43,366	826	130,698	130,012	686
Finance	9	13	(5)	30	40	(10)
Digital Services	3	7	(4)	12	22	(11)
Dir of Strat & Planning	132	144	(12)	492	407	84
Chief Operating Officer	0	0	0	0	0	0
Human Resources	50	96	(47)	160	289	(128)
Medical Director	93	107	(14)	272	221	52
Estates & Facilities	441	399	42	1,224	1,198	27
Nurse Director	124	83	42	279	248	32
Trust Executive	0	(55)	55	0	(50)	50
GTEC	164	163	1	476	490	(14)
Corporate	81	40	41	207	120	87
Total	**48,169**	**47,267**	**902**	**142,231**	**141,661**	**570**

Headline

- Income is £0.9m favourable in month and £0.6m favourable YTD.

Medicine

- Medicine's income is £0.1m favourable in month due to an under performance of Elective API income predominantly within Gastroenterology of £0.1m offset with an over performance on drugs and devices of £0.2m.

Surgery

- Surgery's income is £48k favourable in month predominantly due to an over performance on education income. Elective API income is on plan in month.

Specialist Services

- Specialist Services income is £0.1m adverse in month. Private patient income is £0.2m adverse, unbundled drugs and devices is £0.1m adverse and this is offset with an over performance on ERF API income of £0.1m and education income £0.1m.

Non – Divisional Income

- Non-Divisional income is £0.8m favourable in month.
- £0.2m relates to benefit of the elective API income relating to low value activity (LVA) backdated to month 1 and £0.15m relates to over performance on drugs and devices.
- We have also settled the 2024/25 position for CDC resulting in a one-off benefit of £0.4m.

Human Resources

- £47k adverse in month predominantly due to occupational health income.

Divisional Elective API Activity and Income v Internal Plan

Division	POD	In Month Activity			In Month (£000)			Year to Date Activity			Year to Date (£000)		
		Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,474	1,605	(131)	998	1,056	(58)	4,237	4,661	(424)	2,853	3,068	(215)
Medicine	Electives	39	41	(2)	51	56	(5)	71	119	(48)	112	162	(50)
Medicine	OP Proc New	97	149	(52)	28	55	(26)	269	433	(164)	84	158	(75)
Medicine	OP Proc FUP	640	620	20	143	116	27	1,884	1,802	82	418	337	81
Medicine	OPA New	2,260	2,681	(421)	584	698	(115)	7,104	7,788	(684)	1,820	2,028	(209)
Medicine	A&G	771	276	495	166	59	106	1,322	827	495	284	178	106
Medicine Total		**5,281**	**5,372**	**(91)**	**1,969**	**2,040**	**(71)**	**14,887**	**15,630**	**(744)**	**5,571**	**5,932**	**(361)**
Specialist Services	Day Cases	778	770	8	1,361	1,359	2	2,311	2,297	14	3,804	4,056	(252)
Specialist Services	Electives	370	372	(2)	2,788	2,762	26	1,110	1,124	(14)	8,463	8,363	100
Specialist Services	OP Proc New	954	914	40	161	153	9	2,918	2,656	262	490	444	46
Specialist Services	OP Proc FUP	1,559	1,347	212	218	189	28	4,348	3,913	435	606	550	56
Specialist Services	OPA New	3,180	3,266	(86)	668	687	(19)	9,342	9,487	(145)	1,964	1,997	(33)
Specialist Services	A&G	618	171	446	133	37	96	960	514	446	207	111	96
Specialist Services Total		**7,459**	**6,840**	**618**	**5,329**	**5,187**	**142**	**20,989**	**19,991**	**998**	**15,533**	**15,519**	**13**
Surgery	Day Cases	974	931	43	1,321	1,231	90	2,797	2,705	92	3,593	3,576	17
Surgery	Electives	144	183	(39)	494	517	(22)	416	533	(117)	1,433	1,501	(68)
Surgery	OP Proc New	1,705	1,999	(294)	369	432	(63)	4,983	5,808	(825)	1,109	1,254	(146)
Surgery	OP Proc FUP	3,362	3,154	208	690	643	47	10,356	9,162	1,194	2,128	1,867	261
Surgery	OPA New	3,872	4,132	(260)	788	844	(56)	11,517	12,002	(485)	2,351	2,451	(99)
Surgery	A&G	261	107	154	56	23	33	476	322	154	102	69	33
Surgery Total		**10,318**	**10,507**	**(189)**	**3,718**	**3,689**	**29**	**30,545**	**30,531**	**13**	**10,716**	**10,718**	**(2)**
Divisional ERF Totals		**23,057**	**22,719**	**338**	**11,017**	**10,917**	**100**	**66,420**	**66,152**	**268**	**31,819**	**32,169**	**(350)**

Elective API Performance

- In month 3 the Trust is £0.1m favourable to the Internal Elective API plan.
- Medicine are £0.1m adverse to plan in month predominantly due to Gastroenterology.
- Specialist Services are £0.1m favourable in month, predominantly within Dermatology.
- Surgery are approximately breakeven in month.

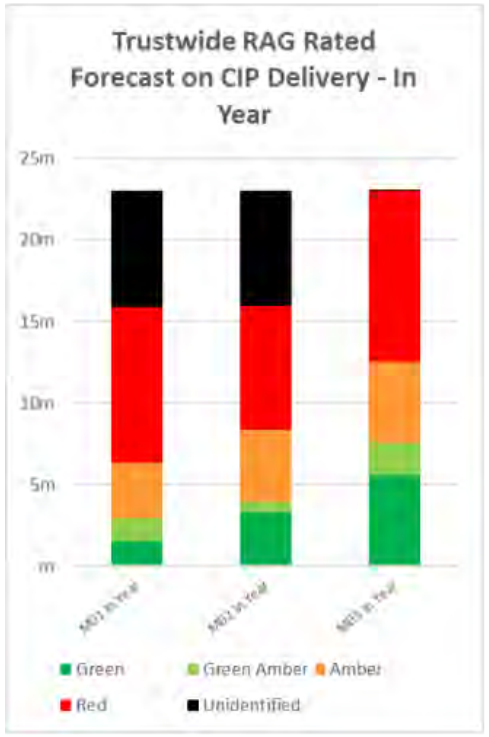
- Medicine £0.1m

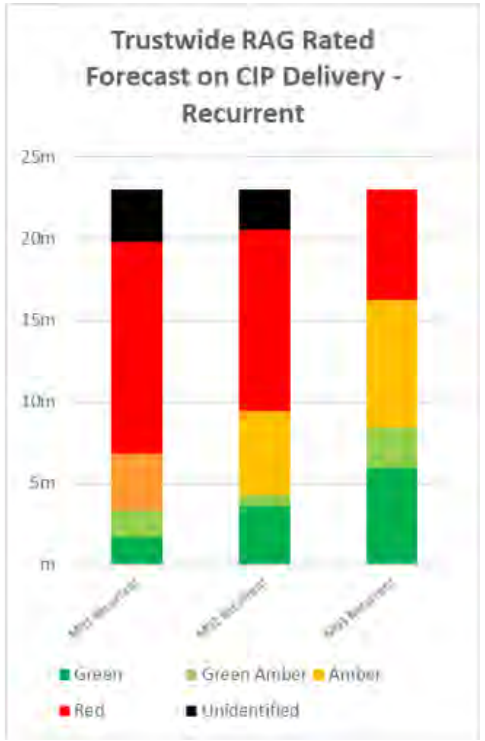
- Specialist Services £0.1m
- Surgery - breakeven

Trust Wide CIP Delivery 2025/26

2025/26 CIP Delivery

- Total CIP delivered in Month 3 is £2.1m, which is £1.3m below plan: £0.8m is recurrent (36%) and £1.3m is non-recurrent (64%).
- The full value of recurrent CIP transacted has increased by £1.7m to £5.6m, however the recurrent delivery in the year to date position is £2.3m behind plan
- The recurrent plan is fully identified which is a significant improvement from the Month 2 position, however there is a significant amount of risk within this - 46% of the forecast is high risk.





June 2025 Reported Position (Rec)

RAG	Value £'000
	0
	10,482
	5,007
	7,531
CIP Total	23,020

May 2025 Reported Position (Rec)

RAG	Value £'000
	7,184
	7,485
	4,432
	3,918
CIP Total	23,020

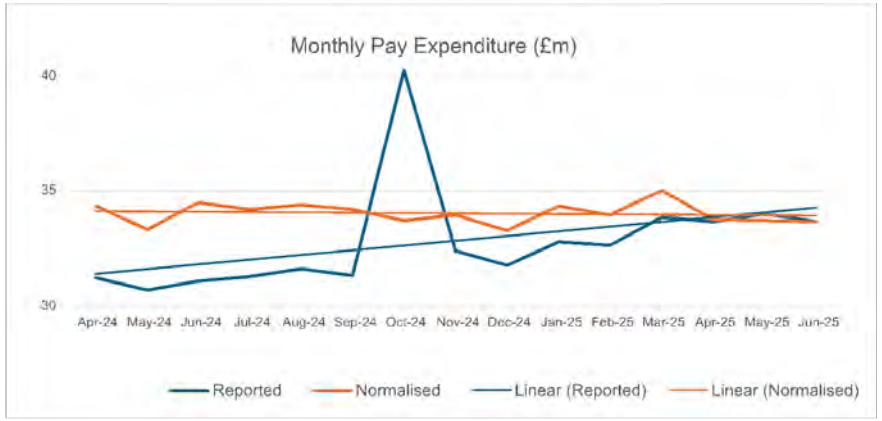
Workforce

Pay expenditure

- The in-month pay expenditure is £33.4m which is £1.0m above plan in month. This is due to unachieved CIP of £1.4m offset by vacancies in Corporate Divisions, Surgery and Specialist Services.
- The position includes a pay award accrual for 2025/26 aligned to the original planning assumptions, in line with NHSE reporting guidance.
- The normalised pay expenditure has been rebased in line with 2025/26 pay scales. Q1 2025/26 normalised pay is £33.7m compared to the 2024/25 Q4 average of £34.5m.

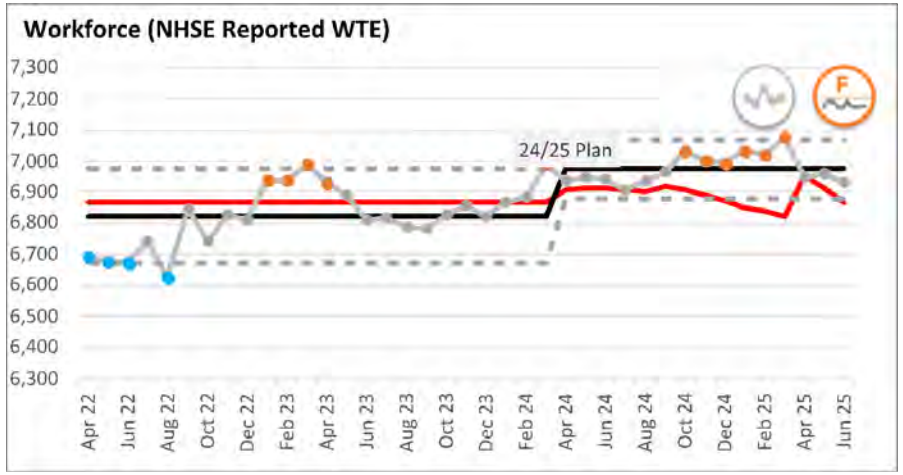
Workforce (WTE)

- Actual workforce 6,931 WTE in June. This is a decrease of 30 WTE from last month, however, is 65 WTE above the workforce plan of 6,866 WTE.
- Substantive staffing has reduced by 7 WTE due to leavers in Specialist Services and Estates & Facilities.
- Bank staffing has reduced by 25 WTE for nursing staff in Medicine, Surgery and Community Services.
- Agency has increased by 2 WTE compared to last month in Specialist Services



Pay £1.2m above plan in month

Normalised pay reduced between Q4 2024/25 and Q1 2025/26



WTE above plan by 65 WTE

Reduction of 166 WTE required to get to the March 2026 plan (6,765 WTE).

Normalised quarterly average

Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
£34.1m	£34.3m	£33.7m	£34.5m	£33.7m

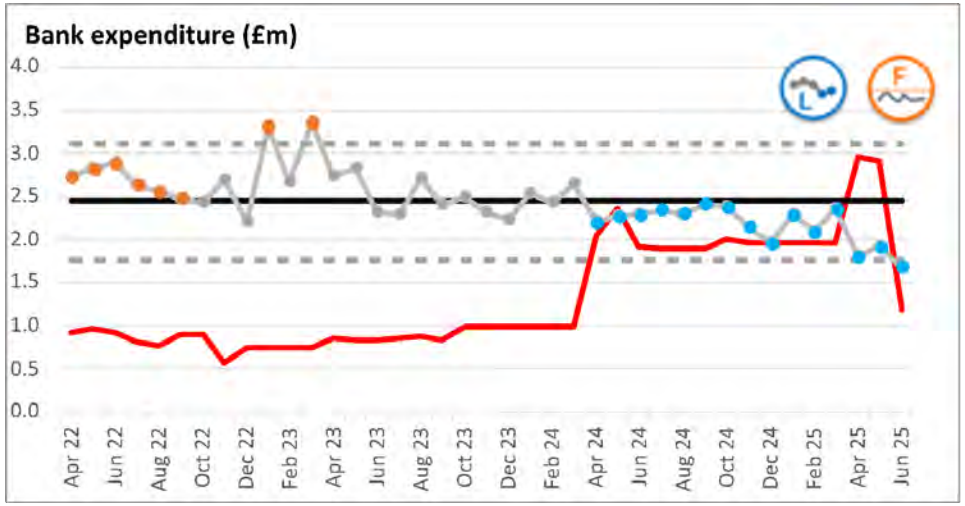
Bank & Agency Staffing

Bank expenditure

- Bank costs were £1.7m in June, a reduction of £0.2m from prior month. This can be seen in Medicine and Community Services
- Bank WTE decreased by 25 WTE in line with spend.
- The chart is showing a special cause of an improving variation.
- In May, Medicine (£1.1m) and Surgery (£0.4m) continue to be the biggest users.
- Bank spend is showing an 13% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) which is above the 10% reduction required by NHSE.
- The bank plan reduces from month 3 associated with the increase in the CIP profile. We are £0.5m above plan in month but £1.6m below plan YTD.

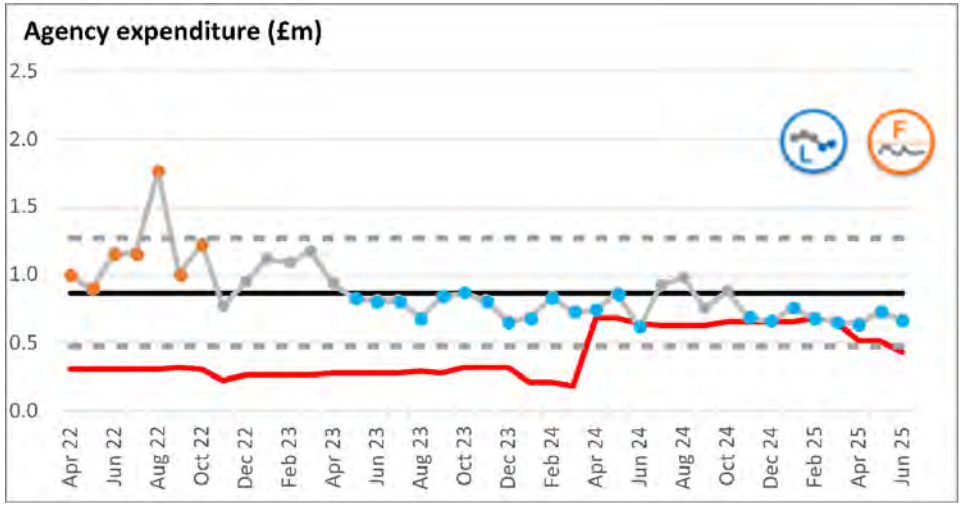
Agency expenditure

- Agency spend in month is £0.7m, comparable to previous months. The trend is still showing common cause improving variation as this is still within the typical process limits.
- There has been an increase in junior doctor agency usage following the GM rate standardisation in May.
- Medicine (£0.3m) continues to have the highest level of agency within the Trust.
- Agency spend is showing a decrease of 3% relative to the NHSE baseline (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.



Bank expenditure decreased in month 3

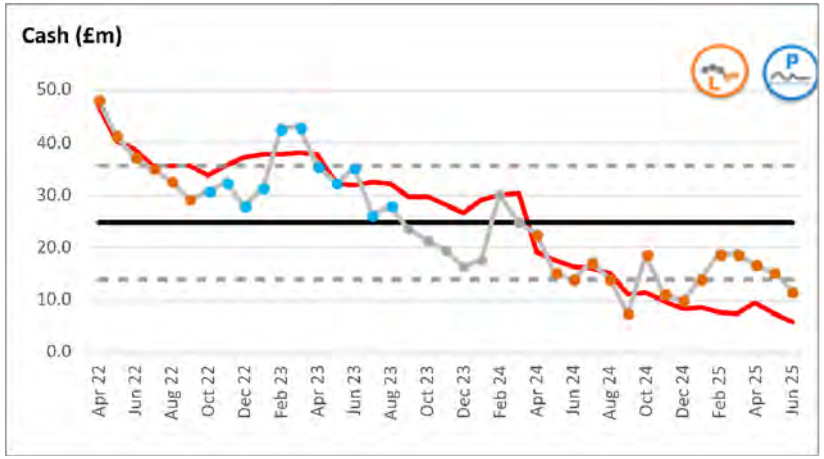
Reduced rates implemented from April 2025

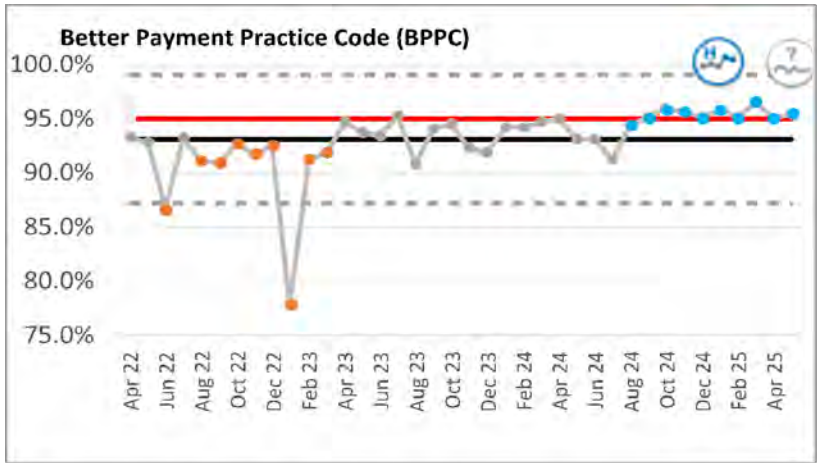


Slight decrease in Agency spend in month

Scrutiny remains high on agency spend

Cash and BPPC





Current cash position

- Closing cash at the end of June was £11.6m, decrease of £3.8m from May.
- Operating cash days have reduced to 8 days.
- This is £6.0m above the plan submitted to NHSE, however it is £2.4m below the revised plan of £14.1m (when adjusted for actual opening balance).
- Key contributing factors are:
  - YTD deficit £1.9m more than plan (adverse)
  - API elective ceiling stretch income of £1.9m not yet transacted in cash, now expected 1 August (adverse)
  - Timing difference of the accrued pay award in the plan but not yet paid c£2.2m (favourable)

Cash forecast

- The cash plan assumes delivery of the revenue, efficiency and capital plans in full. Based on the current run rate and cash management mitigations, the forecast indicates that cash balances would fall below the minimum of £1.5m towards the end of Q3.
- The monthly PFRs have been updated to include a 4-month rolling cash forecast to flag any cash requirements to NHSE ahead of any cash support requests, if required.
- Liquidity remains a high priority area for GM providers with the CFOs supporting the creation of a cash protection group, with a focus on optimising the cash available to providers.

Better Payment Practice Code (BPPC)

- We are now consistently achieving the 95% target.
- The in-month performance was 96.0% by volume and 98.1% by value.
- The YTD performance was 95.6% by volume and 98.2% by value.

Capital

Scheme	In Month (£000) Actual	Plan	Var	Year to Date (£000) Actual	Plan	Var	Full Year (£000) Plan	YTD Actual of Full Year Plan (%)
Operational capital programme	3,403	4,454	1,051	6,064	7,335	1,271	14,117	43%
Over programming and over allocation							(672)	0%
Operational capital (CDEL)	**3,403**	**4,454**	**1,051**	**6,064**	**7,335**	**1,271**	**13,445**	**45%**
National funding (PDC)								
Solar Panels	0	215	215	0	215	215	2,148	0%
Diagnostics prioritisation	0	0	0	0	0	0	273	0%
UEC - Discharge Lounge capacity	0	0	0	0	0	0	572	0%
Elective prioritisation - Theatres 5&6	0	0	0	0	0	0	1,050	0%
Estates Safety bids (Backlog Maintainance)	374	116	(257)	1,003	651	(352)	2,744	37%
UEC (A&E Diagnostics)	0	0	0	0	0	0	3,747	0%
UEC SDEC	0	0	0	0	0	0	1,341	0%
CDC Equipment- Unscheduled bleeding on HRT	0	0	0	0	0	0	109	0%
Sub total national funding	**374**	**331**	**(43)**	**1,003**	**866**	**(137)**	**11,984**	**8%**
Total capital programme	**3,777**	**4,785**	**1,008**	**7,068**	**8,201**	**1,134**	**25,429**	**28%**

Capital plan 2025/26

- Total capital programme for the financial year of £25.4m comprising:
  - Internal operational CDEL £13.4m. A 5% planning tolerance of £0.7m has been included within our plan submitted to NHSE taking the total operational CDEL to £14.1m which will need to be managed in year.
  - National PDC £12.0m. In month we have received notification that our bid for CDC equipment for the Unscheduled Bleeding Pathway has been approved at £0.1m.

Month 3 Headlines

- Capital expenditure in month 3 is £3.8m which is £1.0m behind plan.

Operational CDEL

- Capital expenditure in month 3 is £3.4m which is £1.1m behind the plan of £4.5m.
- In month underspend is due to the delay of the SSDU building lease renewal, which is a joint agreement with the Northern Care Alliance. Negotiations with the landlord's agent are continuing.
- Lease re-measurements of £0.8m have been transacted in the month in line with planned phasing.
- The Capital Strategy Group is monitoring the overcommitment associated with the planning tolerance, which is considered manageable within the overall programme.

PDC funded schemes

- Expenditure on PDC funded schemes is £0.4m in month which is £0.1m above plan and £1.0m year to date which is £0.2m above the plan of £0.8m.
- Confirmation is pending for the remaining constitutional standards business cases. GM ICB approval is required, ahead of NHSE approval. The Board agreed to proceed at risk with elements of the A&E Diagnostics scheme to ensure completion this financial year.

Full Year Forecast Scenarios

Bridge from straight line forecast to actual forecast. This sets out the assumptions and improvement required to hit plan under the mid case scenario.

Straight line forecast - £10.1m deficit	Remove non-recurrent items and phasing adjustments -£0.7m	Key assumptions +£3.2m	Mitigations +£7.7m	Current forecast breakeven (as per plan)
•Extrapolated from £2.5m YTD deficit.	•Non recurrent items, extrapolated impact £1.3m (includes one-off benefits £0.6m from month 3). •Phasing adjustment for Newton Europe Better Lives consultancy £0.6m.	•Cash releasing improvement in run rate of +£5.5m. •Elective activity contribution +£0.9m. •MARS severance -£0.7m. •PP income (inc. Community SOS feeding) +0.7m. •Energy/winter -£1.5m. •Industrial action -£0.3m	•The mid-case scenario currently shows risk of £7.7m. To be mitigated by; • Non-recurrent CIP/enhanced grip and control +£3.6m • CIP increased pace £2.6m • Activity productivity above plan £0.5m • National funding for MARS and industrial action £1.0m	•As submitted to NHSE •All other pressures to be mitigated within existing plan

Key actions to achieve plan

- Deliver CIP plan
- Deliver elective activity plan
- Monthly run rate improvement of £1.1m required (from £0.8m YTD actual average deficit to £0.3m surplus per month)

High level scenarios for full year forecast

Worst Case	Mid Case	Best Case
Unmitigated: £12.5m deficit (£12.5m adverse to plan)	Unmitigated: £7.7m deficit (£7.7m adverse to plan)	Unmitigated: £3.3m deficit (£3.3m adverse to plan)
Mitigated: £5.1m deficit (£5.1m adverse to plan)	Mitigated: Breakeven (on plan)	Mitigated: Breakeven (on plan)

Risk Management and Mitigation

Revenue position

Recurrent CIP delivery: Recurrent CIP delivery is materially behind plan; slippage in Q1 will have to be recovered in year. WWL is benchmarking poorly on the weekly CIP returns. The recurrent plan is fully identified however there is significant risk to this. In month 3, all divisions are significantly behind plan.

Deficit Support Funding: Whilst this has been confirmed for GM ICS for Q2, deficit support funding will need to be earned for Q3 and Q4. An assessment will be made based on financial performance.

Inflation: Our 2025/26 plan is based on the national inflationary assumptions. There is a risk that actual inflation exceeds this in non-pay. At the time of writing, the impact of the cost uplift factor and overall impact of the pay award is being assessed.

Industrial action: Resident doctors (formerly known as junior doctors) have backed strike action as part of demands to secure a 29 per cent pay rise. Resident doctors will strike from 25-30 July; It has not been confirmed whether any financial compensation will be available to support providers.

API activity: Divisional elective API performance has maintained the improvement seen last month. Year to date underperformance is £0.4m adverse which we are currently forecasting to recover.

UEC funding: There are discussions ongoing across GM ICS regarding the allocation of the UEC funding, including the virtual ward, linked to the effectiveness. Whilst the virtual ward reduction in funding is not expected to impact the allocation in year, further clarity is required.

Cost of capital funding: There is a risk associated with the NHSE cost of capital funding, which is received to offset increases in depreciation expenditure. WWL have followed national guidance and agree with the ICB position on how this has been allocated, however we are in the minority across GM providers.

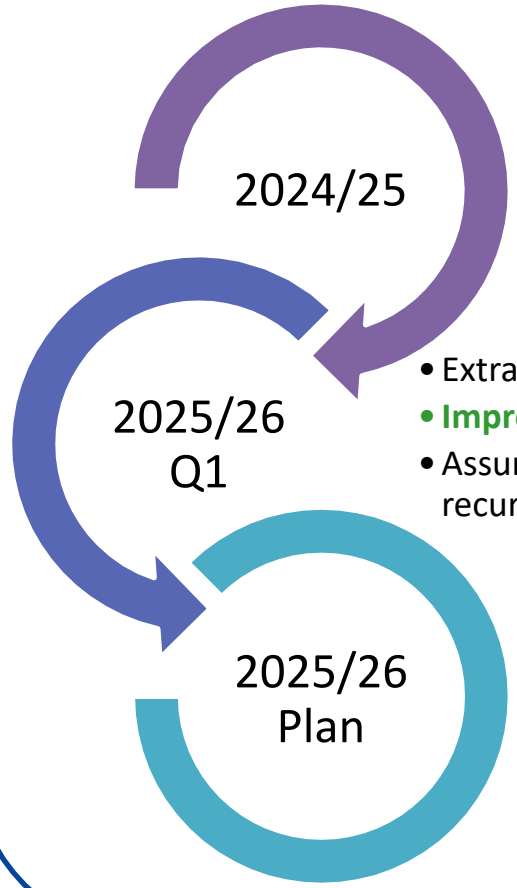
Other

Cash: The cash plan is based on delivery of the revenue and efficiency plans and remains challenging for 2025/26. Based on the current run rate and cash management mitigations, the forecast indicates that cash balances would fall below the minimum of £1.5m towards the end of Q3. Cash management strategies will be implemented to mitigate short term cash shortages, and this is a priority area for the GM system.

Financial environment: The financial environment for 2025/26 for both revenue and capital is highly constrained, and the Trust is operating at a deficit. These may impact on the ability of the Trust to deliver its strategic objectives.

Underlying Position

Quarter 1 refresh



- Underlying run rate £25.8m deficit
- **£7.4m improvement on prior year**

- Extrapolated underlying run rate £21.3m
- **Improvement £4.5m on 2024/25**
- Assumes all income other than DSF is recurrent

- £8.1m planned exit run rate
- **Further improvement required of £13.3m in Q2-4 to deliver plan**

Key messages

- Our underlying position will be assessed quarterly during 2025/26.
- At the end of Q1, this has improved by £4.5m to a deficit of £21.3m. At present all income is assumed to be recurrent, until notified otherwise by GM ICB.
- If the rate of improvement continues then we are on track to meet our plan of an £8.1m underlying deficit as our exit run rate for 2025/26.

Forward look

The government's 10-year plan published on 3 July 2025 outlines a vision for the NHS, delivering the three shifts from hospital to community, from analogue to digital and from treating sickness to prevention. It also outlines the financial, structural and operational changes that are expected as part of the implementation. The plan points to a regime that is aimed at strong financial and operational discipline and governance.

CIP is now fully identified, however there is significant risk within these schemes. Work should be undertaken at pace to work through implementation plans and completed QIAs to support delivery. Weekly CIP monitoring continues with NHSE scrutiny and a wider GM approach to CIP identification and delivery is being scoped.

A BMA ballot to decide whether to take industrial action in pursuit of pay restoration closed on 7th July 2025. Resident doctors have voted for a renewed mandate for strike action, with 5 days industrial action due to take place at the end of July.

The pay awards for 2025/26 will be processed in August 2025. Staff on Agenda for Change NHS terms and conditions will receive a 3.6% consolidated uplift with all pay uplifts backdated to 1 April 2025. Doctors and dentists will receive a 4% consolidated uplift with all pay uplifts backdated to 1 April 2025. The cost uplift factor has been uplifted to fund the additional award above the planning assumptions; the full impact is currently being calculated.

The costing team have submitted the 2024/25 National Cost Collection Index (NCCI) data at the beginning of July. The results are expected to be released at the start of quarter 3.

The corporate services data collection for 2024/25 is due to be submitted on 11 July 2025, with benchmarking reports expected back to us on 11th September 2025. There remains a national focus on expenditure, growth and headcount within corporate functions.

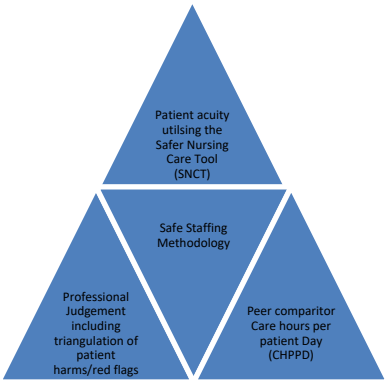
Title of report:	Bi- Annual Nurse Staffing Review
Presented to:	Board of Directors
On:	06 August 2025
Item purpose:	Information
Presented by:	Kevin Parker-Evans Chief Nursing Officer
Prepared by:	Associate Chief Nurse- Safe Staffing Divisional Directors of Nursing & AHP's
Contact details:	Kevin.parker-evans@wwl.nhs.uk

Executive summary

The Bi-Annual Staffing review is presented to provide the board with assurance that nursing establishments are sufficient to meet the needs of the patients in our care, and to meet patients' needs at times of peak demand.

It is mandated that all NHS organisations review staffing levels at least twice a year and the findings of the review to be shared with the Trust board and that decisions made following receipt of the report to be documented and to provide assurance of board level accountability and responsibility for staffing levels.

The review has been undertaken using the National Quality Board guidelines with respect to workforce under the developing workforce safeguards (2018) framework. The review is undertaken using the triangulated methodology:



The report outlines in detail the outputs of the methodology and recommendations. It is worth noting that during the review period (September 2024) the Trust was working in heightened operational pressures, meaning additional areas and escalation capacity were opened during the review period. This has a direct impact of the nurse staffing levels and the ability to report a true reflection of the nurse staffing levels. Additional escalation capacity had a direct impact on the following aspects of a nurse staffing review including and not inclusive of skill mix, redeployment of substantive staff, sickness, staff wellbeing/turnover.

The report identifies that overall, when staffing **core clinical areas** (excluding escalation capacity and the associated movement of staff) there is sufficient staffing levels to meet the needs of patients, however, there remain opportunities for different ways of working that would support a more efficient use of the nursing workforce and the increased ability to flex staffing to meet the needs of our patients.

There are however several recommendations to further support the Safe Staffing review and they are outlined as below:

- Continuation of the Discharge and Flow Programme to reduce escalation capacity and occupancy to support the delivery of core nurse staffing levels across established areas; alongside review of pathways from ED and SDEC to support delivery of the 4-hour ED target and eliminate 12 hour waits for access to beds.
- The current headroom for the Trust is 20%. This low level of headroom results in a lack of resilience within the workforce (unplanned absence and vacancies) and does not support the CPD requirements of staff. Both these factors result in over reliance on temporary staff to augment staffing shortfalls. It is recommended that the Trust Safe Staffing Leads works in collaboration with the Chief Nursing Officer Safe Staffing Fellows to benchmark headroom, and to explore opportunities to flex headroom according to registered and unregistered staffing requirements.
- A capacity and demand review, supported by, a robust winter plan that has changes in specialties within its trajectory and therefore supports the acuity nuances in nursing staffing requirements i.e. Medical Outliers within the surgical footprint.
- Substantive staffing solutions are explored to support the delivery of enhanced care for our patients which is prescribed and overseen by a registrant, (nurse or Allied Health Professional), who can plan care that is specifically tailored to our patients' needs and requirements.
- Embed a programme of work to establish the use of SNCT within community services
- Develop a programme of work with ward leaders and matrons to support the validation of red flags and the recording of staffing decisions within SafeCare.
- Transition in to a new model of managing staffing across the Trust utilising a acuity and dependency tool and move away from traditional ration and/or set numbers methodology of planning staffing levels.

In summary the report provides assurance that **core established areas** are safely staffed in line with guidance. There is further to work to do to further support the fluidity of our nursing workforce to provide resilience and better forward planning of nursing workforce requirements, in addition to ensuring that the Trust becomes fully compliant with NHSI Workforce Safeguards Guidance.

Link to strategy and corporate objectives
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 investment proposed will result in a reduction of spend already been incurred whilst addressing specific patient safety risks identified within the report.

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.

Equality, diversity and inclusion implications

There are no implications arising from this report.

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

Executive Team Meeting

Recommendation(s)

The Board of Directors is asked to note the assurance provided in the report with regards to the nursing staffing establishments and to approve the recommendations detailed within the report.

Biannual Nurse Staffing Review (March 2025)

1 Introduction

1.1 The purpose of this paper is to provide the Board is to provide 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 and the Emergency Village; however, the report will take the opportunity to call out areas that will require further consideration as we move to make our services more sustainable.

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 and are therefore excluded from this report.

2 Background

2.1 Throughout 2012 and 2013[1][2][3][4][5] 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[6]. 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

[1] NHS England (2012): *Compassion in Practice*
[2] The Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013): *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry.*
[3] Prof. Sir Bruce Keogh, NHS England (2013): *Review into the quality of care provided by 14 hospital trusts in England: overview report.*
[4] Don Berwick. Department of Health (2013): *A promise to learn, a commitment to act: improving the safety of patients in England.*
[5] Cavendish, C., Department of Health (2013): *The Cavendish Review: an independent review into healthcare assistants and support workers.*
[6] NHS England (2014): *Safer Staffing: A Guide to Care Contact Time.*

regard to be made within the Trust Annual Governance Statement. This should be jointly signed by the Chief Nurse and the Medical Director.

2.5 The Trust is required to complete an annual self-assessment against the NHSI Workforce Safeguards which can be found at Appendix 6. Areas for improvement are included in the recommendations of this report and will form part of the workplan for the Associate Chief Nurse, Safe Staffing.

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[7]. The tool is recognised by the Quality Management Board (QMB)[8]. 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

[7] Hurst, K (2012): *Safer Nursing Care Tool Staffing Multipliers (2012) – Method and Results*
[8] 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.*

Staffing Tool (CSNCT). The Community Safe Nurse Staffing Tool is currently in beta testing prior to being finalised by the National Team. At the time of writing, a release date for the finalised tool has not been released. This report includes the findings of the ED Safe Staffing Tool from the data captured in September 2024.

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 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 is a rolling programme of training for B7 and B6 clinical leaders to provide further assurance that staff are consistently scoring patients care needs correctly. Additionally, the Associate Chief Nurse for Safe Staffing has undertaken refresher training of the assessment of patients and delivery of training.

5 Quality Indicators

5.1 Data with respect to hours of time required based on acuity and dependency cannot be taken in isolation but must be considered 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 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 referred to as Nurse Sensitive Indicators (NSI's).

5.2 An increase in harm 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 of Nursing and includes the agreed allowance for the uplift of staff.

7.Skill Mix

7.1 There are no mandated staffing ratios for nursing in England. Staffing ratios are recommended by the RCN[9] however these are not enforceable; a ratio of 65:35 registered nurses/unregistered staff in inpatient areas and 70/30 for assessment areas, and NICE makes reference to skill mix within their safe staffing supportive materials.

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

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%.

8.2 It is recognised that the 20% uplift that has been in place for several years is no longer appropriate. This is in part because the percentage uplift associated with sickness is far below that of the actual sickness figures and the mandatory training requirements for staff exceeds the uplift within the headroom and does not take into consideration the additional training staff will require to gain additional skills, experience and competence to assist their personal growth and development.

8.3 The low level of uplift does not align to ambitions to reduce the reliance on temporary staffing, including agency staff, and improvements in patient safety and experience associated with a stable, substantive workforce.

9 Supervisory Ward Leaders

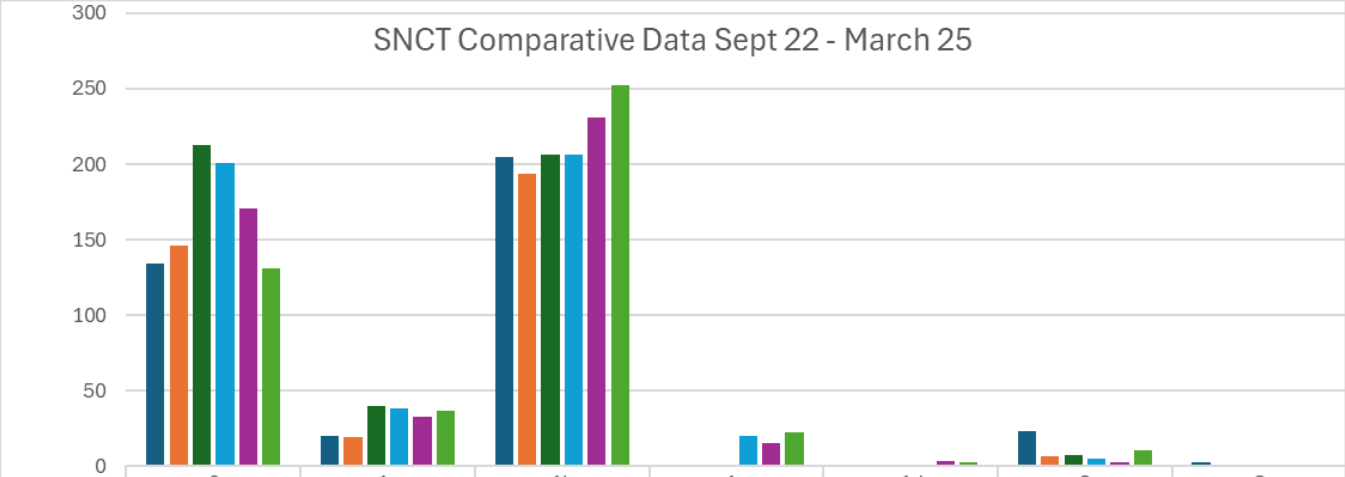
9.1 The Trust Board approved the funding of supervisory ward leaders in October 2021 as part of the strategy to improve local leadership and quality across inpatient areas. Inpatient areas are currently funded for the ward leaders to be 100% supernumerary to practice, although it is recognised that leadership time may also be allocated to B6 staff to support their development. This will be the last report whereby Ward leaders will be supernumerary in line with the revised plans to support the Ward Leaders to become supervisory and back into a clinical roster 2 days per week.

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 level 2 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
Sep-24	171	32	231	15	3	2	0
Mar-25	131	37	252	22	2	11	-

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. The data in chart 1 indicates that there has been a further increase in the number of patients whose care needs are recorded at this level in March 2025. This triangulates with the ongoing capacity pressures the above recommended number of patients who remain in inpatient beds who are awaiting finalisation of discharge plans who have greater dependency needs and may require placement within a care home.

10.5 Level 1c patients are those patients who are receiving 1:1 care by staff paid for from ward budgets. Currently additional staffing is used to augment substantive staffing to provide this level of care. The data in Chart 1 indicates an increasing number of patients who are requiring enhanced care to maintain their safety. In October 2024 the Trust revisited and rewrote the Enhanced Care Policy reflecting the findings of the MIAA audit into Enhanced Care, and observations of patient experience. There has been limited assurance of practice change in the management of patients and divisions have introduced peer review of patient need to provide assurance that patients are not being inappropriately deprived of their liberties using enhanced care, and that there are meaningful therapeutic interventions with patients. A further audit of the use of enhanced care and Depravation of Liberties is scheduled to be undertaken in May 2025.

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 Chart 1, Appendix 1 provides comparative date for the funded establishment for the inpatient areas versus the SNCT recommended staffing levels. In order to deliver care to cohort of patients across the inpatient areas a total of 421.6 WTE staff are recommended against a funded establishment of 451.8 WTE. These figures do not include additional staff required to deliver enhanced care. SNCT recommends an additional 56.57 WTE staff would be required to care for this cohort of patients, however, it is evident from the data above that some of the staff required could be provided from the existing establishment resulting in a reduction in the overall additional recommended staffing to 26.37 WTE.

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 in 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 Appendix 1 Chart 2 provides comparative data of the funded versus worked and temporary staffing used during the data capture period. When considering this data, the combined worked and temporary staffing WTE equates to 505 WTE; 53 WTE above the funded establishment levels.

12.5 Acuity and dependency data for the inpatient wards is provided at Appendix 1, Chart 3. In comparison to the September 2024 establishment review there has been an increase in the number of patients requiring Level 1b, 1c and 2 care. Throughout the data capture period it should be noted that on average there were 21 patients where the division advised the patient was receiving 1:1 care (Appendix 1, Chart 4)

12.6 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.

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

- There were 67 incidents reported, an increase of 22 from the September 2024 report, and 55 nursing red flags during the data capture period, a decrease of 8 red flags since the last report. Of the red flags reported 84% related to a shortfall in RN time, a 2% reduction from the previous report. The remaining reported red flags were raised due to missed intentional rounding. This has been attributed by the division to shortages in the unregistered workforce, and the Chief Nursing Officer has asked for further work to provide assurance over the completion of intentional rounding by all staff groups.
- Shevington ward reported the highest number of red flags within the division, 32 in total, and reported 6 harms occurring to patients during this time.
- Astley Ward and Winstanley Ward reported only 1 harm occurring during the 30 day data capture period.
- The highest number of harms reported (10 in each area) occurred on Lowton and Bryn Wards. These clinical areas raised 5 and 2 red flags during the data capture period and there is no direct correlation between the harms that were reported and staffing levels at the time.
- Forty-three falls in total were reported across the division, with Lowton and Bryn Ward having the highest number of reported falls (14 in total).
- Ten pressure ulcers were reported, the highest recorded number being on Pemberton Ward.
- Thirteen drug administration errors were reported across 8 of the 11 wards an increase of 12 from the last report, with the highest number of errors being reported on Standish Ward.

12.8 The division is proposing skill mix changes on Astley ward which would reduce the number of registered staff by 1 per shift, with an equal increase in unregistered staff. This would not affect the headcount for the clinical area. This skill mix change would be subject to approval via Quality Impact Assessment (QIA).

12.9 There are no proposed changes to the establishment on MAU, Lowton, Pemberton, Shevington, CCU, and Bryn Ward.

12.10 In response to patient dependency needs the division would be looking to increase the unregistered workforce numbers on Standish and Ince Wards on nights. Such a change would be subject to a QIA and a business case would be required to support the changes in accordance with Trust governance procedures. The division should also consider realigning ward budgets where SNCT recommended staffing is above funded establishments to mitigate costs and to maintain the current headcount.

12.11 The division have further advised of plans to increase the footprint of ASU; however, it is recognised that the area has dedicated therapy staff who are also involved in the delivery of cares to patients and therefore alternative roster management and role blending may be required to mitigate the requirement to increase headcount to support any changes.

12.13 Although SDEC is not an inpatient area, the division have taken the opportunity to review attendance and staffing requirements for this area for completeness. It should be noted that 60-80% of patients admitted to SDEC required triage; triage is required within the first 15 minutes of presentation to the area. The clinical area is unable to support this KPI within the existing workforce.

A recommendation from the previous report received was that staffing across urgent and emergency care should be considered in the round to support the service and it is therefore suggested that this work is prioritised over the first half of the financial year to address the issues identified by the division.

12.9 ED SNCT data can be found in Appendix 1 Charts 7-11. Unlike the inpatient areas data is captured over 12 days at 12 hourly intervals. This enables the information to be used to look at hourly occupancy and acuity/dependency throughout a 24-hour period.

12.13 Annual attendances for adult ED have been reported at 107209 with PECCs annual attendances being 19394.

12.14 It should be noted that, unlike the September 2024 review, the department was not in escalation at the time of the data capture. The department has, however, continued to miss the 4-hour ED target resulting in patients experiencing inappropriate lengths of stay in the department. This has been further exacerbated by patients requiring Mental Health Review not being cared for within the designated area by the appropriately qualified staff. Both these factors have contributed to an increase in the number of level 1c patients being cared for by ED staff as noted within the report.

12.15 There are 6 descriptors of levels of care for the ED Department; broad details of the descriptors can be found in Appendix 1 Charts 10 and 11. The same descriptors are applicable to both Adult and Paediatric ED areas, however the multipliers for paediatric areas are slightly higher.

12.16 The Trust agreed a business case 2023 to increase the registered nurse to patient ratio in ED from1:5 to 1:4 in line with national guidance. The ED SNCT tool advocates a registered nurse proportion of 86.2%; the Trust actual proportion of funded registered staff is 85%.

12.17 The current RN position in ED is at the required establishment following national guidelines of a 1:4 nurse to patient ratio and correct resuscitation patient ratio to cubicle space.

12.18 It has been noted that the number of breaches reported within UTC is increasing associated with an increase in patients being streamed directly to the area. The breaches are occurring as patients are waiting for treatments to be completed following medical review and the workforce within the area is insufficient to ensure that all patients are treated within 4 hours. The hourly attendance data and the acuity of the patients suggests that the ratio of RN to patients could be reduced to enable the clinical area to move staff to UTC at times of peak pressure.

12.19 PECC funded establishment is 14.0 WTE staff. SNCT advises that the correct staffing for the volume of patients attending PECC should be 21.3 WTE. The previous Bi-annual Staffing Review recommended an increase in staffing for the area. Since the last report a business case has been progressed and approved, and recruitment will commence in the new financial year. To mitigate risk in the interim the division has continued to utilise temporary staffing until the vacancies are recruited to, there has been a direct reduction in the temporary staffing alongside the substantive staffing recruitment against the business case.

Division of Surgery

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

12.21 Based on the nursing care needs across the surgical inpatient wards Swinley ward remains under-established to meet the needs of the patients. This remains largely attributable to outlying medical patients occupying surgical beds which has increased the dependency needs of the patients being cared for within this clinical area. Swinley Ward has seen an increase of 8 reported harms from the September report received, the majority of which have been associated with pressure damage to patient skins. Furthermore, there has been an increased number of red flags raised by the clinical area. Further work is required to achieve right patient, right ward before a decision can be made about changes to the establishment, however it is recognised that to maintain patient safety the clinical area may need to utilise temporary staffing to mitigate risk.

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

12.23 Orrell Ward admits predominantly surgical patients which is reflected in the SNCT needs of the patients reported. There has been a notable decrease in the number of patients reported to require 1b care arising from the correct patients being cared for within this clinical area. The plans to increase extend the Surgical Assessment area co-located within the ward footprint have not been progressed at the time of writing the report, and any changes to the establishment required because of divisional plans will be subject to a business case in accordance with Trust governance procedures.

12.24 On average there were 2 patients a day receiving 1:1 care within the division; these patients were cared for on Langtree and Orrell.

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

- The number of reported red flags has increased from the previous review received; 58 red flags were raised in comparison to 14 in the September 2024 review. This is in part related to the ongoing education of staff in the application of red flags to raise staffing risks.
- Ten inpatient falls were reported in total across the inpatient areas, an increase of 3 falls from the previous report received. The greatest increase in falls was noted on Langtree Ward.
- Five medication administration errors were reported all of which were no harm incidents, an increase of two from the previous report.
- Eighteen pressure ulcers were reported across the inpatient wards this is an increase from the 10 reported in September 2024. 78% of the pressure ulcers were reported across Langtree and Swinley Wards.
- 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.
- One CDT was recorded within the surgical division on Swinley Ward. The Division continues to work with the IPC team to implement learning points from the review of patients.

Specialist Services Division

12.26 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.

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

12.28 JCW is a 16 bedded Private Patient facility which is comprised entirely of single rooms therefore the single room multipliers have been used to calculate the staffing required. The SNCT recommended aligns to the funded establishment for this private inpatient area.

12.29 Ward B is a 22 bedded inpatient area with a 50% split between bays and single rooms, therefore, the single room multipliers are applied when calculating staffing requirements in accordance with the SNCT methodology. It should be noted that there was a reduction in available beds associated with the agreed expansion and agree uplift in staffing of the Enhanced Care Unit (ECU), however the funded establishment for Ward B was not reduced at this time.

12.30 Ward A is a 28 bedded inpatient area with a 50/50 split of single rooms and bays and therefore the single room multipliers have been used when calculating staffing requirements. On average 22.2 beds were occupied during the data capture period. The SNCT recommended staffing is closely aligned to the funded establishment. As with the other two inpatient areas review of activity and bed occupancy continues to be undertaken.

12.31 Aspull Ward is a 28 bedded Trauma Orthopaedic Ward sited on the Royal Albert Edward site. SNCT data details that most of the patients in the clinical area require the assistance of 2 staff to support the patient care needs. The funded establishment for the area is slightly lower than the SNCT recommended staffing levels. There are several quality concerns on the inpatient area and the number of harms reported has continued to increase most notably in pressure damage (increase of 8) and drug administration errors (increase of 2); the division currently has a risk on the risk register relating to these concerns. Review of cases highlights the same learning issues suggesting that learning is not being embedded across the team and is also suggestive that there is a lack of consistency with leadership styles and application of appropriate professional standards. It is also worthy of note that there have been a high number of new to care unregistered staff appointed to the area and staff movement at Band 6. The division have been working with the professional practice team to upskill staff clinically and in leadership and management with emphasis on ownership and accountability.

Community Division

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

12.34 The Community Assessment Unit (CAU) consists of 21 beds and 6 Frailty SDEC assessment chairs. The nursing and AHP team on CAU work across the Frailty SDEC assessment chairs as one team and are a shared resource. The unit had 100% occupancy on average throughout the data capture period. The data was captured from census which ran 1st March 2025 to 30th March 2025.

12.35 Currently CAU is showing as being 4.87 wte under established. However, in a previous staffing review a business case was approved and an additional 4.48 wte Band 3 HCA were funded to be added to the establishment. This uplift will be added to the establishment from April 2025 taking the total nursing establishment (registered and unregistered) to 44.07 wte.

Bringing it almost in line with the SNCT recommendation of 44.46 wte. Recruitment to this uplift is in progress.

12.36 The CAU model of care is still being developed to support the introduction of a true frailty model of care which incorporates a 72-hour short stay bedded unit alongside an ambulatory care service. The acuity and dependency data for the unit is recorded via Safe care and for the census period the average levels recorded for CAU was Level 1b patients.

12.37 CAU at times of trust escalation does see an increase in higher acuity patients being admitted to the unit. These patients often have higher levels of frailty and require more rehabilitation to facilitate their discharge home. There is a focus over the coming months of ensuring that the unit delivers its proposed model of being a 72-hour short stay frailty unit with a collocated ambulatory care area. When this happens, it is expected that we will see a reduction in the number of level 1b patients on the unit, with more patients being assessed as Level 0 patients.

12.38 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).

12.39 Jean Hayes Rehabilitation Unit (JHRU) has 24 beds and a dedicated nursing and therapy resource that work on the unit. The unit had 100% occupancy on average throughout the data capture period. Data was captured from the census period which ran 1st March 2025 to 30th March 2025.

12.40 JHRU provides intermediate care (which is nursing and therapy lead) to help patients recover before their return home. All patients transferred to JHRU do so for a period of rehabilitation. These patients no longer require care in an acute hospital bed and are deemed Medically Optimised for Discharge (MOFD). Currently SNCT does not have a specific model to use for a nursing and therapy lead rehabilitation ward and so the adult acute inpatient SNCT tool is used to provide a SNCT recommendation. For JHRU, this has always been the case in previous staffing reviews undertaken. Therefore, reviewing the SNCT outcome for JHRU alongside professional judgement allows us to make a recommendation regarding registered and unregistered nursing establishment needed for the unit. Professional judgement indicates that a higher proportion of Health Care Assistants (HCAs) band 2 and 3 are needed for the unit to meet patients care and rehabilitation needs rather than registered nursing needs.

12.41 It is of note, that due to the cohort of patients sent to JHRU, the majority of which are frail, for a period of rehabilitation, there are occasions when these patients become acutely unwell and are transferred back to the acute hospital for care. Therefore, many of the patients are identified as requiring level 1b care to reflect the complexity of discharges and the need for the patients to have the assistance of 2 staff to deliver cares. Currently there is no daily onsite medical or ACP oversight of the patients at JHRU as they are deemed MOFD at the point of transfer to JHRU.

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

12.43 On CAU there were 11 reported falls over the course of the 30 days of data capture which is an increase from the last census where 5 falls were reported. Previous reports have noted that the ward layout makes patient observation difficult which is why a previous business case has been approved to enable an additional Band 3 HCA to be on duty every shift throughout the 24-hour continuum enabling a presence in each bay throughout all shifts. This resource has now been funded by the trust and recruitment into these posts has commenced.

12.44 CAU continues to see an increase in the complexity of patients particularly in relation to mental health needs including dementia and patients remaining in the acute settings for prolonged lengths of time whilst awaiting appropriate placements which impacts on the delivery of care on the unit and the nurse staffing requirement to care for these patients.

12.45 On JHRU there were 7 reported falls over the course of the 30 days of data capture which is an increase from the last census where 3 falls were reported. Whilst patients fall within our hospital environment, that does not automatically mean there was a fault in the plan of care for the patient. The purpose of a rehabilitation unit is to maximise the patient's ability to cope out of hospital and to remobilise. When a patient falls, a full review is undertaken to identify any opportunities for learning. Patients on JHRU are encouraged to use their nurse call bell to summon assistance to help them mobilise rather than mobilise independently unless deemed safe to do so.

12.46 Previous reports have noted that the ward layout makes patient observation difficult as the unit has a mixture of side rooms and bays. There is no change in the number of drug administration errors in this data collection period.

12.47 Despite SNCT recommending a higher establishment to meet patients needs there are currently no recommendations to increase staffing due to the hybrid staffing model on the area which incorporates therapy staff who also undertake the delivery of cares to patients as part of their therapeutic interventions.

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 22 patients/day who were in receipt of 1:1 care throughout March 2025. This an increase from the average of 15 patients' day who were in receipt of 1:1 care in the September 2024 Biannual Staffing review.

13.3 Current ward establishments do not contain any additional staff to support the delivery of enhanced care and temporary staffing is utilised to augment the workforce in these areas. The Chief Nursing Officer Safer Nursing Faculty and SNCT recommend that substantive staffing solutions are explored to support the delivery of enhanced care for our patients which be prescribed and overseen by a registrant, (nurse or Allied Health Professional), who can plan care that is specifically tailored to our patients' needs and requirements.

13.4 In March 2025 3229 hours of additional Band 2 temporary staffing was used to support the delivery of enhanced care; this equates to an additional 86.1 WTE staff at a cost of £149k. SNCT data suggests that for the number of patients in our care an additional 62.99 WTE staff would be required. It is recommended that a proposal for an alternative model of care that is explored in the new financial year that will ensure interventions with patients are therapeutic, add value to the patients journey and experience, and support the promotion of self-care which in turn will support patient flow.

13 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 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 Trust overall CHPPD for January 2025 was 9.1. The GMICB provider median was 9.1. This places the Trust in Quartile 4.

14.4 Registered staff provided 5.1 hours of care on average/day, which is unchanged from the previous report, and is the GMICB and national provider median suggesting that we are not an outlier in the care delivered by our registrants to our patients. The Trust is currently in Quartile 3 in this element.

14.5 Unregistered staff provided 4 hours of care using the methodology advocated which is equal to the GMICB and National median.

14.6 Details of overall CHPPD by ward can be found in Appendix 5, Chart 4.

15 Recommendations

15.1 The purpose of this report is to provide assurance that staffing levels within the Trust are safe and that there are sufficient staff to flex to the peaks and troughs of escalation, and to be responsive to patient needs. It should be noted that the Trust was in escalation at the time of the review resulting in high levels of outlying patients primarily on the surgical wards. The report has identified that there are sufficient staff within **cored funded areas** to meet these needs but identifies opportunity for further service and establishment review to provide greater resilience across the workforce.

15.2 The report highlights the high levels of temporary staffing being utilised by the Trust, particularly with regards to enhanced care, and that in some cases, the additional staff are not impacting on a reduction in avoidable harms, most notably falls and pressure ulcers which have increased from the previous report received.

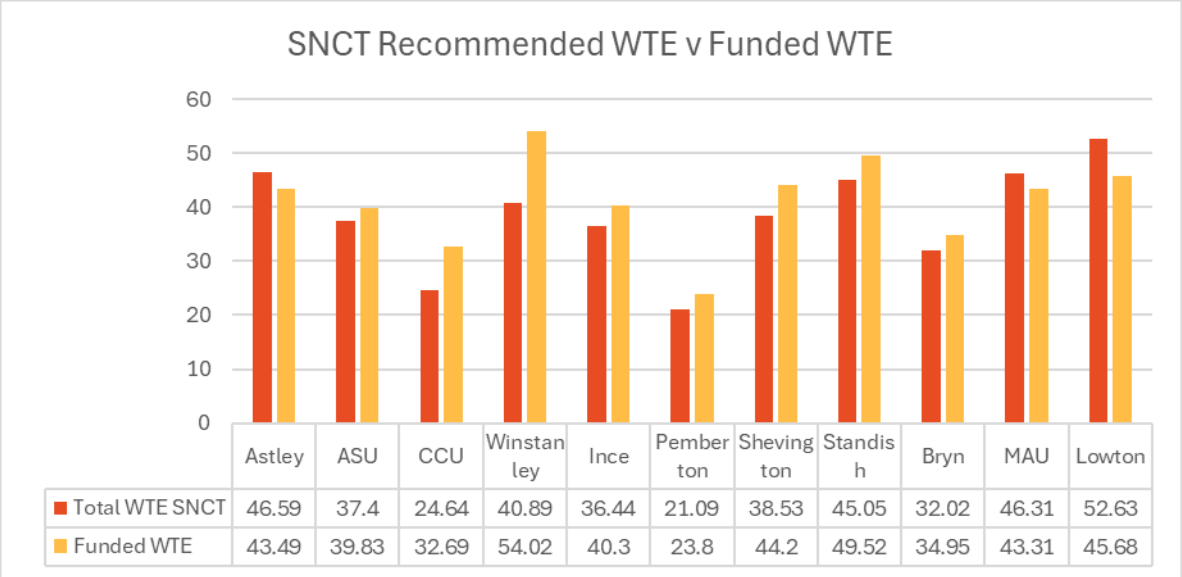
15.3 The Division of Medicine have progressed with the development of a business case to support the noted shortfalls in the PECC establishment which will address the staffing shortfalls in the area and positively impact on the reduction in the use of temporary spend.

15.4 The report highlights that there are sufficient staff employed within adult ED to support the delivery of safe care, however, acknowledges the department continues to miss the 4-hour ED target resulting in patients experiencing inappropriate lengths of stay in the department. As improvements continue to be made this will enable the department to flex staffing to meet increased demands in UTC and SDEC.

15.5 The report recognises that further work is required to ensure that the nursing workforce has the right skills, in the right place and the right time to further promote patient safety and experience, ensure the quality of care delivered is consistent and to a high standard and that there is sufficient resilience within the workforce to meet the peaks and troughs of activity and patient need. Therefore, the following programmes of work are recommended for the forthcoming year which will also address the areas for improvement against the Workforce Safeguards.

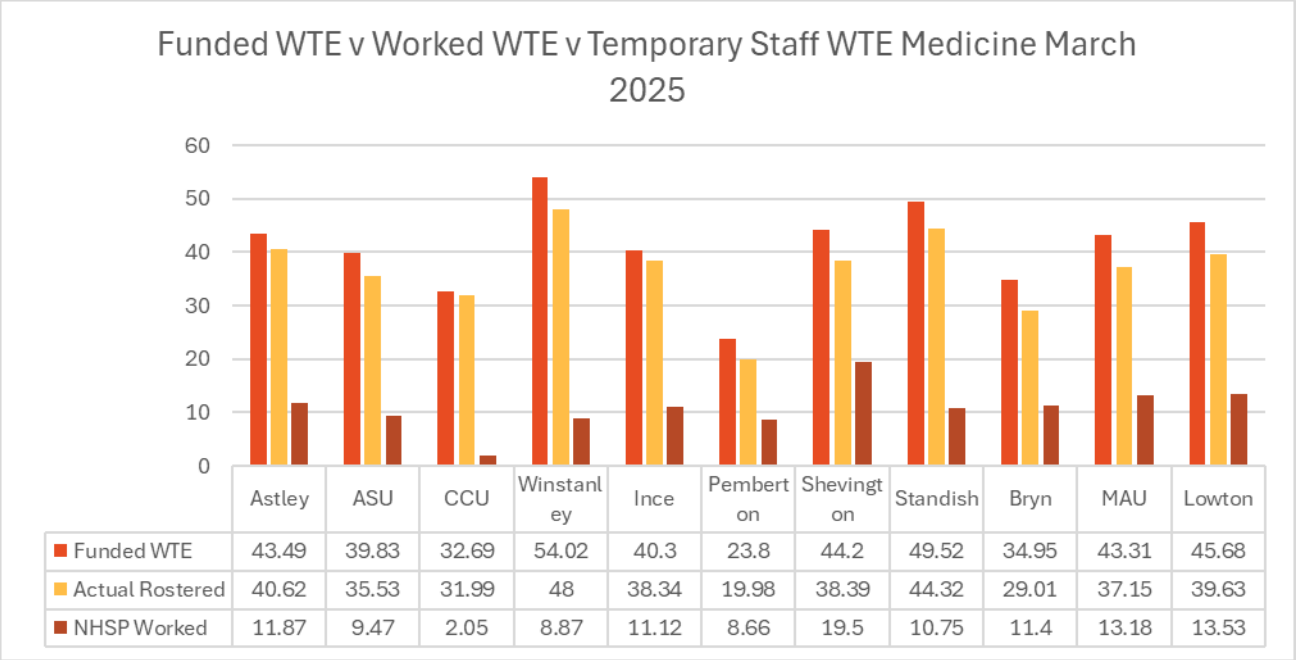
- Continuation of the Discharge and Flow Programme to reduce escalation capacity and occupancy to support the delivery of core nurse staffing levels across established areas, alongside review of pathways from ED and SDEC to support delivery of the 4-hour ED target and eliminate 12 hour waits for access to beds. This will create additional resilience within the Emergency Department which will support peaks and troughs of attendances.
- The current headroom for the Trust is 20%. This low level of headroom results in a lack of resilience within the workforce (unplanned absence and vacancies) and does not support the CPD requirements of staff. Both these factors result in over reliance on temporary staff to augment staffing shortfalls. It is recommended that the Trust Safe Staffing Leads works in collaboration with the Chief Nursing Officer Safe Staffing Fellows to benchmark headroom, and to explore opportunities to flex headroom according to registered and unregistered staffing requirements.
- A capacity and demand review, supported by, a robust winter plan that has changes in specialties within its trajectory and therefore supports the acuity nuances in nursing staffing requirements i.e. Medical Outliers within the surgical footprint.
- Substantive staffing solutions are explored to support the delivery of enhanced care for our patients which is prescribed and overseen by a registrant, (nurse or Allied Health Professional), who can plan care that is specifically tailored to our patients' needs and requirements.
- Embed a programme of work to establish the use of SNCT within community services
- In partnership with the Chief AHP and Medical Director develop process to capture assurances around other professional groups to provide further assurances with regards to safe staffing and resilience within the workforce.
- Finalise the Trust Workforce Plan.
- Develop a programme of work with ward leaders and matrons to support the validation of red flags and the recording of staffing decisions within SafeCare.

Appendix 1 Medicine



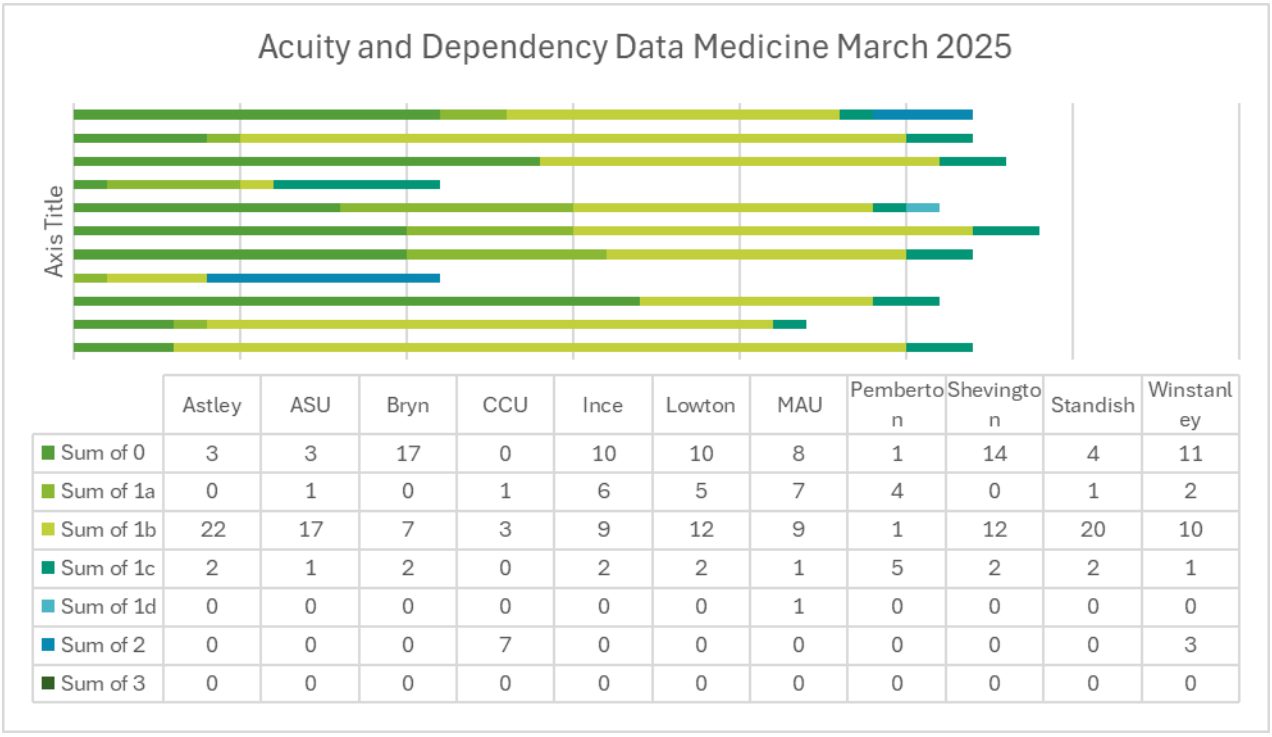
	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Total WTE SNCT	46.59	37.4	24.64	40.89	36.44	21.09	38.53	45.05	32.02	46.31	52.63
Funded WTE	43.49	39.83	32.69	54.02	40.3	23.8	44.2	49.52	34.95	43.31	45.68

Chart 1



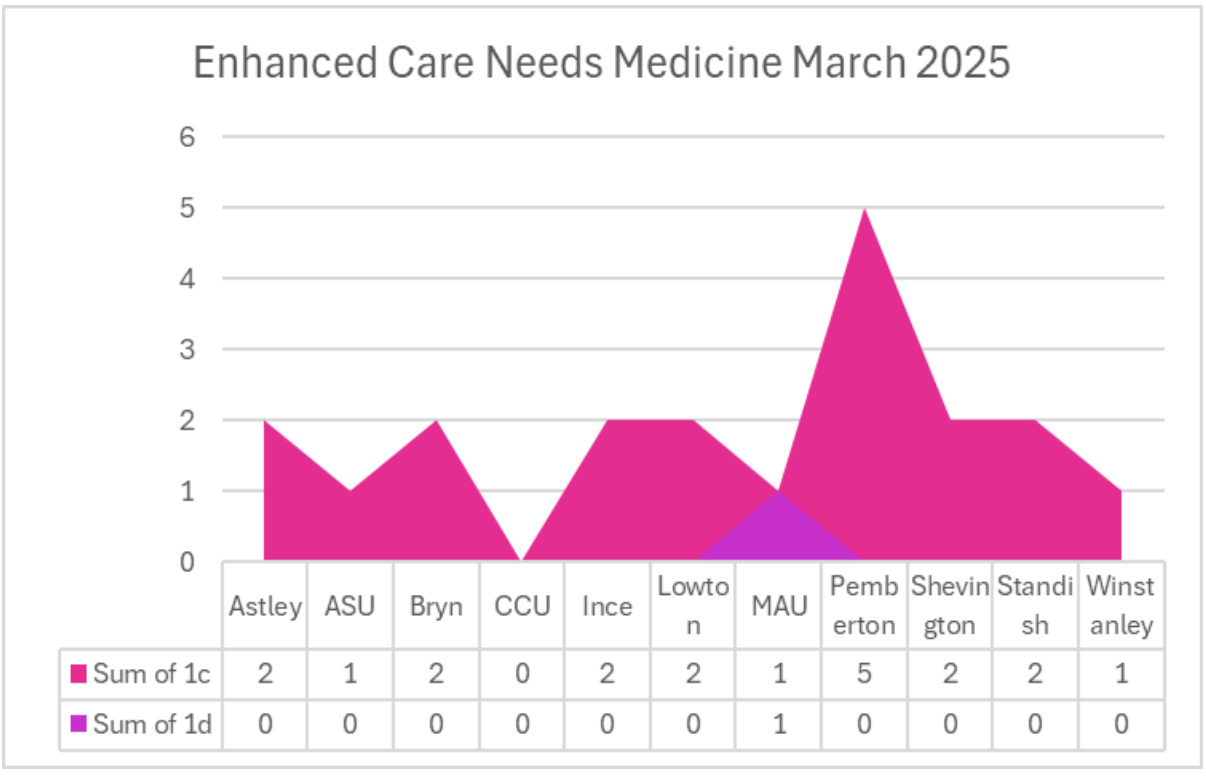
	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Funded WTE	43.49	39.83	32.69	54.02	40.3	23.8	44.2	49.52	34.95	43.31	45.68
Actual Rostered	40.62	35.53	31.99	48	38.34	19.98	38.39	44.32	29.01	37.15	39.63
NHSP Worked	11.87	9.47	2.05	8.87	11.12	8.66	19.5	10.75	11.4	13.18	13.53

Chart 2



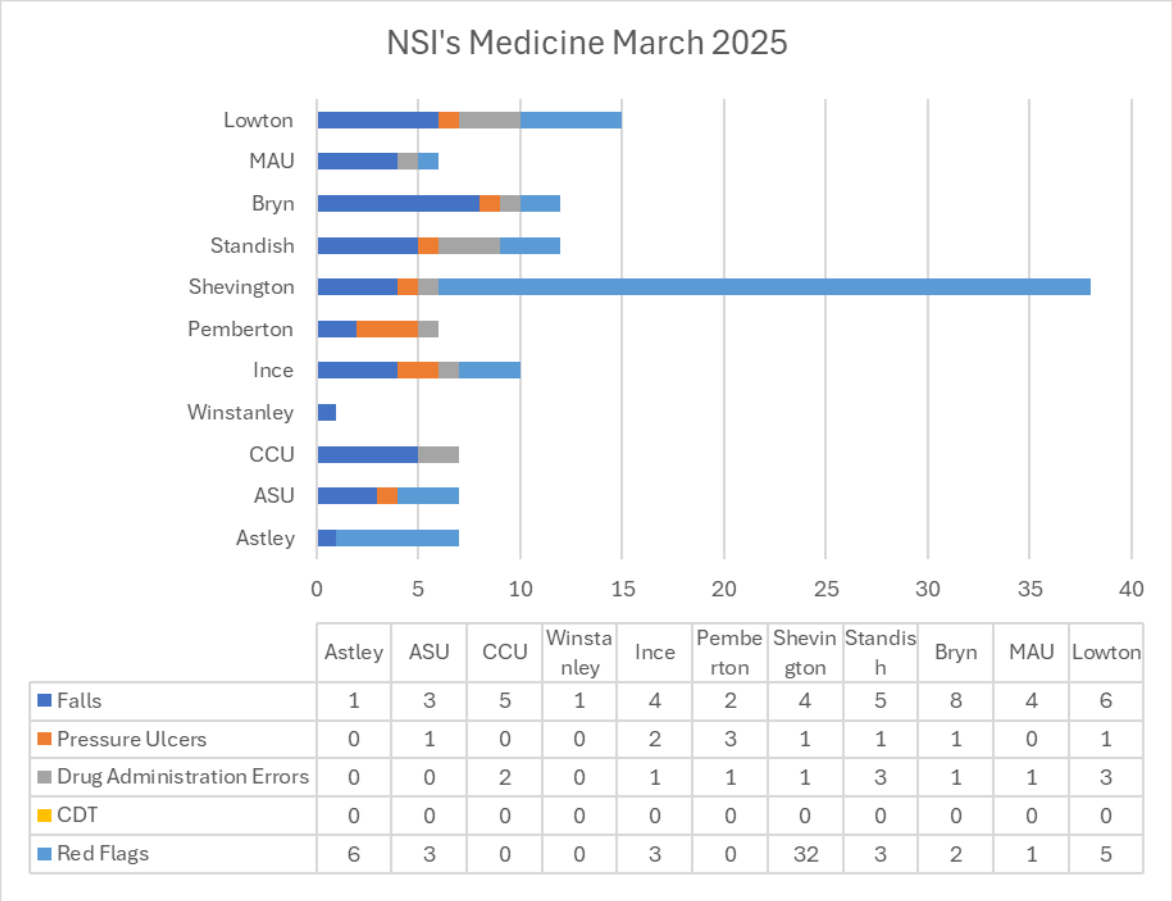
	Astley	ASU	Bryn	CCU	Ince	Lowton	MAU	Pemberton	Shevington	Standish	Winstanley
Sum of 0	3	3	17	0	10	10	8	1	14	4	11
Sum of 1a	0	1	0	1	6	5	7	4	0	1	2
Sum of 1b	22	17	7	3	9	12	9	1	12	20	10
Sum of 1c	2	1	2	0	2	2	1	5	2	2	1
Sum of 1d	0	0	0	0	0	0	1	0	0	0	0
Sum of 2	0	0	0	7	0	0	0	0	0	0	3
Sum of 3	0	0	0	0	0	0	0	0	0	0	0

Chart 3



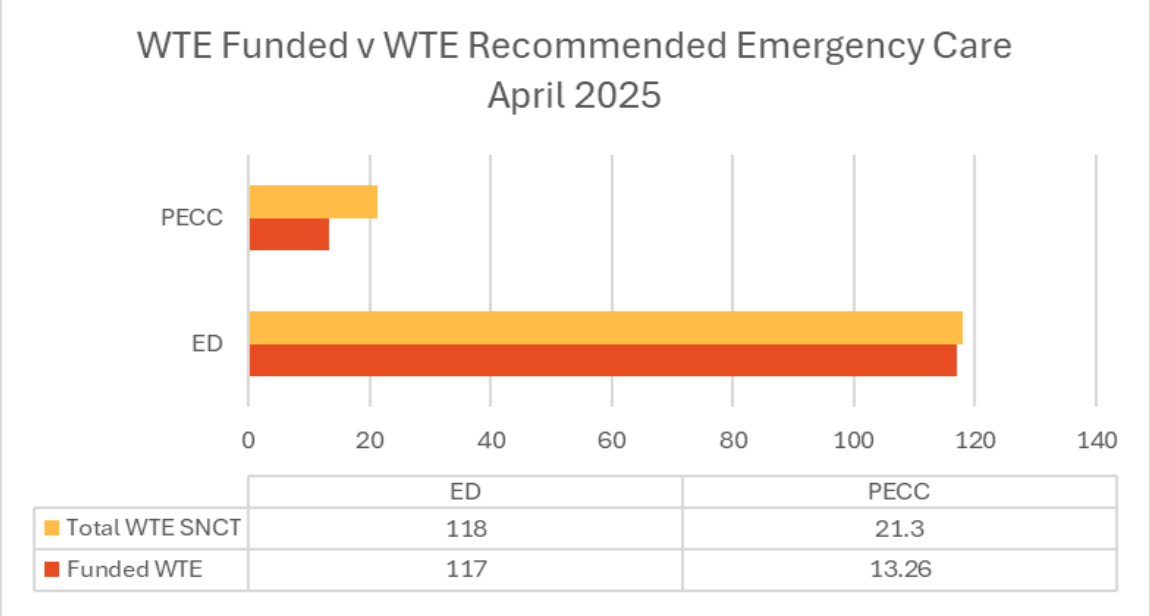
	Astley	ASU	Bryn	CCU	Ince	Lowton	MAU	Pemberton	Shevington	Standish	Winstanley
Sum of 1c	2	1	2	0	2	2	1	5	2	2	1
Sum of 1d	0	0	0	0	0	0	1	0	0	0	0

Chart 4



	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Falls	1	3	5	1	4	2	4	5	8	4	6
Pressure Ulcers	0	1	0	0	2	3	1	1	1	0	1
Drug Administration Errors	0	0	2	0	1	1	1	3	1	1	3
CDT	0	0	0	0	0	0	0	0	0	0	0
Red Flags	6	3	0	0	3	0	32	3	2	1	5

Chart 5



	ED	PECC
Total WTE SNCT	118	21.3
Funded WTE	117	13.26

Chart 6

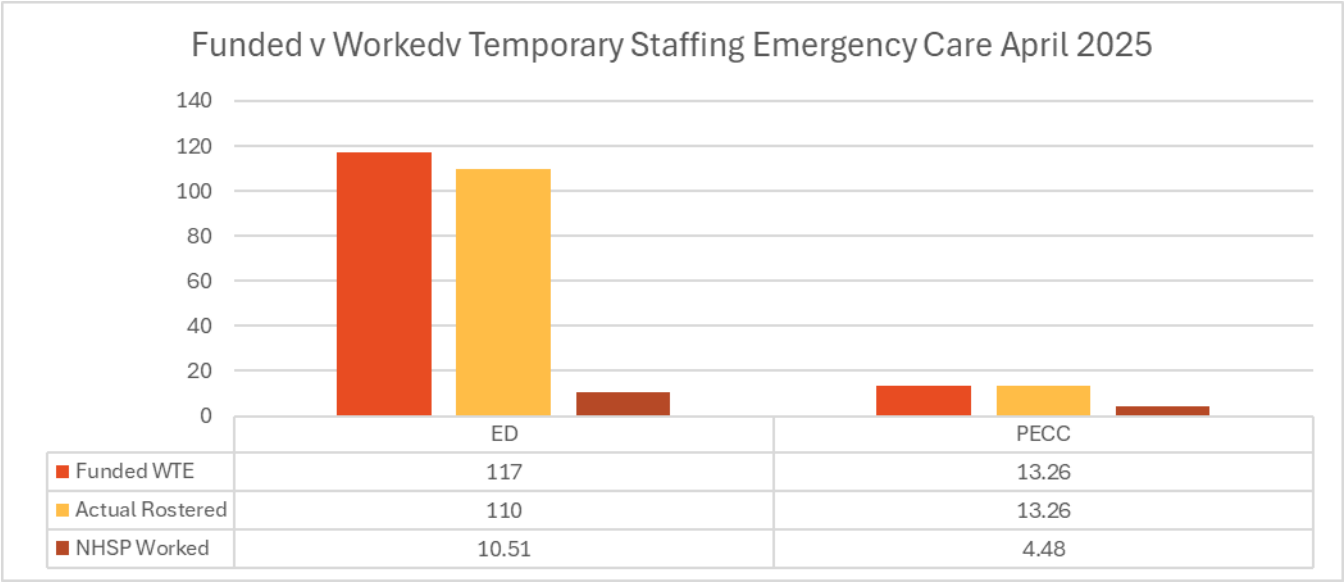


Chart 7

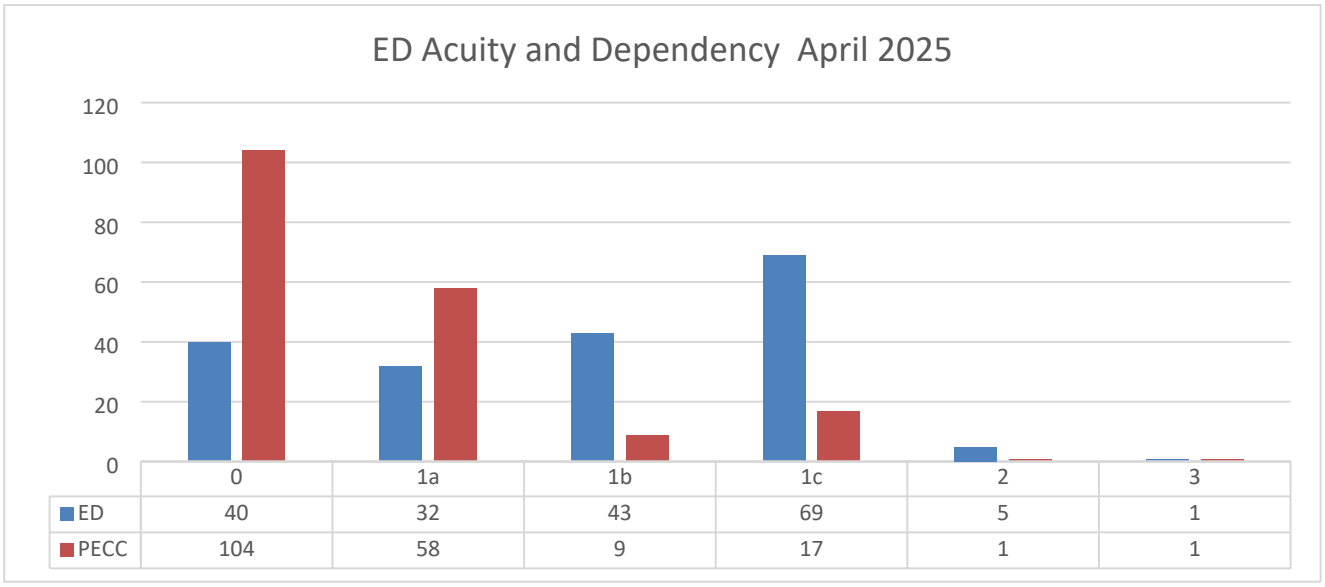


Chart 8 ED A&D Average Daily Attendances ED

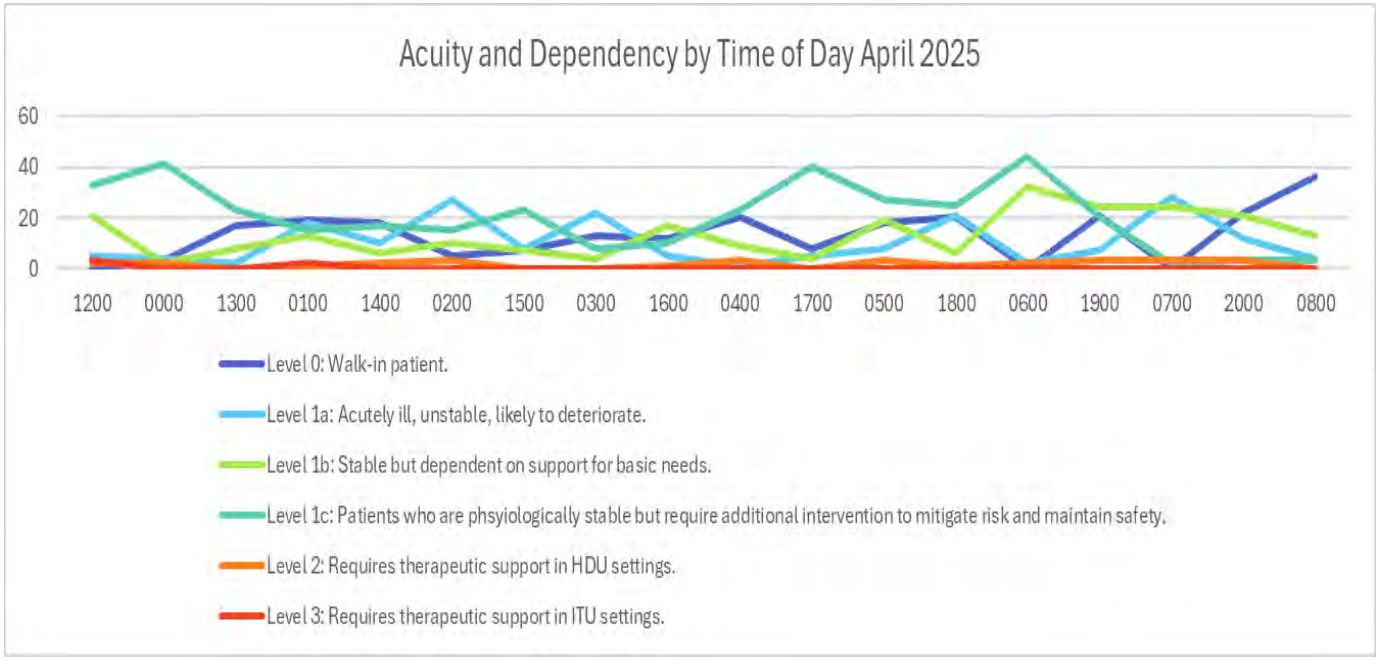
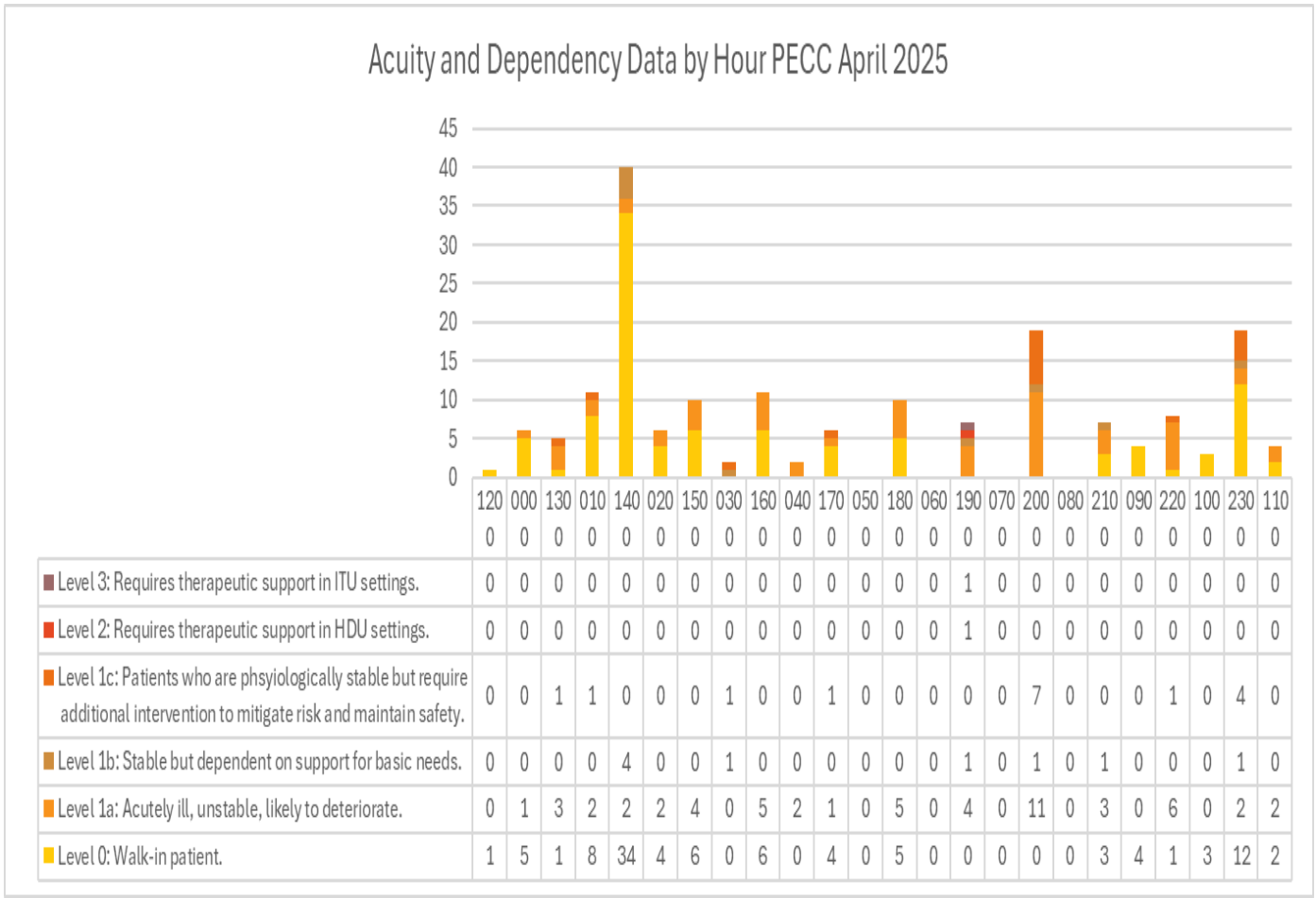


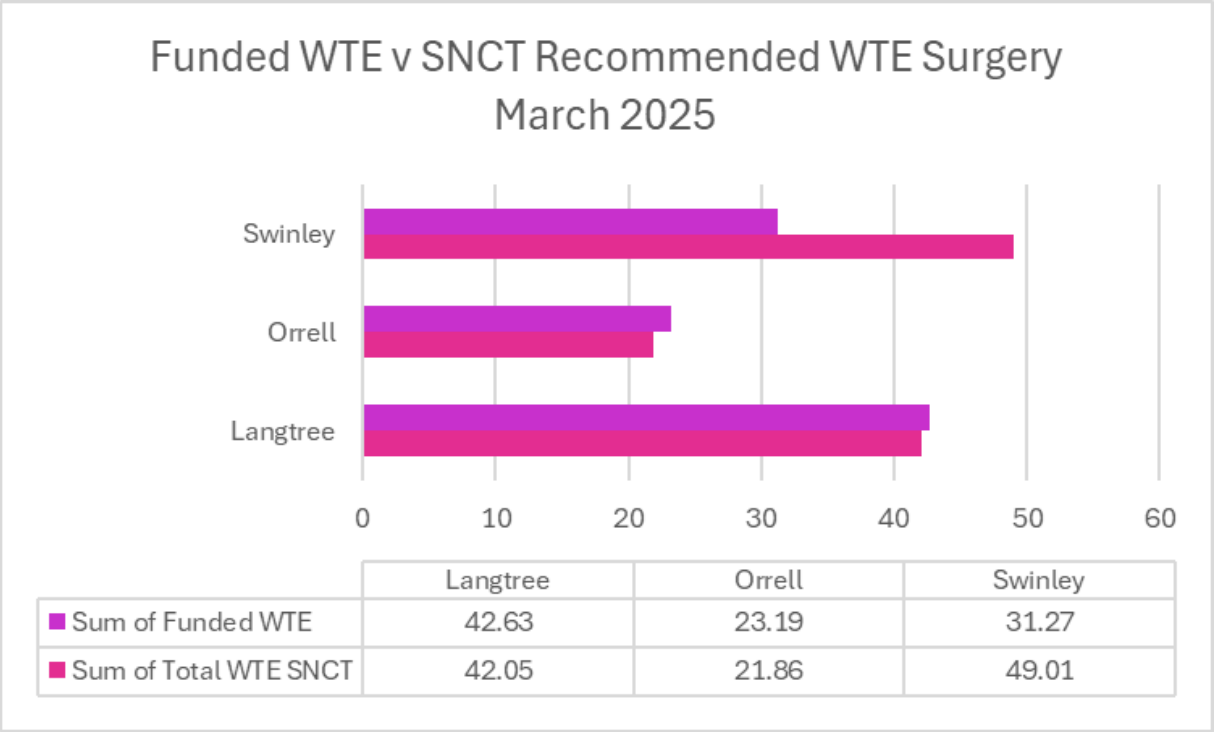
Chart 9 Adult ED A&D by time of day



	120	000	130	010	140	020	150	030	160	040	170	050	180	060	190	070	200	080	210	090	220	100	230	110
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Level 3: Requires therapeutic support in ITU settings.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Level 2: Requires therapeutic support in HDU settings.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Level 1c: Patients who are phsyiologically stable but require additional intervention to mitigate risk and maintain safety.	0	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0	7	0	0	0	1	0	4	0
Level 1b: Stable but dependent on support for basic needs.	0	0	0	0	4	0	0	1	0	0	0	0	0	0	1	0	1	0	1	0	0	0	1	0
Level 1a: Acutely ill, unstable, likely to deteriorate.	0	1	3	2	2	2	4	0	5	2	1	0	5	0	4	0	11	0	3	0	6	0	2	2
Level 0: Walk-in patient.	1	5	1	8	34	4	6	0	6	0	4	0	5	0	0	0	0	0	3	4	1	3	12	2

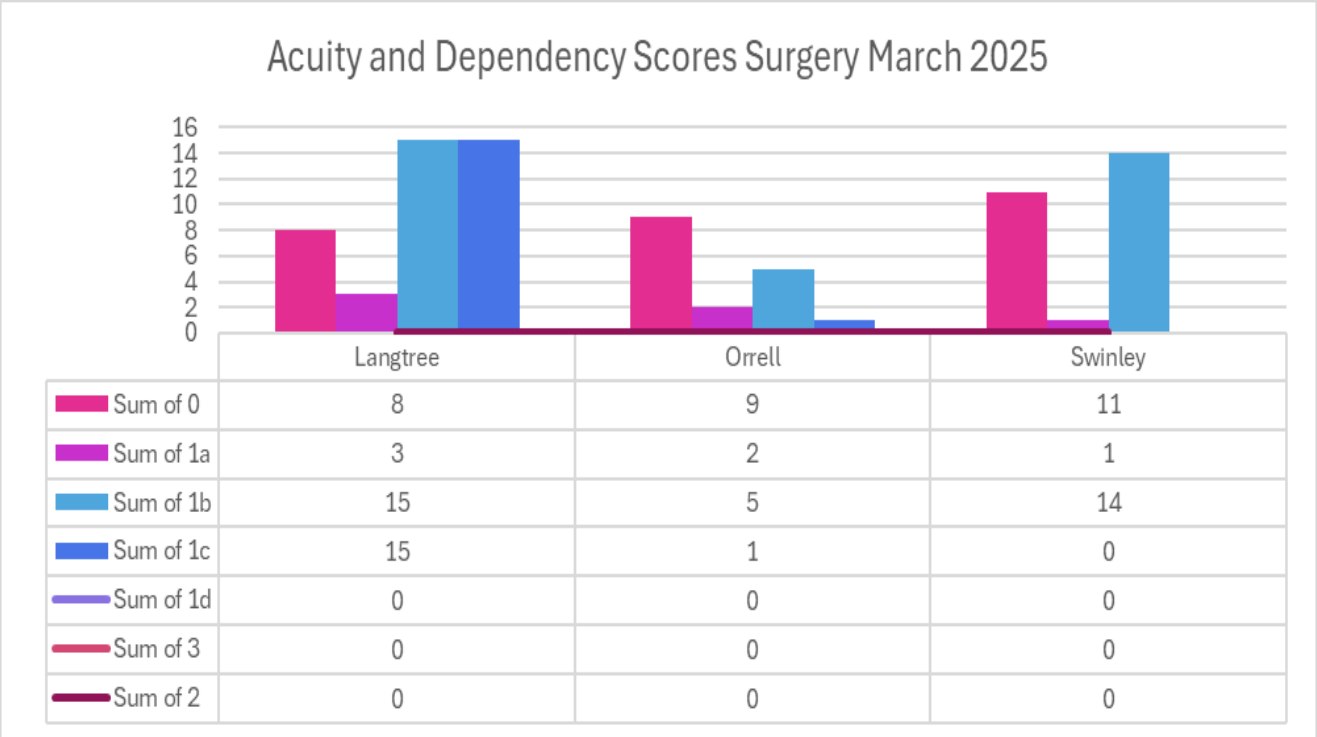
Chart 10 PECC A&D by time of Day

Appendix 2 Surgery



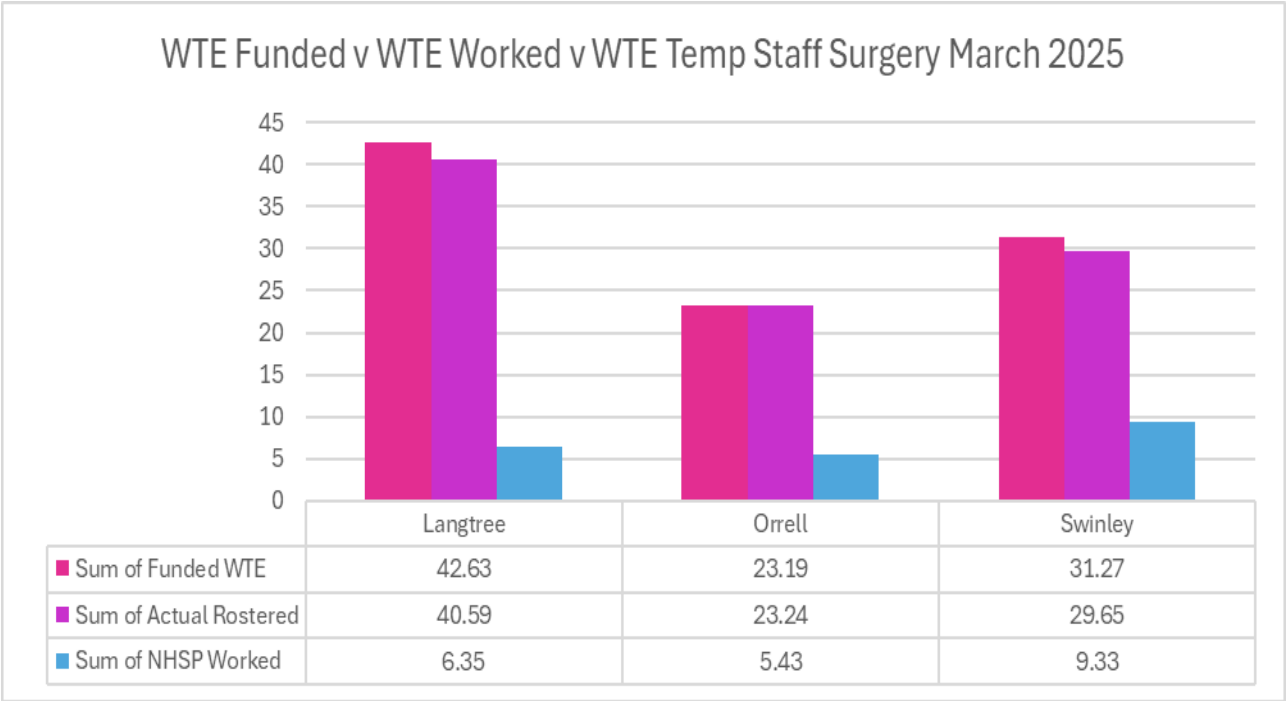
	Langtree	Orrell	Swinley
Sum of Funded WTE	42.63	23.19	31.27
Sum of Total WTE SNCT	42.05	21.86	49.01

Chart 1



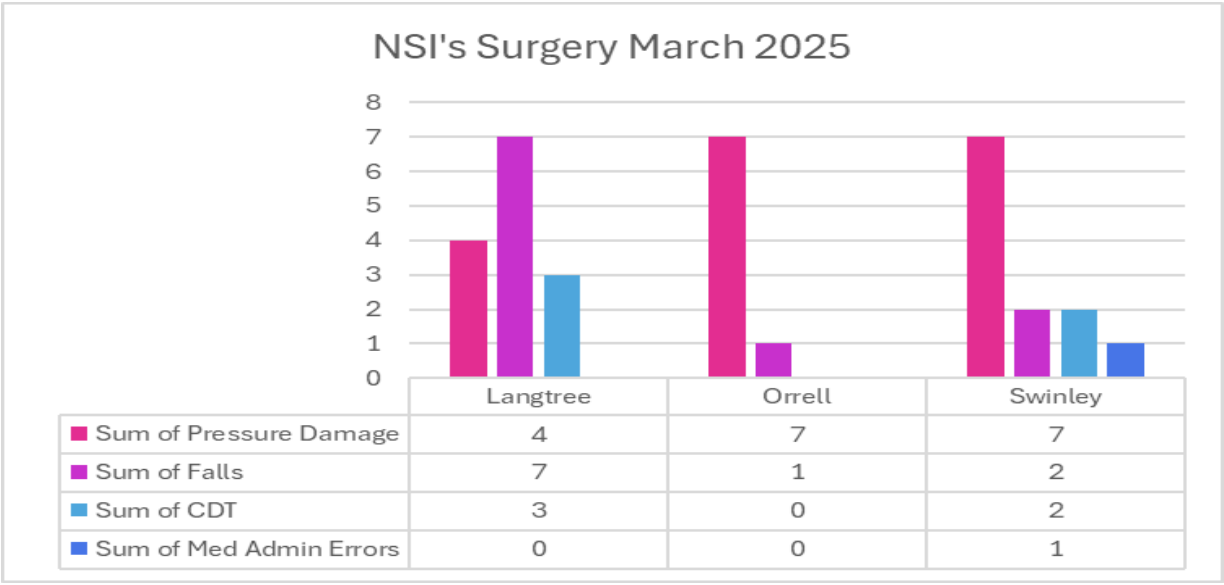
	Langtree	Orrell	Swinley
Sum of 0	8	9	11
Sum of 1a	3	2	1
Sum of 1b	15	5	14
Sum of 1c	15	1	0
Sum of 1d	0	0	0
Sum of 3	0	0	0
Sum of 2	0	0	0

Chart 2



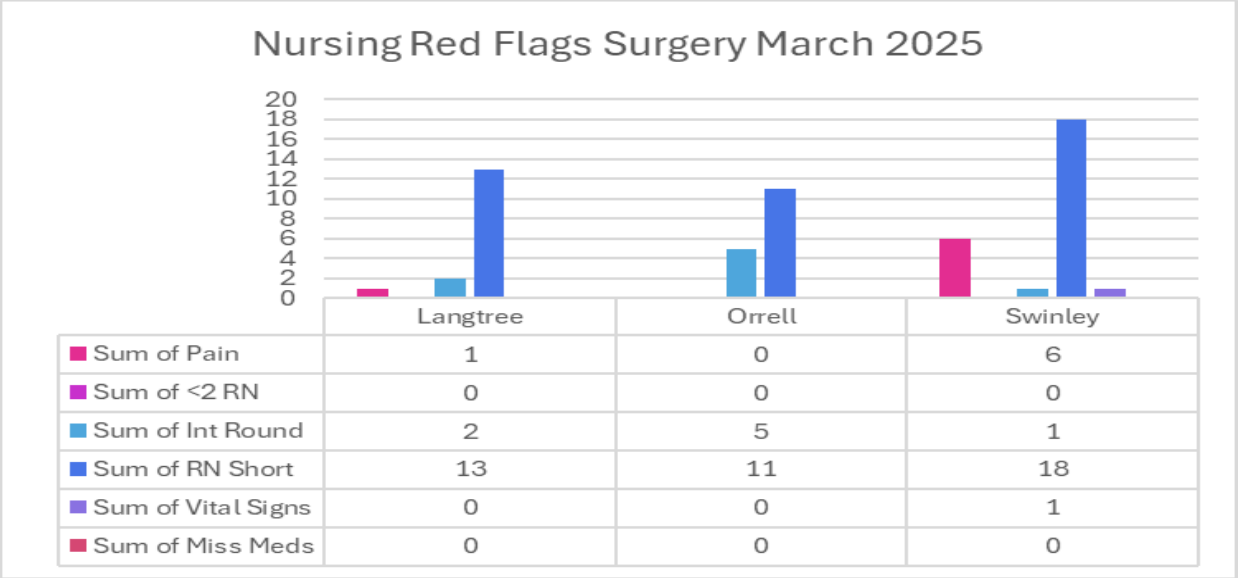
	Langtree	Orrell	Swinley
Sum of Funded WTE	42.63	23.19	31.27
Sum of Actual Rostered	40.59	23.24	29.65
Sum of NHSP Worked	6.35	5.43	9.33

Chart 3



	Langtree	Orrell	Swinley
Sum of Pressure Damage	4	7	7
Sum of Falls	7	1	2
Sum of CDT	3	0	2
Sum of Med Admin Errors	0	0	1

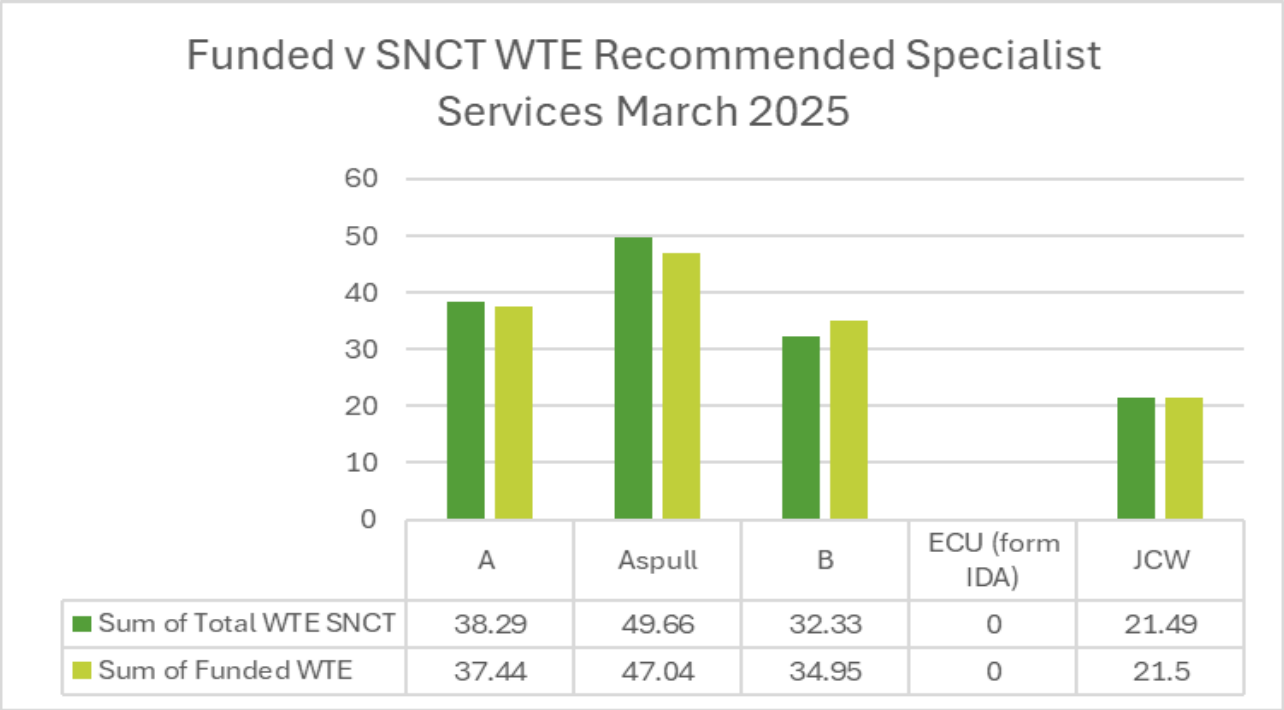
Chart 4



	Langtree	Orrell	Swinley
Sum of Pain	1	0	6
Sum of <2 RN	0	0	0
Sum of Int Round	2	5	1
Sum of RN Short	13	11	18
Sum of Vital Signs	0	0	1
Sum of Miss Meds	0	0	0

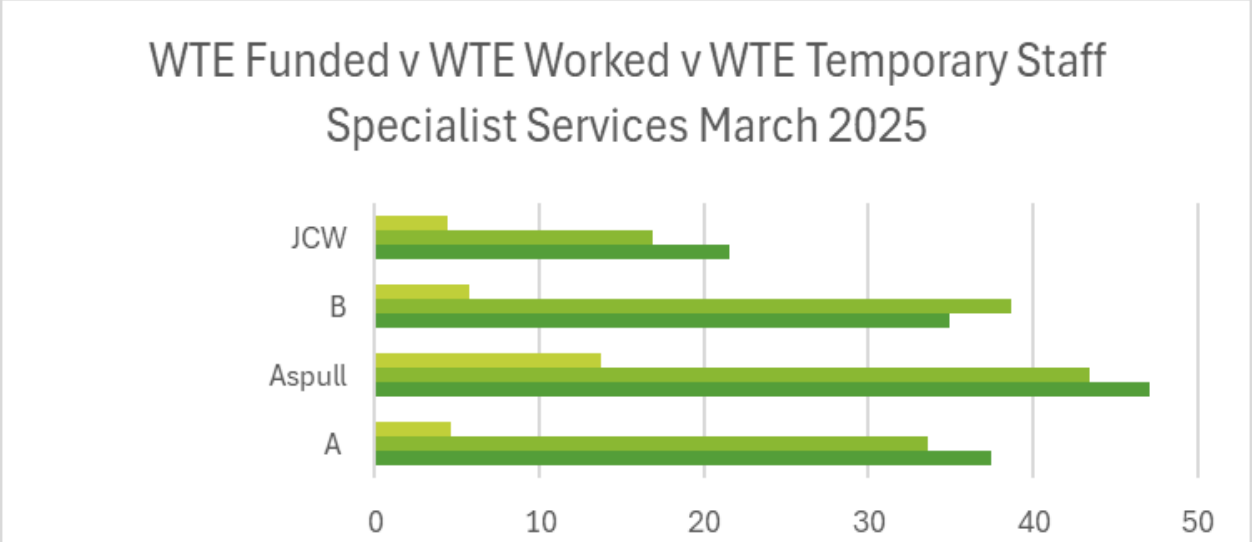
Chart 5

APPENDIX 3 Specialist Services



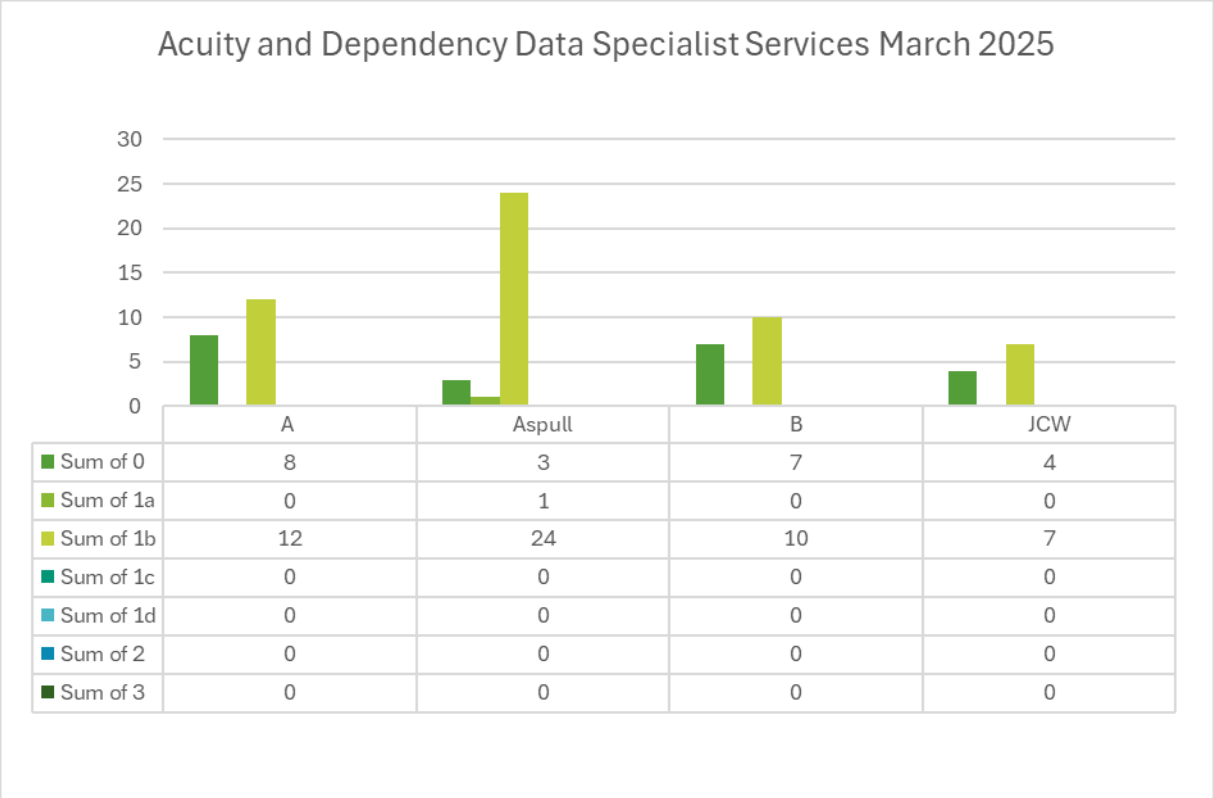
	A	Aspull	B	ECU (form IDA)	JCW
Sum of Total WTE SNCT	38.29	49.66	32.33	0	21.49
Sum of Funded WTE	37.44	47.04	34.95	0	21.5

Chart 1



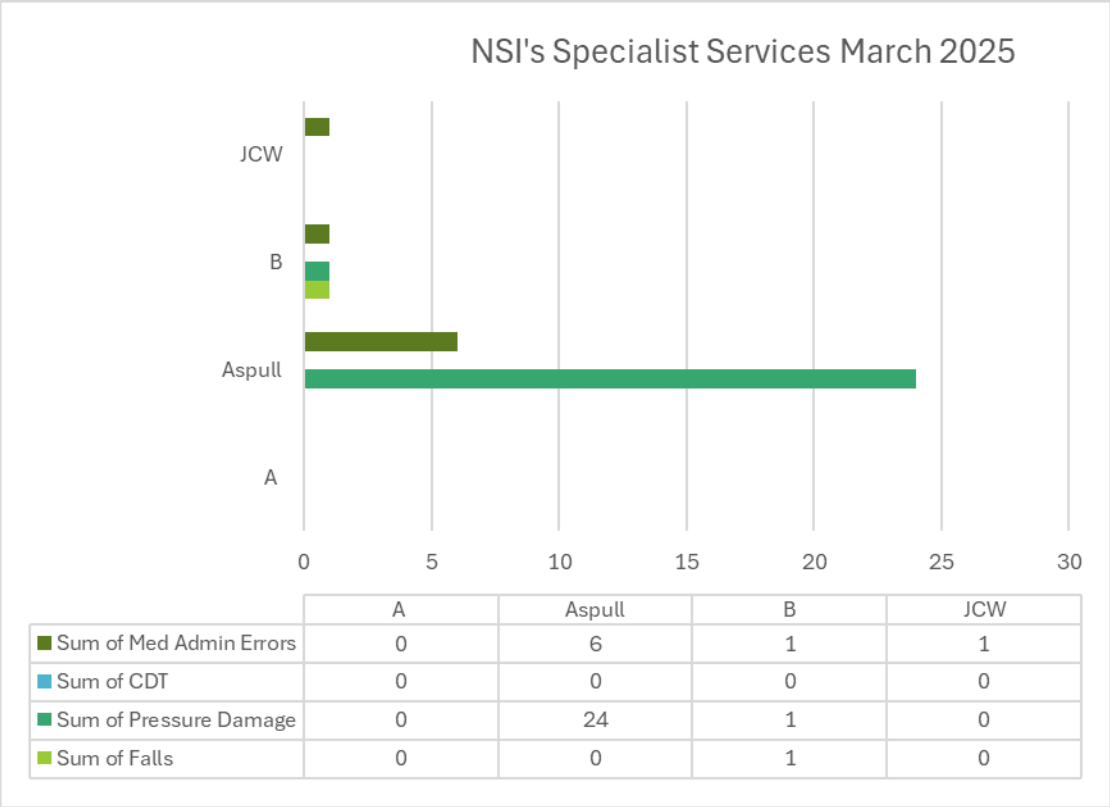
	A	Aspull	B	JCW
Sum of NHSP Worked	4.57	13.76	5.73	4.41
Sum of Actual Rostered	33.6	43.44	38.71	16.85
Sum of Funded WTE	37.44	47.04	34.95	21.5

Chart 2



	A	Aspull	B	JCW
Sum of 0	8	3	7	4
Sum of 1a	0	1	0	0
Sum of 1b	12	24	10	7
Sum of 1c	0	0	0	0
Sum of 1d	0	0	0	0
Sum of 2	0	0	0	0
Sum of 3	0	0	0	0

Chart 3



	A	Aspull	B	JCW
Sum of Med Admin Errors	0	6	1	1
Sum of CDT	0	0	0	0
Sum of Pressure Damage	0	24	1	0
Sum of Falls	0	0	1	0

Chart 4

	A	Aspull	B	JCW
Sum of Pain	0	6	0	0
Sum of <2 RN	0	0	0	0
Sum of Int Round	0	4	0	0
Sum of RN Short	0	11	0	0
Sum of Miss Meds	0	0	0	0
Sum of Vital Signs	0	0	0	0

Chart 5

Appendix 4 Community Services

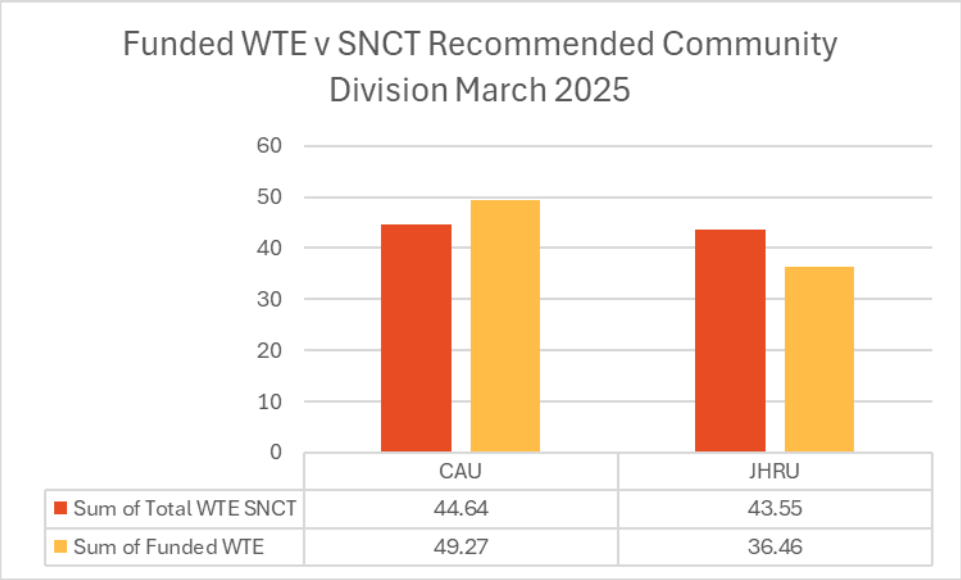


Chart 1

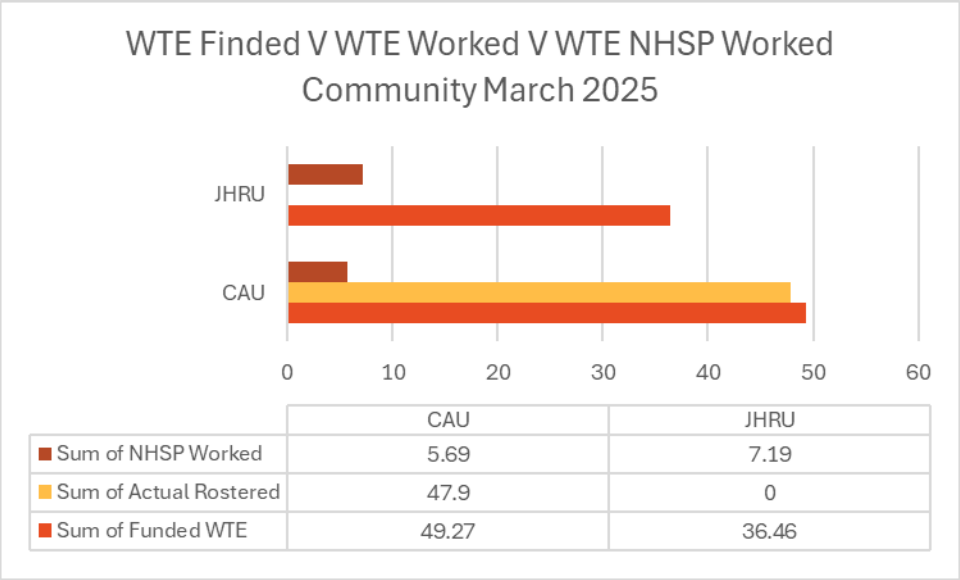
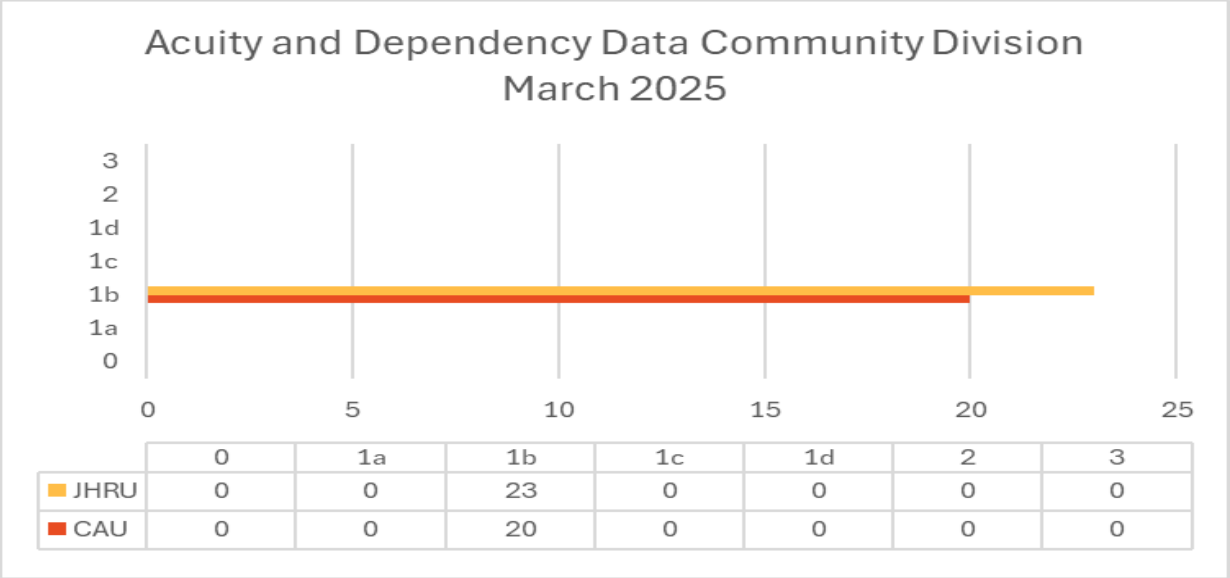
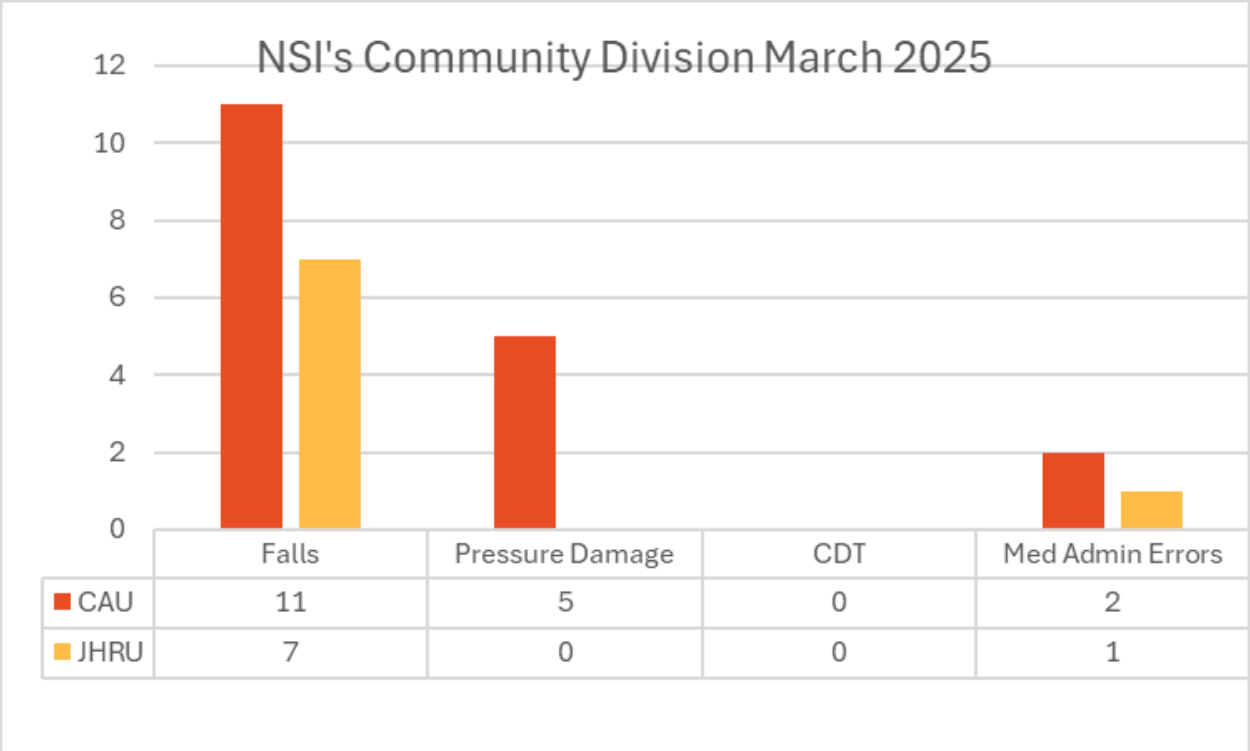


Chart 2



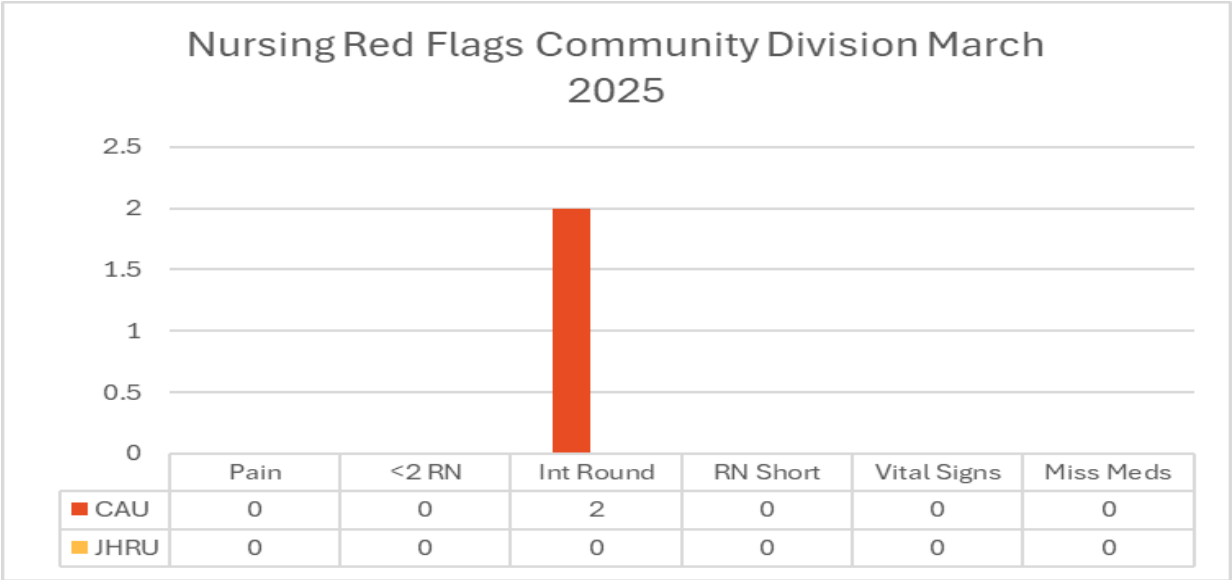
	0	1a	1b	1c	1d	2	3
JHRU	0	0	23	0	0	0	0
CAU	0	0	20	0	0	0	0

Chart 3



	Falls	Pressure Damage	CDT	Med Admin Errors
CAU	11	5	0	2
JHRU	7	0	0	1

Chart 4



	Pain	<2 RN	Int Round	RN Short	Vital Signs	Miss Meds
CAU	0	0	2	0	0	0
JHRU	0	0	0	0	0	0

Chart 5

Appendix 5 Benchmark Data

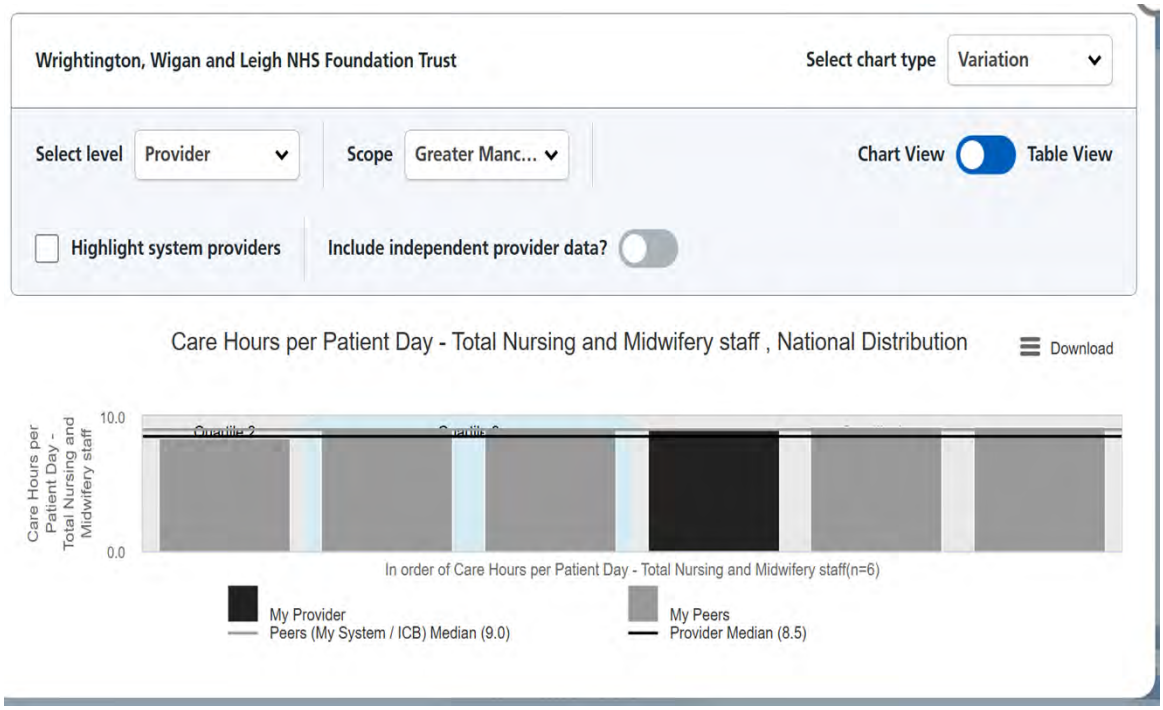


Chart 1 CHPPD V GM ICB (Data source Model Hospital January 2025)

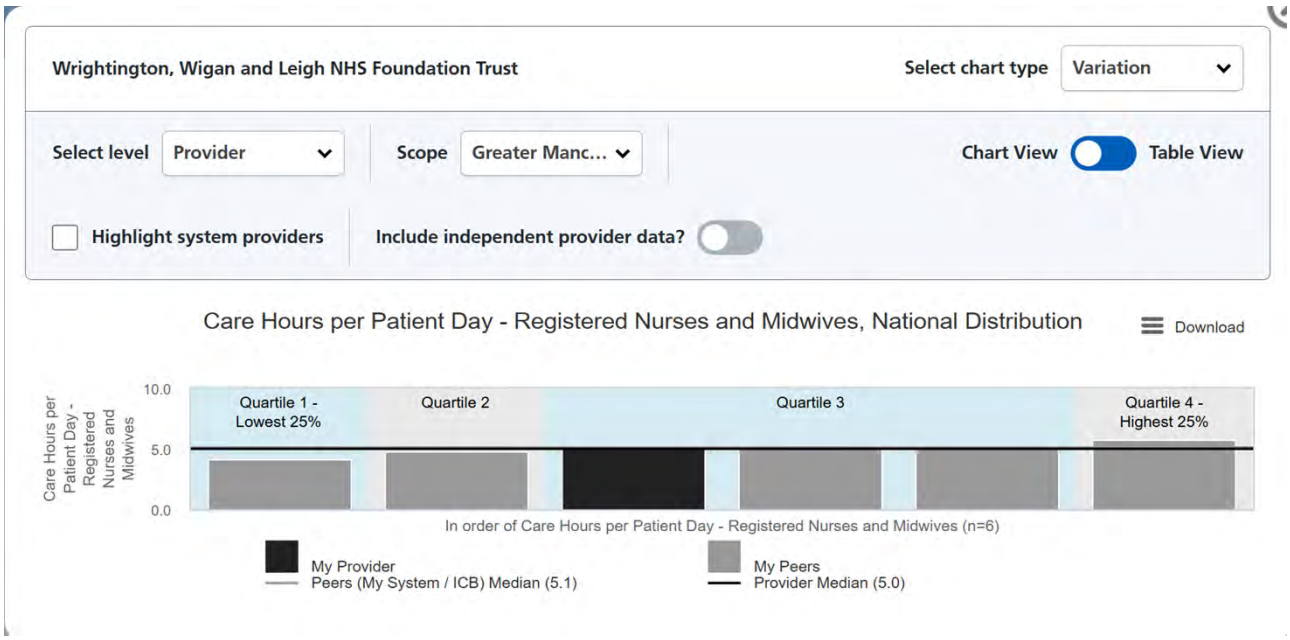


Chart 2 CHPPD Registered Staff v GMICB (Data source Model Hospital January 2025)

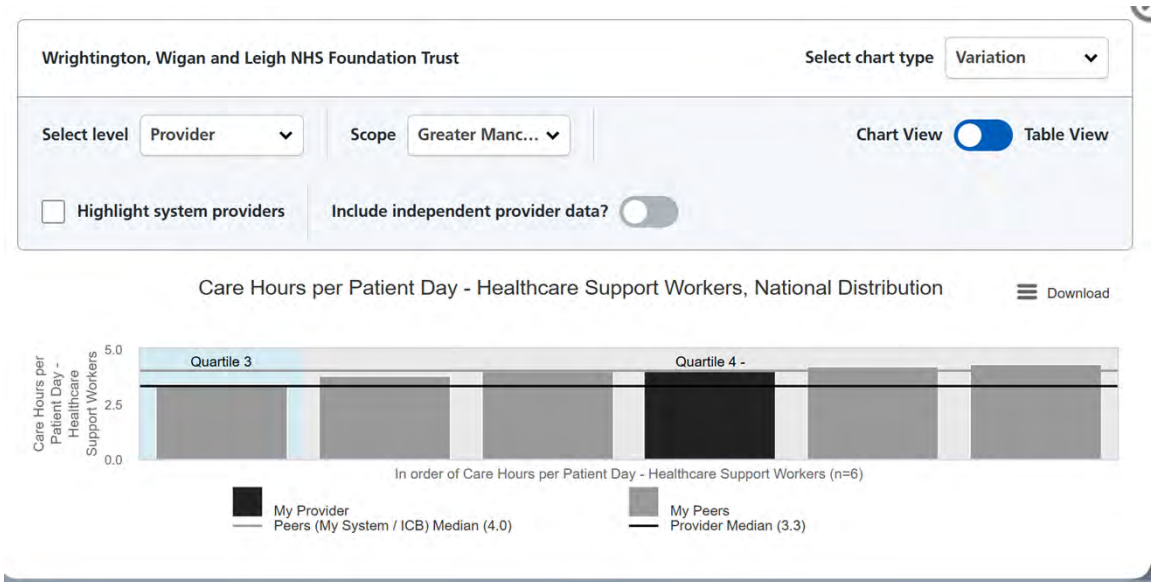


Chart 3 CHPPD Unregistered Staff V GMICB (Data source Model Hospital January 2025)

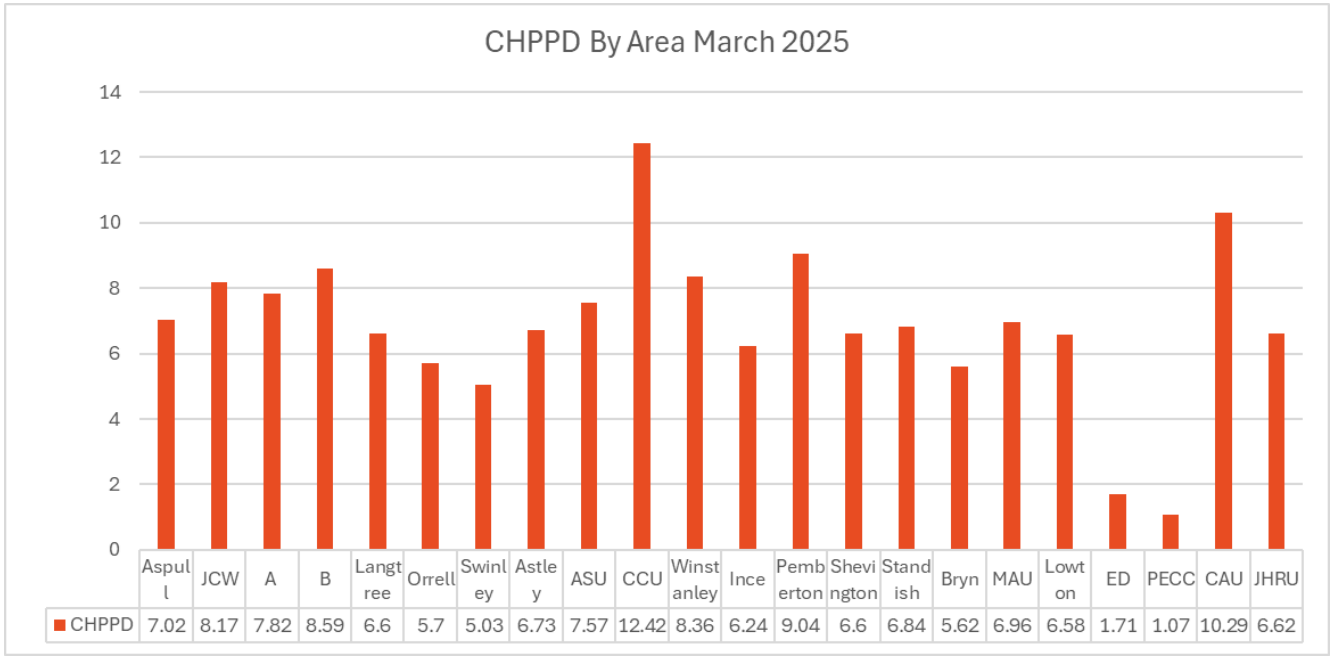


Chart 4 CHPPD Combined per Area March 2025

Appendix 6 - Wrightington Wigan and Leigh Teaching NHS Foundation Trust Gap Analysis against the NHSI Workforce Safeguards Recommendations.

Ref No	Recommendation	Compliance	Date: 30 April 2025 Completed by Allison Luxon (Associate Chief Nurse Safe Staffing) Rationale
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Partially Compliant	SNCT is embedded across all inpatient areas and within ED Birthrate Plus is embedded within Maternity Services A programme of work is required to embed SNCT processes within the Community Division. Safe Staffing Policy awaiting ratification by PARG.
2	Trust must ensure the three components are used in their safe staffing process.	Partially Compliant	SNCT is used across inpatient areas and Birthrate plus is used in Maternity. SNCT process requires embedding within community services. The Trust needs to explore mechanisms of capturing information for other health professional groups.
3	Staffing and Governance processes in place - monthly review of all workforce groups	Compliant	Process in place for quartlery safe staffing reports to be presented at Quality and Safety Committee, a sub-committee of the Board. The report presented incorporates all the quality indicators recommended by the NQB, vacancies, benchmarking data, and risks associated with staffing.
4	Assessment will be based on a review of the annual governance statement in which Trusts will be required to confirm their staffing governance processes are safe and stainable.	Compliant	Annual statement completed.
5	As part of the yearly assessment, assurance will be sought through the Single oversight Framework (SOF) in which performance is montitored against five themes.	Compliant	Data is reviewed monthly and reported quarterly as per the Trust governance processes. This includes workforce metrics and quality measures which is triangulated with operations measures and trajectories.
6	As part of the safe staffing review, the Chief Nurse and Medical Director must confirm in a statement to their Board that they are statisfied that staffing is safe, effective and sustainable.	Compliant	The Board workplan incorporates review and sign off the safe staffing review,
7	Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting.	Partially Compliant	Data is collected monthly and reported quarterly via the Safe Staffing report which contains details of vacancies, temporary staffing used, avoidable patient harms, acuity and dependency of patients, risks, and roster KPI's. A temporary staffing report is produced monthly. Further workforce metrics are provided via the Oversight Plan shared with Board. The reports are presented to Quality and Safety Committe in accordance with Trust governance process who then provide assurance to the Trust Board. We need to consider workforce planning outwith nursing and midwifery professional groups.
8	They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly.	Compliant	The dashboard, quality metrics and benchmarking data is provided within the quarterly safe staffing reports.
9	An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	Compliant	Annual programme for Bi-annual Staffing review is in place and aligned to pertinent reporting Committees. SNCT and Birthrate plus data is shared with the local teams to support the application of professional judgement; this is reviewed alongside outcome and other quality metrics for each area.
10	There must be no local manipulation of the identified nursing resource from the evidence based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Compliant	The Trust holds licences for SNCT for Adult Inpatient, ED, and Children and Young People. There is no manipulation of the tools provided. There is an established programme in place for training of staff in use of the tool, and staff training records are held within the e roster system.
11	As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review.	Complaint	All new roles and changes to establishment or skill mix are subject to QIA.
12	Any introduction of new roles would be considered a service change and in line with Recommendation 11 must have a full QIA Compliant	Compliant	All new roles and changes to establishment or skill mix are subject to QIA.
13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Partially Compliant	Safe Staffing Policy awaiting ratification by PARG. Divisional risks are reported quarterly via the Safe Staffing Reports. Staffing meetings are held twice daily with the option to add a third meeting if required; SafeCare is used to assess staffing risks based on patient acuity/dependency, staffing skill mix, and nursing red flags. Maternity services utilise a daily staffing tool which also records midwifery red flags, and locally agreed red flags. There are processes in places to validate the information and decision making relating to staffing risk within the system and a clear mechanism for escalation of risk when needed. Further work is required to embed the validation of nursing red flags and the recording of decisions relating to staffing risks within SafeCare which will also support the triangulation of patient harm with staffing risks.
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality.	Compliant	Divisional risks are reported quarterly via the Safe Staffing Reports. Staffing meetings are held twice daily with the option to add a third meeting if required; SafeCare is used to assess staffing risks based on patient acuity/dependency, staffing skill mix, and nursing red flags. Maternity services utilise a daily staffing tool which also records midwifery red flags, and locally agreed red flags. There are processes in places to validate the information and decision making relating to staffing risk within the system and a clear mechanism for escalation of risk when needed. Further work is required to embed the validation of nursing red flags and the recording of decisions relating to staffing risks within SafeCare which will also support the triangulation of patient harm with staffing risks. Business continuity plans are in place across the Trust.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Midwifery 1st Biannual Staffing review July 2025
Presented to:	Board of Directors
On:	August 6th 2025
Purpose:	Information
Presented by:	Kevin Parker Evans Chief Nurse and DIPC
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	01942 773107 cathy.stanford@wwl.nhs.uk

Executive summary

The purpose of the Biannual staffing report is to provide oversight and assurance to the Board that there are sufficient numbers of Midwives to provide a safe and effective service. **Safety Action 5 of the Maternity (Perinatal) Incentive Scheme** requires the service to demonstrate that:

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate Plus® organisation (or equivalent) should demonstrate this.

b) Board of Directors to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the MIS year seven reporting period.

Staffing levels and skill mix are key elements of a safe, effective, and high-quality service. In maternity, workforce planning is unique as each care 'episode' spans 6-9 months, within both hospital and community settings, and involves a series of scheduled and unscheduled care which often involves unexpected inpatient admission as well as the birth itself.

The activity within maternity services is dynamic and can rapidly change. It is therefore essential that there is adequate staffing in all areas to provide safe high-quality care by staff who have the requisite skills and knowledge.

Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers. The BR+ Acuity tool supports this, which is a safe staffing tool for delivery suite and Maternity ward activity.

The final Ockenden Review published in March 2022 details a series of immediate recommendations for all NHS hospital trusts in England to meet, with the aim of providing assurance of maternity safety within each provider trust's maternity services.
NICE (2015) published guidance on safer midwifery staffing and identifies red flags where further action is required to ensure safety of women and babies. This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations.

Individual risks are detailed in the report body.

Financial implications

If standards are not met there will not be a 10% refund of the Trusts contribution to the scheme.

Legal implications

Unsafe staffing levels can result in patient harm and therefore litigation and staff absence due to burnout.

People implications

Patient Safety and Staff wellbeing considerations

Equality, diversity, and inclusion implications

E&E considered within all aspects of recruitment and retention and patient pathways.

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

None

Recommendation(s)

The Board of Directors are asked to:

- Review the findings of the report and consider that it demonstrates that an effective system of midwifery workforce planning and monitoring of safe staffing levels from Quarter 4 2024/2025 to Quarter 1 2025/2026 is in place. This is a requirement of the NHSLA Maternity Incentive Scheme for Safety Action 5.
- Review the findings of the report, outlining the current establishment and existing vacancies in line with The Maternity Incentive Scheme Safety Action 5 and receive a biannual staffing report for maternity services.
- Note the request for an additional uplift to be added to the baseline establishment to allow for the increased training needs to comply with Saving Babies Lives and The Maternity (Perinatal) Incentive Fund Year 7 training requirements.
- The final Ockenden Report also recommends that average sickness levels from the previous 3 years, maternity leave, and annual leave (inclusive of Trust Birthday Leave) is calculated within the uplift**.**

Maternity Safe Staffing for 2025/26

Report

In Q4 and Q1 period we have recruited 5.40wte Midwives. In the same period there were 2.42 wte leavers. The main period for recruitment within maternity services occurs predominately September to November each year following the third-year student midwives completing and qualifying.

Midwives	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	June 2025
New Starters	0.0	0.8	0.0	2.68	1.92	0.0
Leavers	1.42	0.0	0.0	0.0	0.0	1.0

Recruitment.

In September 2025, 8 Student Midwives who have undertaken their training programme here at WWL are due to qualify and WWL will be able to offer 2 substantive wte posts to this cohort and 4 fixed term to cover maternity leave. A further 6 will be qualifying between October and January.

Midwife to Birth Ratio

This is reported monthly on the maternity dashboard and remains fully compliant. Workings take into consideration births per months and Shift fill rate with Substantive and Bank shifts

Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**
1:28	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**

Senior Leadership posts

All senior leadership posts are fully recruited to ensure the correct senior leadership is in place across the service.

Current Registered Midwife Vacancy Position (Staffing figures correct at 31.12.2024)

	Band 3/4	**Band 5/6**	**Band 7**	**Band 8a and above Total**
Clinical Vacancies	**4.30**	**5.84**	**0.10**	**0.0**
Projected vacancies in next 3 months	**2.30**	**5.72**	**0.28**	**0.0**
Supernumerary Ward manager change			**0.80**	
Total		**4.92**	**0.38**	**0.0**
Additional Birthrate+ recommendations		**n/a**		
Additional uplift to 25%		**4.83 wte**		

Total proposed vacancies inclusive of additional uplift to 25%.		**9.75 wte**

Retention.

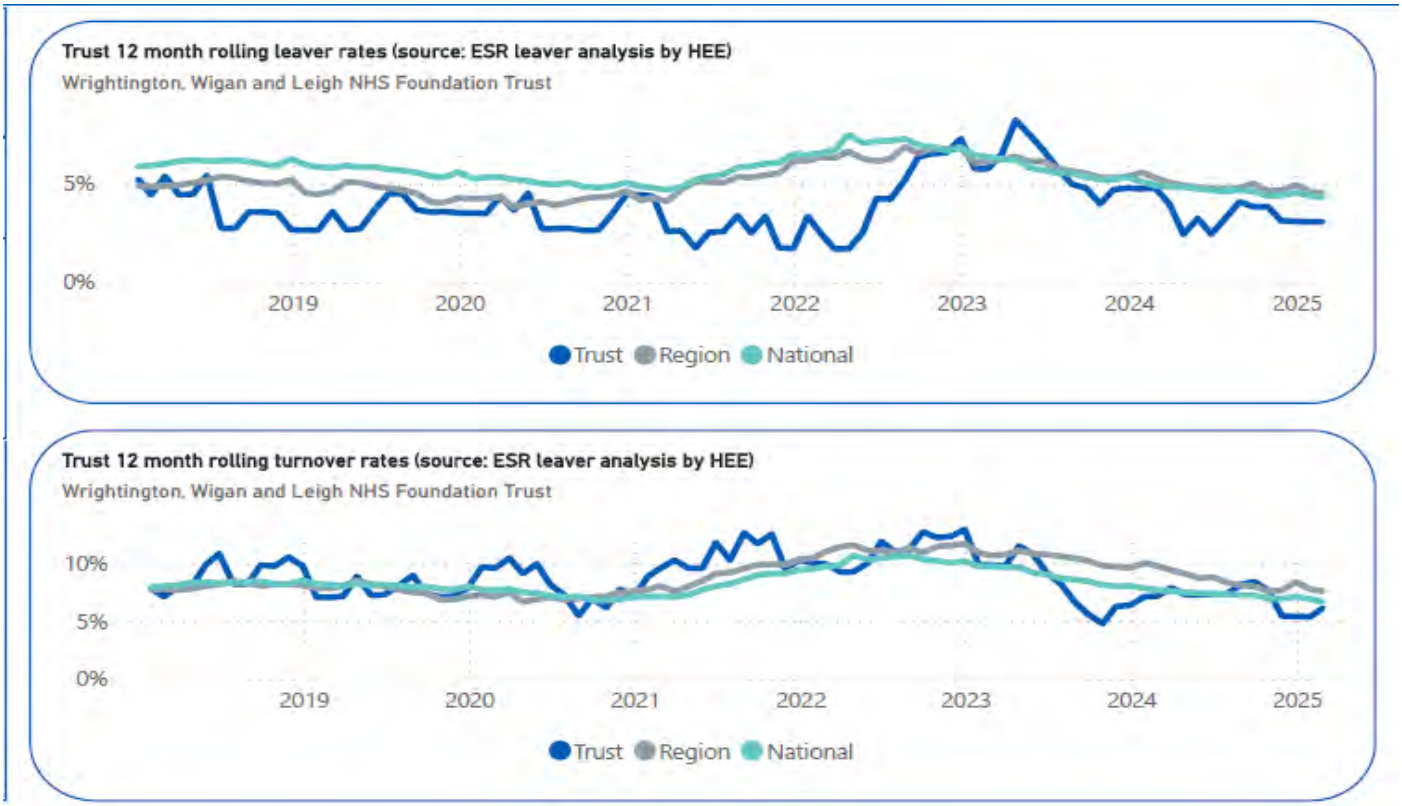
The Band 5 – 6 preceptorship program continues to be successful in maintaining our current staff with all progressing to Band 6 posts on completion of their preceptorship. There have been zero Band 5 to Band 6 progressions in the last 2 quarters but there will be several later in the year who will have successfully completing their 18-month preceptorship programme.

The recruitment and retention lead midwife funded by NHSE has undertaken a secondment with clinical informatics to support the implementation of the new electronic Maternity system, so this role is currently vacant for 9 months and open to an internal secondment (as this is external funding there is a requirement to backfill into the role).

The purpose of the role is to focus on recruitment and retention, working with the preceptorship lead Midwife to provide a comprehensive preceptorship package, pastoral support throughout the recruitment process and to ensure ongoing support is available throughout the preceptorship period as newly qualified Band 5 Midwives and when transitioning into Band 6 posts

The RCM has raised awareness around the lack of experienced midwives and the challenges around their retention, therefore supportive development package for midwives progressing to Band 6 is in place as it has been recognised that the additional responsibilities can be a factor in high attrition rates if the support that has been in place during the preceptorship period is withdrawn.

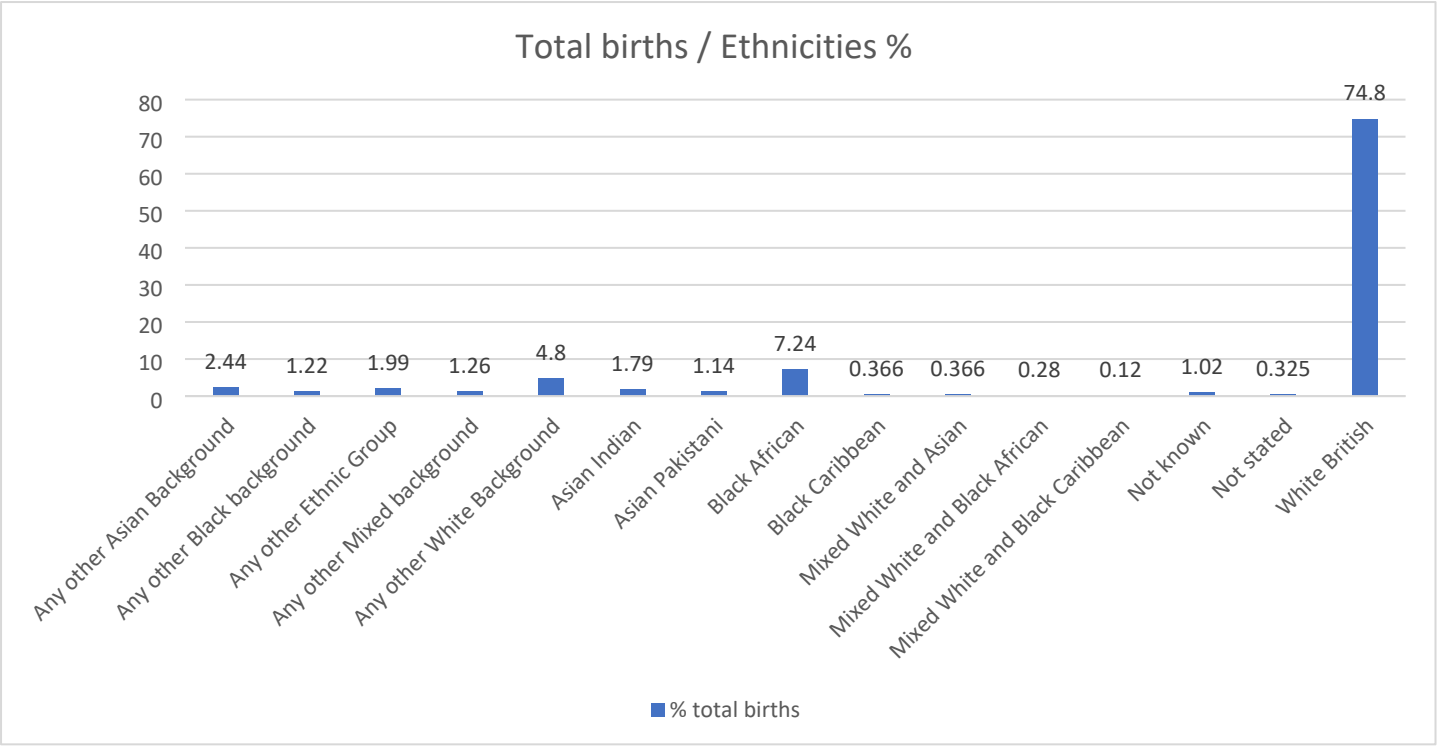
To ensure the retention of all grades inclusive of band 7 and above, development plans are in place to support their transition into the senior posts and to allow for succession planning.



Enhanced continuity Community Teams

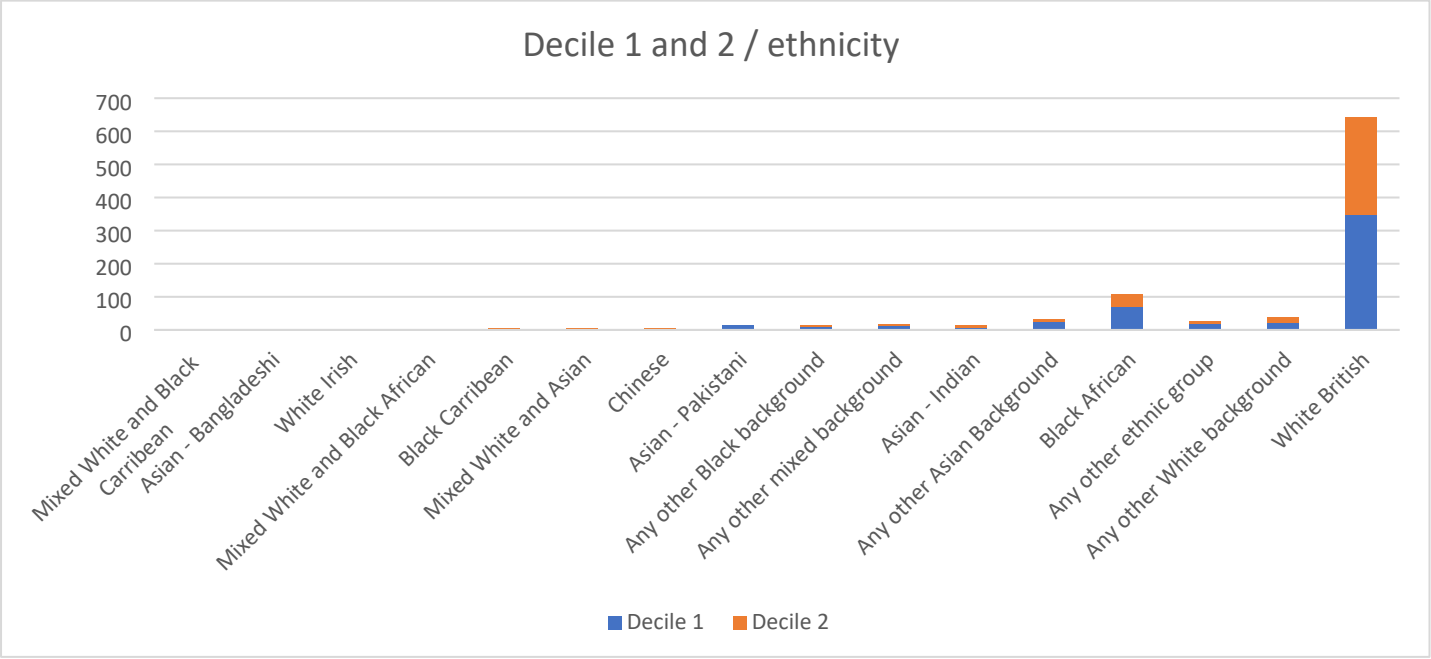
The roll out of enhanced continuity teams is linked to the 3 Year Delivery Plan for maternity and Neonatal Services to help improve outcomes for the most vulnerable mothers and babies. At present there are two enhanced Community Teams established which focus care on women at greatest risk of poor outcomes. Fern Team provide care to women and families from the most deprived neighbourhoods in deciles 1&2, as defined by the Indices of multiple Deprivation (IMD). They also provide care to all non-English speaking women.

Plans are also in place to ensure that all women from a Black, Asian, and Ethnic backgrounds regardless of deprivation decile are provided a level of enhance care within the current community teams. It is notable that the number of Black, Asian, or Mixed ethnicity women living within the Borough is increasing year on year and currently is approximately 18%. (up 2% from 2024)



There are approximately 42% of women within the Borough that live in a postcode from the bottom deciles of deprivation i.e., Decile 1&2. However, postcode alone is not a reliable method of measuring deprivation, and these are utilised in conjunction with other risk factors.

Funding has been allocated via the LMNS to support a continuity model of care, and a pilot is to be commenced within Fern team to provide additional support and continuity, however at present this is non-recurrent.



Daisy Team.

Daisy team is the second enhanced care team which consists of 7 Midwives, 2 maternity Support workers and an admin assistant. Daisy team provide care to the most complex and vulnerable women within the Borough and hold a much-reduced caseload which is approximately 125 women per annum. Currently WWL receive partial funding from the local authority.

Funding for this service from the Local Authority will be withdrawn from March 31st, 2026, and a full-service review is currently being completed to establish the best way forward with enhanced care provision and best utilisation of Midwifery resources.

The service now needs to expand enhanced care to a greater cohort of women, who have risk factors for poor outcomes which may be a clinical or social risk or due to pre-existing health inequalities. By addressing the wider determinants of health, this will help improve health equity as well as overall health.

Options for provision of enhanced care will be shared with the teams in due course. (this will be covered within a separate report)

WWL are currently working with the local authority to agree KPI's linked to national, local, and regional objectives and working towards an integrated model of care which will include services from within the local authority and Health Visiting to provide a think Family Safeguarding approach to this group of women and families.

Immunisation Team.

The Respiratory Syncytial Virus (RSV) programme was rolled out for pregnant women
from 1 September 2024. All pregnant women are offered a vaccine after they have reached 28 weeks gestation, to protect their babies against RSV.
RSV is a common virus which can cause a lung infection called bronchiolitis. In small babies this condition can make it difficult to breathe and to feed. Most cases can be managed at home but around 20,000 infants are admitted to hospital with bronchiolitis each year in England and significantly contribute to the paediatric winter pressures.
Infants with severe bronchiolitis may need intensive care and the infection can be fatal. RSV is more likely to be serious in very young babies, those born prematurely, and those with conditions that affect their heart, breathing or immune system.
The staffing for this programme has been fully funded by NHSE with recurrent monies and the establishment has been adjusted to fully reflect this.

WWL have successfully rolled this out and seen a good uptake of the RSV vaccine with increased uptake of Flu and Pertussis which is also included within the service. WWL were noted to be an outlier for the uptake of the BCG vaccine for at risk infants, therefore this was incorporated into the immunisation team and there has been a significant increase in the uptake of this vaccine across the Borough.

Workforce Age Profile

The age profile of the midwifery workforce has shifted slightly within the last 6 months with the biggest group of registered midwives dropping slightly to 61% being under 50.

Approximately 39% of the workforce is over 50, with this being more heavily weighted within the higher bands.

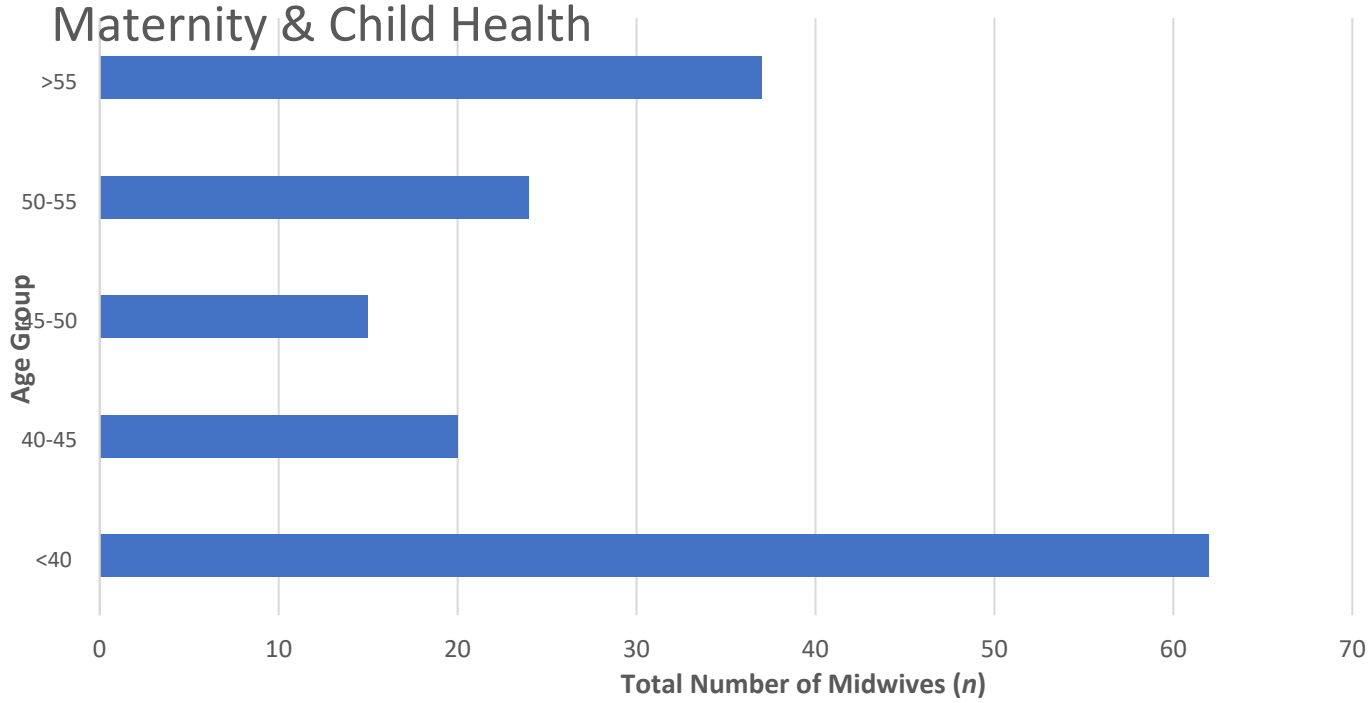
Regional and national workforce planning has seen a year-on-year increase in the numbers of student midwives being recruited to Midwifery training programmes in response to the ageing workforce and high attrition rates in some areas.

Greater Manchester LMNS has requested assistance from Birthrate Plus® Associates to use the Birthrate Plus® workforce methodology for calculating the midwifery staffing required for the next 5 and 10 years. This project will commence in August 2025, following individual service intelligence to fully understand local service needs currently and those predicted over the next 5 and 10 years.

Registered Midwives by Age Group

Maternity & Child Health

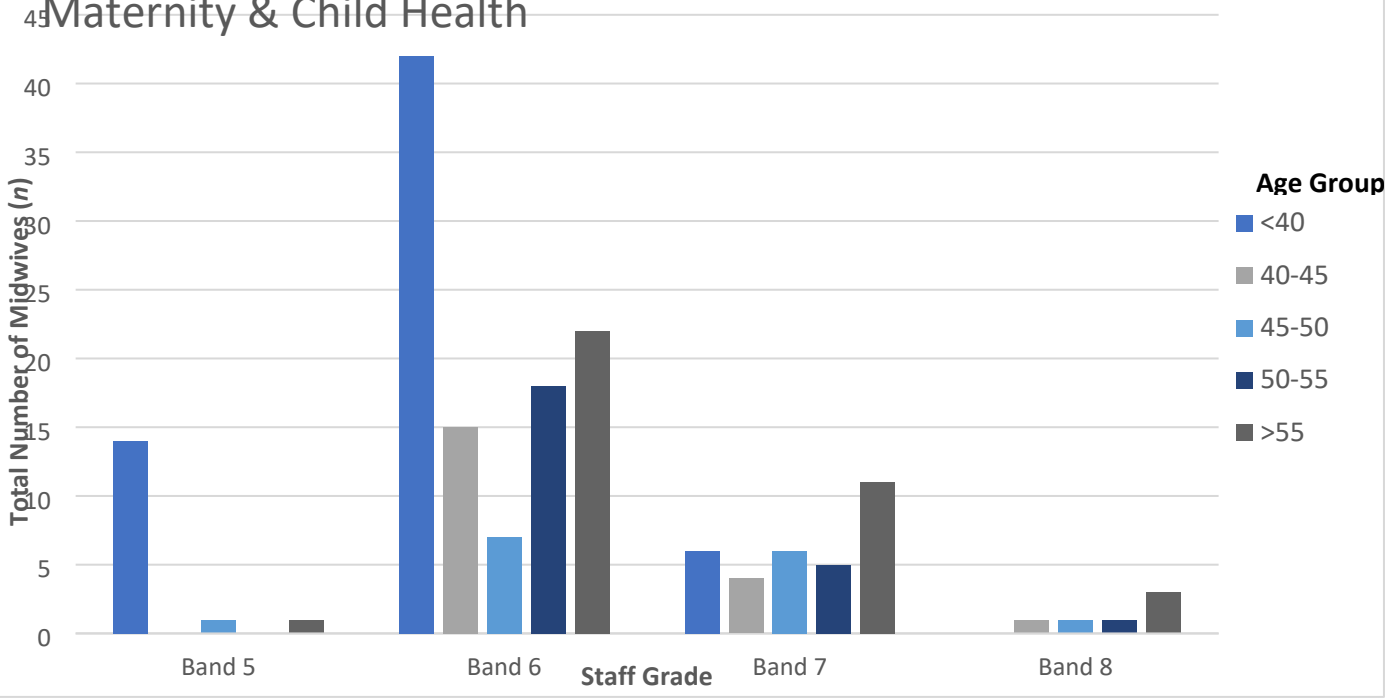
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust



Registered Midwives by Age and Grade

Maternity & Child Health

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust



Sickness

Sickness within Maternity services has been high across all areas and is leading to significant pressures to provide safe staffing levels. Within the quarter the average sickness for Registered Midwives was approximately 9.5% and 8% for unregistered staff.
Significantly the top reason for all staff grades was anxiety/ depression/other psychiatric illness and of note the category other known causes not classified elsewhere is also used for mental health conditions to maintain confidentiality within smaller staff groups.

All support measures are in place for staff wellbeing and staff are sign posted as appropriate to the wellbeing team and occupational Health services.

Professional Maternity Advocates are available for all staff to also support with wellbeing, along with robust adherence to the sickness processes with HR support. Roster management has been reviewed to ensure shift patterns are not too onerous and assurance that Roster rules are in place to support staff health and wellbeing.

Quarter 4 (Jan - March 2025)

Staff Sickness – Q4 (Jan 25 –Mar 25)
Top 5 Sickness Reasons

Band 5		
Reason	**Hours**	**%**
Anxiety/stress/depression/other psychiatric illnes	393.00	56.75%
Ear, nose, throat (ENT)	72.00	10.40%
Injury, fracture	67.50	9.75%
Chest & respiratory problems	60.00	8.66%
Cold, Cough, Flu - Influenza	33.00	4.77%

Band 6		
Reason	**Hours**	**%**
Anxiety/stress/depression/other psychiatric illnes	778.17	30.57%
Other known causes - not elsewhere classified	398.00	15.64%
Gastrointestinal problems	396.50	15.58%
Cold, Cough, Flu - Influenza	302.50	11.89%
Pregnancy related disorders	180.00	7.07%

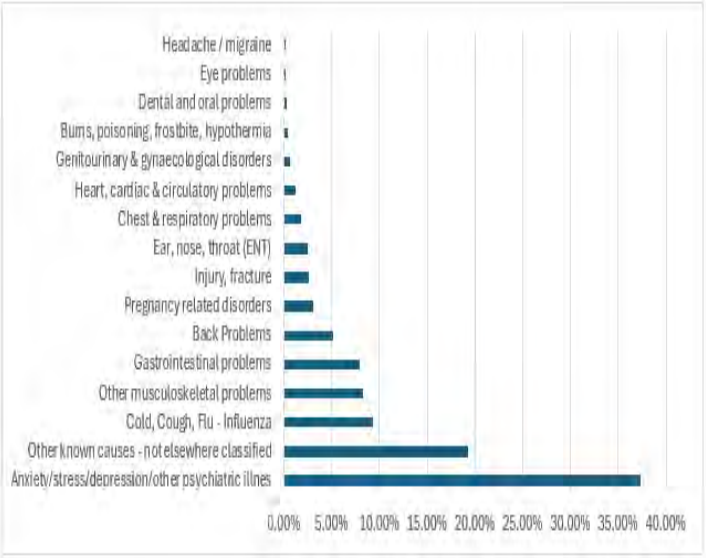
Band 7		
Reason	**Hours**	**%**
Anxiety/stress/depression/other psychiatric illnes	656.00	60.71%
Other musculoskeletal problems	279.50	25.87%
Other known causes - not elsewhere classified	89.50	8.28%
Cold, Cough, Flu - Influenza	48.00	4.44%
Ear, nose, throat (ENT)	7.50	0.69%

Band 8		
Reason	**Hours**	**%**
Other known causes - not elsewhere classified	516.00	86.87%
Other musculoskeletal problems	40.50	6.82%
Gastrointestinal problems	37.50	6.31%

Unregistered		
Reason	**Hours**	**%**
Anxiety/stress/depression/other psychiatric illnes	403.5	38%
Back Problems	307.5	29%
Cold, Cough, Flu - Influenza	171	16%
Other known causes - not elsewhere classified	150	14%
Heart, cardiac & circulatory problems	21.5	2%

Staff Sickness – Q4 (Jan 25 – Mar 25)
All Staff

Reason	Hours	%
Anxiety/stress/depression/other psychiatric illnes	2230.67	37.32%
Other known causes - not elsewhere classified	1153.5	19.30%
Cold, Cough, Flu - Influenza	554.5	9.28%
Other musculoskeletal problems	493	8.25%
Gastrointestinal problems	477	7.98%
Back Problems	307.5	5.14%
Pregnancy related disorders	180	3.01%
Injury, fracture	156.5	2.62%
Ear, nose, throat (ENT)	145.5	2.43%
Chest & respiratory problems	105.5	1.76%
Heart, cardiac & circulatory problems	75.5	1.26%
Genitourinary & gynaecological disorders	36	0.60%
Burns, poisoning, frostbite, hypothermia	24	0.40%
Dental and oral problems	16	0.27%
Eye problems	12	0.20%
Headache / migraine	10.5	0.18%



Quarter 1 (April – June 2025)

Staff Sickness – Q1 (Apr 25 – Jun 25)
Top 5 Sickness Reasons

Band 5		
Reason	**Hours**	**%**
Heart, cardiac & circulatory problems	242	66.76%
Gastrointestinal problems	57.5	15.86%
Anxiety/stress/depression/other psychiatric illnes	34	9.38%
Cold, Cough, Flu - Influenza	17	4.69%
Headache / migraine	12	3.31%

Band 6		
Reason	**Hours**	**%**
Anxiety/stress/depression/other psychiatric illnes	1293	29.58%
Other known causes - not elsewhere classified	651.2	14.90%
Pregnancy related disorders	585	13.38%
Gastrointestinal problems	446	10.20%
Back Problems	367.5	8.41%

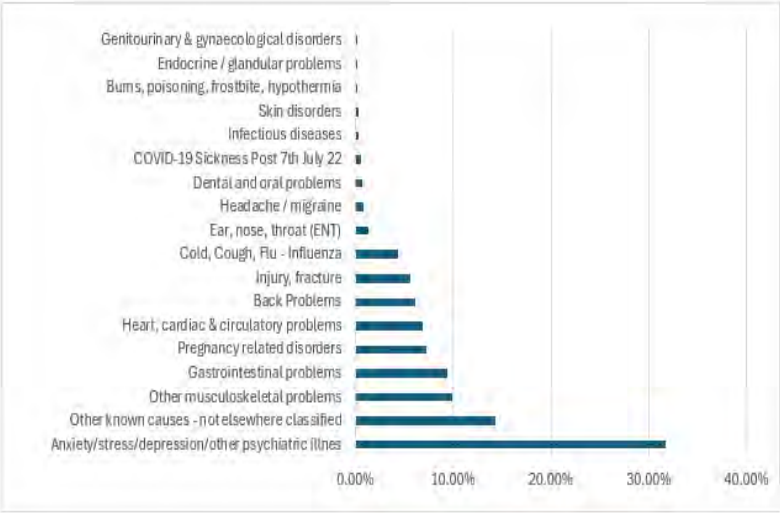
Band 7		
Reason	**Hours**	**%**
Anxiety/stress/depression/other psychiatric illnes	538.5	47.88%
Other musculoskeletal problems	439	39.03%
Heart, cardiac & circulatory problems	111	9.87%
Ear, nose, throat (ENT)	19	1.69%
Other known causes - not elsewhere classified	12	1.07%

Band 8		
Reason	**Hours**	**%**
Other known causes - not elsewhere classified	480	100.00%

Unregistered		
Reason	**Hours**	**%**
Anxiety/stress/depression/other psychiatric illnes	709	39.71%
Injury, fracture	454	25.43%
Gastrointestinal problems	253.5	14.20%
Back Problems	130.5	7.31%
Cold, Cough, Flu - Influenza	54	3.02%

Staff Sickness– Q1 (Apr 25– Jun 25)
All Staff

Reason	Hours	%
Anxiety/stress/depression/other psychiatric illnes	2574.5	31.69%
Other known causes - not elsewhere classified	1158.2	14.26%
Other musculoskeletal problems	804	9.90%
Gastrointestinal problems	762.25	9.38%
Pregnancy related disorders	585	7.20%
Heart, cardiac & circulatory problems	558.5	6.87%
Back Problems	498	6.13%
Injury, fracture	454	5.59%
Cold, Cough, Flu - Influenza	356	4.38%
Ear, nose, throat (ENT)	110.85	1.36%
Headache / migraine	65.5	0.81%
Dental and oral problems	51	0.63%
COVID-19 Sickness Post 7th July 22	45	0.55%
Infectious diseases	30	0.37%
Skin disorders	30	0.37%
Burns, poisoning, frostbite, hypothermia	18	0.22%
Endocrine / glandular problems	15	0.18%
Genitourinary & gynaecological disorders	8	0.10%



Uplift to baseline staffing.

Training requirements for Midwives continues to increase significantly since the introduction of the Maternity Incentive Scheme and the Saving Babies Lives Care Bundle V3 and the Core Competency Framework. Each Midwife needs a minimum of 5 days annually to be compliant with current requirements, this does not include the Trust mandated eLearning and any additional role specific modules such as NIPE (new-born and Infant Physical examination), Accredited Neonatal Life Support, Leadership and Critical Care, therefore it is requested that the uplift of 20% is increased to 25% which will incorporate training needs but also the recommendations within the final Ockenden Report that average sickness levels from the previous 3 years, maternity leave and annual leave (inclusive of Trust Birthday Leave) is calculated within the uplift and meet the training requirements of the 3 Year plan.

An increase in uplift from 20% to 25% would increase the establishment by 4.83 wte.

WWL will have its 3 yearly Birthrate Plus® review in Autumn

Therefore, the overall staffing shortfall including current vacancies and an agreement to uplift to 25% is 9.75 wte.

1:2:1 Care & Supernumerary Shift Coordinator

Evidence from an acuity tool (which may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation/escalation to cover any shortfalls

WWL utilises the Birthrate+ Acuity tool across the Maternity Floor.

The twice daily Safety Huddle monitors, among other things, the provision of 1:1 care in labour and the supernumerary status of the Delivery Suite Co-ordinator.

If there is an occasion when 1:1 care in labour is in jeopardy and/or the Delivery Suite Co-ordinator does not have supernumerary status this is promptly escalated to the Maternity manager on call. Mitigating action is then taken to address the issue and the corresponding Red Flag is uploaded to the Birthrate Plus® acuity tool as appropriate.

This data is also reviewed at the Maternity Clinical Governance monthly meetings and reported as part of the safer staffing reports and additionally included within the Maternity Governance reporting to Trust Board and Quality and Safety Committee.

The Birthrate Plus® acuity tool is utilised across the maternity floor, this supports real time reporting of acuity and activity and identifies where staff are required to provide assurance that the correct staffing levels are in place against activity and acuity.

Safety action 5 of the maternity (Perinatal) Incentive Scheme requires

- There must be a rostered planned and an actual supernumerary shift coordinator at the start of every shift to ensure oversight of all birth activity within the unit.
- All women in active labour receive one-to -one midwifery care.
- Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six-month period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising.

In this period there has been 100% compliance with the provision of 1:1 care in labour and supernumerary Delivery Suite Co-ordinator status as per Maternity and Perinatal Incentive Scheme Year 7 requirements.

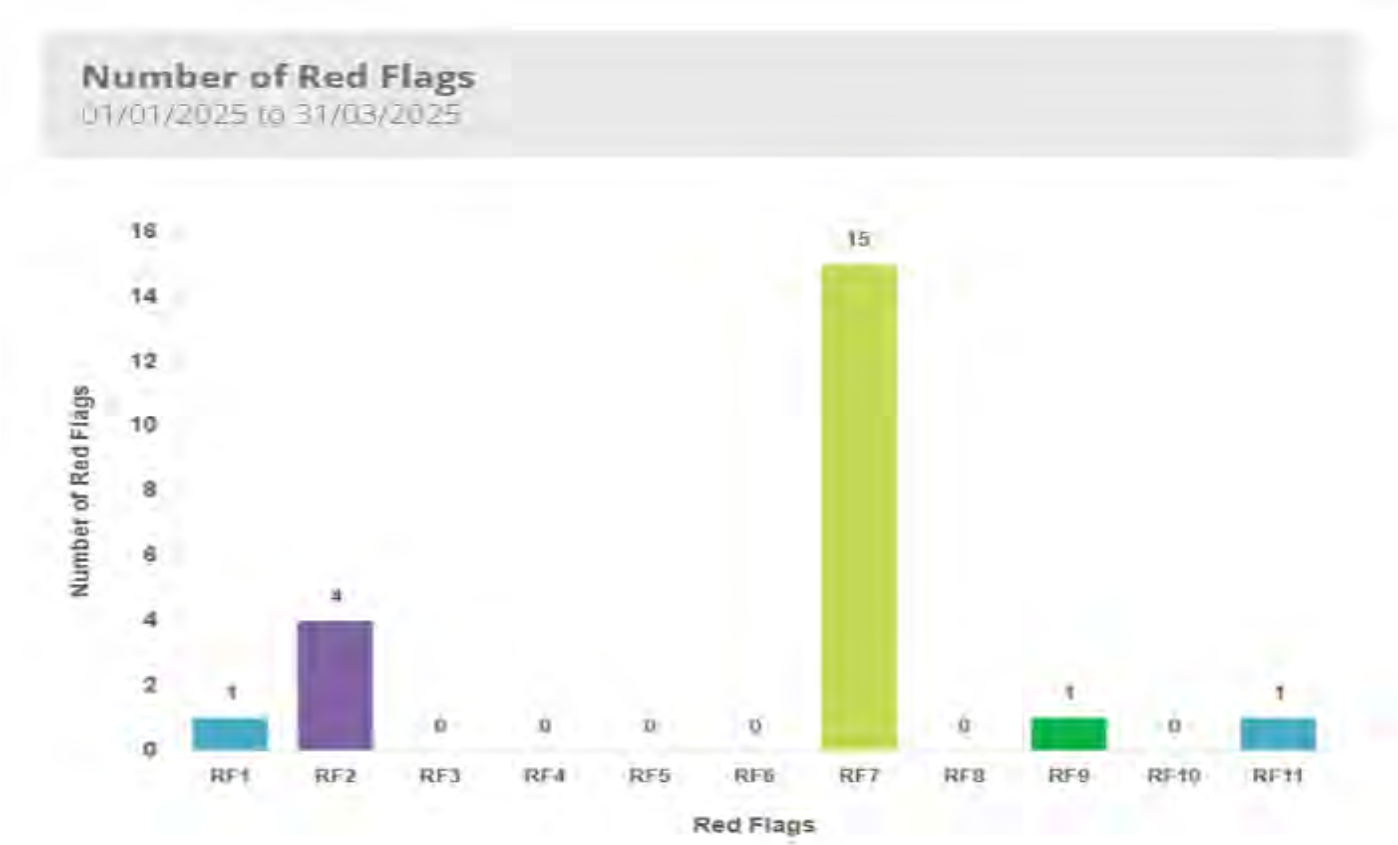
Red Flags

Midwifery red flags are reported Monthly in the Divisional Performance reviews, and Clinical Cabinet. Additionally, they are captured within the Quarterly Perinatal Quality Surveillance Reports which are submitted to Quality and Safety Committee, Safety Champions and Trust Board as well as Divisional and

Directorate Governance Forums. These are reported via the Birthrate Plus+ Acuity tool and validated monthly.

In Q4 2024/2025 there were 22 validated staffing red flag events which is a decrease from Q3. Most staffing red flags in Q4 were due to a delay between admission and commencing the induction of labour process (15 cases) largely due to staffing shortages caused by short term sickness. Escalation was in line with Trust guidance and there was no harm reported.

In Q4 24/25 there was 1 maternity unit divert due to registrar sickness on the 30.03.2025. The unit diverted 3 women to neighbouring units. 0 women birthed in other units during the 11 hr 45 minute divert. Letters of apology were sent to all 3 women.



Number of Red Flags recorded

01/07/2025 to 31/03/2025

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	1	5%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	4	18%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	15	68%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	5%
RF10	Coordinator unable to maintain supernumerary status - providing 1:1 care	0	0%
RF11	Coordinator unable to maintain supernumerary status - NOT providing 1:1 care	1	5%
TOTAL		22	

*The % is rounded to nearest whole number

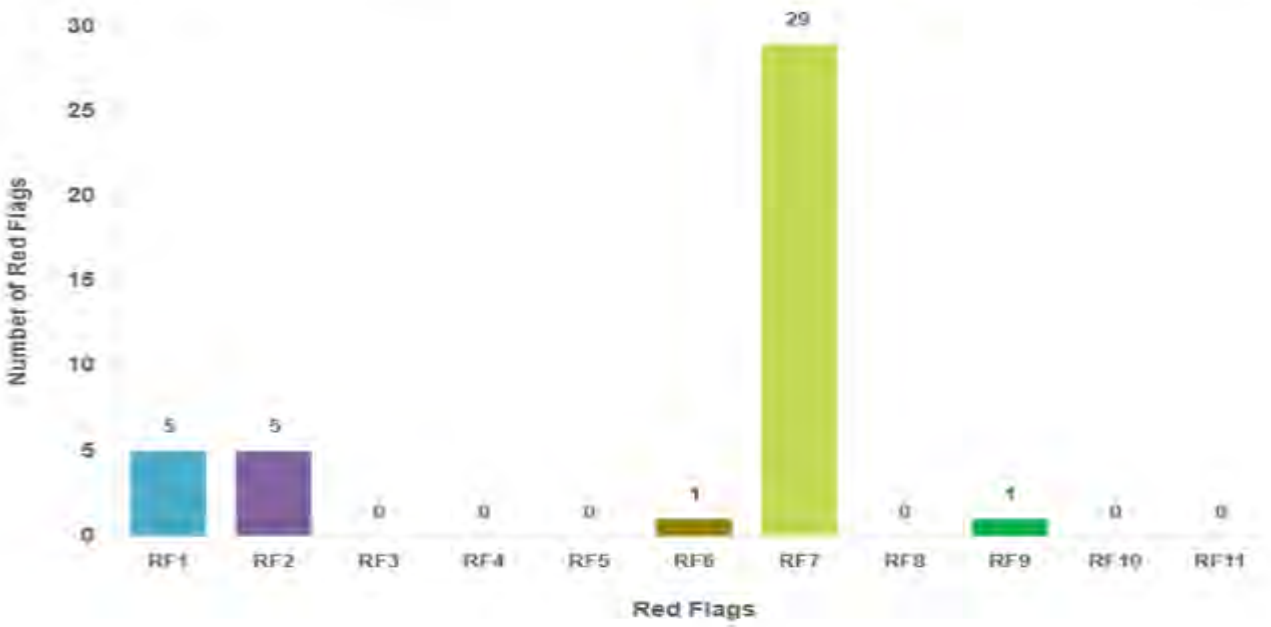
In Q1 2025/2026 there were 41validated red flag events The induction rate rose to 40.57% (up from 36.38 for q4), which will have impacted the timeliness of commencing the induction process.

The delay in commencing IOL from admission was additionally impacted by unexpected sickness levels on delivery suite during April:

- 11.48% registered
- 23.86% unregistered

It has been identified that the recording of red flags via the birth acuity tool may have some inconsistences, and additional work is needed to ensure we are accurately recording the data and duplicate entries can be identified. Training has been commissioned for ward leaders.

Number of Red Flags
01/04/2025 to 30/06/2025



Number of Red Flags recorded
01/04/2025 to 30/06/2025

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	5	12%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	5	12%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	1	2%
RF7	Delay between admission for induction and beginning of process	29	71%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	2%
RF10	Coordinator unable to maintain supernumerary status - providing 1:1 care	0	0%
RF11	Coordinator unable to maintain supernumerary status - NOT providing 1:1 care	0	0%
TOTAL		41	

*The % is rounded to nearest whole number

Escalation policy

The maternity service follows the agreed Greater Manchester and Eastern Cheshire Maternity Escalation Procedures leading to a Temporary Divert Policy, which includes mitigation and escalation for managing any shortfalls in staffing.

A maternity SitRep is completed daily and shared with maternity managers. A GM wide electronic SipRep is also in place to be completed daily and will include the status from all GM Maternity units and monitored through the Local Maternity System (LMNS) in conjunction with NWAS.

BirthRate Plus®

The 2023 BirthRate Plus® report recommended that management or specialist midwife roles should not be included in the clinical numbers. The report noted that within WWL management and specialist roles the clinical specialist midwives have both a clinical and non-clinical role. It is a local decision of senior midwifery management as to the % contribution to the clinical staffing. The remaining % is included in the non-clinical roles. Currently there are 16.17wte Specialist Midwives of which 2.47wte are allocated to the clinical total. The remaining 13.70wte are included in the additional wte.

A skill mix of 90/10 is applied so that 10% of the clinical wte are suitably qualified MSWs (Band 3s), working in postnatal services in the ward and on community. It is a local decision by the senior midwifery management team as to an appropriate skill mix for this area of care.

We continue to review maternity services staffing to ensure the appropriate level of manager and specialist midwives are not included in the midwifery numbers, however during periods of escalation managers and specialist midwives are required and continue to work clinically to support safe care provision.

Senior maternity Managers (8a and above) also participate in an on-call rota and provide cover out of hours from 5pm until 08.00 7 days per week with 24/7 cover at weekends and Bank Holidays

Specialist Roles

Role.	Band	WTE	Funding Linked to :
Infant Feeding Lead /Infant Feeding Midwife	7/6	1.80	Core
Fetal Surveillance Midwife.	7	1.0	SBL

Smoking Cessation Lead Midwife	7	1.0	SBL
Saving babies Lives Midwife	7	1.0	SBL
Diabetes Specialist Midwife	7	1.0	SBL
Pre-Term Birth Midwife (SBL)	7	0.60	SBL
Bereavement Midwife	7	1.60	Ockenden
Antenatal / Newborn Screening	7	1.20	Core
Perinatal Mental Health Midwife and Lead	7/6	2.0	Ockenden
Practice Education Facilitator (PEF) **Funded by Corp Practice Ed Team**	7	0.80	Core.
Practice Educators	7	2.0	Core.
Preceptorship Lead	7	0.80	Ockenden
Third Trimester Scanning Midwife	7	0.77	SBL
Patient , Public & Staff Engagement Lead	7	0.60	Ockenden
Total		**16.17**	**%11.40**
Funded Establishment		**16.56**	

Senior Management & Governance Team

Role	Band	WTE	**Funding Linked to :**
Divisional Director of Midwifery	8d	1.0	Core
Deputy Divisional Director of Midwifery	8c	1.0	Core
Head Of Governance	8b	1.0	Core
Community Matron	8a	1.0	Core
Specialist / SBL / Fetal Surveillance Matron	8a	1.0	Core
Inpatient, ANC and Elective Pathway Matron	8a	1.0	Core
Intrapartum and Triage Matron	8a	1.0	Core
Digital Midwife	7	1.0	Core
Deputy Head of Governance	7	1.0	Core
Quality and Safety Midwife	7	1.0	Ockenden

Recruitment and Retention Lead Midwife	7	1.0	Ockenden
Consultant Midwife	8b	**0.0**	Ockenden
Advanced Midwife Practitioner	8a	**0.0**	
Total		**11.0**	**7.55%**
Funded Establishment		**11.0**	

In Q4 and Q1 the number of specialist and managerial midwife roles in post accounted for 18.95% of the current budgeted workforce.

However, recurrent funding streams have been made available from Ockenden and Saving Babies Lives since the initial Birthrate+ report in 2023 which has mandated the recruitment to these posts.

Clinical Roles

Area	Band	Budget	Actual	Vacancy
Delivery Suite	7	6.24	6.24	**0**
	6	31.42	30.25	**1.17**
	5			
	4	5.38	0	**1.86**
	3		3.52	
Mat Ward	7	0	0	**0**
	6	20.37	18.84	**1.53**
	5			
	4	8.83	0	**1.87**
	3		6.96	
Triage	7	0.5	0.5	**0**
	6	7.56	7.72	**-(0.16)**
	5			
	4	6.18	0	**0.58**
	3		5.6	
ANC	7	0.5	0.5	**0**
	6	6.92	6.99	**(-0.07)**
	5			
	4	4.06	0	**(-0.94)**
	3		5.0	
Community - Wigan	7	0.5	0.5	**0**
	6	9.2	8.80	**0.20**
	5			
	4	1	0	**0**
	3		1	
Community - Ashton	7	0.5	0.5	**0**
	6	7	5.76	**1.24**

	5			
	4	1	0	**0.2**
	3		0.8	
Community - Leigh	7	0.5	0.5	**0**
	6	6.4	6.11	**0.29**
	5			
	4	1	0	**0.4**
	3		0.6	
Fern	7	0.5	0.5	**0**
	6	9	8.80	**0.20**
	5		1.0	
	4	1	0	**0**
	3		1	
Daisy	7	1.5	1.40	**0.10**
	6	5	5	**0**
	5		0	
	4	1.88	1	**0.33**
	3		0.55	
DAU	7			
	6	1.44	1	**0.44**
	5		0	
	4			
	3			

	Band	Budget	Actual	Vacancy
Immunisation Team	**7**	0	0	0
	6	2.64	2.57	0.07
	5		0	
	4	0	0	0
	3		0	

Current	Band	Budget	Actual	Vacancy
Total	7	10.74	10.64	**-0.10**
	6	104.31	98.47	**5.84**
	5			
	4	30.33	26.03	**4.30**
	3			

Area	Band	Budget	Actual	**Vacancy**	Perm	Temp
Future	7	10.74	10.36	**0.38**	0.10	0.28
	6	104.31	98.59	**5.72**	1.90	3.82
	5					
	4	30.33	28.03	**2.30**	1.72	0.58
	3					

Supernumerary Ward Manager adjustment	0.80	Band 5/ 6 adjusted 4.92 wte
25% Uplift	4.83 wte for clinical Bands 5, 6 & 7	
Total Inclusive of Uplift	**9.75 wte Band 5/6**	

***Band 5 Posts are rotational during the preceptorship period and will be allocated to all areas in the service. They are included within the overall contracted actual WTE.**

NHS Resolution

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Year 7 Maternity Incentive Scheme Compliance.

Wrightington Wigan. And Leigh Teaching Hospital NHS Foundation Trust

Name of Person completing the form:		Cathy Stanford - Divisional Director of Midwifery and Child Health
Date form completed:		16 July 2025
Date due to Trust Board for final Sign off of declaration form:		August Mid Point review
Do you submit your CNST progress to the Trust Board as per the Perinatal Quality Surveillance Model?:		Yes
Date of update to Trust Board:		6 August 2025

NHS Resolution is operating year seven of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a lower level than the 10% contribution to the MIS fund and is 4 subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon on 3rd March 2026. and must comply with the following conditions**

- **Trusts must achieve all ten maternity safety actions.**

- **The declaration form is submitted to the Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for maternity services.**

- **The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. The Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered**

In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

The proposed process for oversight and assurance allows for overall compliance of the ten safety actions.

The process includes three elements:

A. The submission of evidence to the LMNS/ ICB stated in the CNST document.
B. The development of an assurance process to have oversight and gain assurance of the ten safety actions.
C. The process of sign off by NHS GMEC ICB CEO

Trusts are required to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.

For WWL to meet the CNST requirements for sign off, The Board declaration form and presentation will need to be presented to the Board in December 2025 and any outstanding actions for Training completion communicated for assurance to the Board Members in January 2026. (as training completion will be after Board papers are submitted)

The CNST document outlines that the LMNS, or in some instances the ICB require sight of or 'sign off' of certain pieces of evidence. A list of the evidence required, and dates required to be submitted to the LMNS, are presented in the table within the next slides:

NHS Resolution

- Actions will only become Blue when signed off By LMNS.
- Amber actions are those that are ongoing and compliance cannot be declared until the end of the reporting period but are on track to achieve.
- Green actions are in place and fully complaint awaiting LMNS sign off
- There are no Red Metrics

Within each safety Standard there are multiple elements for compliance. (not all are listed in the tables)

*Mandated Safety Action Requirements:

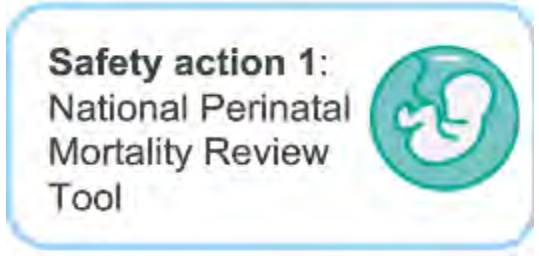
Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	0	2	0	0	2
3	0	2	3	0	5
4	0	14	4	0	18
5	0	1	10	0	11
6	0	4	4	0	8
7	0	1	2	0	3
8	0	21	0	0	21
9	0	8	1	0	9
10	0	9	0	0	9
Total	0	69	24	0	93

Key:

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

*Non-mandated sctions will not be included in this table.

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1st December 2024 to 30 November 2025 to the required standard?

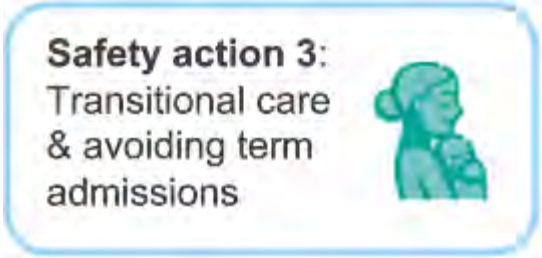


Requirements	Safety action requirements	Likely to be compliant for submission date? (Yes/ No /Not applicable)	Actions for compliance
A	**Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.	Yes	**Reported in Quarterly Perinatal Quality Surveillance Report and Monthly Perinatal Quality Surveillance Dashboard which is received at Trust Board, Quality and Safety Committee and Safety Champions Forum** **Q2 2024/2025**, Trust Board December 2024. **Q3 2024/2025** Trust Board 5th February 2025 Safety Champions 10th March 2025 **Q4 2024/2025** Trust Board 4th June 2025 Quality and Safety Committee 10th June 2025 **Q1 2025/2026** Trust Board 6th August 2025 **Q2 2025/2026**
B	**Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	Yes	
C	**Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	Yes	
D	**Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	Yes	

Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

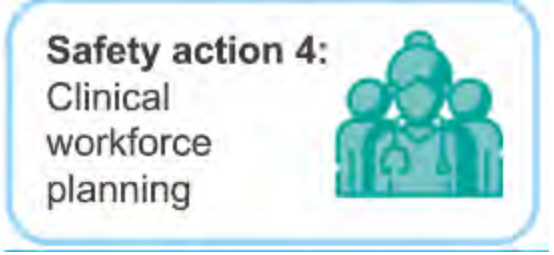
Requirement	Safety action requirements	Confident/ Requirement met? (Yes/ No /Not applicable)	Actions for compliance
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.			
1	July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405).	Yes.	**Confirmation of compliance from NHS Digital is expected in October 25.** **No issues expected** **Evidence of MSDS Scorecard compliance will be submitted To Trust Board December 2025 in final CNST Update Report**
2	July 2025 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (Relevant data tables include MSD001; MSD101).	Yes	

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?



Requirements	Safety action requirements	Requirement likely to be met by Submission date? (completed /Yes/ No /Not applicable)	Actions for compliance
A	Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice	Yes.	**ATAIN audits and presentations reported in Quarterly Perinatal Quality Surveillance Report which is received at Trust Board, Quality and Safety Committee and Safety Champions Forum as detailed below.** **Q2 2024/2025**, Trust Board December 2024. **Q3 2024/2025** Trust Board 5th February 2025 Safety Champions 10th March 2025 **Q4 2024/2025** Trust Board 4th June 2025 Quality and Safety Committee 10th June 2025 **Q1 2025/2026** Trust Board 6th August 2025 **Q2 2025/2026** *November 2025*
	Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.	N/A	
B	Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS. By 2 September 2025, register the QI project with local Trust quality/service improvement team. 2. By the end of the reporting period, present an update to the LMNS and Safety Champions regarding development and any progress.	Yes.	

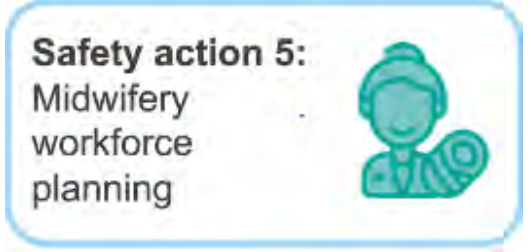
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?



Requirements	Safety action requirements	Likely to be compliant by submission date? (Yes/ No /Not applicable)	Actions for compliance
a) Obstetric medical workforce			
1	NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums.		**In place and on track. To be presented at October Trust Board**
2	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.		**To be presented at December Trust Board**
3	Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**		**Action plan in place. To be presented at December Trust Board**
4	Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.		**Ongoing audit in place now added quarterly to Perinatal Quality Surveillance Report . Submitted to August 6th Trust Board and ongoing quarters.**

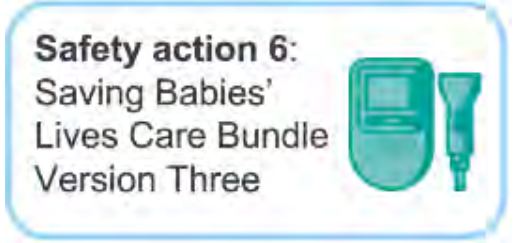
Requirements	Safety action requirements	Likely to be compliant by submission date? (Yes/ No /Not applicable)	Actions for compliance
b) Anaesthetic medical workforce			
1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes	**Evidence will be submitted to Trust Board December 2025 in CNST Report and presentation, and LMNS in December 2025**
c) Neonatal medical workforce			
1	The neonatal unit meets the relevant BAPM national standards of medical staffing. or the standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	Yes	**Completed Action Plan will be submitted to LMNS/ NWNODN in December 2025, demonstrating compliance Tier1 Action plan to be submitted to Trust Board in December 2025 demonstrating compliance.**
d) Neonatal nursing workforce			
1	The neonatal unit meets the BAPM neonatal nursing standards. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal ODN.	Yes	**Annual staffing paper submitted to Trust Board in October 2025, outlining BAPM compliance with Nurse staffing**

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?



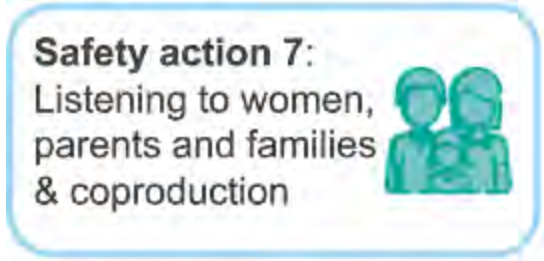
Requirements	Safety action requirements	Requirement met or likley to be met for the submission date? (Yes/ No /Not applicable)	Actions for compliance
A	A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.	Yes	**Birthrate + review undertaken and completed in March 2023 Due to be repeated Autumn 2025**
B	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	Yes	**Biannual staffing reports submitted/ to be submitted to** Trust Board 6th August 2025**. (1st)** *January 2026 (2nd)* **Quality and Safety Committee** September 2025(1st) *January 2026 (2nd)*
C	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes	**Supernumerary Shift coordinator compliance and 1-2-1 care in labour reported monthly on maternity Dashboard which is submitted to Trust Board, Quality and Safety Committee and Safety Champions Forum.** **Additionally, compliance is reported in the Biannual Staffing reports submitted in August 2025 and January 2026**
D	All women in active labour receive one-to-one midwifery care.	Yes	
E	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Yes	

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?



Requirements	Safety action requirements	Requirement met or likely to be met for the submission date? (Yes/ No /Not applicable)	Actions for compliance
A	Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.	Yes	. June LMNS check in …Overall 96% of interventions fully implemented,
B	Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes	**All six elements of Saving Babies Lives are compliant and submitted quarterly on the National implementation tool. LMNS Validation will be finalised January 2026 after quarterly reviews in** January 2025 June 2025 *September 2025* *December 2025*
C	*The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.	Yes	**In place and compliant**
D	To support compliance, a national Implementation Tool is available for trusts to use if they wish on the Maternity Transformation Programme's Future NHS platform. If used, the tool can support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory.	Yes	**Action to be confirmed by NHSR**

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

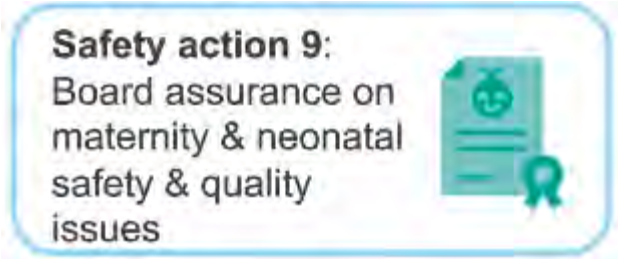


Requirements	Safety action requirements	Likely to meet requirement by submission date? (Yes/ No /Not applicable)	Actions for compliance
1	Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Engagement and listening to families. b) Strategic influence and decision-making. c) Infrastructure. Evidence of MNVP infrastructure being in place from your LMNS/ICB including all of the following: • Job descriptions for MNVP team • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare costs	Yes	**Bi Monthly meetings in place. Listening events scheduled throughout the year with families. Co production with MNVP embedded and in place. Fully funded Chair in place and supporting infrastructure.**
2	Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	Yes	**Co produced annual Picker/CQC survey action plan tabled at MNVP .** **Presented at Safety Champions** November 2024 July 2025 **LMNS on request.**

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

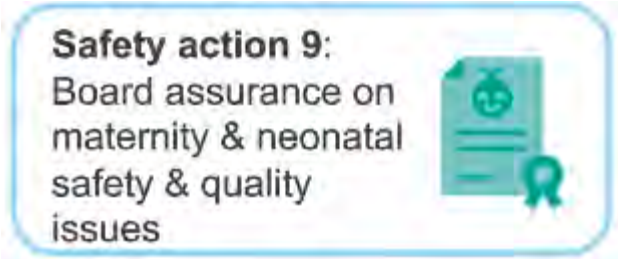
Requirements		Safety action requirements	Requirement likely to be met by submission date? (Yes/ No /Not applicable)	Actions for compliance
90% of attendance in each relevant staff group at:	1	**Fetal monitoring training**	Yes	**Training needs analysis in place and agreed with all staff groups. Ongoing monitoring in place for all groups to ensure full compliance with all elements by 30 November 2025 as per Saving Babies Lives and CNST requirements.** **Any deviations from trajectory are escalated to Divisional and clinical leads for each speciality**
	2	**Multi-professional maternity emergencies training**	Yes	
	3	**Neonatal Life Support Training** In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance. **Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.**	Yes	
	4	ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for every staff group by the end of the MIS year 7 period (30 November 2025). For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust. **It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.**	Yes	

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?



Requirements	Safety action requirements	Requirement likely to be met prior to submission date ? (Yes/ No /Not applicable)	Actions for compliance
All Trust requirements of the Perinatal Quality Surveillance Model (PQSM) must be fully embedded with evidence of Trusts working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025. The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends, with evidence of reporting/escalation to the LMNS/ODN/ICB/ Local & Regional Learning System meetings. All Trusts must have Maternity and Neonatal Board Safety Champions (BSC) who are actively supporting the perinatal leadership team in their work to better understand and craft local cultures.			
a	• Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop collaborative relationships between staff, the frontline Maternity, Neonatal and Obstetric Safety Champions, the Perinatal Leadership Team and the Trust Board to understand, communicate and champion learning, challenges, and best practice.	Yes	In place and embedded
b	• Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly. This should be presented by a member of the Perinatal leadership team to provide supporting context. In line with the PQSM, this must include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent.	Yes	**Quarterly Perinatal Quality Surveillance Report is received at Trust Board, Quality and Safety Committee and Safety Champions Forum as detailed within Safety Action 1&3.**
c	• Evidence of collaboration with the LMNS/ODN/ICB lead(s), showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes	Ongoing Monthly, through LMNS Safety SIG and LfPSE reporting

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?



Requirements	Safety action requirements	Requirement likely to be met prior to submission date ? (Yes/ No /Not applicable)	Actions for compliance
Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:			
d	• Evidence of ongoing engagement sessions with staff as previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025.	Yes	Ongoing , walkabouts and engagement sessions in place discussed at : Bimonthly Safety Champions Quality and Safety Committee Trust Board
e	• Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is triangulated with other quality and safety metrics to inform targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	Yes	Ongoing , discussed at : Bimonthly Safety Champions Quality and Safety Committee Trust Board
f	• Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal Leadership Team and the MNVP lead (where their infrastructure is in, as per safety action 7 place) at a minimum of bimonthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes	discussed at : Bimonthly Safety Champions Quality and Safety Committee Trust Board As required
g	• Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes	Ongoing , discussed at : Bimonthly Safety Champions Quality and Safety Committee Trust Board

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Safety action 10:
Maternity & Newborn Safety Investigations & Early Notification Scheme reporting

Requirement	Safety action requirements	Requirement likely to be met prior to submission date? (Yes/ No /Not applicable)	Actions for compliance
A	Reporting of all qualifying cases to MNSI from 1st December 2024 to 30 November 2025.	Yes	**Evidence will be Submitted to Trust Board December 2025.** **Also included in Quarterly Perinatal Quality Surveillance Reports**
B	Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from1st December 2024 until 30 November 2025.	Yes	**Evidence will be Submitted to Trust Board December 2025.** **Also included in Quarterly Perinatal Quality Surveillance Reports**
C	For all qualifying cases which have occurred during the period 1st December 2024 to 30 November 2025, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes	**Evidence will be Submitted to Trust Board December 2025.** **Also included in Quarterly Perinatal Quality Surveillance Reports**

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Freedom to Speak Up Annual Report 2024/25
Presented to:	Board of Directors
On:	6th August 2025
Item purpose:	Information
Presented by:	Selina Morgan, Freedom to Speak Up Guardian
Prepared by:	Selina Morgan, Freedom to Speak Up Guardian
Contact details:	T: 07826860276 E-mail: selina.morgan@wwl.nhs.uk

Executive summary

The purpose of this report is to provide the Board with:

- Assurance on Freedom to Speak Up (FTSU) Guardian approach and activity throughout 2024/25.
- An update on FTSU Guardian's continuous developments, progress and proactive work.
- An overview of FTSU casework including activity, themes and trends 2024/25.

Key points for noting include:

- There were 99 cases in 2024/25,
- Attitudes and behaviours were the predominant theme followed closely by Leadership and Management in 2024/25.
- A FTSU related question was added to the PULSE survey
- There are continuing triangulation meetings with other areas of the Trust, including Staff Side and Staff Experience Team and OD Team.

Link to strategy and corporate objectives

- To ensure we improve experience at work by actively listening to our people and turning understanding into positive action.
- To promote a strong safety culture within the organisation
- To improve the quality of care for our patients

All staff and volunteers within the organisation should feel safe, comfortable and confident to speak up and by adopting our organisational values to create the right environment, by

doing this we improve health and care outcomes for the population we serve and staff experience.

Risks associated with this report and proposed mitigations

There is a risk to the quality and safety of patient care, and to staff engagement and productivity, if staff do not feel able to speak up regarding their concerns.

Financial implications

The FTSU Guardian role is currently provided as part of a contractual arrangement via GM ICB. The contract is due to expire 27th February 2026, and the Trust is in discussion with the ICB in relation to impact on provision. The Trust has valued the support of the ICB and would not be seeking to end this agreement at that point, however, Board should note the external influences that may impact this.

Legal implications

Trust Board should note the national announcements regarding the future of the National Guardians Office. Whilst the alternative model has yet to be confirmed, initial confirmation has been received to confirm that this should not impact on local provider organisations and the work they are doing with Guardians in relation to speaking up.

People implications

By speaking up staff can help the Trust learn and improve. By listening up, leaders can make sure they understand what change is required. By following up we can make sure that learning leads to action, making speaking up business as usual.

Equality, diversity and inclusion implications

It is important a wide range of staff are encouraged to speak up and the FTSU Guardian ensures all workers who may face additional barriers to speaking up are able to do so.
The Freedom to Speak Up Guardian now also gathers protected characteristics data, however no national directive from the NGO (National Guardian Office) has been received to date.

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

The report was shared with People Committee on the 10th June 25.

Recommendations

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

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 Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust Freedom to Speak Up (FTSU) Guardian over the 12-month period 1st April 2024 to 31st March 2025.

2 Background

2.1 The roles 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. One of the recommendations from the Sir Robert Frances report was the development of a FTSU Gurdian role. He wanted all NHS organisations/Trusts to appoint a FTSU Guardian and for the role to be mandated.

2.2 FTSU Guardians help support staff, protect patient safety and the quality of care, improve the experience of workers, and promote learning and improvement. They do this by ensuring that workers are supported in speaking up, listened to, and that the issues raised are used as opportunities for learning and improvement. They work within their organisation's to help ensure that barriers to speaking up are addressed and a positive culture of speaking up is fostered.

3 Outline of Roles / Responsibilities for FTSU

3.3 WWL has 1 WTE FTSU Guardian who works impartially and independently and has been supported throughout 2024-25 by the Senior Leads, CEO Mary Fleming, CPO Juliette Tait and A Non-Executive Lead also supports the program.

3.4 The FTSU Guardian is also supported by a network of FTSU champions. The role of FTSU champions is voluntary and appointees carry out this important work alongside their substantive posts. Their role is to raise awareness of FTSU by being visible and accessible, role modelling the values and behaviours associated with speaking up and listening up, providing signposting and support to individuals who need to raise concerns, particularly in the absence of the FTSU Guardian.

3.5 The NGO 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".

4 Champion Expansion & Development

4.1 During 2024-25, there has been ongoing expansion of the FTSU network of FTSU Champions across WWL. There were 29 Champions, 2 have left the organisation and 1 unable to commit to fulfill the role, due to capacity. There are now 26 Champions accessible to support staff with ongoing awareness of the role. The following table provides information in relation to the location of Champions.

Organisation Division	Number of Champions
Corporate	5
Community	10
Surgery	5
Specialist Services	2
Estates & Facilities	4

4.2 A yearly communication with expression of interest form (EOI) has gone out to all staff, if they are interested in the role. Work will be ongoing to ensure parity of Staff: There is a continued aspiration that all areas will have a least 1 champion by 2025-year end. Staff are informed they can contact any Champion across WWL regardless of role or location and Champion contact details are on the FTSU Intranet page.

Freedom to Speak Up Champions

Selina Morgan, our Freedom to Speak Up (FTSU) Guardian is still looking for additional FTSU Champions to assist her in raising awareness of the FTSU Guardian Service across the organisation by encouraging and empowering staff to speak up. An Expression of Interest (EoI) application form is available on the intranet.

You will be joining a diverse network of 29 Champions, but if we are to truly make a difference, we need more! If you have a passion for ensuring that staff voices are heard, for developing a positive organisational culture, and if you feel you can be a listening ear and a supportive voice to help in getting concerns resolved, please get in touch with Selina.

FTSU Champions do not manage cases, their role is to thank, support, and signpost people to available routes that can offer resolution, including (where appropriate) the Freedom to Speak Up Guardian. Champions will be expected to complete Freedom to Speak Up e-Learning modules which are available on the e-Learning portal.

Freedom to Speak Up Guardian

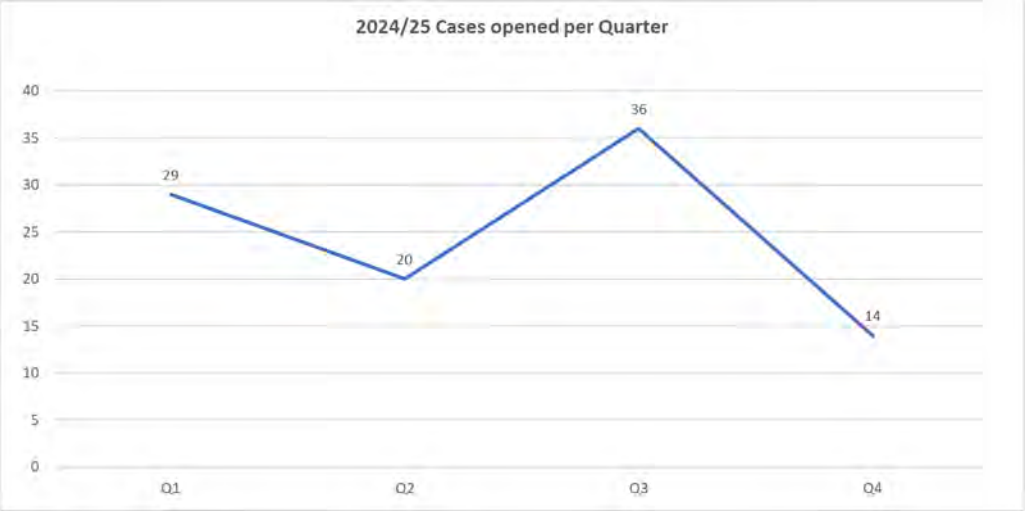
4.3 To support champions in having FTSU conversations, there is a rolling training program which was designed and is delivered by the WWL FTSU Guardian in partnership with Manchester ICB every quarter. 24 of the 26 Champions have all attended and completed this training and received a certificate signed by the CEO.

5 ACTIVITY IN YEAR

5.1 During 2024-25, with no comparable year, the graph below shows that **99** concerns were reported to the FTSU Guardian during the period **1st April 2024 to 31st March 2025** and illustrates the number of concerns reported each quarter during 2024/25.

5.2 Q1 (29 contacts) started off steadily and accounted to the proactive awareness raising by the FTSU Guardian of the service launch. There is a reduction in contacts received during Q2 (20 contacts).

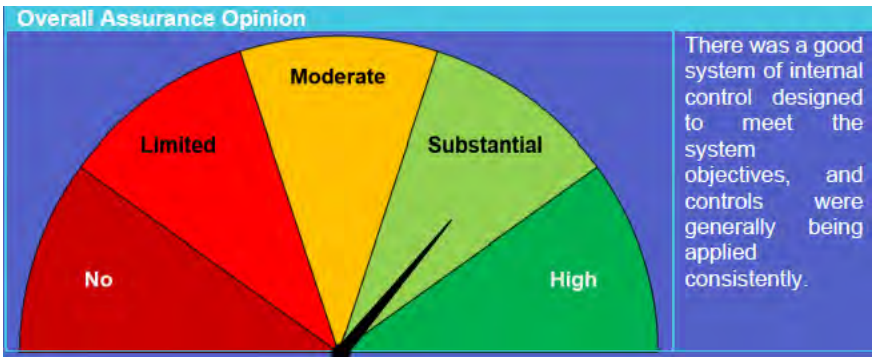
This is attributed to the summer season and staff being on annual leave. However, the number of cases in Q3 (36 contacts) showed an upward trend. During Q4 (14 contacts) there was a vast reduction compared to the previous quarter.



*NB: There were **108** cases in total from March 24 when the FTSU Guardian commenced in post and **123** to date (End of Q1 2025).*

5.2 Cases remain complex, and the FTSU Guardian is logging themes such as patient safety and staff wellbeing. The role of the Guardian is not only to offer support and guidance, but to signpost to relevant areas for support and resolution. The FTSU Guardian continues to work with relevant colleagues across the Trust to ensure resolutions and positive outcomes.

5.3 External Auditors, from MIAA reviewed the FTSU service and process at WWL, the final assignment reported on the 12th February 2025 with a rating of just over substantial.



6 ANONYMITY

6.1 Over the past 12 months the FTSU Guardian reported a high volume of anonymous concerns raised via the FTSU Contact Form, particularly in Quarters 1 and 3 of 2024/25.

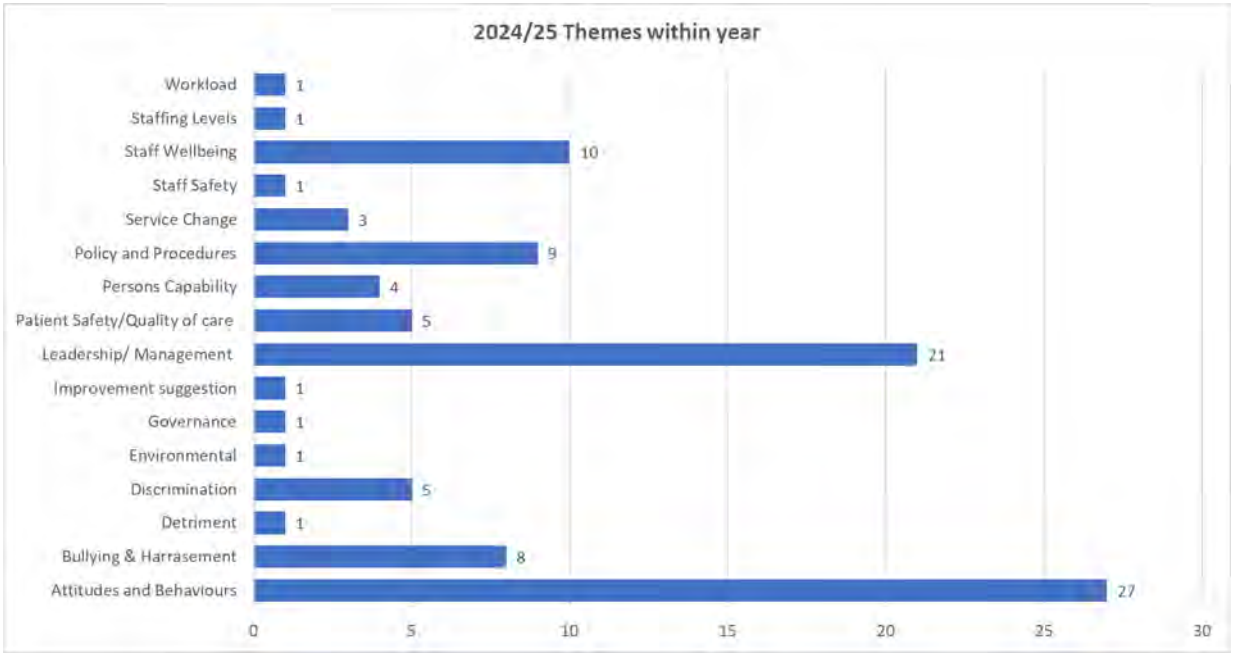
6.2 The National Guardians Office confirms that anonymity is important to ensure staff feel safe from reprisals, this is of course on top of Trusts ensuring that staff are supported to raise concerns openly. Whilst no feedback can be provided to anonymous concerns it is felt that it is better to raise anonymous concerns than not having the issue highlighted at all.

6.3 The FTSU Guardian currently provides staff with an option to raise anonymous concerns via an online FTSU contact form and the FTSU Guardian has considered the appropriateness of this. WWL are advised to retain the anonymous reporting option as the number of concerns may decrease if the anonymous option is removed. It provides the Trust with intelligence around culture and could keep staff and patients safe. To enable WWL to understand why and how staff want to utilise the anonymous function the form was amended to include a question in the FTSU contact form to ask, 'Why do you want to remain anonymous'?

7 THEMES AND TENDS

7.1 Themes are recorded via a drop-down box on the FTSU Guardians tracker. Themes of concern which have been raised via FTSU at WWL have included Leadership and Management styles and inappropriate attitudes and behaviours, these cultures impacting on patient safety, impacting on staff wellbeing and levels of care provided. All concerns have been escalated to the relevant senior teams.

The graph below illustrates the themes including the nationally reported categories of the cases raised to FTSU within the year 2024/25:



7.2 To address the predominant themes, the FTSU Guardian delivered 4x Leadership/Management Lunch time learning sessions online across March & April 2025. The sessions were advertised through communications and the invite sent via e-mail to over 800 members of staff Band 7s and above, attendance:

Thursday 13th March -13 staff in attendance,
Thursday 20th March -20 staff in attendance
Thursday 3rd April - 26 staff in attendance
Thursday 10th April - 11 Staff in attendance

7.3 Evaluation: The FTSU Guardian developed Feedback questionnaire, 6 have responded to date with excellent feedback. In answer to the question 'Would you attend a FTSU session again in the future?' All responses were 'Yes'.

8 PROMOTION AND ENGAGEMENT

8.1 Continuous proactive work has included:

- **FTSU Intranet Page** – Centralised resource hub for staff awareness and access.
- **FTSU Posters** – Placed in and around Wrightington, Wigan, and Leigh hospitals to increase visibility.
- **Various Team Talks and presentations** – Raising awareness of the importance and how to contact the Guardian if the need arises.
- **FTSU Draft Strategy** – Developed to align with national best practices and Trust priorities.
- **FTSU Policy Update** – Revised in accordance with NHSE guidelines to ensure compliance.
- **FTSU Champion Network** – Established via Expression of Interest (EoI) process; now expanded to 26 Champions**,** from a diverse background

and skill mix**,** fostering a culture of openness. Quarterly Network Meetings – Providing peer support and shared learning opportunities.

- **Quarterly Champion Training** – Delivered through a rolling programme in partnership with Manchester ICB, equipping staff with essential skills.

8.2 **FREEDOM TO SPEAK UP MONTH – OCTOBER 24**

Included a dedicated awareness campaign, reinforcing the importance of speaking up.

- **All-Staff Team Briefing Presentation** – Delivered to strengthen organisational commitment to FTSU. A FTSU Champion was in attendance to talk about why she applied for the role.
- **Newsletter Collaboration** – Jointly promoting National Staff Survey (NSS) and FTSU Month, reinforcing key messages.
- **Community Outreach** – FTSU stalls set up at Wigan and Wrightington hospitals to facilitate direct engagement. Goody bags provided to staff who signed up to become FTSU Champions.
- Hospital Radio slot
- Leaders' Forum presentation
- FTSU Agenda item at Inclusion week

9 CASES CLOSED

9.1 58 cases now closed in year, after escalation to appropriate routes, leading to resolution. The more complex the case, the more time it takes to close.

Status 2024/25	
Closed	58
Live	41

For those cases not yet closed the FTSU Guardian is in regular contact with Divisional Leaders and managers to check on progress made and in contact with the PSU (Person Speaking Up) to update on progress, whether they have seen improvements and how they are feeling in terms of their wellbeing. Check in sessions are held as often as the PSU wishes.

10 NEXT STEPS

- Continue to grow Champion Network, looking at areas where we don't have Champions.

- Continue with triangulation work between Staff Side and Staff Experience/OD Team to check onward referrals, cross referencing of our individual trackers to check status of matters raised and planned interventions to resolve cases and improve culture and staff experience.

- Given the growth in cases over the course of the year, future reports can focus more on the themes from cases that have been raised with the FTSU Guardian and the learning that has taken place as a result.

- More sessions with Teams Leaders and Senior Leaders

- Incorporate FTSU training modules into WWL Trust induction day. 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'.

- The FTSU Guardian is conducting a benchmarking exercise to see how WWL Trust compare in terms of numbers, themes, anonymity etc. to another 5/6 Trusts across the Northwest. The outcome of this will be shared at the next Board meeting.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard and Optimisation Report
Presented to:	Board of Directors
On:	6th August 2025
Item purpose:	Information
Presented by:	Kevin Paker-Evans (Chief Nursing Officer & DIPC)
Prepared by:	Gemma Weinberg (Digital Midwife)
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

Link to strategy and corporate objectives

The dashboard aids in providing the safest care for birthing people. It is submitted to GM to ensure that WWL is performing at the required level.

Risks associated with this report and proposed mitigations.

The June dashboard has highlighted that there are some areas for increased observation.

Financial implications

N/A

Legal implications

N/A

People implications

Areas where the figures flag as red consecutively can indicate that there are areas which need to monitored and or reviewed to ensure that birthing people and their families are receiving the safest possible care.

Equality, diversity, and inclusion implications

Where audits and deep dives are required, these factors are included to see if flagged issues are more prevalent in certain groups.

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

None

Recommendation(s)

The Board of Director are asked to note the June 2025 dashboard and overview of indicators as outlined below.

Report

June 2025 Exception report - Maternity
Summary

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

- There were six validated midwifery red flags reported in June, five for delay from admission to start of IOL and one for missed or delayed care (e.g. obs). It should be noted here that the method of collecting red flag reports has changed.
- We are now validating these figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. However, they only relate to Delivery suite There is a separate red flag report which investigates the red flags in more detail.
- The shift coordinator was able to remain supernumerary for all shifts in June.
- 1:1 care is validated at 100% in June.
- There were 0 Maternity complaints received in June, and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

PSII Commissioned Incidents

There were no PSII Commissioned incidents reported in June.

StEIS reported incidents.

There were no StEIS reported incidents in June.

Green

Supernumerary Shift Coordinator
This has remained green for the past 3 months after a dip into red levels in March.

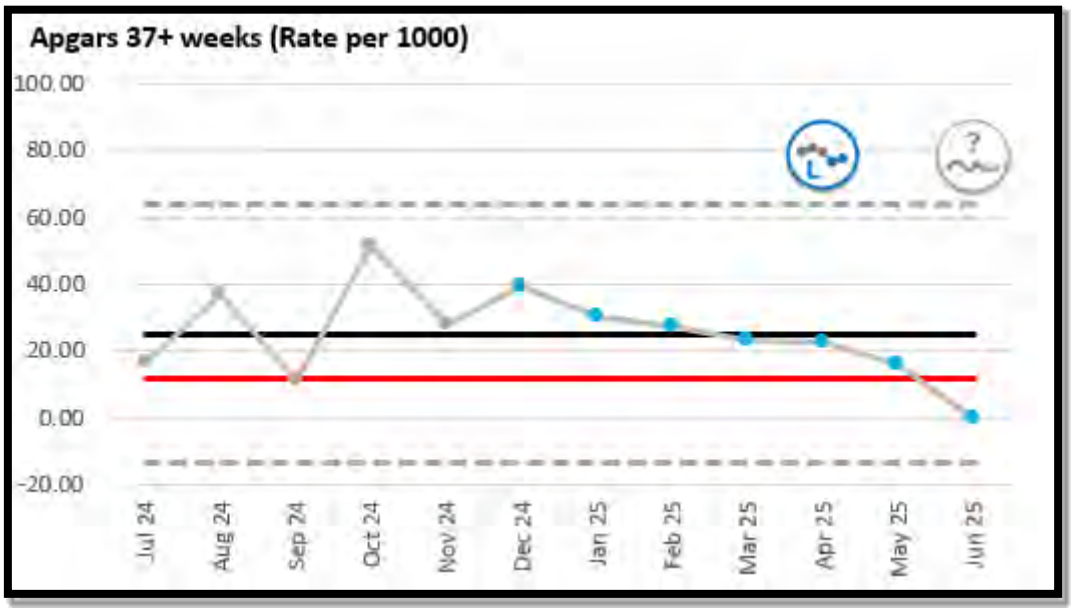
1:1 care in labour (%).
There were no women in June reported to have not had 1:1 care.

Skin to skin contact (%)
This metric continues at green levels after a slight drop into amber levels in March. Work continues to improve this metric with antenatal education and Midwifery training. The infant feeding team have been asked to attend the pregnancy circles which are commencing in Hindley and Tyldesley. It is hoped that reaching out to women regarding skin-to-skin contact will help to improve this metric.

Women booked by 12+6 weeks (%)
These figures saw a slight dip into amber levels in May, but June sees them return to normal levels. Work continues to ensure that women are booked early, the ideal being before 10 weeks.

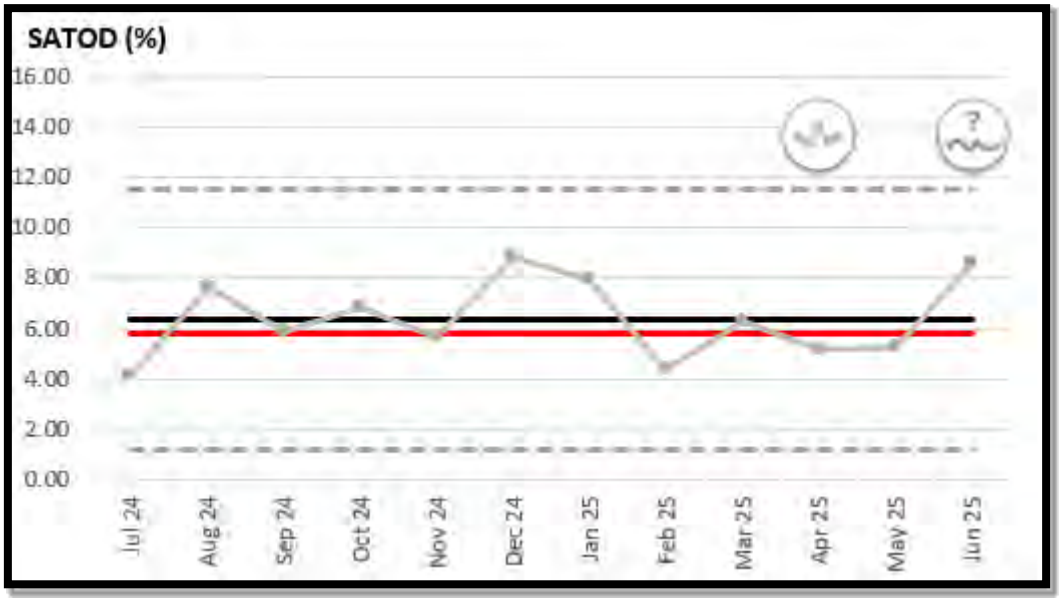
Women readmitted within 28 days of Delivery (rate per 1000).
There were three maternal readmissions to the obstetric unit in June. No omissions in care were noted. One was readmitted for a diabetic review following self-discharge, one was readmitted for possible retained products and one for abdominal pain. There were also two admissions to the main hospital. One for gastroenteritis and one for gallstones. As these are not readmissions into maternity, these are not included in this metric.

All infants with Apgar's less than 7 (rate per 1000).
This metric has fallen to zero for the first time since June 2023. We have been seeing a downward trend in the rates for this metric. The rate per 1000 in June equates to zero babies. Any cases that do arise will continue to be investigated in depth by the governance team. The below SPC chart shows how our figures compare to the 2024 GM average (red line) and demonstrate the continual improvement following the focused work that has been undertaken around training and documentation.



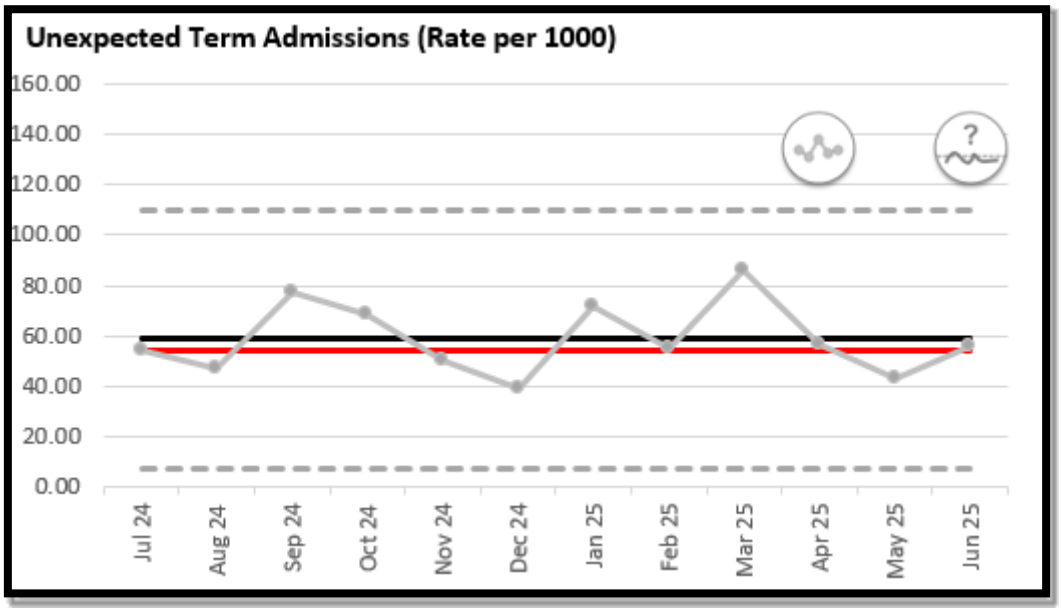
Amber

Smoking at the time of Delivery (SATOD) (%).
February saw the lowest figure for this metric since recording of it on the dashboard began. June sees this figure rising into amber levels. Work continues to promote and encourage smoking cessation throughout pregnancy. Changes have been made by the smokefree pregnancy team where contact is established earlier in pregnancy. It is hoped that by Q3 this will show a positive shift in the data for SATOD. The smoking cessation team also report that the premature deliveries in June have caused up to a 2% shift in the data. The below SPC chart shows our % SATOD rates in com parison to the 2024 average from GM (red line).



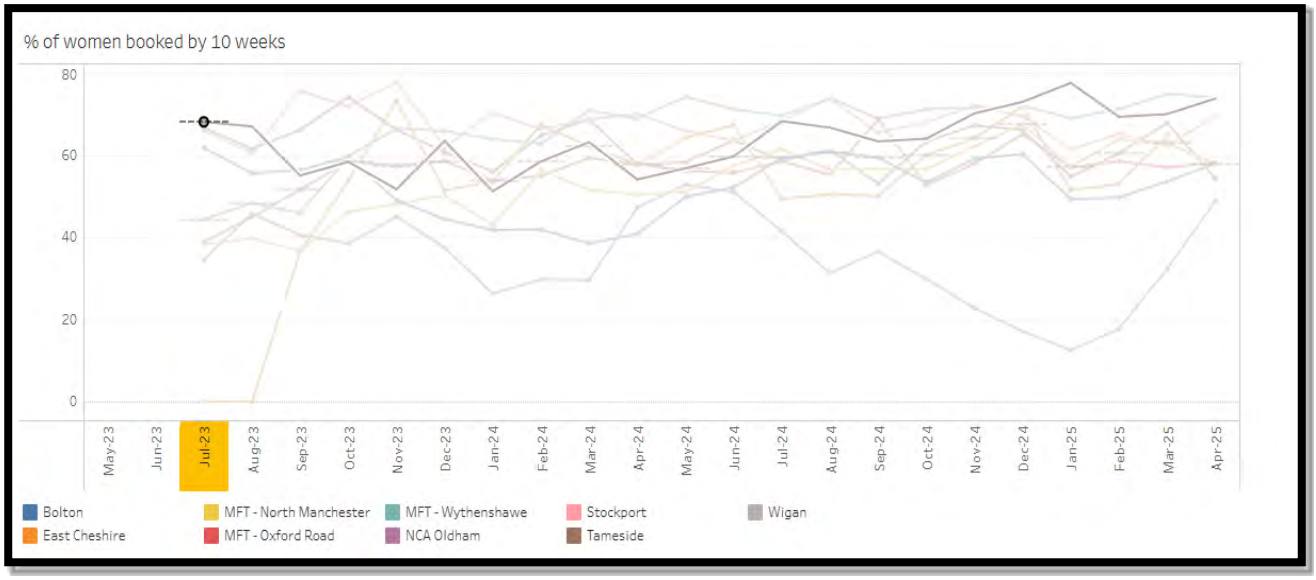
Term admissions to NNU (rate per 1000).

This figure is recorded as rate per 1000 and equates to ten babies in June. This metric is beginning to see a downward trend. 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 2024 GM average (red line).



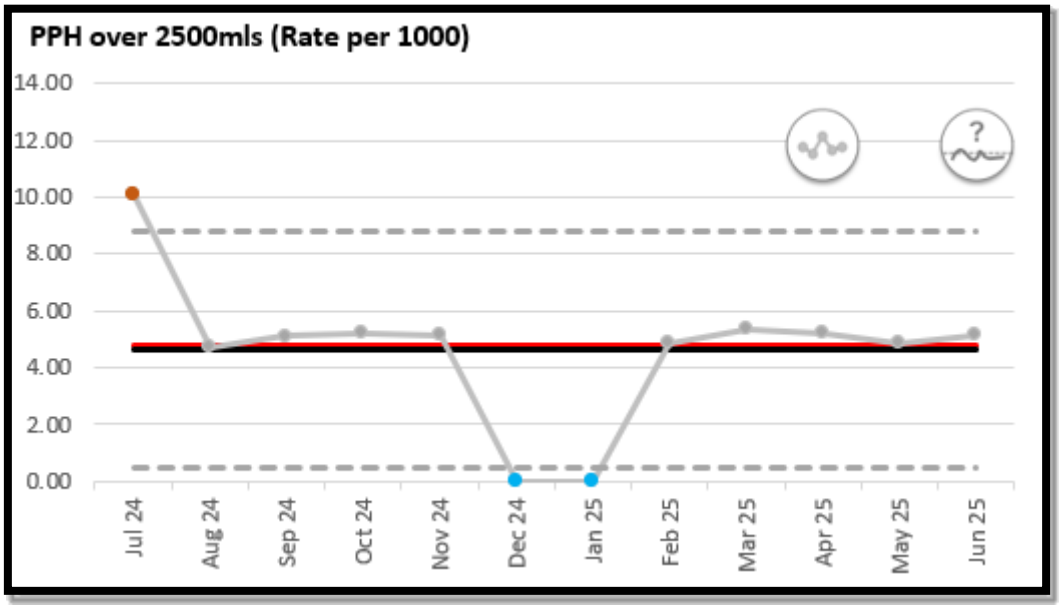
Booked by 9+6

The aim is to work towards booking all women before 10 weeks of pregnancy. Whilst our figures are in amber levels, they have seen significant improvement since the start of 2024. The chart below shows how WWL is performing in relation to GM. As this is not currently one of the key parameters assessed by GM there is no GM average to be able to provide an SPC chart. However, WWL are performing well in comparison to other providers within the region.

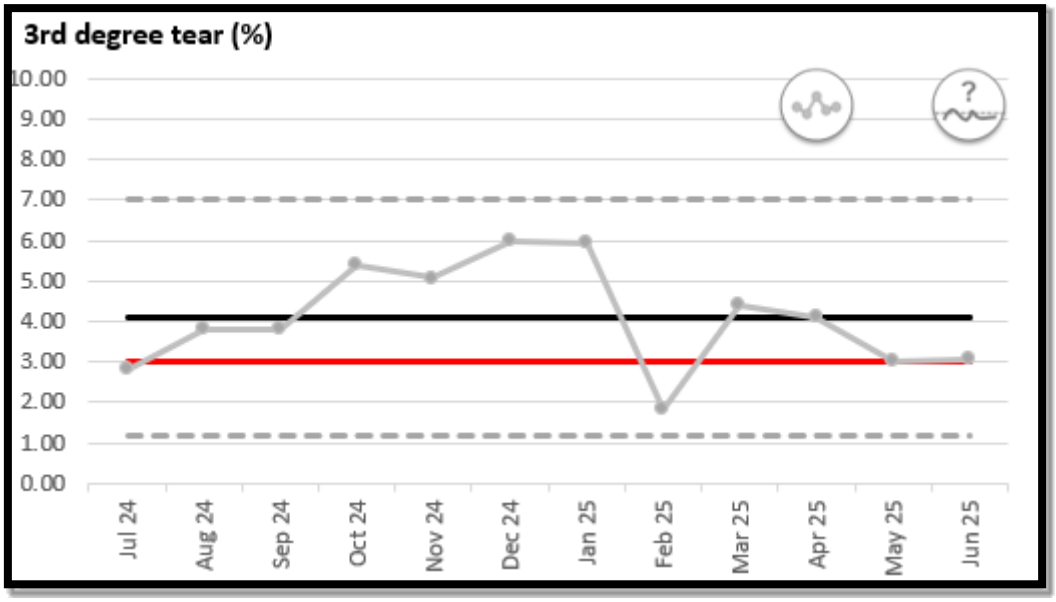


The number of mothers who have opted to breastfeed (%) –
This metric has been green for several months. Work continues to improve this metric by the infant feeding team. The team have been asked to attend the pregnancy circles which have just started at Hindley and Tyldesley. The first infant feeding session was very well received.

PPH over 2500mls (rate per 1000).
There was one woman who had a PPH of over 2500mls in June (2544mls). The below SPC chart shows how WWL compare with the 2024 GM average (red line). The figures for this metric are recorded as rate per 1000.

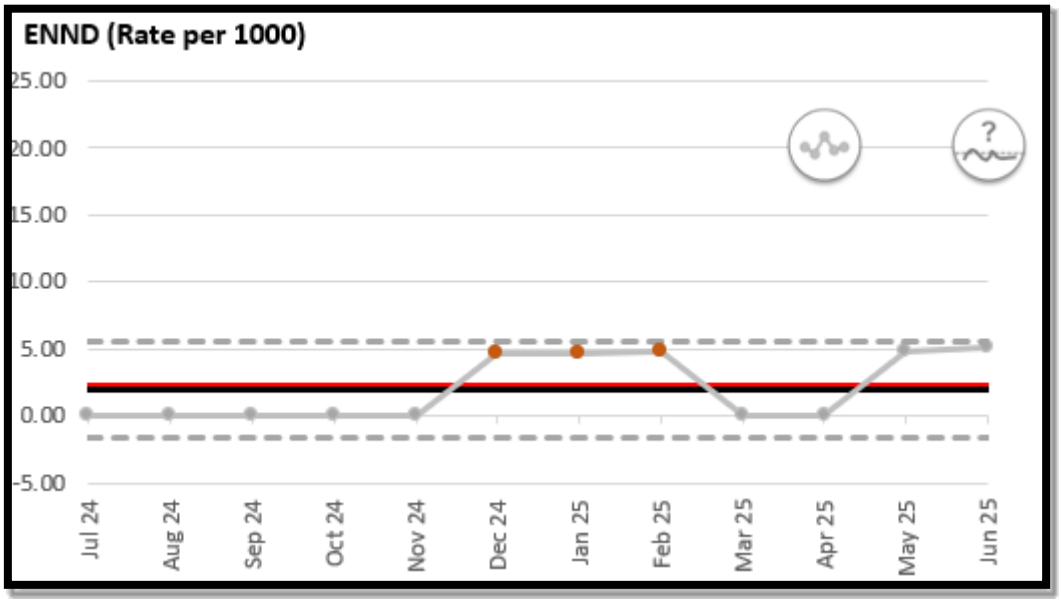


3rd / 4th degree tear (%).
The figure is recorded as a rate per 1000. There were three women who had a 3rd degree tear in June. The below SPC chart shows how we compare to the 2024 GM average for this metric (red line). An OASI working group is continuing to look at this metric and at ways to improve it. Several QI projects are in place to support the ongoing work to reduce perineal injury.

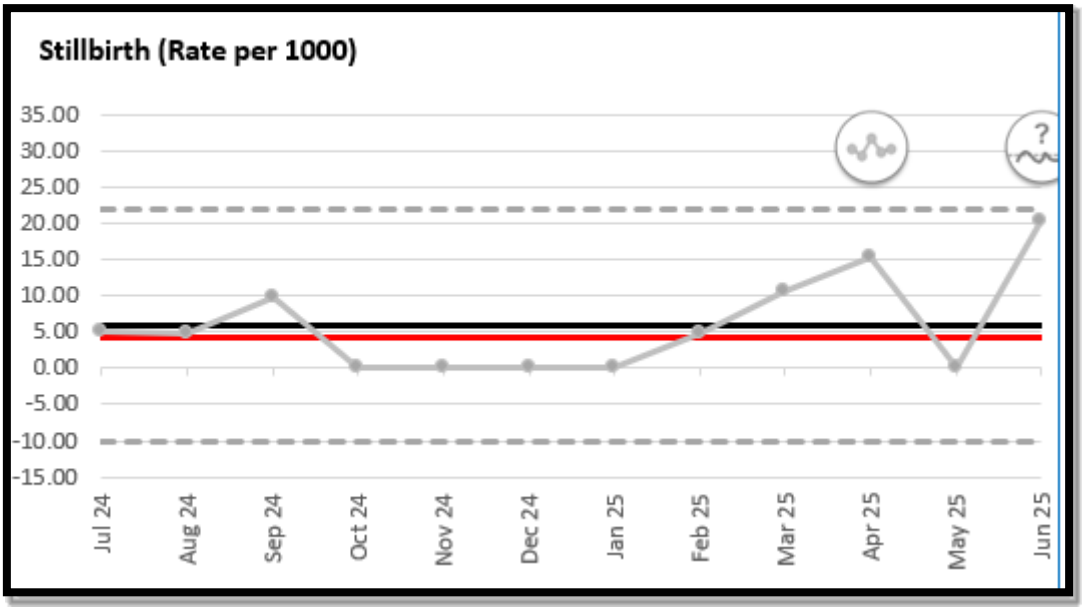


Red

Number of Neonatal Deaths (rate per 1000).
The figure is recorded as a rate per 1000. There was one ENND in June. This was a MTOP at 21+ weeks and the baby showed signs of life at delivery (which would always be a risk at this gestation). The below SPC chart shows how WWL compare with the 2024 GM average (red line).



Number of stillbirths (rate per 1000).
This figure is recorded as a rate per 1000. There were four stillbirths in June. The governance and bereavement teams are completing a deep dive into these cases to establish if there were any themes or trends. Any learning will be fed back once this is completed. All cases also undergo a PMRT review. The below SPC chart shows how WWL compare with the 2024 average from GM (red line).



Induction of Labour (IOL) – (%).
These levels have fluctuated over the past few months. May saw the figure drop into amber levels. However, June sees a spike into red levels. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes, with no outlying themes and trends noted.

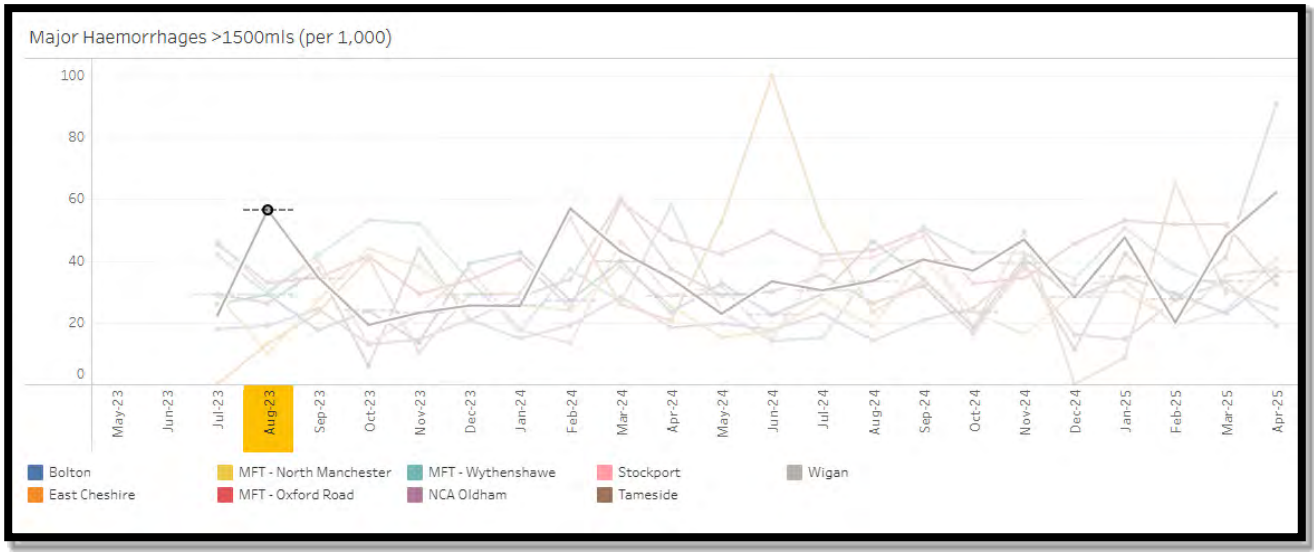
Category 1 Caesarean Sections with no Delay in Decision to Delivery interval (%).
Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and delivery. June sees this figure continue at red levels. 4 women out of ten women had an interval of more than 30 minutes. The times where there was a delay ranged from 32 to 38 minutes.

Category 2 Caesarean Sections with no Delay in Decision to Delivery interval (%).
Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and delivery. In June there were seven women out of thirty-five who had an interval time of more than 75 mins. The times where there was a delay ranged from 77 minutes to 3 hours 34 minutes.

In view of these metrics being continually red a recommendation was taken to the Obstetric body is that all Cat 1 and Cat 2 CS be audited weekly to highlight problems / delays. This will enable possible omissions or issues to be addressed in a timely manner. The recommendation is that the hot week consultant be responsible for this alongside a Midwife. Should the hot week consultant be unable to do the audit then they must allocate this to another doctor for completion.

Other areas not RAG rated.

PPH 1500mls – 2500mls
The figure shown on the dashboard is shown as a rate. The rate in June equates to three women. The chart below shows how WWL is performing in relation to the rest of GM. As this is not currently one of the key parameters assessed by GM there is no GM average to be able to provide an SPC chart. WWL are currently participating in a nation PPH study called OBSUK. It is hoped that the data from this study may help to reduce the PPH figure nationally in the future.



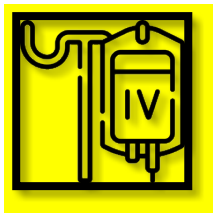
Conclusion

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

Optimisation Metrics - June

The below relates to four mothers who delivered four babies.

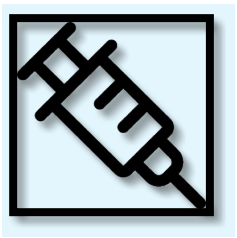
- There were 0 babies not born in an appropriate care setting.
- 0 babies born < 30 weeks gestation.
- 4 babies born < 34 weeks gestation.



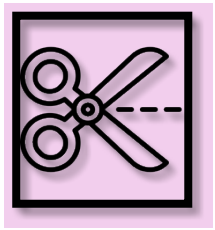
There were no babies born under 30 weeks so MgS04 24 hours prior to delivery is N/A.

All mothers were over 30 weeks but did still receive MgS04

75% of babies received steroids within 7 days of delivery (< 34 weeks).



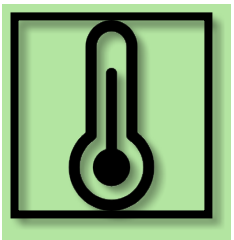
- 3 mothers received a full course.
- 1 mother received a partial dose and went on to have a precipitate delivery before the 2nd dose could be administered.



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

- 4 babies 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).

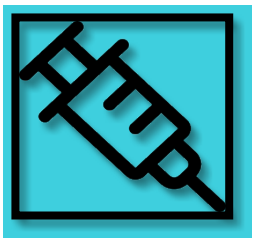


- 4 babies had a normothermic temperature taken within an hour of birth.

75% of babies received maternal breast milk (EBM) within 24 hours of birth (< 34 weeks).

- 3 mothers gave EBM within 24 hours of birth
- 1 mother declined.

0% received Intrapartum Antibiotics >4 hrs prior to delivery (< 34 weeks)



- X1 received just one dose as precipitate delivery.
- X3 N/A as CS prior to labour.

Safety Dashboard 2025

Maternity

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

		Goal	Red Flag	Measure	2025 Jan	Feb	Mar	Apr	May	Jun	Jul	2025 Q1	Q2	Q3	Q4	YTD	Trend
Activity	Bookings (Total bookings)				245	228	233	198	248	242		706					
	Booked by 10 weeks (as % of total bookings – Exclude transfer to area)	Above 80%	Below 50%		77.55%	69.30%	69.96%	73.74%	62.10%	62.40%		72.27%					
	Booked by 12+6 weeks (as % of total bookings – Exclude transfer to area)	Above 90%	Below 80.9%		92.65%	90.35%	95.28%	95.96%	89.92%	92.98%		92.76%					
	Registerable births				214	205	191	195	209	198		610					
	Planned home births (as % of all births)				0.93%	0.00%	1.05%	1.03%	0.96%	2.02%		0.66%					
	Unplanned home births (as % all births) – BBA				0.93%	0.49%	0.52%	0.51%	0.48%	0.51%		0.65%					
	NVD (as % of total births)				40.65%	46.34%	41.88%	42.05%	38.76%	42.42%		42.96%					
	Instrumental deliveries (as % of total births)				6.54%	7.32%	5.76%	8.21%	8.61%	7.07%		6.54%					
	Total number of Caesarean Sections (all categories – as % of total births)				53.74%	46.34%	52.36%	64.62%	52.15%	50.00%		50.81%					
	Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour				3	6	6	6	6	4		15					
	Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour				19	21	22	20	24	15		62					
	Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS				9	11	14	15	14	7		34					
	Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour				4	1	1	2	2	1		6					
	Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour				11	5	6	7	7	8		22					
	Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS				15	8	7	2	8	12		30					
	Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy				32	26	23	26	27	32		81					
	Robson Group 6: Nulliparas; single breech pregnancy				5	2	4	3	6	4		11					
	Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus)				5	2	2	3	0	3		9					
	Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus)				6	5	7	4	8	6		18					
	Robson Group 9: All women with a single oblique or transverse pregnancy (including women with a scarred uterus)				0	0	0	1	1	1		0					
	Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus)				6	8	8	7	7	6		22					
	Number successful VBAC				6	4	8	5	3	2		18					
	% of Category 1 Caesarean Sections with no Delay in decision to delivery (over 30 minutes) – as % total cat 1 CS	Above 90%	Below 80.9%		72.73%	71.43%	71.43%	83.33%	63.64%	60.00%		71.86%					

	% of Category 2 Caesarean Sections with no Delay in decision to delivery (over 75 minutes) – as % total cat 2 CS	Above 90%	Below 80.9%		80.65%	84.38%	66.67%	69.23%	63.89%	80.00%		77.23%					
	Number of Caesarean Section at Full Dilatation				8	2	8	6	10	2		18					
	IOL (as % of all women delivered – excluding pre labour SROM)	Under 35.9%	Above 40%		33.18%	42.44%	33.51%	42.56%	38.76%	40.40%		36.37%					
	Number of women induced when RFM is the only indication <39 weeks				0	3	0	0	2	0		3					
	Number of women induced for Suspected SGA				7	9	2	10	5	4		18					
	Number of In-utero transfers in from other units				4	7	2	2	2	4		13					
	Number of In-utero transfers out to other units				2	2	6	4	0	0		10					
	Average Postnatal Length of Stay				1.7	1.7	1.9	1.7	1.7	1.5		1.76					
Maternal Morbidity	3rd and 4th degree tears (as % vaginal births)	Under 2.5%	Above 3.5%		5.94%	1.82%	4.40%	5.10%	3.03%	3.06%		4.05%					
	Of which 4th degree tears (number)				0	0	0	0	0	0		0					
	PPH 1500 – 2500 mls (Rate per 1000)				46.73	19.51	47.12	61.54	71.77	15.15		37.79					
	PPH > 2500mls (Rate per 1000)	Under 4	Above 6		0.00	5.00	5.35	5.18	4.88	5.15		3.45					
	Number of Women Requiring Level 2 Critical Care				2	2	2	0	1	.		6					
	Number of Women Requiring Level 3 Critical Care				0	0	0	0	0	.		0					
	Number of Blood Transfusions > 4 Units				0	0	0	0	0	.		0					
	Number of Maternal deaths				0	0	0	0	0	0		0					
	Number of women re-admitted within 28 days of delivery (Rate per 1000)	Under 25	Above 35		23.36	24.39	26.18	10.26	9.57	15.15		24.64%					
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis (Number)				0	2	0	0	0	0		2					
nd Mortality	Total stillbirths (as rate per 1000)	Under 3.5	Above 4		0.00	4.88	10.47	15.38	0.00	20.20		5.12					
	Stillbirths (excluding MTOP as rate per 1000)				0.00	4.88	5.24	15.38	0.00	15.15		3.37					
	Number of stillbirths (excluding MTOP)				0	1	1	3	0	3		2					
	Early neonatal deaths (as rate per 1000)	Under 1	Above 1.77		9.35	4.88	0.00	5.13	4.78	5.05		4.74					
	Early neonatal deaths (excluding MTOP as rate per 1000)				4.67	4.88	0.00	0.00	0.00	0.00		3.18					
	Number of Early Neonatal Deaths (excluding MTOP)				2	1	0	1	0	0		3					
	Number of babies born below 37 weeks				18	21	14	15	22	18		53					
	Shoulder Dystocia (as % of total births)				1.87%	0.98%	1.57%	0.51%	0.96%	1.01%		1.47%					
	Number of singleton babies born under 27 weeks				0	0	0	0	0	0		0					
	Number of multiple babies born under 28 weeks gestation				0	0	0	0	0	0		0					

Neonatal Morbidity a	Number of above babies where transfers out not facilitated				N/A	N/A	N/A	N/A	N/A	0		0						
	% of Mothers who delivered under 34 weeks who received AN steroids				25%	50%	50%	40%	40%	43%		42%						
	% of Mothers who delivered under 34 weeks who received AN Magnesium Sulphate				25%	8%	0%	20%	40%	14%		11%						
	% of Mothers who delivered under 30 weeks who received AN Magnesium Sulphate				N/A	100%	N/A	N/A	N/A	N/A		100.00%						
	Number of mothers who delivered under 34 weeks who received a partial dose of steroids				1	1	0	1	2	1		2						
	Number of mothers delivered under 34 weeks who did not receive any course of steroids and omissions in care noted				0	0	0	0	0	0		0						
	% of babies who had delayed cord clamping (% of total births)				88.79%	88.29%	79.06%	85.64%	85.65%	85.86%		85.38%						
	% of babies born <37 weeks whose mother received intrapartum IV Antibiotics (% of births under 37 weeks)				56.25%	92.31%	64.29%	35.71%	28.57%	50.00%		70.95%						
	Neonates with Apgars <7 at 5 minutes (>_37 weeks gestation) - Rate per 1000	Under 15	Above 21		30.61	27.32	22.99	22.60	16.04	0.00		26.97						
	Term Admissions to NNU (births >_ 37 weeks gestation) - Rate per 1000	Under 54	Above 65		71.43	54.64	86.21	56.50	42.78	55.56		70.76						
	Number of babies re-admitted with 28 days of birth				16	18	18	19	16	14		52						
	Number of babies born < 3rd centile				13	5	8	7	9	12		26						
	Number of babies born < 3rd centile >_ 38 weeks				6	1	1	2	5	3		8						
Public Health	% women smoking at time of booking (as % of total bookings)				7.76%	3.95%	14.16%	7.58%	6.45%	6.20%		8.62%						
	% women smoking at time of delivery (as % of total births)	Under 5.84	Above 10%		7.94%	4.39%	6.28%	5.13%	5.26%	8.59%		6.21%						
	Babies in Skin-to-Skin within 1 hour of birth (as % of total births)	Above 75%	Under 65%		75.23%	74.15%	72.77%	82.05%	78.95%	75.76%		74.05%						
	Percentage of Women Initiating Breastfeeding (as % of total births)	Above 58%	Under 50%		58.41%	62.44%	68.06%	59.49%	66.03%	57.60%		62.97%						
Workforce	1:1 Care in Labour (as % all births - excluding El CS and BBA)		Under 100%		98.96%	100.00%	98.75%	100.00%	100.00%	100.00%		99.24%						
	Percentage of shifts where shift Co-ordinator able to remain supernumerary		Under 100%		100%	100%	98.39%	100%	100%	100%		99.00%						
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	0	0	0		0						
	Number of vacancies				1.82	2.22	1.94	6.04	7.97	5.84		1.99						
	Midwife : Birth Ratio				1.28	1.28	1.28	1.28	1.28	1.28		1.28						
	Prospective Consultant hours on Delivery Suite				60	60	60	60	60	60		180						
	Number of Midwifery Red Flags Reported				8	5	7	20	17	6		21						
Incidents	Number of incidents reported				87	77	76	52	47	44		240						
	Number of MNSI Investigations				0	0	0	0	0	1		0						
	Number of StEIS Reported Incidents				2	1	1	0	1	0		4						
	Number of Complaints received in the month				3	5	2	3	2	0		10						
	Number of Letters of Claim Received in the month				0	0	0	0	0	1		0						
	HIE 2 &3 > 37 weeks (rate per 1000)			GM average 2023 0.555/1000	0	0	0	0	0	0		0						

Maternity Perinatal Quality Surveillance Dashboard June 2025

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

June Exception report

Stillbirth	Neonatal Death	CNST
There were 4 stillbirths in June 2025. All 3 still births and are reviewed through PMRT Woman 26+1 and 34+0 both attended with Reduced Fetal Movements, and 35+0 - known Patau's syndrome We have had 1 MTOP of a baby who attended tertiary for fetocide and delivered at 25+2 at with a diagnosis of Wolf-Hirschhorn syndrome Data captured on the Perinatal Quality Surveillance Dashboard amended to excluded MTOP as Maternity Dashboard	There was 1 Neonatal Death of a MTOP for Severe Bilateral Ventriculomegaly born at 21+3	CNST Year 7 Standards evidence collection for all standards underway

Supernumerary Shift coordinator	1:1 care in labour	All cases eligible for referral to MNSI
The shift coordinator remained supernumary throughout June 2025	100% 1:1 care in June 2025	There were 0 WWL cases eligible for referral to MNSI M1 - 043442 - Maternal Death at Aintree of an unbooked Wigan women. Referred at request of LMNS.

Cardiotocograph (CTG) training	Practical Obstetric Multi-Professional Training (PROMPT)
Midwives = 98% rolling compliance Obstetric Consultants = 85% rolling compliance Obstetric Registrar = 80% rolling complaince 2 outstanding and both now booked	Midwives 7 attended (10.4%) rolling figure (93%) MSWs 4 attended (11%) rolling (92%) Obstetric Registrars 1 attended (6.6%) rolling figure (93%) Obstetric Consultants 0 attended (0%) rolling figure (100%) Anaesthetists 1 attended (0%) rolling figure (94%) **Over 90% Complaince for PROMPT for all staff**

Feedback

Service User Voice Feedback	Staff Feedback from Frontline Champions & Walkabouts (Bi-Monthly)
Feedback from Service User A Nigerian Mum shared her experience with the Patient and Public Engagement Midwife. The Mum who had a previous caesarean was initially booked for an elective. She tried for VBAC when attending in early labour, then required an Emergency Caesarean. When the Newborn and Physical Examination (NIPE) was performed, the baby was noted to have a superficial scalpel mark which Mum had not been aware of. We apologised, that no one had mentioned to her, and a full explanation was provided by the NIPE midwife and reassured her that the injury was superficial, clean and dry. Mum shared, 'My care has been just amazing. The whole Team both day and night have been caring, supportive and looked after me and helped me with my baby so well.' When asked for anything that could be improved after some consideration felt that the food could be improved but she would give this a 7/10.	Formal Walkabout The next formal Walkabout takes place on Thursday 3rd July 2025 @ Thomas Linacre Centre with Amanda Cheesman and Mary Moore, Non Executive Director. A Walk the Patch engagement event with the MNVP Lead was held at Leigh Antenatal Clinic in June 2025 Feedback includes **Midwife Continuity & Relationship Building** - Seeing different Midwives at appointments **Waiting Times & Appointment Locations** - long waits in clinics, appointments in different locations **Birth Choice Awareness** - not aware of options available **Partner Involvement** - positive feedback on inclusion of partners **Specific Needs & Challenges** - issues highlighted for neourodivere individuals who are afected by long wait times One individual highlighted the success of Smoking Cessation Support stopping after 25 years of smoking, crediting the midwives

Maternity Perinatal Quality Surveillance Dashboard 2025

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-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Cardiotocograph (CTG) training and competency assessment	Midwives	99% rolling compliance	99% rolling compliance	99% rolling compliance	96% rolling compliance	93% rolling compliance	98% rolling compliance						
	Consultants	92% rolling compliance	100% rolling compliance	92% rolling compliance	92% rolling compliance	77% rolling compliance	85% rolling compliance						
	Registrars	93% rolling compliance	86% rolling compliance	100% rolling compliance	100% rolling compliance	87% rolling compliance	80% rolling compliance						
Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)	Midwives	9 attended (5.5%) 95% rolling compliance	13 attended (7.5%) 87% rolling compliance	14 attended (8.755%) 89% rolling compliance	10 attended (6.3%) 92% rolling compliance	13 attended (8%) 92% rolling compliance	7 attended (10.4%) 93% rolling compliance						
	MSW	4 attended (10.5%) 95% rolling compliance	1 attended (2.4%) 82% rolling compliance	4 attended (10.5%) 89% rolling compliance	2 attended (5.2%) 85% rolling compliance	4 attended (11%) 88% rolling compliance	4 attended (11%) 92% rolling compliance						
	Obstetric Consultants	0 attended (0%) 86% rolling compliance	0 attended (0%) 83% rolling compliance	0 attended (0%) 83% rolling compliance	4 attended (38%) 100% rolling compliance	1 attended (7.6%) 100% rolling compliance	0 attended (0%) 100% rolling compliance						
	Obstetrics Registrars	0 attended (0%) 86% rolling compliance	1 attended (6.25%) 79% rolling compliance	2 attended (13%) 93% rolling compliance	0 attended (0%) 93% rolling compliance	1 attended (6.6%) 93% rolling compliance	1 attended (6.6%) 93% rolling compliance						
	Anaesthetists	0 attended (0%) 94% rolling compliance	0 attended (0%) 82% rolling compliance	2 attended (11.76%) 94% rolling compliance	1 attended (5.8%) 94% rolling compliance	1 attended (5.8%) 94% rolling compliance	1 attended (5.8%) 94% rolling compliance						
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)		60	60	60	60	60	60						
1:1 care in labour		99%	100%	99%	100%	100%	100%						
Maternity Red Flags reported (>3)		8	5	7	20	17	6						
Diverts: Number of occasions unit unable to accept admissions(>1)		0	0	1	0	0	0						
Supernumeray Shift Co-ordinator		100%	100%	99%	100%	100%	100%						
The number of incidents logged graded as moderate or above (>5)		1	2	1	0	0	0						
All cases eligible for referral to MNSI.		0	0	0	0	0	0						
Number of Datix submitted when shift co-ordinator not supernumerary*		0	0	1	0	0	0						

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Healthcare Safety Investigation Branch (HSIB)/NHS Resolution (NHSR)/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0						
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0						
Progress in achievement of CNST 10	Complaint with all 10 CNST Standards CNST board declaration signed ready for submission to NHS Resolution	Awaiting the publication of CNST Year 7 (standards from Year 6 maintained)	Full guidance for Year 7 of the Maternity Incentive Scheme publshed in April 2025	Publication of CNST Year 7 Standards Review of all standards underway	Publication of CNST Year 7 Standards Review of all standards underway	CNST Year 7 Standards evidence collection for all standards underway						
Number of StEIS Reportable Incidents**	2	1	0	0	0	0						
Number of Stillbirths	0	1	2	3	0	4						
Number of Early Neonatal Deaths ***	2	1	0	0	0	1						
Number of Maternal Deaths	0	0	0	0	0	0						

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

Complete										Ongoing				Overdue	
Recommendations			2022 Score	2023 Score	2024 Score	From 2023 to 2024		External Average	Comparison	Action	Lead	Timeframe	Rag Rating	Evidence
Care while you were pregnant															
B6	Bottom 5 Scores vs Picker Average	**Felt midwives or doctors aware of medical history**	84	83	82	-1	↓	87	-5	Communication and discussion at Team meetings with Antenatal Staff regarding the importance of reading patient history prior to consultation/ appointment. Remind midwives & doctors of the importance of completeing the p15 PC plan in the green antenatal notes when new risks identified and management plans need changing. Re launch/ reminder of Post natal care plans for type 1/ pre- exisitng diabetes and raising awareness of these to the midwives. Awaiting evidence. Bereavement Team to share the video of the Becky and Tom France which highlights the upset that can be caused by not being aware of patient history at MT. Awaiting updated copy.	Team leaders Amy Henry Bereavement midwives Medical Team.	30th June 25		Link for patient story illustrating the upset that may be caused by not knowing a patient history. This will be included in MT by the PP lead midwife on the Specialist midwives day from Sept 25. Discussion at Out patinet Teams Leaders meeting 15th May 25, for cascade to Teams. Medical Team reminded of the importacee of this by Dr Dauleh - Delivery suite Lead Consultant. Team Leaders meeting minutes 15.05.25 (002).doc PICKER Action Plan - SD.pdf
B8		**Felt midwives listened (antenatal) C/F - evidence then Monitor**	98	95	99	4	↑	98	1	Remind staff to check and ensure that there are no further questions at the end of appointments.	Team leaders	31st May 25		Discussion at the Out patient Team leaders meeting and Teams leaders to remind staff to confirm with the patientsthere ate no questions or queries at the end of appointments. Team Leaders meeting minutes 15.05.25 (002).doc
B14		**Provided with relevant information about feeding their baby**	83	74	81	7	↑	84	-3	Demonstrate how we are currently providing information for mothers and if this can be improved.	Infant feeding Team	31st March 25		QR codes provided in the antenatal period and at transfer home from the Maternity home following the birth. Information avaiable on the website and the ANYA app has been commissioned in the last 12 months. B14 Re_ Picker Action - KA.pdf
B16		**Treated with respect and dignity (antenatal) C/F - evidence then Monitor**	97	96	99	3	↑	98	1	Back to basics / good to outstanding in planning stage for rollout. Nowhere because of staffing				Trust roll out delayed. Chief Nurses wishes all areas to commence at the same time. Strategy awaiting finalisation.
Your labour and the birth of your baby															
C4	Bottom 5 Scores vs Picker Average Mosts Declined Scores	**Given information/advice on risks of induced labour. Was C5 in 2023**	66	69	66	-3	↓	74	-8	Staff to be reminded of the importance of having the discussion and documenting the information and advice that has been given to women. Ward information folders nearing completion which contains information about the IOL process. There is a Patient information leaflet which is currently being updated and a category for risks/ benefits of induction to be considered. Consideration being given to producing a patient information video.	Delivery suite Leader and Matron. Lead Delivery suite Consultant	31st July 25		MNVP/ Patient engagement midwife survey of women in 2024.79% of ladies felt they were given enough information/ advice. Slide 13. Ward information folders now completed and to be printed/ laminated for distribution to be patient areas. Presentation
C5	Bottom 5 Scores vs Picker Average	**Involved enough in decision to be induced. Was C6 in 2023**	82	85	85	0	-	91	-6	Staff to be reminded of the importance of having the discussion and documenting the information and advice that has been given to women. Information leaflet is currently being updated, and will be sent for review input by the MNVP Action 2023 & 2024	Delivery suite Leader and Matron. Lead Consultant for Delivery suite.	31st July 25		MNVP/ Patient engagement midwife survey of women in 2024. 67% of those survey felt we involved with decision and 18% were sometimes involved - Slide 12. Presentation
C6	Mosts Declined Scores	**Felt that given appropriate advice and support at the start of labour**	86	85	81	-4	↓	84	-3	Information board in the Induction bay 'What is happening to my body?' to outline the phsiological changes that take place during Induction and labour. Reminder to midwives who work in the induction bay of the importance of giving this information.	Delivery suite Leader and Matron	31st July 25		Awaiting completion of the information board to 'What is happening to my body?'

C8	Mosts Declined Scores	**Professionals did everything they could to help manage pain after the birth**		91	88	-3	↓	86	2	Guidelines have been reviewed and there needs to more information in them around postpartum pain relief. Q&S Midwife informed and appropriate guidelines reviewed. Treat women on an individual basis and listen to their requirements.	Delivery suite Leader and Matron	31st July 25		
C9		**Partner / companion involved (during labour and birth). Was C9 2023**	93	91	91	0	-	94	-3	Planned Dads matters survey to further understand gaps. Need Survey Results Dad present at time of completion of questionnaire	Delivery suite Leader and Matron	31st July 25		Awaiting update from Dads matters
C17		**Treated with dignity and respect during labour and birth**	98	98	97	-1	↓	96	1	Staff to be reminded of this on the Delivery suite Comm cell	Delivery suite Leader and Matron	31st July 25		Awaiting evidence from Del suite Leader
C20		**Felt midwives or doctor aware of medical history during labour and birth**	85	87	87	0	-	88	-1	This is in line with the QI for ASPIRE. Delivery suite Leader is planning to promote to use of white boards for basic medical and obsteric information. This will be audited weekly on Tenable for complaince.	Delivery suite Leader and Matron	31st July 25		Awaiting evidence of completion from Delivery suite leader. ASPIRE boards are up by each bed sapce and embedded in practice supported by the Tenadable audit.
Care in the ward after Birth (Postnatal care) & Feeding our Baby														
D2	Bottom 5 Scores vs Picker Average Most Declined Scores	**Discharged without delay.**	63	61	53	-8	↓	58	-5	Improve TTO service, pharmacy have still not appointed a Maternity link which is delaying the improvement. Matron is in the process of arranging a meeting with Lead pharmacist to seek improvements and possible electronic prescribing. NIPE Medical team to improve communication to mothers so they are aware the midwife caring for them will advise of the potenial discharge time. Paeds ANP and Maternity Paediatric Consultant requested to communicate this information with the Medical team. From 7th April there will be twice weekly rota for NIPE trained midwives to assist on the ward in completing NIPE from 8- 12MD. Action 2023 & 2024	Ward Leader and Matron. Paediatric Service.	30th June 25		Pharmacy have worked with the midwifery and medical team to devise a checklist form for the Junior doctors completeing discharge medication precriptions to utilise. This will support the completion of these in a more timley fashion. The infromation has been distributed to staff on the Maternity ward matters newsletter. Rota coomenced on 7th Apr 25 for midwives to complete NIPE's 2 mornings/ week. MWM 27.5.2025.docx D2 - NNU - ANP.msg NIPE Rota - 2025-26.xlsx
D3	Top 5 Scores vs Picker Average Most Improved Scores	**Able to get help when needed (after the birth) C/F - evidence then Monitor**	93	84	95	11	↑	88	7	Staffing reviewed in 2023 and an increase of 1 midwife/ shift during the summer 23. TC covered by a NNU staff member at each shift who remains in the TC bay. Maternity ward Leader to put an item on 'Mat Ward Matters' newletter for staff. Awaiting Mat ward matters for evidence	Ward Leader and Matron	31st July 25		
D6	Bottom 5 Scores vs Picker Average	**Found partner was able to stay with them as long as they wanted (in hospital after birth)**	32	40	47	7	↑	67	-20	Working with the MNVP- this has been discussed at GMEC MNVP Leads meeting and it is felt to be a common theme across the GM area. The GMEC MNVP lead is to raise this at LMNS level for assitance and advise.	Ward Leader, Matron, MNVP & LMNS	30th Nov 25		Awaiting further assistance and advise GM wide from the LMNS. At a local level there are systems in place to support women who are vulerable to have a birth partner remain with them when side rooms are available.
Care After Birth														
F4	Mosts Declined Scores	**Saw the midwife as much as they wanted (postnatal)**	72	67	65	-2	↓	59	6	To be disussed with Team leaders and to remind their teams to signpost women to how they can access any additional postnatal checks or assistance. Sticker for the community midwifery teams contact numbers devised and is attached to the front of the Purple postnatal records with the appropriate Team highlighted.	Community Team leaders and Matron	31st May 25		Discussion at the Out patient Team leaders meeting and Teams leaders to remind staff to offer additional appointmenst if the patient requiresit was confirmed by the staff presenrt that was already taking place. Team Leaders meeting minutes 15.05.25 (002).doc F4 contact number sticker for Purpel notes.doc
F11		**Given information about changes to mental health after having baby. Was F12 2023 C/F - evidence then Monitor**	88	85	86	1	↑	84	2	Maternity ward Leader to put an item on the 'Mat Ward Matters' newsletter for staff, to highlight and thank them for the improvements made. Specialist mental health midwife to confirm the process of stickers in purple notes, QR codes and phoning ward each day.	Ward Leader	31st May 25		Awaiting evidence from the maternity ward manger of postnatal discussion and documentation. Women are seen on a regular basis by midwives in the postnatal period, both in hospital and at home, when mental health and wellbeing is a part of the routine postnatal examination. MH Support MP.pdf

F12	Top 5 Scores vs Picker Average	**Told who to contact for advice about mental health after having baby. Was F13 in 2023 C/F - evidence then Monitor**	**80**	**81**	**88**	7	↑	**81**	7	Maternity ward Leader to put an item on the 'Mat Ward Matters' newsletter for staff, to highlight and thank them for the improvements made. Awaiting Newsletter. Stickers devised to be added to the purple postnatal booklet and cascaded to staff on the Mat ward matters newsletter to staff.	Ward Leader	30th June 25		Awaiting evidence from the maternity ward manger of postnatal discussion and documentation. Stickers for the Purple postnatal records devised by the specialist mental health team and cascaded to maternity staff.
F15		**If needed it received support and advise about feeding their baby during evenings, nights or weekends C/F - evidence then Monitor**	**64**	**72**	**76**	4	↑	**70**	6	All women who initiate breast feeding or expressing breast milk are contacted by the Infant feeding Team by text within 48 hours of transfer home and again at 10- 14 days. This includes those that have birthed out of area. Contact numbers for the hospital are on the Purple Postnatal records. Feedback from the Baby Friendly Initiative assessment.	Kathryn Ashton Infant feeding coordinator	31st May 25		Confirmation of the support offered by the WWL Infant feeding team. Confirmation of the BFI assessment score of 100% for being signposted to feeding support . F15 - Infant Feeding - Mo.pdf Presentation

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Annual Summary of Deaths 2024
Presented to:	Board of Directors
On:	06 August 2025
Item purpose:	Information
Presented by:	Consent Agenda
Prepared by:	Dr Martin Farrier
Contact details:	Martin.Farrier@WWL.nhs.uk

Executive summary

In 2024, there were 1,382 deaths recorded—fewer than in 2023, though the cause of this reduction remains unclear. This trend mirrors national data and may reflect lower viral infection rates or statistical variation.

Mortality Review

- 698 deaths (50%) were reviewed by the Corporate Mortality Review Team.
- 5 deaths were classified as Potentially Preventable (PPDs), consistent with previous years but fewer than last year.
- Common themes in PPDs included:
  - Misdiagnosis and wrong-site surgery
  - Delayed recognition of airway obstruction
  - Missed sepsis and deterioration
  - Prolonged A&E stays

Clinical Care Quality

- Sepsis Care: 68% compliance (improved from 50% in 2023); most failures due to missing blood cultures.
- AKI Care: 80% compliance (improved from 78% in 2023); most failures due to lack of renal imaging.

System Pressures

- Ambulance arrivals accounted for 90% of deaths reviewed
- 50% of non-resus deaths waited over 24 hours in A&E

- Corridor care and delayed transitions remain significant challenges, especially in the first 24 hours of admission.

Capacity and Flow

- Inpatient bed numbers have increased, but flow remains constrained.
- A&E is functioning as if it has 100 beds, absorbing excess demand.
- Weekend discharge rates are lower, contributing to admission bottlenecks and 4-hour target breaches.

Place of Death

- Most patients continue to die in hospital.
- Deaths at home rose during COVID but have since plateaued.
- 17% of reviewed deaths were from care home admissions.

Strategic Priorities

- Expand Whole-System Capacity: Not just inpatient beds, but community and discharge pathways.
- Improve Discharge Processes: Address complexity and delays, especially at weekends.
- Reduce Ambulance Dependency: Explore alternatives for non-urgent admissions.
- Enhance Senior Clinical Input: Evidence shows senior decision-makers reduce length of stay.
- Invest in Out-of-Hospital Care: Virtual wards and home care are essential, especially for frail elderly patients.

Conclusion

While the number of deaths has decreased, the underlying system pressures remain. The work with Newton Europe offers a critical opportunity to address these challenges holistically and sustainably.

Link to strategy and corporate objectives

N/A

Risks associated with this report and proposed mitigations

N/A

Financial implications

N/A

Legal implications

N/A

People implications

N/A

Wider implications

N/A

Recommendation(s)

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

Report

There were 1382 Deaths in the year 2025. This is fewer deaths than last year, but the reason why is unclear. The same pattern is repeated nationally. Presumably, there could be random variation and lower viral infection rates.

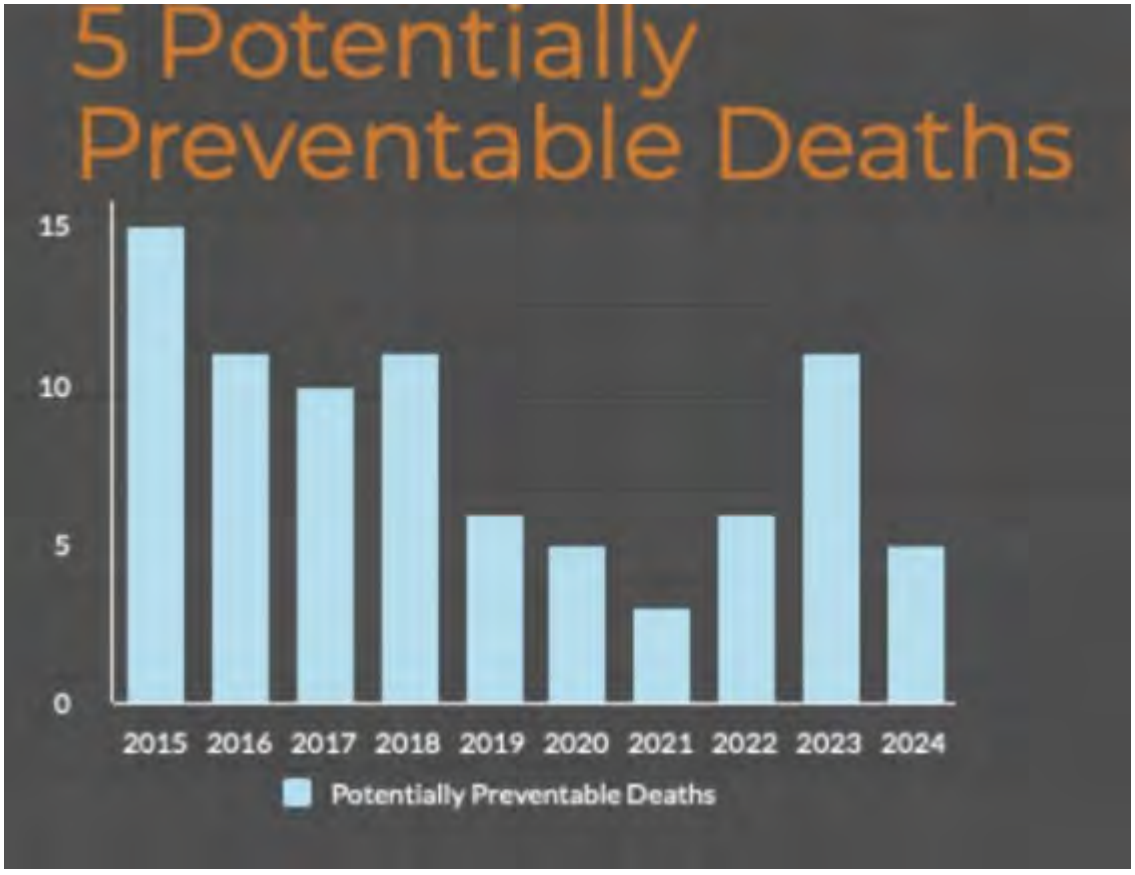
There were 698 reviews completed by the corporate mortality review team, which accounts for 50% of total deaths. 62 patients had an advanced care plan in place.

48 of the patients reviewed had had an operation.

90% of patients who died arrived by ambulance. The queue of people arriving by ambulances is the most important in admissions / discharges.

50% of the deaths reviewed that did not die in resus waited over 24 hours in A&E. This compares to 37% last year.

There were 5 potentially preventable deaths.

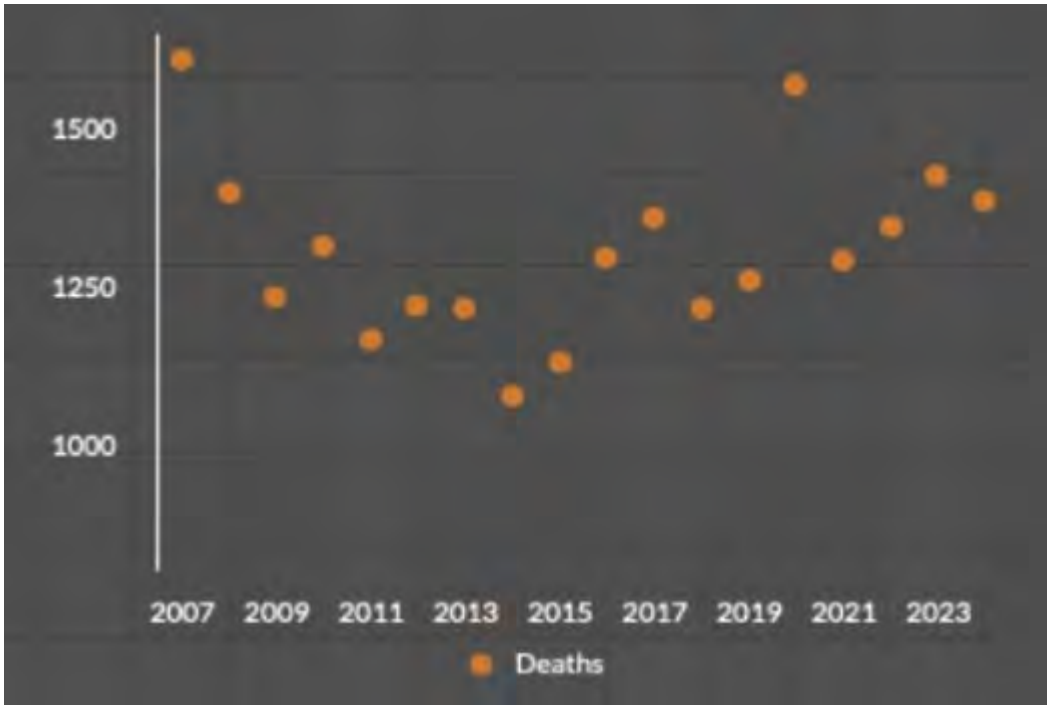


These were:

1. Wrong site surgery / misdiagnosis
2. Late recognition of airway obstruction
3. Ischaemic limb after fracture
4. Missed development of sepsis
5. Missed deterioration / 48 hour AE stay

The pattern of PPD (Potentially Preventable Death) is similar to previously, and lower than last year. The causes of problems again are not unique and have been seen before, through the precise nature of the problems are different.

The pattern of deaths remains in keeping with a slow, steady rise of the total number of deaths, which will peak around 2035. The number of deaths this year is actually less than last year, It is not clear why that is true, but it is reflected in the total deaths for the whole of England. The most likely explanation will be linked to viral infection rates. You could also invoke statistical variation around the mean.
The image below shows the number of deaths per year at WWL from 2007 to date.



Sepsis
68% of patients had good compliance with sepsis care. This compares to 50% last year. We identified 98 triggered cases. 67 of these cases were treated appropriately. The commonest fail was because of us not sending blood culture. This accounted for 90% of fails.

AKI
80% of patients had good compliance with AKI care. This compares to 78% last year. We identified 77/559 reviews where AKI was considered, 61/77 cases were treated appropriately. The commonest fail was because of us not imaging the renal tract (75% of fails).

Capacity
The numbers of patients who are cared for through the inpatient wards has stayed much the same, though there are more beds.

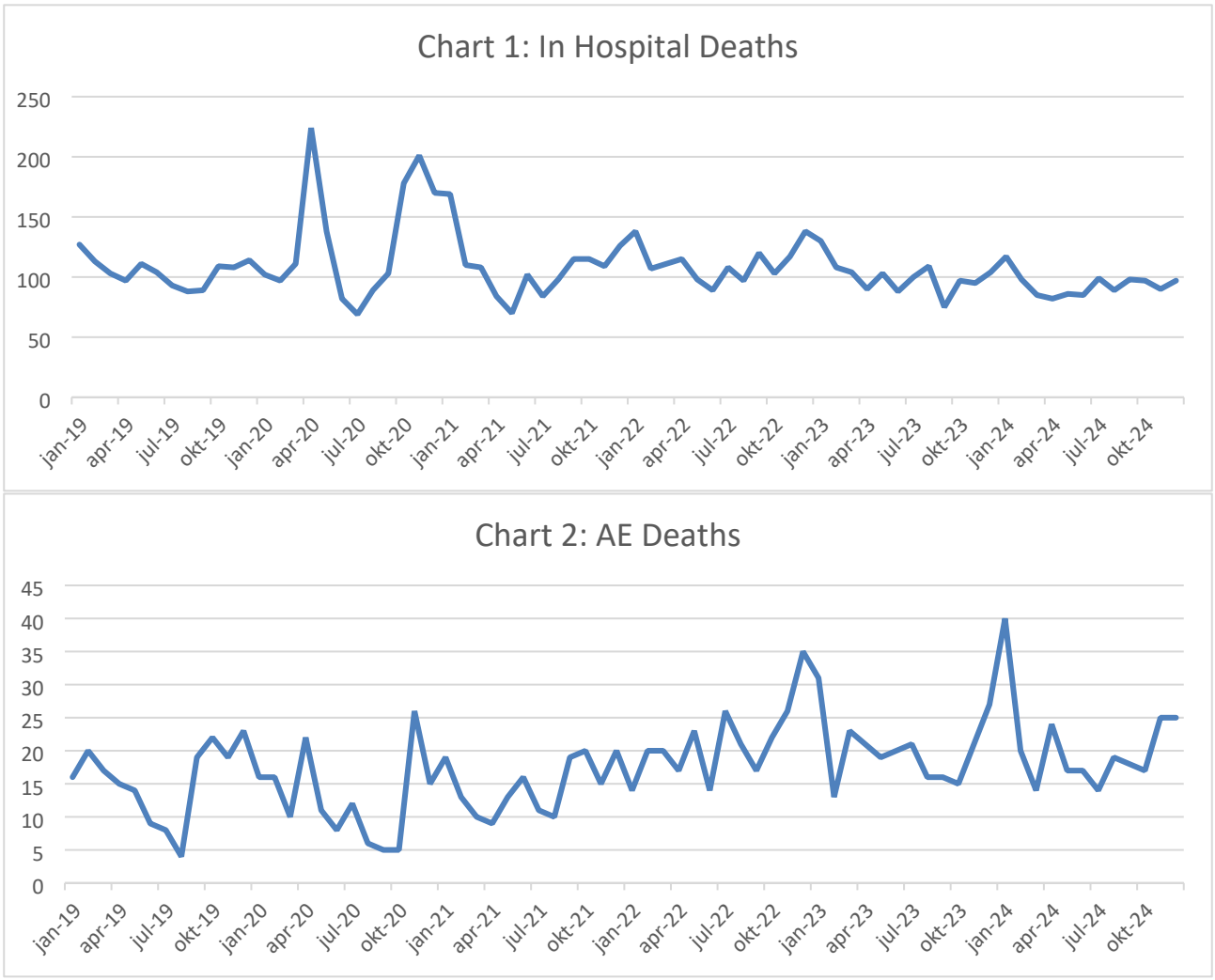
The numbers of patient who are cared for through A&E is significantly larger, but then the numbers of people in A&E is also much larger with A&E functioning as if it had 100 beds.

This can be split into two hypotheses:

- Hypothesis 1: There is insufficient flow through the inpatient wards

- Hypothesis 2: There is insufficient capacity and that is made up by extra capacity in A&E.

Chart one below shows in hospital deaths, which have remained relatively static annually post COVID, compared to an increase in deaths in A&E over the same time period.

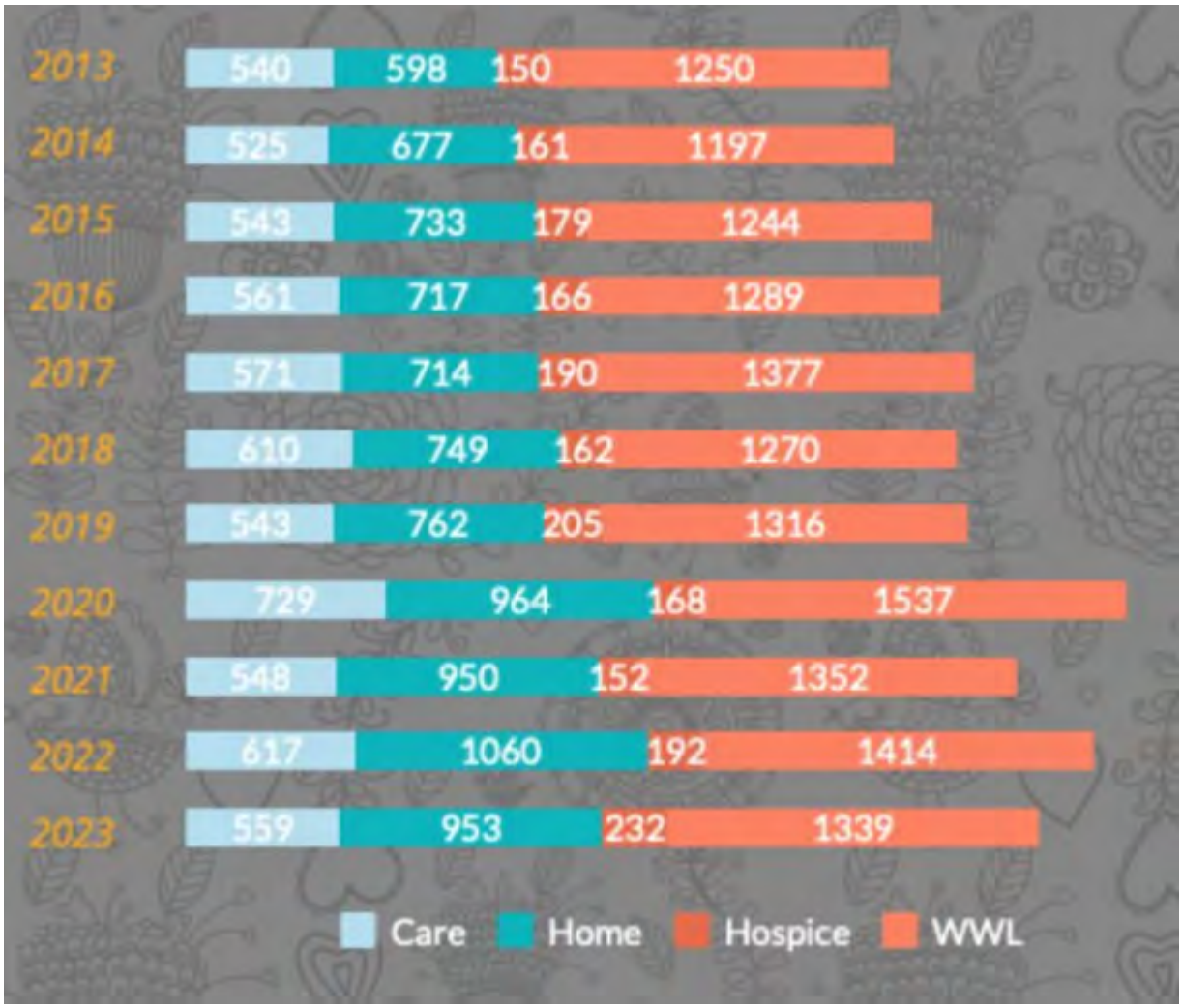


Where We Die

The place we die isn't changing much The commonest place to die is in hospital. Care Homes provide a static but important part of the provision. The proportion of people who die at home increased around COVID and has been static since. Perhaps more significantly, the number of people dying at home hasn't gone up in the last 4 years, but our expectations of care at home has increased.

The chart below shows where patients die. This has been provided by the Public health Team at Wigan Council, the data goes up to 2023.

Chart 3: Where we die:



Care Homes

There are now 370,00 care home bed in the UK. That went up by 3% last year. 50% of care home beds are privately funded in more affluent areas. Self-funding is higher in older people and those without dementia. Fixing social care will therefor tend to fund the wealthy and may have a limited effect on the overall problem of healthcare. The government's spending would be diluted by some of the money being directed to fund people who would already have adequate provision.
120/698 (17%) of the cases reviewed in the deaths audit were admitted from care homes. These would look to be some of the most preventable admissions.

Problems with Care:

IV Fluids
This was very similar to the issues faced last year. Too much or too little fluid causes problems.

Missed diagnosis
The root of most medical errors and legal cases are missed diagnosis. Unsurprisingly, it happens and we see evidence of it. Though we are obviously guilty of being wise after the event.

Airway Obstruction
This was also an issue last year. It is ABC for a reason. Nothing else works if you miss the airway problem.

Waits/Corridor Care
Managing corridor care is immensely challenging and consumes large amounts of staff. They wait with the patient. Little happens and the first 24 hours of admission is often just a wait.

Capacity
Capacity continues to be an issue. It is the biggest problem of our time and causes harm.

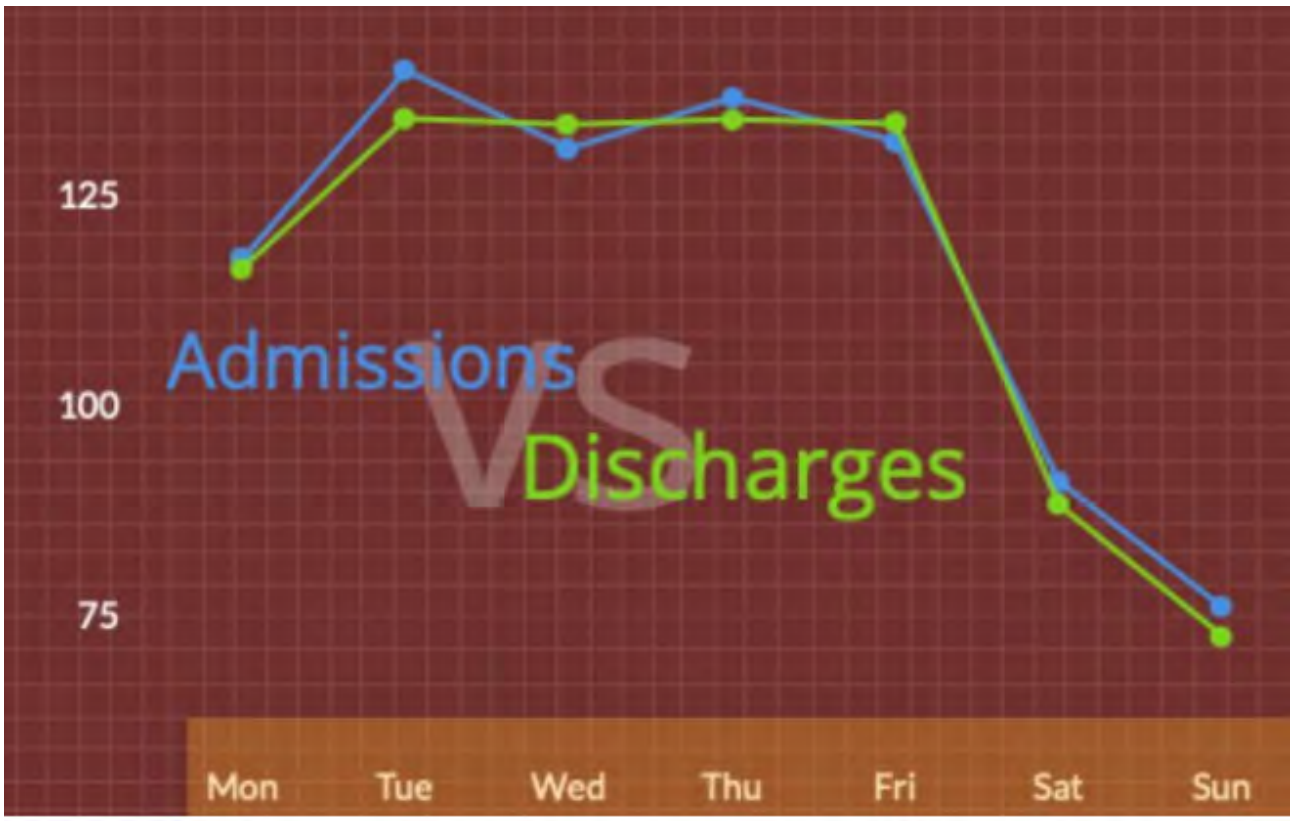
Missed deterioration
Cause Celebre, but also our ability to predict the future and prevent collapses.

Deconditioning
Long stays cause harm. Elderly patients loose strength are increasingly less able to return home.

These are all issues we have highlighted in the weekly deaths audit. Each comes with their own stories.

Admissions Vs Discharges

Everyone knows that weekends are quieter. What is odd is the perfect balancing of discharges with admissions. It is almost like we only discharge enough people to cope with the admissions, or, we only admit as many people as there are beds. Those can both be true but amount to the same. Chart4 shows the number of admissions and discharges per day in 2024:
Chart 4: Admissions Vs Discharges

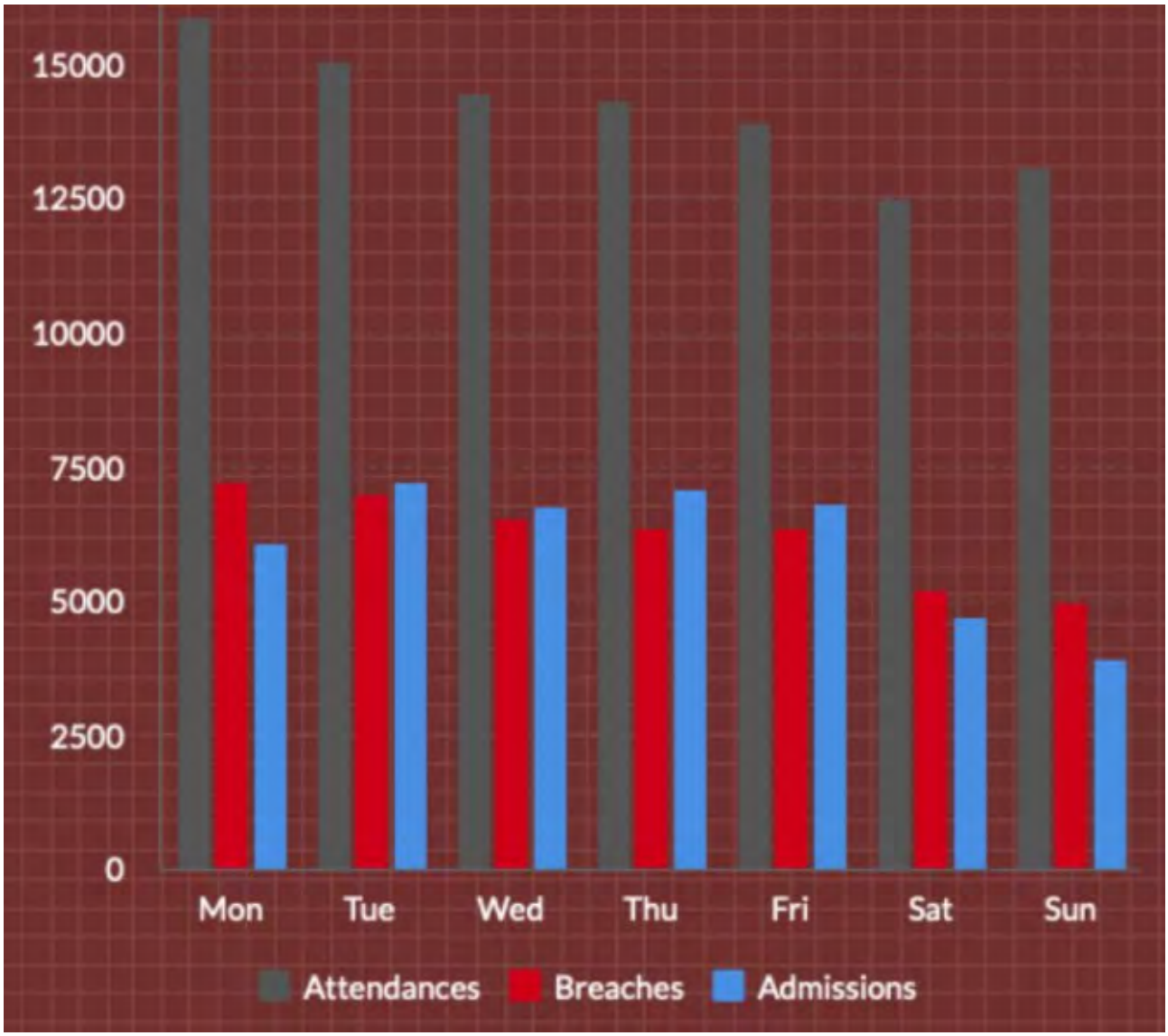


The same is true for breaches. If it is quieter, we might expect the 4 hour breaches to be a smaller proportion. They aren't. It looks like the core admission queue is much the same on all days, but our capacity to manage them is reduced at the weekend.

Inability to discharge at a weekend is a major problem to healthcare systems. Some of that maybe within our control.

Chart 5 shows the comparison on attendances/breaches and the number of admissions in 2024:

Chart 5:



What Next? Solutions to the Problems:

1. Capacity: capacity remains an issue despite the fact that we have expanded. But it's a whole system capacity that is important, not merely inpatient capacity. Better Lives Programme is assisting with system wide solution.
2. Discharge: Discharge is slower now than it was 5 years ago. Complexity is an issue, which is both the patients and the discharge system, both being addressed through Better Lives programme (admission avoidance)
3. Ambulances: Most admissions arrive by ambulance. This is the most significant queue. During the ambulance strikes, there were fewer such patients and they didn't appear in the days after, There are admissions that could be prevented.
4. Senior Review: The strikes this year have given a repeated experimental opportunity to understand the effect of putting Senior Doctors as first decision makers. There is some evidence that it reduces length of stay but it has a significant impact on other areas (elective work at significant cost)
5. Care of Out Hospital: Virtual Wards work. Care at home is possible and more common this year. For elderly people, it is essential if we are to reduce their deconditioning in hospital.

Solutions are not going to be simple. We have work commencing across the Healthcare Economy with Newton Europe (Better Lives Programme). It is the best chance we have of getting to the solutions.