# Board of Directors - Public meeting

*Wed 01 October 2025, 14:00 - 16:15*

**Boardroom, Trust Headquarters**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

## Agenda

1 min

### 10. Declarations of Interest

*Information* *Francine Thorpe*

Verbal item

#### 10.1. Register of directors' interests

*Information* *Francine Thorpe*

Public - Directors DoIs - Oct 2025.pdf (3 pages)

1 min

### 11. Minutes of the previous meeting

*Approval* *Francine Thorpe*

Minutes_Board of Directors - Public Meeting _060825.pdf (8 pages)

2 min

### 12. Action Log

*Discussion* *Francine Thorpe*

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

4 min

### 13. Research story

*Information*

Video to be shared during the meeting.

5 min

### 14. Chair’s report and stakeholder update

*Information* *Francine Thorpe*

Anti-Racism Board statement D2.pdf (1 pages)

12 min

### 15. Chief Executive's report

*Information* *Mary Fleming*

CEO Board Report_October 2025_Public FINAL.pdf (4 pages)

20 min

### 16. Committee chairs' reports

*Information* *Non Executive Directors*

#### 16.1. People Committee

*Information* *Mark Wilkinson*

*To follow*

### 16.2. Research Committee

*Information* *Clare Austin*

Reserach Committee Sept 25 Triple A report.pdf (1 pages)

### 16.3. Quality and Safety

*Information* *Mary Moore*

25 09 AAA Q&S Sept MM.pdf (2 pages)

### 16.4. Audit Committee

*Information* *Simon Holden*

AAA - Audit Committee - 24 Sep 2025.pdf (2 pages)

### 16.5. Finance and Performance

*Information* *Julie Gill*

*To follow*

30 min

## 17. Integrated performance report

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

IPR_M5_2526.pdf (24 pages)

10 min

## 18. Board Assurance Framework

*Decision* *Steve Parsons*

*To follow*

10 min

## 19. Finance report

*Information* *Tabitha Gardner*

Board Cover Sheet - Finance Report M5.pdf (3 pages)
Trust Finance Report 25-26 August Month 5 Board.pdf (14 pages)

10 min

## 20. Partnerships report

*Assurance* *Richard Mundon*

Trust Board - Partnerships Report October 2025.pdf (7 pages)

10 min

## 21. Update- University Teaching Hospital status

*Assurance* *Sanjay Arya*

*To provide assurance on the current position*

University Hospital Status Progress Report Oct 25 Final.pdf (6 pages)

5 min

## 22. Annual complaints report

*Information* *Kevin Parker-Evans*

Complaints PRD annual final June 2025.pdf (19 pages)

2 min

## 23. Reflections on equality, diversity and inclusion

*Discussion* *Francine Thorpe*

Verbal item

2 min

## 24. Chair's closing remark

*Information* *Francine Thorpe*

Verbal item

*Board members are asked to advise at the earliest opportunity and in advance of the meeting should they have queries on the items listen under the consent agenda*

# Consent Agenda

0 min

## 25. Maternity reports

*Information*

- CNST update Report Sept 2025.pdf (7 pages)
- Perinatal Quality Oversight Briefing Report.pdf (7 pages)
- NNU Staffing Paper August 2025 MIS Safety Action 4 Final .pdf (17 pages)
- Maternity Dashboard Report - August 25.pdf (10 pages)
- Maternity Dashboard - August 25.pdf (3 pages)

0 min

## 26. EPRR Core Standards report

*Information*

- 250923 - Board Report on NHS EPRR Core Standards 2025.pdf (4 pages)
- EPRR Statement of Compliance 2025-26 - TRUST.pdf (1 pages)

0 min

## 27. Date, time and venue of the next meeting

*Information* *Francine Thorpe*

3 December 2025, 2pm, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Directors' declarations of interest |
| **Presented to:** | Board of Directors |
| **On:** | 1 October 2025 |
| **Purpose:** | Information |
| **Prepared by:** | Head of Corporate Governance and Deputy Company Secretary<br>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<br>Governor, Learning Training Employment (LTE) Group<br>Non-Executive Director, Home Group Housing Association<br>Spouse is The Rt Hon Lord Bradley of Withington |
| **GILL, Julie** | Nil declaration |
| **HOLDEN, Simon** | Chairman of Governors, Pear Tree Academy School<br>Director, Simon Holden Associates Limited (CRN: 09546681)<br>Non-Executive Director, LocatED Property Ltd (No: 10385637) |
| **MOORE, Mary** | Nil declaration |
| **WILKINSON, Mark** | Non-Executive Director and Vice Chair, Bolton At Home Ltd<br>Non-Executive Director, Mastercall Healthcare<br>Governor, Edge Hill University<br>Director and shareholder, Fairway Consulting Services Ltd (CRN: 13767002)<br>Wife employed by Lancashire County Council public health department<br>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.<br>Undergraduate Clinical Lead in Cardiology, Edge Hill University.<br>Honorary position on the Advisory Panel at Bolton University Medical School (non-remunerated)<br>Director, High Bank Grange (Bolton) Residents Association Limited (CRN: 04300183) (non-remunerated)<br>Spouse is General Practitioner in Bolton<br>Medical Director, Centre for Remediation, Support and Training (CRST) at Bolton University (voluntary)<br>Executive Committee member, British International Doctors Association (UK) (non-remunerated)<br>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<br>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)<br>Honorary Senior Clinical Lecturer at Edge Hill University |

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

# Board of Directors - Public Meeting

*Wednesday 6 August 2025, 13:30 - 16:15*

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

## Attendees

### Board members

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

Absent: Mary Moore (Non-Executive Director), Juliette Tait (Chief People Officer), Francine Thorpe (Non-Executive Director)

### In attendance

Nina Guymer (Head of Corporate Gov & Deputy Company Secretary), Steve Parsons (Director of Corporate Governance), Member of the public 1, Member of the public 1, Member of the public 1, Member of the public 2

## Meeting minutes

### 14. Declarations of Interest

Information

Rhona Bradley

No further declarations of interest were made and the report which had been shared in advance of the meeting was noted.

### 14.1. Register of directors' interests

Information

Rhona Bradley

14.1. Directors DoIs - Aug 2025.pdf

### 15. Minutes of the previous meeting

Approval

Rhona Bradley

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

15. Minutes_Board of Directors - Public Meeting _040625.pdf

### 16. Action Log

Discussion

Rhona Bradley

The update in the action log, in respect of action 24/25 was noted, with the nurse staffing biannual review scheduled for later in the agenda.

Regarding action 76/25, Mr R Mundon advised that the final version of the Green Plan is currently being formatted by an external company and that the timeframe for completion is unfortunately longer than initially anticipated, barring any increase in fees.

The Board accepted both updates.

16. Public Board Action Log 2025.pdf

## 17. Patient Story

Information

Kevin Parker-Evans

Mr K Parker Evans summarised the story, of a patient with complex needs received inconsistent responses regarding reasonable adjustments, highlighting in the main, the actions now in place to support patients with reasonable adjustments and the efforts made by the Patient Experience and Engagement Team. Lessons learned led to:

- Community engagement events.
- IT system flags for patients needing adjustments.
- A proposed “Reasonable Adjustment Charter”.
- Emphasis on delivering services closer to home to reduce stress.
- Better use of pharmacy services

Prof C Austin asked what support will be in place to the non-clinical the staff (such as medical secretaries) dealing with requests around support relating to reasonable adjustments and he advised that consideration is being given to how to support these teams to either resolve of refer the requests.

17. EDI Patient Story April 25V1.1.pdf

## 18. Chair's comments

Information

Rhona Bradley

Lady R Bradley began by offering recognition of Prof C Austin's retirement from Edge Hill University but continuation as a nominated NED for WWL for a further few months, which would support the Trust and allow the University time to find an appropriate successor.  She went on to note the celebration of Prof S Arya receiving an OBE at Windsor Castle for contributions to medicine and diversity.

## 19. Chief Executive's report

Information

Mary Fleming

Ms M Fleming presented the report which had been shared prior to the meeting.

She was particularly pleased to highlight several staff focussed achievements:

- John Mosley who was honoured for vascular surgery contributions.
- Gideon Agbemafle being awarded 'Nurse of the Year' at the Caribbean and African Health Network Awards
- WWL being shortlisted in six Nursing Times award categories.

The Board received and noted the report, with no queries raised.

19. APPROVED CEO Board Report_August 2025.pdf

## 20. Committee chairs' reports

Information

Non Executive Directors

The reports which had been circulated in advance of the meeting were presented.

## 20.1. Quality and Safety

Information

Sanjay Arya and Kevin Parker Evans

Lady R Bradley asked when the sepsis performance is expected to improve.

Prof S Arya noted that the problem area is blood cultures and that WWL will be undertaking learning from Bolton NHS FT, who has better performance in this area

It was noted by non-executives that there is a huge amount expected of trust to deliver on maternity and reporting and regulation.

In response to a query around providing robust assurance on this Mr Parker Evans explained that work is beginning to ensure that impact is measured through triangulation of data and better use of voices instead of dashboards. He noted there there is no set requirement around reporting on culture performance but highlighted the significant impact that this has on patient harms and mortality.

20.1. AAA Q&S July.pdf

## 20.2. Finance and Performance

Information

Julie Gill

It was noted that the report would be shared in close proximity to the meeting, Mrs J Gill summarised the content.

Lady R Bradley asked about the proposals for addressing the gaps in gastroenterology.

Ms S Brennan advised that there is a transformation programme which covers this and a business case will be put to the Wider Leadership Team Meeting in the following week, which aims to ensure that WWL has the right staffing levels to consistently deliver what the organisation needs in terms of core activity in this areas.

AAA - FP - Jul 2025.pdf

## 20.3. People Committee

Information

Mark Wilkinson

Prof S Arya noted that all medics have job plans which in the main do not change from one year to another, the matter of gaining sign off for those plans is a technical part of the process and this is where the issue lies. It was noted that this is required to ensure that the job evaluation system is working in the way intended by NHSE and that colleagues are being paid appropriately.

20.3. People Committee - Jun 2025 AAA.pdf

## 20.4. Research Committee

Information

Clare Austin

Prof C Austin summarised the report which had been shared prior to the meeting. She wished to highlight that a letter received from NHSE to clarify that research work should not be impacted by the reduction in whole-time equivalent staff.

Prof S Arya noted that he is considering whether time can be allocated within job plans for staff to undertake work on commercial trials which will support income generation.

The Committee AAA reports were received and noted.

20.4. AAA - Research - Jun 2025.pdf

## 21. Integrated performance report

Information

Richard Mundon

Lady R Bradley highlighted that the summary hospital-level mortality indicator is improving with stabilisation also of hospital standardised mortality ratios.

Mr M Wilkinson queried if the organisation knows why it is improving in these areas.

Prof S Arya noted that six or seven years ago, WWL was the worst in the country in terms of these metrics. He explained the process for assessing these indicators and that outcomes aim to identify where WWL is an outlier and how it can improve on pathways identified to reduce mortality. He explained the processes put in place to improve the position, emphasising that a multidisciplinary approach is now taken.

Mr S Holden noted that the price cap compliance is down and asked if it is likely to get back to 25%. A query was raised around whether this is linked to A&E pressures.

The Deputy Chief People Officer advised that this is related to the NHSE price cap allowance to be paid to agency staff nationally. No trust excels in price cap compliance for medical staff because it is not achievable to be able to get agency locums. Whilst actions are in place to improve agency tiering and the renegotiation of rates, there is an acceptance that it is unlikely that the organisation will become compliant again.

Prof C Austin asked if it is a positive thing in the current climate to see a high vacancy rate, noting that some vacancies exist without a desire for them to be filled.

The Deputy Chief People Officer explained that every vacancy is heavily scrutinised and that managers are asked to ensure that they have explored different options to fill the roles before classifying them as vacant. It was noted that the approach is nuanced, depending on the areas that the vacancy is in, the related position on agency use, and also varying from trust to trust.

The item was concluded with clarification that the position reported in respect of vacancies will continue to be reviewed and triangulated with other data and articulated through the IPR narrative to give the board a sense of whether it should feel assured or not by the position set out.

21. Board of Directors IPR M3 2526.pdf
21a. IPR_M3_2526.pdf

## 22. Board Assurance Framework (BAF)

Information

Steve Parsons

Mr S Parsons introduced the report, noting that it has been updated to include the refreshed corporate objectives and related, revised risks, these having been reduced in number from 16 to 8. He explained that there has been a request for the document to be simplified and made easier to use and that he will be carrying out an exercise to review the BAFs of other organisations, with an item scheduled at the Board's September 2025 workshop to discuss development further.

Mrs J Gill highlighted that the Finance and Performance Committee discussed the need to increase the finance related risk score on the BAF to 20. The difficulty with utilising one financial risk was noted given that there are three underpinning strands to this.

The Board received and noted the update.

22. BAF Report Board August 2025 v2.pdf

## 23. Finance report

Information

Tabitha Gardner

Ms T Gardner presented the report - adding for clarification that strikes are not budgeted for and would increase the deficit.

Lady R Bradley noted the need to the Board to be mindful of how the financial landscape has shifted and the impact that has on board-level leaders. She asked about the action which could or would likely be taken should the financial position committed to not be delivered.

Mr S Parsons advised that there is no statutory obligation on NHS boards to balance the budget each year and they are currently not set to receive criminal sanctions for failure to do this, however, he added that the Secretary of State has indicated that changes in leadership will be imposed where considered necessary.

Mr Wilkinson noted the detail for a mitigated an unmitigated decision and asked about how these are differentiated.

Ms T Gardner advised that the unmitigated position projects the likely outcome if the Trust continues on its current trajectory but that progress with plans is regularly reviewed by the executive team and where plans are falling behind, mitigating steps will be out in place, such as increasing pace, to regain the progress made.

The Board heard that there would also be consideration given to utilising less favourable approaches to cost saving if this was deemed unavoidable.

The Board received and note the update.

23. Board Cover Sheet - Finance Report M3.pdf
23a. Trust Finance Report 25-26 June Month 3 Board.pdf

## 24. The NHS 10-Year plan

Information

Mary Fleming/Richard Mundon

Mr R Mundon provided slides to summarise the key points from the government's launch of the 10 Year Health Plan for England. The plan includes three major shifts: from hospital to community, analogue to digital, and treatment to prevention.

Mrs AM Miller advised as to an upcoming meeting for NHS Communications Directors and commented upon how positive this is in terms of ensuring that they are engaged to support the promoting of the 10 year plan and helping to drive it forwards. In particular, she noted the role of organisations in helping the public to become better informed and also, working with local media to share messaging with residents.

The progress made by the Wigan Borough thus far was noted and it was appreciated that this does align with the 10 year plan's priorities. Ms S Brennan noted upcoming meetings with primary care colleagues, an area where a little more focus and development is required although the positive working relationship between the Trust and GPs locally was noted.

The Board received and note the update.

## 25. Safe nursing staffing biannual report

Information

Kevin Parker-Evans

Mr K Parker- Evans shared some slides to support the item. He noted that the outcomes and recommendations within the report must be guided by professional judgement and the agreed approach of the Board moving forwards. He highlighted that staff are being engaged with in early course around the inevitable need for them to cover work in other areas during the period of winter pressures.

It was appreciated that staff understandably do not like being moved to work in less familiar areas and Mrs M Fleming sought assurance on how staff's voices are being considered in that regard.

Mr K Parker- Evans felt that early communication would mean this feels different to staff and would set out the rationale for it. Further, a passport would be developed to support the staff moves, with staff not being moved to areas outside of their scope of practice and also being buddied up with a colleague working in the area that they have moved to.

Mr M Wilkinson asked about community staffing and when this is likely to be in the right position, given, in particular the guidance within the 10 year plan.

Mr K Parker- Evans advised that in March 2026 the new community safe care tool is to be launched but in the meantime, WWL will make efforts to carry out work to improve the staffing provision here. He wished to highlight that the recommendations come down to professional judgement, the report indicates that WWL is operating safely so a review will take place once the awaited national guidance is received.

The Board **ACCEPTED** the recommendations.

25. Bi Annual Safe Nurse Staffing Review March 2025.pdf

### 25.1.

## 26. Maternity

Mr K Parker- Evans shared some slides to support the item. He highlighted that the Trust remains fully compliant with one-to-one care in labour and maintains a supernumerary delivery coordinator. A Birthrate Plus review is expected in Q3, and 13 newly qualified midwives are ready to be appointed if vacancies arise.

Examples of good practice were shared, such as midwives proactively supporting each other across departments, demonstrating flexibility and teamwork. The Board noted the strong collaboration which has helped focus attention on maternity safety and workforce planning.

The Board received and noted the reports which had been shared in advance of the meeting, it **ACCEPTED** the recommendations. made therein.

### 26.1. Maternity Biannual staffing report

26.1. Maternity 1st Biannual Staffing Report July 2025 v2.pdf

### 26.2. CNST Board update

26.2. CNST BOARD REPORT UPDATE - July 20025.pdf

## 27. Freedom to Speak Up (FTSU) Guardian's report

**Information**

Ms S Morgan joined the meeting virtually to summarise the report which had been shared in advance of the meeting. She began by advising that the National Guardian's Officer will be transferring in to the Department of Health and Social Care, which would likely result in changes to the service but that there has been a commitment to support local guardians in terms of continuation.

Ms M Fleming asked if she suspects that the numbers of cases have reduced due to the education and training delivered and wondered if there was any indications around this.

Ms S Morgan agreed to keep this under review.

Prof C Austin asked how assurance is provided that the themes are issues raised are closed off and it was noted that this would be reported through the People Committee.

Mr K Parker-Evans observed that a culture report would be helpful, as would further insight around which protected groups are raising concerns and where concerns related to patient safety.

Ms M Fleming suggested that Mr K Parker-Evans leads on this piece of work.

Prof S Arya asked that themes amongst anonymous concerns are identified and it was noted that this will be monitored and reported the next time around.

Ms S Morgan noted plans to benchmark against other trust suggested that themed case studies are included in the report for the next meeting, which the Board agreed would be helpful in terms of providing assurance around the issues raised.

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

27. FTSU Annual Report 2024-25 for Board 060825 v2.0.pdf

## 28. Reflections on equality, diversity and inclusion

**Discussion**

Rhona Bradley

The Board reflected on how their discussions had reflected upon equality, diversity and inclusion, listing in particular the report content and discussions relating to

- Safer staffing and fair, supported promotion of colleagues
- Job evaluation
- The patient story
- Maternity
- FTSU
- External recognition around the work of Prof S Arya and Mr Agbemafle
- The 10 year plan aim to widen inequalities

# Consent Agenda

## 29. Maternity Dashboard Reports and Dashboard

**Information**

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

29. Maternity Dashboard Report - June 25 final.pdf
29a. Maternity Dashboard - June 2025.pdf
29b. Perinatal Exception Report - June 2025.pdf
29c. Perinatal Dashboard - June 2025.pdf

### 29.1. CQC Picker Action plan

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

## 30. Annual Summary of Deaths

**Information**

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

30. Deaths Audit Summary 2024 (003).pdf

## 31. Date, time and venue of the next meeting

**Information**

1 October 2025, 1.15pm, Trust Headquarters

# Action log: September 2025

| Date of meeting | Minute ref. | Item | Action required | Assigned to | Target date | Update |
|---|---|---|---|---|---|---|
| 02 Jul 2025 | 76/25 | Green Plan | Re-Submit the finalised Green Plan for the consent agenda | R Mundon | Pending | Deferred due to availability of external design support. |

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

**Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust**

**Board statement of commitment to becoming an Anti-Racist organisation**

The Trust is committed to becoming a fully anti-racist organisation, embedding this ambition across strategic, operational and cultural domains. Our approach is guided by the NW BAME Assembly Anti-Racist Framework and aligned with NHS England's high-impact actions.

Our commitment is firmly embedded within our newly published People & Culture Strategy and as a Board we assure ourselves of progress against these goals through the following mechanisms-

- Monitoring progress through the EDI Steering Group, with oversight from the Board's People Committee;
- Having dedicated work-streams, including Anti-Racist Framework; Civility and Respect; Inclusive Recruitment; and Health Inequalities. These work to reduce disparities, improve experience and foster a culture of belonging
- Hearing, and listening deeply to, the staff voice and the uncomfortable messages it provides to support improvement.

There is also regular reporting to and challenge to improve by the Board as a whole; and we remain committed to development in this area. The Board has challenged itself, and individual Directors, about how we can both personally and organisationally become anti-racist, together with challenging ourselves to go further and faster to address and eliminate health inequalities.

Through transparent reporting, regular Board assurance and inclusive leadership we are pushing to drive meaningful change.

| | |
|---|---|
| **Title of report:** | Chief Executive's Report |
| **Presented to:** | Board of Directors |
| **On:** | 01 October 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**

There are no financial risks associated with this report.

**Legal implications**

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

**People implications**

There are no people risks associated with this report.

**Equality, diversity, and inclusion (EDI) implications**
There are no EDI implications in this report however it does describe our commitment to being an anti-racist organisation and celebrates our diversity.

**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.

**NHS National Oversight Framework**
Following the recent publication of the NHS National Oversight Framework I want to acknowledge WWL's current position and how it marks an important step forward in making local NHS provider performance more transparent to the public. The new framework describes a consistent approach to assessing Integrated Care Boards (ICBs) and NHS Trusts and Foundation Trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

In this first cycle, WWL has been placed in segment three of the framework, ranking 92nd out of 134 Trusts. This reflects the significant operational and financial challenges we are actively addressing this year. Despite these pressures, we have made strong progress in several areas such as enhanced 62-day cancer referral-to-treatment times, improved productivity, meaning we are seeing more patients for every pound we spend, and the ongoing programmes to reduce waiting times for urgent and emergency care, elective operations, and diagnostics. We are ahead of plan to deliver the NHS standard of treating patients within 18 weeks of referral, and over the past two months, we have seen improvements in our Emergency Department for both four-hour and 12-hour waits, with the best performance against the four-hour standard for three years.

I am proud of the dedication and hard work of our staff and partners, whose efforts drive these improvements, and we also appreciate the valuable feedback and involvement from our patients and community members, which guide our ongoing work. Patient safety is always our highest priority, as shown by our positive hospital mortality indicators. We are committed to putting patients at the centre of our improvement plans, ensuring everyone in our community receives high-quality, compassionate healthcare, now, and in the future.

**Better Lives and Winter Planning**
Our Better Lives programme continues to provide us with green shoots, contributing to the latest improvements to the reduction in our Emergency Department wait times. This programme is a tripartite agreement between the Trust, the Council, and the Integrated Care Board, designed to enable residents, particularly older and frail individuals, to remain in their homes rather than be admitted to hospital beds. This approach not only supports necessary improvements in urgent and emergency care but also enhances residents' ability to live independently, thereby contributing to a higher quality of life. The 'All Roads Lead to Home' workstream is piloting a new way of working in relation to discharge planning, identifying patients who will need support on discharge and putting plans in place before patients become medically fit.

The work to date and planned for our Better Lives programme is an essential component of our Winter Plan 2025/26, which received approval from the Board of Directors in September. Our robust preparations are prioritising efforts to increase staff uptake of flu vaccinations, clear escalation protocols to ensure safe and efficient service delivery, and maintain a collaborative approach to managing any peaks in demand with our system partners to support the residents of Wigan Borough throughout the winter period.

**JAG Accreditation at Leigh Infirmary**
WWL recently announced that the endoscopy unit at Leigh Infirmary has achieved full accreditation by the Joint Advisory Group (JAG) on Gastrointestinal (GI) Endoscopy. JAG accreditation is regarded as the national standard for endoscopy services in the UK and is awarded following a comprehensive quality assurance program that evaluates services against an established set of criteria. This process ensures that the Trust is providing care that meets recognized benchmarks for safety, quality, and patient experience.

Congratulations are extended to the Leigh Infirmary team on achieving this accreditation. JAG accreditation signifies an independent measure of quality, indicating to endoscopy patients that the service has met high national standards for safety, effectiveness, and patient care. This achievement also aligns with the Trust's aim to maintain ongoing improvements in service

provision. The accreditation process included an extensive review of all aspects of the service, including clinical protocols, staff training, decontamination procedures, and patient pathways. The team was required to demonstrate adherence to a wide range of standards through thorough preparation, detailed audits, and collaboration among all involved parties.

**Recognition of Our People and Services**
Last month, Helen Titu, Wigan's first Cardiology Nurse Consultant, received the Chief Nursing Officer for England Gold Award, marking the first time this award has been given at WWL. Helen has more than 20 years of experience and has developed nurse-led thrombolysis and changes in cardiac care delivery. She is currently completing a Health Education England internship focused on early identification of heart disease risk factors, with potential impact on the local population. Gideon Agbemafle, a Global Majority Practice Development Nurse within WWL's Professional Education Team, also received a CNO Silver Award. Both Helen and Gideon were recognised for their contribution to nursing. The Chief Nursing Officer, Duncan Burton, stated: "Helen and Gideon embody what it means to be nurses. They are compassionate leaders, making real changes for their patients and communities, and supporting changes and wider improvements across the NHS."

In other national recognition, Emma Addie, WWL's Associate Chief Nurse for Education, Workforce and Professional Practice, has been shortlisted for a HSJ Awards 2025 for Clinical Leader of the Year - the only representative of a Greater Manchester Trust in that category. A senior clinical leader at WWL, Emma has led many pivotal nurse-led initiatives and has pioneered Nursing Associate apprenticeships in care homes. Her investment in staff development and patient safety training has driven continuous improvement within the Trust, and she is a much respected and highly valued member of the nursing workforce. One such initiative that Emma has been leading from the front on is the 'Passport to Progression' project, developed to address the underrepresentation of global majority nurses in senior NHS roles. Despite bringing extensive clinical and leadership experience from their home countries, many of these nurses faced systemic barriers to advancement within the NHS. At WWL, Emma and her team created a bespoke, supportive development pathway that recognised and built upon their existing expertise, enabling them to transition confidently into leadership roles. The programme has sparked wider cultural change, encouraging open dialogue about equality and inclusion across the Trust, and its success has led to plans for expansion, with future cohorts open to all nursing staff groups for progression opportunities. Award results will be announced in November.

**Wigan Pride**
WWL was once again proud to be involved in this year's Wigan Pride event as it celebrated its 10th anniversary. As a dedicated supporter, WWL staff shared in the celebrations of equality, diversity and inclusion for all. Over 30 colleagues, including Executive Members and Trust Governors, proudly marched in the parade along with our Three Wishes Charity Mascot, Albert the Bear, all carrying NHS banners, flags and rainbows. A big thank you to everyone who supported and got involved on the day, and to UNISON for providing funds towards sponsorship and goodies to hand out. Pride has become a firm fixture in Wigan and Leigh over the past 10 years - bringing thousands together in joy and celebration. But more than that, Pride is a statement. A statement of love, of visibility, of unity, and commitment to building a borough where everyone feels safe, valued, appreciated and that they belong.

**Statement on Anti-Racism, Violence, and Harassment**
On this important point about feeling safe, WWL is an organisation committed to equality, compassion, and excellence in care. We reaffirm that WWL stands firmly as an anti-racist organisation and does not tolerate any form of racism, violence, or harassment towards our staff. Every member of our workforce deserves to feel safe, respected, and valued in their place of work. We are actively strengthening our policies, procedures, and support systems to ensure that all staff - regardless of role, background, or identity - have a safe and inclusive environment from which to deliver the highest standards of treatment and care. Our commitment is clear: discrimination and abuse have no place in our organisation.

# Committee report

| | |
|---|---|
| **Report from:** | Research Committee |
| **Date of meeting:** | 2nd September 2025 |
| **Chair:** | Professor Claire Austin |

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

**ALERT**

- The Committee failed to have a quorum to discharge business, for the second meeting in a row. The members suggest to the Board that a further Non-Executive Director is appointed to the Committee to ensure that it can reach and maintain a quorum.
- The members draw the Board's attention to the recent changes in the methodology for funding and the RDN
- The members will be seeking assurance that appropriate colleagues, in all disciplines, have sufficient time allowed within their working plans to undertake research in accordance with the Trust's policies; and that there is sufficient resources to progress grant applications in a timely and appropriate manner. The Committee have requested that ETM considers this question.

**ASSURE**

- The members welcomed that the Research Assurance Framework continued to show good performance, with good recruitment of patients to participate in trials.
- Members welcomed the presentation made on research being undertake by non-medical advanced practitioners, and the clear levels of engagement and enthusiasm shown

**ADVISE**

- The members welcomed the partnership in the Commercial Research Delivery Centre, but noted the need to encourage more commercial research across the Trust.
- The members noted the desirability of having greater visibility for research work, and communication of the successful outcomes of research that supported patient care.
- The members noted the scale of opportunities that have been presented through the Research Network

**RISKS FOR ESCALATION**

None

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# Committee report

| | |
|---|---|
| **Report from:** | Quality and Safety Committee |
| **Date of meeting:** | 17 September 2025 |
| **Chair:** | Mary Moore |

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

**ALERT**

- **Board Assurance Framework** A review of the BAF highlighted current performance on timely admissions for hip fracture patients is low, prompting agreement to develop and monitor an improvement plan**.** Prof S Arya agreed to coordinate this with the divisional leads and update Q&S on whether key patient groups (heart attack, stroke, acute abdomen, fracture neck of femur) are admitted to the correct wards.

**ASSURE**

**Patient Story – General Medicine Division** presented a story of a patient with a profound stroke and demonstrated assurance of a cohesive multi-disciplinary team approach which resulted in significant recovery, positive outcomes, enabling a return to her own home.

**Divisional highlight report: Maternity, child health and neonatal** This comprehensive report demonstrated positive assurance in the understanding and mitigation of key risks and progress against plans. The division addresses health inequalities through targeted data analysis and initiatives like smoking cessation workshops for deprived groups, achieving 99% compliance with the Saving Babies' Lives Care Bundle. The ATAIN (Avoiding Term Admissions in Neonates) audit identified that increased C-section rates contribute to neonatal admissions (a national trend also) however the committee was assured that reducing admissions did not impact skills and competence maintenance for the unit meeting the necessary respiratory care days.

**Harm free care quarterly report** positive trends in reducing pressure ulcers and falls, with improvements prevention and data use, the Committee noted a slight rise in infections associated with emergency department pressures.

**Patient Safety Incident Response quarterly report: themes, trends & learning** The Committee received and noted the report and the assurance provided therein. Reassurance was sought that whether, in the transition to PSIRF, any learning was being missed, referencing national concerns raised by coroners. Positive assurance was subsequently received following an internal audit by MIAA.

Several reports addressed equality diversity and inclusion (ED&I) topics and were recommended for noting in this report highlighted. An opening reminder to consider health inequalities and ED&I focused the discussions, and that the meeting appropriately addressed these elements.

**ADVISE**

**Escalation Patient Safety Assurance Insight report** The Committee were presented with the dynamic dashboard's role in monitoring patient safety during escalation and highlighted the need for ongoing oversight to ensure reduced escalation spend does not harm care quality. The dashboard demonstrated ability to analyse multiple metrics, and breakdowns by location, age, and ethnicity. She explained how it tracks incidents, capacity, and protocol adherence.

**Biannual mortality/learning from deaths report the** report highlighted that Wigan's population has a lower average age at death compared to wealthier areas, reflecting significant health inequalities.

- Over half of patients who died waited more than 24 hours in A&E, which delays care and is a recent trend
- About 16% of deaths reviewed involved patients who might have been better managed outside hospital, often with advanced care plans.
- Four cases were identified as potentially preventable deaths and will be further investigated.
- The mortality review process aims to prompt reflection and improvement by sharing findings with the organisation weekly

The committee agreed the mortality data, particularly regarding patients in A&E who should not be there, would be useful for the Better Lives programme.

This data is presented annually to Board in June.

**IPC Annual report** Flue vaccinations are ongoing with many initiatives in place to offer a high level of take up. Chief Nurse is organising opportunities for Board Members.

C-diff remains a concern with work ongoing to rationalise testing to exclude symptomless patients. A ward closure has increased the opportunity for decanting and deep clean of other wards.

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

Key risks include the maternity information system, with a new system in progress, and ongoing priorities are reducing inequalities, improving patient flow, and leadership development.

Right Patient Right Place (see alert)

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# Committee report

| | |
|---|---|
| **Report from:** | Audit Committee |
| **Date of meeting:** | 24 September 2025 |
| **Chair:** | Simon Holden |

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

**ALERT**

- An outstanding audit recommendation relating to Patients property, from an internal audit in 2023/24, still remains outstanding, and unresolved (although a new timeframe has been agreed).
- The Data Security & Protection Toolkit (DSPT) Audit for 2024/25 was received, with thanks expressed, and Action Plan noted.
- The new failure to prevent fraud offence, part of the Economic Crime & Corporate Transparency Act, came into effect on 1 September 2025.
- There were 69 cases of Losses & Special Payments totalling £105,000 in the first 5 months of 2025/26, compared with 25 cases and £51,000 for the similar period in 2024/25.
- Three new risks raised concerns, as they all reportedly had the potential to cause patient harm (i.e. rheumatology nursing, point of care testing & prolonged stay in the waiting room), with further deep dives being requested.

**ASSURE**

- Further Audit work is being jointly commissioned with Bolton FT, from MIAA & Local Counter Fraud in order to better understand any gaps in processes with regards the new failure to prevent fraud offence.
- The review by MIAA of the Patient Safety Incident Response Framework (PSIRF) received a substantial assurance (plus also refreshing to see this item was included within the recent Team Brief, to raise awareness).
- The Trust has self-assessed as meeting the national Counter Fraud Standards for 2024/25, and work continues in several areas (including staff attendance policy, National Fraud Initiative etc.).
- The completion by the Trust, of the MIAA Artificial Intelligence (AI) Checklist, noting the strong foundations in place and existing governance measures for adopting AI, although recognising the need to ideally develop an ethical framework to support further roll out.

- The Committee noted the additional assurances gained from the deep dives into two previous risks, namely: Improving Quality in Psychological Services (IQIPS) Accreditation, and the lack of suitable space in ICU for essential equipment and confidential discussions.

**ADVISE**

- MIAA are rotating their audit managers, in line with best practice.
- Assurances on the implementation of the Fuller Report recommendations will be led by the Quality & Safety Committee (and not by the Audit Committee).
- An advisory report was received on waiting list initiative operation, which had been requested by management, with recommendations made (noting the WLI spend of circa £5.3m in 2024/25).
- MIAA continue to make good progress with the annual audit plan, with EPRR, appraisals, cash management, consultant job planning & esr/payroll all in the fieldwork stage, and with no changes made to the original plan.
- The Trust has processed £1.0 of Waivers, in the first 5 months of the financial year, on 17 individual Waivers. This compares favourably with £2.5m on 62 Waivers for a comparable period in 2024/25.
- The new salary sacrifice policy was reviewed and approved (noting this was a recommendation from a previous Audit Report).

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

- Nothing in addition.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

# 25/26 Integrated Performance Report

## Meeting presented to:

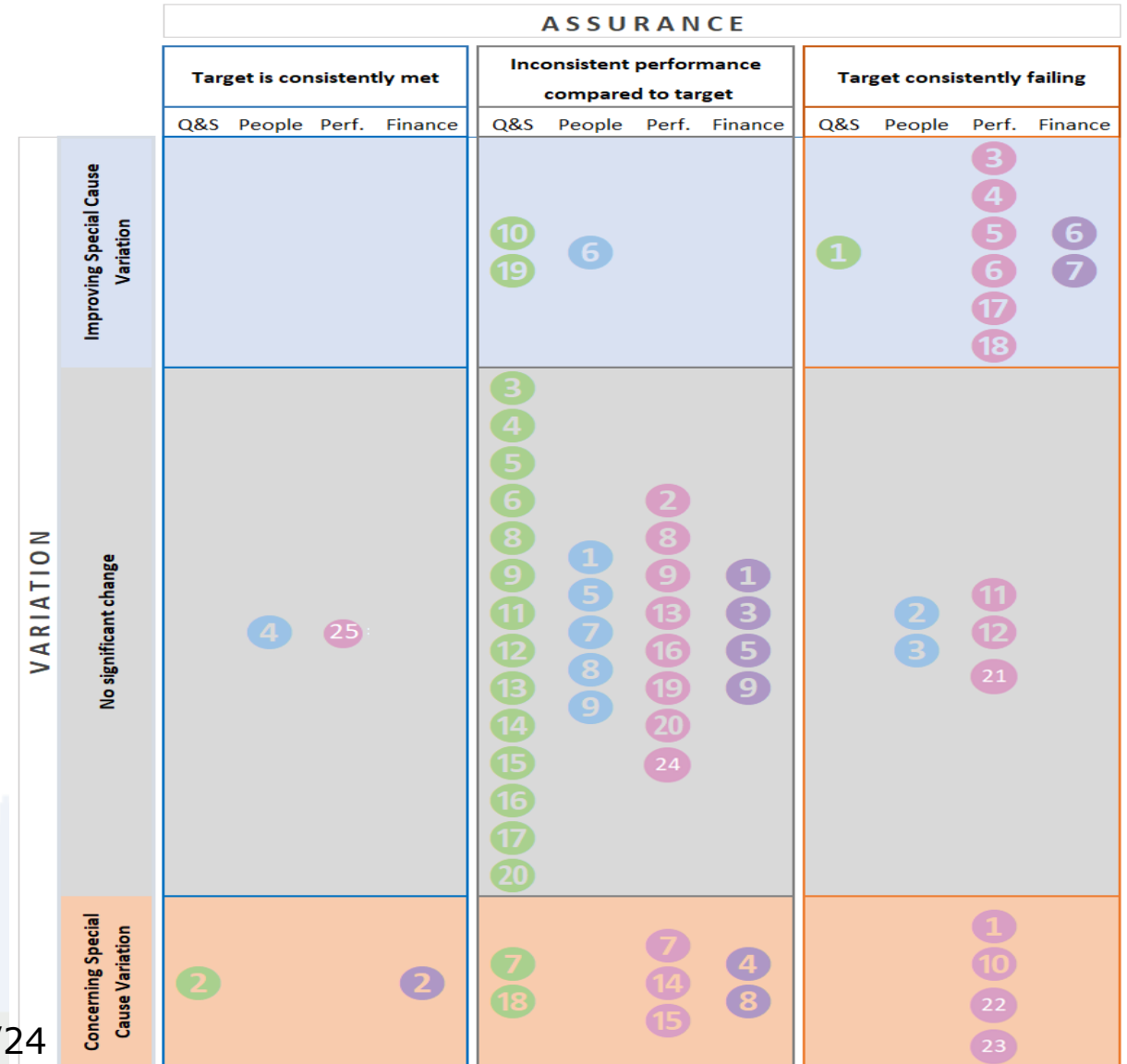
## Board of Directors : 01/10/2025

# Contents

# Trust Matrix : M5 25/26

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

# Trust Matrix : M5 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 - Medical |
| 4 | Price Cap Compliance - Non Medical |
| 5 | % Turnover Rate |
| 6 | Vacancy Rate |
| 7 | Number of Whole Time Equivalent Posts |
| 8 | Sickness - Percentage Time Lost (%) |
| 9 | 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 cases where a patient is waiting 18 weeks or less for elective treatment |
| 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) |

# 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

| Variation | | | Assurance | | |
|---|---|---|---|---|---|
|  |  |  |  |  |  |
| Common cause – no significant change | Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values | Special cause of improving nature or lower pressure due to (H)igher or (L)ower values | Variation indicates inconsistently hitting passing and falling short of the target | Variation indicates consistently (P)assing the target | Variation indicates consistently (F)alling short of the target |

## 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<br>3 = Amber<br>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<br>3-4 = Amber<br>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<br>3-4 = Amber<br>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 | |

# Trust Holistic Narrative : M5 25/26

The National Oversight Framework metrics for quarter 1 of 2025/26 were published in September. WWL has been placed in Segment 3, with organisations in Segments 3 & 4 being subject to greater scrutiny and interventions. Many of the NOF metrics are already part of our Integrated Performance Report (IPR), and we will be reviewing future Board reporting to ensure that all key NOF measures are routinely reported alongside those which have been deemed to be important locally, to ensure we are focussed on improvement across these key areas.

Mortality metrics remain stable and within expected ranges. Our Summary Hospital-level Mortality Indicator (SHMI) improved again in Month 5 to 102.6, while our Hospital Standardised Mortality Ratio (HSMR) is 95.1, remaining below the national benchmark. There were no category 3 or above healthcare-acquired pressure ulcers (HAPUs) linked to omissions in care. Encouragingly, overall numbers continue to decline, with learning well embedded into improvement plans. Our weekly safety events groups ensure that we continue to embed oversight and learning. Two PSIRF-eligible incidents were escalated during the month, one of which related to delayed recognition and escalation of pre-eclampsia, and the other related to an administrative error resulting in a delayed listing of a patient with a carcinoma. Both incidents are undergoing PSII investigations and findings, and learning will be reviewed and monitored via LFPSE and Learning from Experience Groups.

Complaints handling has seen notable progress, with August achieving a 92.7% response rate — the highest since COVID and above our internal target for the first time this period.

Infection control remains a key area of focus. August saw instances of C. difficile and E. coli above monthly thresholds, although it is important to note that these thresholds were set based on the previous year, when infection rates were particularly low. We continue to prioritise robust surveillance and mandatory reporting of all healthcare-associated infections (HCAIs). Every case is thoroughly reviewed, with learning and best practice shared quickly across the Trust.

Workforce numbers in August stood at 6,983 WTE, 104 above plan. While substantive and agency WTEs have reduced slightly, bank staff increased by 18 WTE, accounting for the overall rise. Vacancy rates have reduced further to 3.1%, comfortably below our 5% target. Workforce grip and control actions remain firmly in place, supported by a robust Quality Impact Assessment process to ensure patient safety and service continuity are not compromised.

Appraisal compliance decreased slightly in August to 82.1%, remaining below our 90% target. Divisional action plans are in place and monitored through assurance processes. Non-medical price cap compliance remains well above the 80% standard at 92.1%, though medical compliance remains extremely low at 0.6%, reflecting ongoing reliance on high-cost locums.

Our Referral to Treatment (RTT) waiting list increased to 49,416 in August. The proportion of patients waiting over 52 weeks remains at 3.8%, above the 1% target. However, there are statistically significant signs of improvement, supported by independent sector capacity now in place. The number of 65-week breaches is low, however plastics/dermatology, ENT, gynaecology, and vascular surgery continue to be the most pressured specialties.

Cancer performance has seen some deterioration. July's 31-day performance was 92.7%, down from 94.9% earlier in the year and below the 96% standard. The 28-day standard performance remains unchanged from last month at 76.4%, and the 62-day standard saw a dip in performance to 68.6% - both of these are below the standard. Capacity challenges in colorectal and breast services have contributed to these outcomes. Diagnostic pressures in breast imaging are expected to improve, although recruitment challenges are delaying restoration of full capacity.

Emergency Department (ED) flow continues to show positive signs. Four-hour performance improved for the second consecutive month, reaching 77% in August — the highest level in three years. Twelve-hour waits also reduced, though at 15% they remain above the 10% target. Patient acuity increased in August and early September, creating sustained operational pressures. This underlines the importance of maintaining momentum in our Better Lives improvement programme.

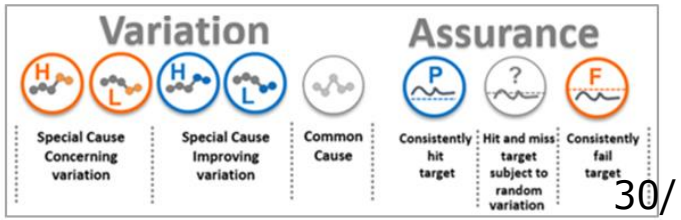
Ambulance handover times improved significantly in August, averaging 23 minutes, well below the 38-minute trajectory, following focused improvement work under the Hospital Handover 45 initiative. However, 26.8% of inpatients continue to have no criteria to reside, impacting flow across the hospital.

Financially, the Trust reported a year-to-date deficit of £1.9m at Month 5, £1.3m worse than plan. The primary driver is under-delivery of CIP, with slippage reaching £3.2m. This is a significant concern, and recovery plans are being tightly monitored through executive huddles. Cash holdings at the end of August were £16.2m, though without recovery of cash-releasing CIP there is a risk of deterioration, with potential cash support required in Q3.

# Quality & Safety Overview 1 of 2: M5 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 | Apr 25 | 102.59 | 100 | | | 104.46 | 103.24 | 105.67 | S | T | P |
| 2 | HSMR Rolling 12 Months | Jun 25 | 95.07 | 100 | | | 92.46 | 90.36 | 94.55 | S | T | P |
| 3 | Never Events | Aug 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 | Aug 25 | 2 | 4 | | | 2 | 0 | 8 | S | T | P |
| 5 | How Many Incidents Triggered a Patient Safety Review | Aug 25 | 20 | 33 | | | 26 | 1 | 51 | S | T | P |
| 6 | No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care | Aug 25 | 0 | 0 | | | 2 | 0 | 5 | S | T | P |
| 7 | Reduction in Category 2 and DTI HAPU and CAPU Overall | Aug 25 | 60 | 46 | | | 37 | 17 | 57 | S | T | P |
| 8 | 25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care | Aug 25 | 1 | 1 | | | 1 | 0 | 4 | S | T | P |
| 9 | To reduce the total number of falls per 1000 bed days | Aug 25 | 6.9 | 6.1 | | | 7.0 | 4.3 | 9.8 | S | T | P |

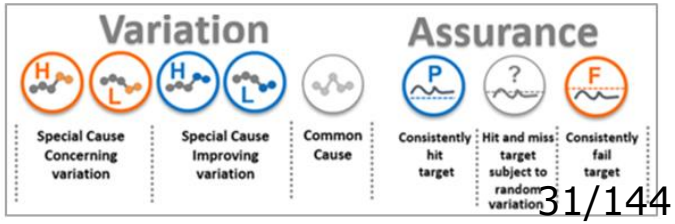
Summary icons key:



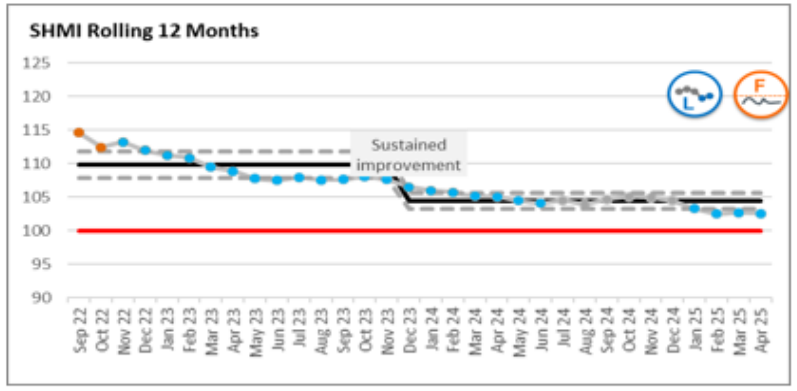
# Quality & Safety Overview 2 of 2: M5 25/26

| | 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) | Aug 25 | 0 | 0 | L | ? | 0 | 0 | 0 | S | T | P |
| 11 | Methicillin-Susceptible Staphylococcus Aureus (MSSA) | Aug 25 | 2 | 0 | | ? | 1 | 0 | 5 | S | T | P |
| 12 | WWL Clostridium Difficile (CDT) | Aug 25 | 9 | 5 | | ? | 6 | 0 | 17 | S | T | P |
| 13 | Escherichia Coli (E.coli) | Aug 25 | 5 | 3 | | ? | 4 | 0 | 10 | S | T | P |
| 14 | Klebsiella Species | Aug 25 | 0 | 1 | | ? | 1 | 0 | 4 | S | T | P |
| 15 | Pseudomonas Aeruginosa | Aug 25 | 0 | 0 | | ? | 0 | 0 | 2 | S | T | P |
| 16 | Reduction in the Number of Patients who Transfer Between Wards More Than 5 Times | Aug 25 | 8 | 8 | | ? | 7 | 0 | 13 | S | T | P |
| 17 | Mixed Sex Accomodation Breaches - Non Clinically Justified | Aug 25 | 24 | 19 | | ? | 19 | 5 | 33 | S | T | P |
| 18 | Reduction in the Number of Complaints | Aug 25 | 62 | 40 | H | ? | 42 | 20 | 63 | S | T | P |
| 19 | Complaints Responses | Aug 25 | 92.7% | 90.0% | H | ? | 68.9% | 45.8% | 92.1% | S | T | P |
| 20 | Patient Experience (FFT) - Patients who Would Recommend the Service | Aug 25 | 90.0% | 90.0% | | ? | 87.5% | 81.4% | 93.5% | S | T | P |

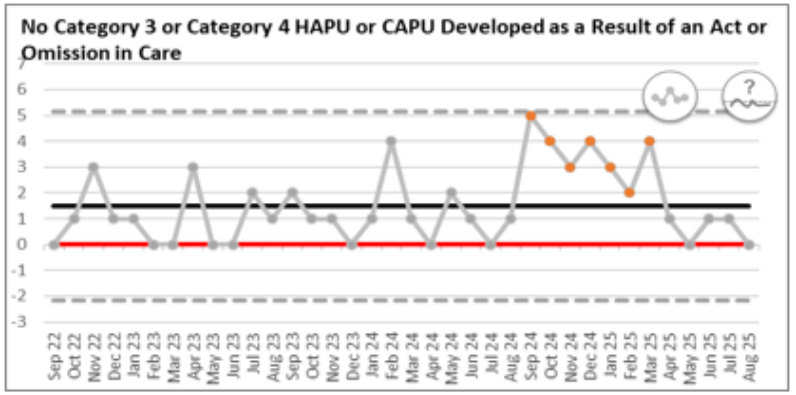
Summary icons key:



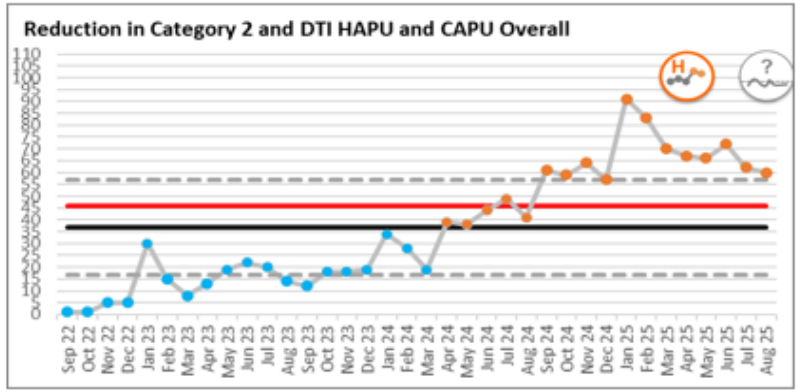
# Quality & Safety Insight Report 1 of 2: M5 25/26



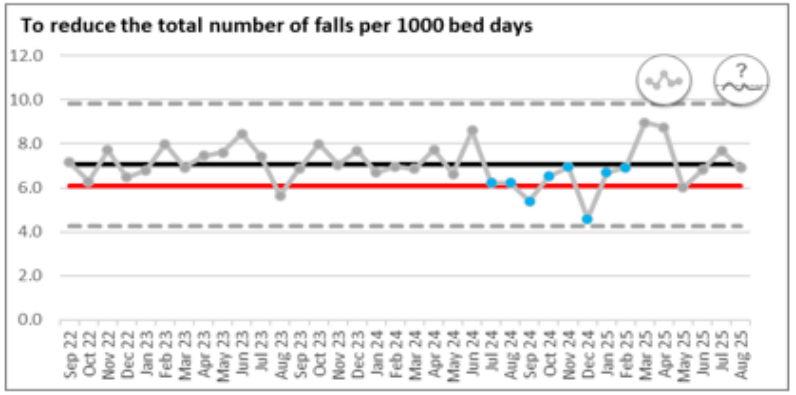

| Apr-25 |
|---|
| 102.6 |
| **Variance Type** |
| Special cause improving variation points |
| **Threshold** |
| 100 |
| **Target achievement** |
| Metric is consistantly missing the target/ threshold |




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



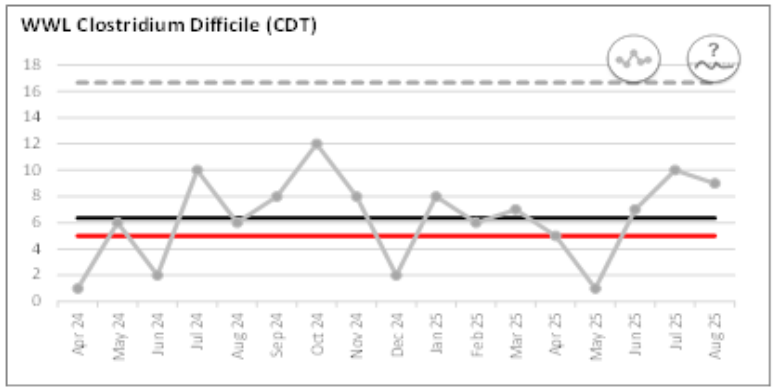

| Aug-25 |
|---|
| 60 |
| **Variance Type** |
| Special cause concerning variation points |
| **Threshold** |
| 46 |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |



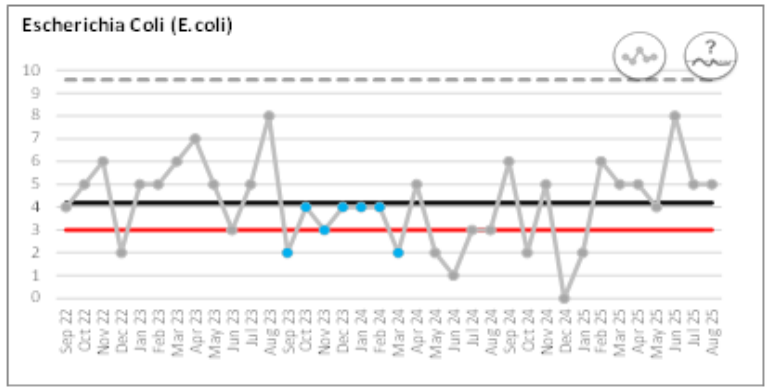

| Aug-25 |
|---|
| 6.9 |
| **Variance Type** |
| Common Cause Variation |
| **Threshold** |
| 6.1 |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |

| Summary: | Actions: | Assurance: |
|---|---|---|
| **1 . SHMI :** 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. There continues to be a reduction in SHMI over a number of months<br>**2. Pressure ulcers, omissions in care:** There were 7 historical category 3 HAPU in August 2025 that were presented to the Pressure Ulcer Panel that developed as a result of an omission or act of care. To note none of these incidents occurred in August 2025.<br>**3. Pressure Ulcers :** The number of category 2 and above pressure ulcers acquired and reported in hospital has decreased overall during month 6. In month 6 Community figures have been included.<br>**4. Falls per 1000 bed days** : the incidences of falls per 1000 bed days remains static. | **1. SHMI:** Continue improvement plans to ensure that patients are appropriately managed. Continue to work with system partners to ensure appropriate discharge placements for patients<br>**2. Pressure ulcers, omissions in care: A Trust wide comprehensive action plan is in progress and is actively monitored at the Pressure Ulcer Steering Group.**<br>**3. Pressure Ulcers :** Embed learning from the thematic reviews completed with the actions informing the overarching PU improvement work agenda<br>**4. Falls per 1000 bed days** – the falls steering and incident review groups are in place. | **1. SHMI :** SHMI is currently within national expected range 'funnel plot' and has been so for many months. SHMI continues to improve and is consistently better than some other similar sized GM Trusts<br>**2. Pressure ulcers, omissions in care**: The actions taken in response to recent thematic reviews demonstrates commitment to strengthening leadership, improving patient safety monitoring, and embedding Trust wide learning into practice<br>**3. Pressure Ulcers :** Pressure ulcer Trust wide action plan continues. It is important to note that Community have not reported an omission is care for over 24 months.<br>**4. Falls per 1000 bed days –**less falls and less falls with harm are noted; audits are in place to identify learning. |

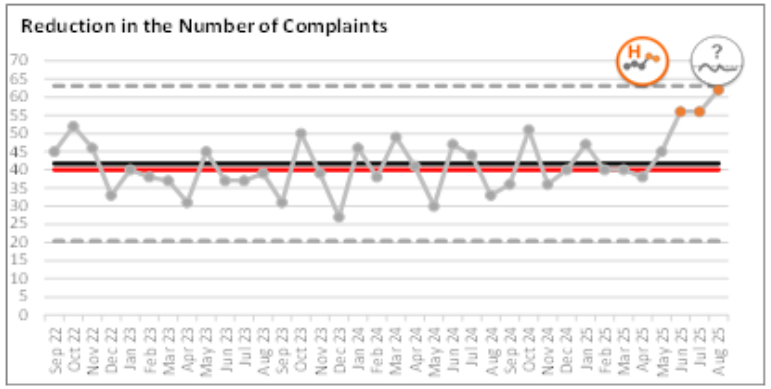
# Quality & Safety Insight Report 2 of 2: M5 25/26



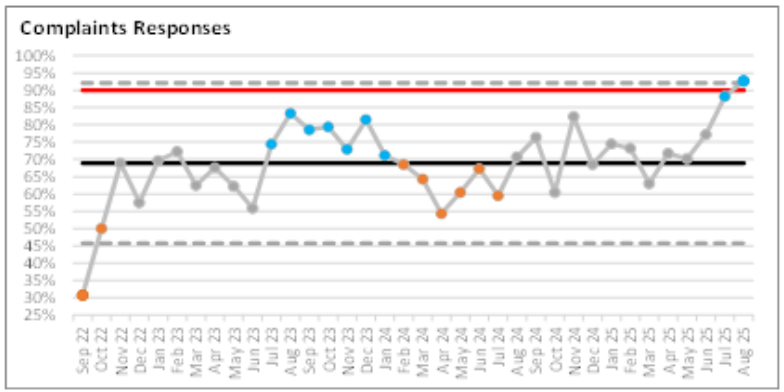

| Aug-25 |
|---|
| 9 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| 5 |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |




| Aug-25 |
|---|
| 5 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| 3 |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |




| Aug-25 |
|---|
| 62 |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| 40 |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |




| Aug-25 |
|---|
| 92.68% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| 90% |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |

| Summary: | Actions: | Assurance: |
|---|---|---|
| **1. CDT** - there was an increase in month<br><br>**2. E-Coli** – there was an increase in June, with a decrease and sustain in August.<br><br>**3. Complaints** - We have seen a continued improvement with response rate in August (92.6%).<br><br>**4. Complaints** – there has been a slight increase in August 2025. A number of these have been deescalated with early resolution identified. | **1. CDT -** 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.<br>**2. E- Coli** – cases are subject to information gathering and the review process is being progressed, aligned with the Trust HCAI / Gram negative blood stream infection (GNBSI) format.<br>**3. Complaints – Trust wide process mapping events have taken place to harness consistency with the process .**<br>4. Triangulation of themes continues and is reported via the Patient Experience and Engagement Group. | **1. CDT -** All incident themes are reported through Infection Control Groups. All Q1 cases have been reviewed, and the identified learning and good practice themes and trend information have been shared with the divisions.<br>**2. E-Coli –** All cases are subject to the review process to identify themes and trend information that will be collated and shared with all divisions.<br>**3. Complaints :** The number of compliments received has continued to exceeds recorded formal complaints<br>**4.** All complaints are reviewed at LFPSE weekly meetings, divisional group meetings and Corporate Patient Experience Group |

# Quality & Safety Narrative: M5 25/26

**SHMI / HSMR**

The Trust most up to date SHMI for the rolling 12-month period to April 2025 is 102.59 which is a slight reduction from last month and well within the 'funnel plot' for expected range. Alerting groups are reviewed within the monthly and quarterly mortality groups to ensure plans are in place for any areas of concern. WWL is consistently better performing than many other GM Trusts.

**Incidents**

In month 5, August 2025, the Trust escalated two incidents for formal investigation under the Patient Safety Incident Response Framework. The first incident related a maternity patient admitted with severe hypertension and treated for pre-eclampsia before undergoing an emergency caesarean under general anaesthetic, following which she suffered a cardiac arrest. Initial findings highlight multiple safety concerns including delayed recognition and escalation of pre-eclampsia, unclear blood pressure monitoring plans, fragmented prescribing practices, prolonged uncontrolled hypertension, and complex medication interactions. The second case related to a urology patient diagnosed with bladder carcinoma in Jan 21. Following resection in May 21, patient received immunotherapy and normal follow ups that took place that noted no recurrence in Oct 2024. Patient was due for a flexible cystoscopy in January 2025; however, due to a failure in completing the listing proforma, the procedure was not scheduled.  Delay was only identified during a follow-up clinic in June 2025, at which point the cystoscopy revealed a solid bladder tumour. Both incidents are undergoing PSII investigations and findings, and learning will be reviewed and monitored via LFPSE and Learning from Experience Groups.

**Complaints**

We continue to observe a sustained improvement trajectory in complaints response performance, with an improved response rate reaching 93% in August 2025. Fortnightly complaints oversight meetings, chaired by the Executive Chief Nurse, Associate Chief Nurse and attended by Divisional Directors of Nursing, remain a key forum for strategic support and scrutiny.
To ensure consistency across the organisation and to learn from excellent practice the Trust have hosted two process mapping events with Continuous Improvement support. This will support Trust wide improvements  with the Complaints process and reduce any duplication.

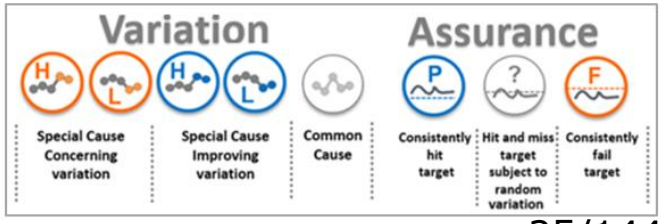
**Holistic Summary**

In August 2025, the Trust sustained an improved performance in complaints handling, resulting in achievement of 93% which is the highest this has been post COVID and escalated two incidents under PSIRF, details of which are above

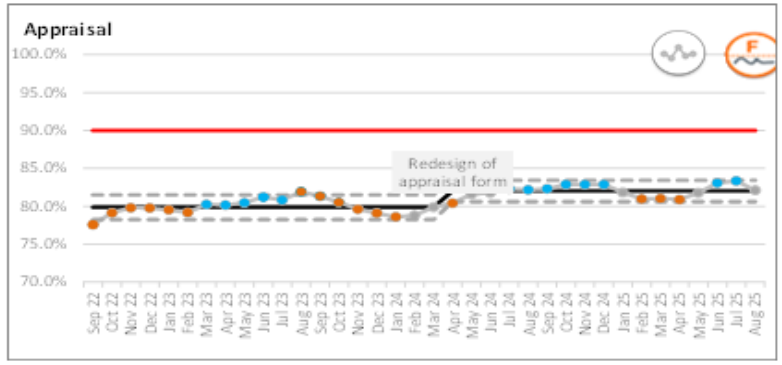
# Our People Overview : M5 25/26

| | KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit | Data Quality Indicators: Sign-off & Review | Timely & Complete | Process & System |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Mandatory Training Compliance | Aug 25 | 94.6% | 95.0% | | | 94.8% | 93.7% | 96.0% | S | T | P |
| 2 | Appraisal | Aug 25 | 82.1% | 90.0% | | F | 82.0% | 80.6% | 83.4% | S | T | P |
| 3 | Price Cap Compliance - Medical | Aug 25 | 0.6% | 60.0% | | F | 0.6% | -0.8% | 2.0% | S | T | P |
| 4 | Price Cap Compliance - Non Medical | Aug 25 | 92.1% | 80.0% | | P | 98.0% | 88.0% | 108.0% | S | T | P |
| 5 | % Turnover Rate | Aug 25 | 8.8% | 8.5% | | | 8.7% | 8.4% | 9.1% | S | T | P |
| 6 | Vacancy Rate - Variance to plan | Aug 25 | 3.1% | 5.0% | L | | 5.8% | 4.7% | 6.9% | S | T | P |
| 7 | Number of Whole Time Equivalent Posts | Aug 25 | -103.96 | 0.00 | | | -89.81 | -217.36 | 37.75 | S | T | P |
| 8 | Sickness - Percentage Time Lost (%) | Aug 25 | 5.7% | 5.0% | | | 5.5% | 4.8% | 6.2% | S | T | P |
| 9 | Time to Hire | Aug 25 | 67.7 | 65.0 | | | 58.3 | 46.4 | 70.2 | S | T | P |

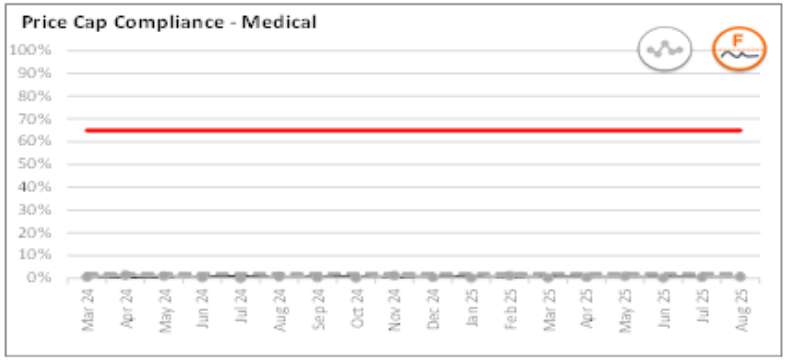
Summary icons key:



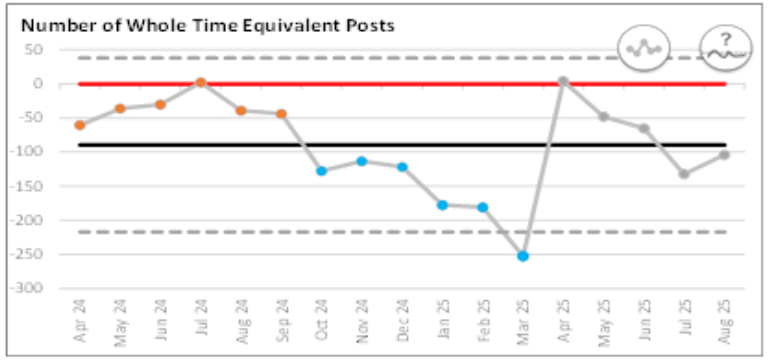
# Our People Insight Report : M5 Month Year



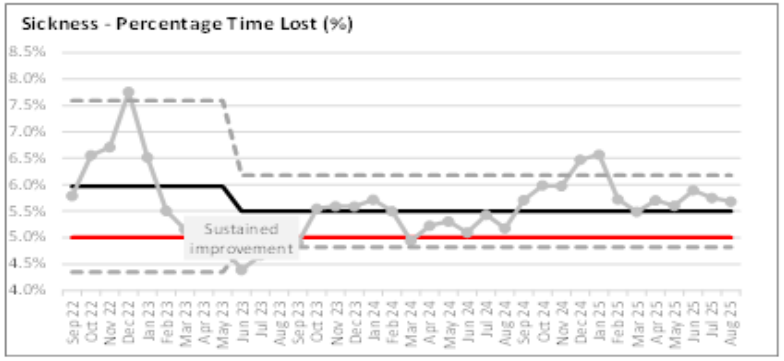

| Aug-25 |
|---|
| 82.1% |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 90% |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |




| Aug-25 |
|---|
| 0.6% |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 60% |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |




| Aug-25 |
|---|
| -103.96 |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 0 |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |




| Aug-25 |
|---|
| 5.7% |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 5.0% |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |

| Summary: | Actions: | Assurance: |
|---|---|---|
| 1. At 82.1% appraisal rates continue to remain below the target of 90%<br>2. Non medical price cap compliance continues to meet the target despite a reduction from 100% to 92% and exceeding the national target set at 80%. However, despite continuous improvement in the Medical price cap compliance to 0.6% from 0.5%, this remains a challenge and significantly below the national target set at 60%<br>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.<br>4. The total workforce WTE in July was 104 WTE above the planned workforce, whilst substantive staff in post remains above plan (+126.3WTE), both bank (-15WTE) and agency (-7.4WTE) remain below the plan | 1. Continued monitoring of appraisal completion rates through monthly Divisional Performance . Divisions have plans in place to improve compliance<br>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<br>3. Vacancy rate : Continued grip and control of vacancies through Executive Vacancy Control Panel.<br>4. Divisions continue to refine and enact workforce plans to bring about reductions. Continued scrutiny of bank and agency usage. More data is being developed by workforce and provided to the four divisions, to inform current WTE and WTE trajectory, to help better visibility and actions being taken to reduce WTE. | 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<br>2. Medical Price cap compliance monitored through Executive Medical Control Group, Wider Leadership Team and People Committee<br>3. Vacancy rate – oversight though Divisional Performance Meetings, Wider Leadership Team and People Committee<br>4. WTE reported and monitored through Divisional Performance meetings, Finance Improvement Group, Wider Leadership Team and People Committee |

# Our People Narrative : M5 25/26

**Appraisals –** In M5, appraisal compliance has decreased to 82.1%, which is below the Trust's 90% target. All divisions remain under close scrutiny through Divisional Performance Reviews, with progress monitored against local action plans.

**Price cap compliance : –** the non-medical price cap compliance continues to meet the target despite a reduction from 100% to 92% and exceeding the national target set at 80%. However, despite continuous improvement in the Medical price cap compliance to 0.6% from 0.5%, this remains a challenge and significantly below the national target set at 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.

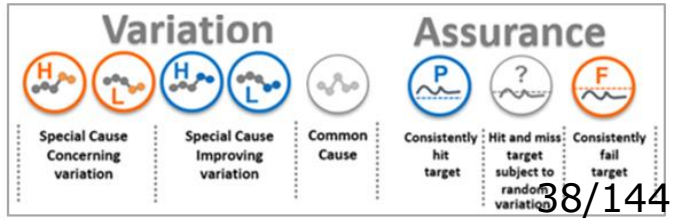
**Vacancy Rate –** The Trust-wide vacancy rate has decreased to 3.11 %, remaining below the 5% target. We started to see the impact of the recruitment hold introduced in June was still in place in July. A robust Quality Impact Assessment (QIA) process is in place to ensure any impacts on patient safety and service continuity are fully considered.

**WTE –** Actual total workforce 6,982.8 WTE in August. This is an increase of 12.8 WTE from last month and is 104 WTE above the total workforce plan of 6,878.8 WTE. Actual substantive workforce saw a slight decrease by 1 WTE but remains above the substantive workforce plan (+126.3 WTE) . Bank staffing has increase by 18WTE, driven by Nursing and Support to clinical staff, but remains 15 WTE below the plan. Agency has 4.2WTE decrease compared to last month, this remains below the plan by 7.4WTE

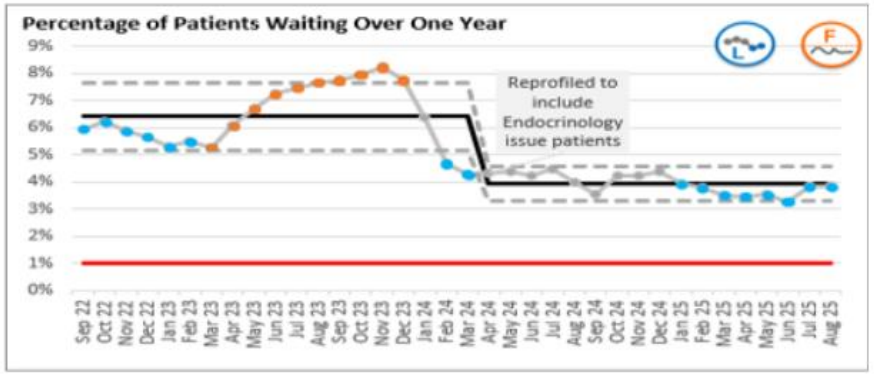
# Our Performance Overview – Elective Care : M5 25/26

| | 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 | Aug 25 | 37969 | 30039 | H | F | 33937 | 30438 | 37436 | S | T | P |
| 2 | RTT Waiting List | Aug 25 | 49416 | 52241 | | ? | 50693 | 47821 | 53565 | S | T | P |
| 3 | Percentage of Patients Waiting Over One Year | Aug 25 | 3.8% | 1.0% | L | F | 3.9% | 3.3% | 4.6% | S | T | P |
| 4 | Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under | Aug 25 | 0.4% | 0.3% | L | F | 0.8% | 0.4% | 1.1% | S | T | P |
| 5 | Total Patients Waiting Over 65 Weeks | Aug 25 | 74 | 0 | L | F | 237 | 23 | 452 | S | T | P |
| 6 | Percentage of cases where a patient is waiting 18 weeks or less for elective treatment | Aug 25 | 56.5% | 65.0% | H | F | 54.3% | 46.8% | 61.8% | S | T | P |
| 7 | Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks | Jul 25 | 76.4% | 80.0% | L | ? | 80.9% | 74.4% | 87.3% | S | T | P |
| 8 | Cancer 31 Day Treatment Standard Performance | Jul 25 | 92.7% | 96.0% | | ? | 92.5% | 85.4% | 99.6% | S | T | P |
| 9 | Percentage of Patients Treated for Cancer Within 62 Days of Referral | Jul 25 | 68.7% | 75.0% | | ? | 78.1% | 67.4% | 88.8% | S | T | P |
| 10 | Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test | Aug 25 | 38.6% | 5.0% | H | F | 21.9% | 14.2% | 29.6% | S | T | P |
| 11 | Outpatient New : Follow-up Ratio | Aug 25 | 2.27 | 2.00 | | F | 2.25 | 2.06 | 2.44 | S | T | P |
| 12 | Elective Theatre Utilisation - Capped Touchtime | Aug 25 | 81.0% | 85.0% | | F | 81.0% | 78.9% | 83.2% | S | T | P |
| 13 | Elective Recovery Plan : Day Case Activity Performance | Aug 25 | 93.8% | 100.0% | | ? | 97.0% | 84.2% | 109.8% | S | T | P |
| 14 | Elective Recovery Plan : Inpatient Activity Performance | Aug 25 | 87.4% | 100.0% | L | ? | 99.0% | 79.2% | 118.8% | S | T | P |
| 15 | Percentage of Patients Waiting Over 52 Weeks for Community Services | Aug 25 | 1.3% | 0.0% | H | ? | 0.1% | 0.0% | 0.2% | S | T | P |

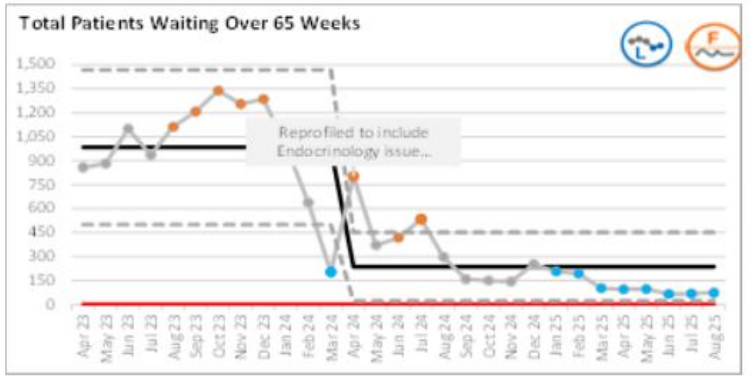
Summary icons key:



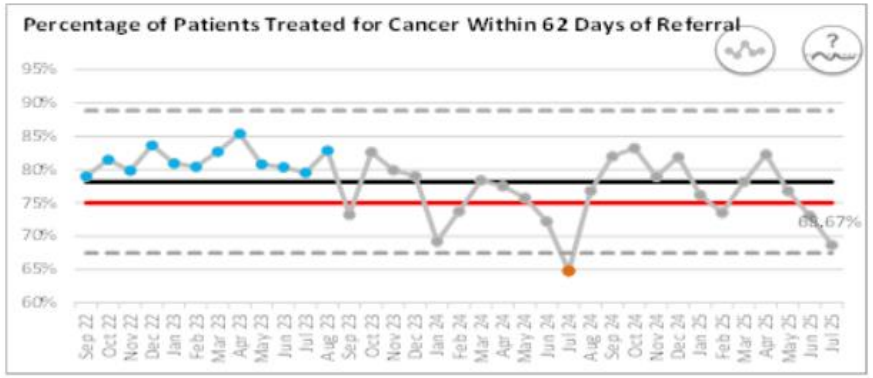
# Our Performance Insight Report : Elective Care M5 25/26



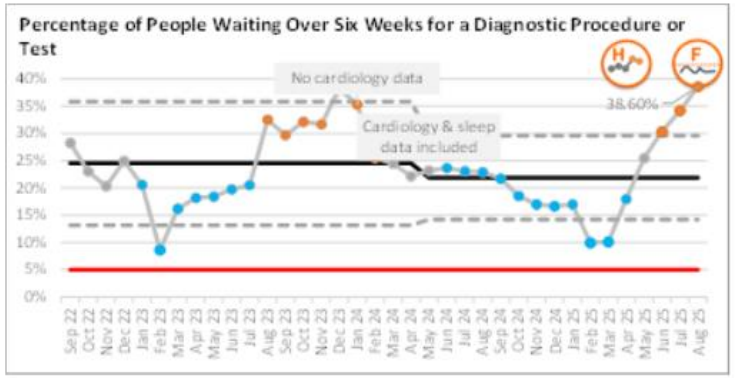

| Aug-25 |
|---|
| 3.82% |
| **Variance Type** |
| Special cause improving variation |
| **Target** |
| 0 |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |




| Aug-25 |
|---|
| 74 |
| **Variance Type** |
| Special cause improving variation |
| **Target** |
| 0 |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |




| Jul-25 |
|---|
| 68.67% |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 75% |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |




| Aug-25 |
|---|
| 38.60% |
| **Variance Type** |
| Special cause concerning variation |
| **Target** |
| 5% |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |

| Summary: | Actions: | Assurance: |
|---|---|---|
| 1. The number of patients waiting over one year remains at the lower mean value.<br>2. The total number of 65-week capacity breaches remains low and is decreasing further. The main pressured specialties continue to be in plastics/dermatology along with ENT, Gyn and vascular within surgery.<br>3. 76.45 % of urgent referrals to receive definite diagnosis within 4 weeks has failed the target set at 80%<br>4. Deteriorating position attributable to NOUS and Endoscopy capacity constraints | 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<br><br>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<br><br>3. Recovery planning, risk management, link to action below<br><br>4. Notice on AQP contract for NOUS will be served by the end of September. Endoscopy In-sourcing capacity has been agreed and is currently being mobilised. | 1. Weekly PTL/ long waits week mtg with COO to go through each service area.<br><br>2. Weekly PTL/ long waits week mtg with COO to go through each service area.<br><br>3. System level monitoring. Trust assurance via Divisional Assurance Meeting<br><br>4. Limited however potential for reduce demand with contract changes |

# Our Performance Elective Care Narrative : M5 25/26

**RTT Waiting List:** As of August 2025, there were 74 pts in breach of the RTT (Referral To Treatment) Waiting List for patients waiting over 65 weeks, this is in line with our planned target to be at 0 by the end of October. The percentage of patients waiting over 52 weeks reached 3.85% in August 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 cohort of patients transferred to the I/S have now been treated or are now dated. A second cohort has followed, and we are now looking at November and December breaches to send over. Unfortunately, the I/S are not able to receive redirected new referrals as they are above their agreed plan with the ICB.

The 31-day cancer performance for July was 92.67%, 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. (76.4% and 68.6% respectively). Capacity/Pathway issues in colorectal and breast services have contributed to the decrease in performance. Diagnostic capacity issues in breast imaging are expected to improve although there are challenges to recruitment which is delaying the anticipated restoration of capacity.

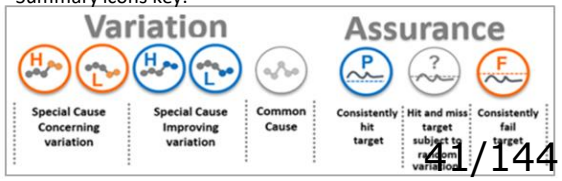
Radiology performance remains challenging across several modalities with significant clinical risks evident in the provision of non-obstetric and obstetric ultrasound. 38% of patients are waiting more than 6-weeks for routine appointments which is at a significant variance to the 5% interim target. Mitigations 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 October 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. Both modalities have reported an improving position from the end of August.

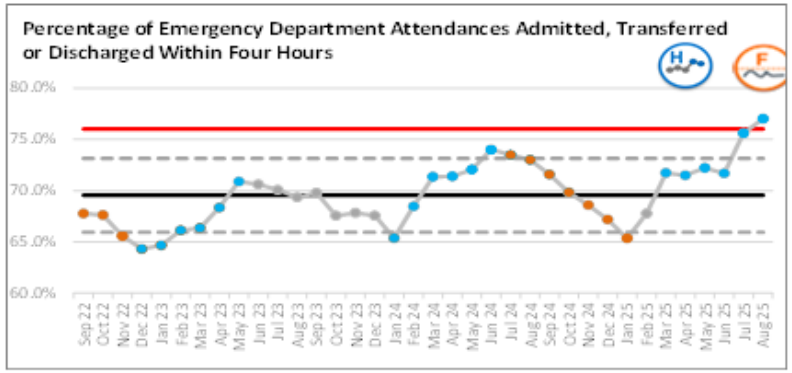
# Our Performance Overview – Urgent & Emergency Care: M5 25/26

| | KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit | Data Quality Indicators: Sign-off & Review | Timely & Complete | Process & System |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Average Time to Ambulance Handover | Aug 25 | 00:23:11 | 00:38:00 | | ? | 00:40:17 | 00:16:57 | 01:03:37 | S | T | P |
| 17 | Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours | Aug 25 | 77.0% | 76.0% | H | F | 69.5% | 65.9% | 73.1% | S | T | P |
| 18 | Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department | Aug 25 | 15.0% | 10.0% | L | F | 19.5% | 16.2% | 22.7% | S | T | P |
| 19 | Overnight Total General and Acute Beds and the Number of Which are Occupied | Aug 25 | 93.9% | 96.0% | | ? | 93.6% | 89.9% | 97.4% | S | T | P |
| 20 | Virtual Ward Occupancy | Aug 25 | 77.5% | 80.0% | | ? | 73.8% | 45.0% | 102.7% | S | T | P |
| 21 | Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days | Aug 25 | 1991 | 1439 | | F | 1919 | 1632 | 2205 | S | T | P |
| 22 | Average Number of Days Between Planned and Actual Discharge Date (Excludes patients discharged on discharge ready date) | Aug 25 | 12.0 | 4.2 | H | F | 10.6 | 7.2 | 13.9 | S | T | P |
| 23 | Percentage of Patients who do not Meet the Criteria to Reside | Aug 25 | 26.8% | 12.5% | H | F | 23.5% | 18.0% | 28.9% | S | T | P |
| 24 | Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days | Aug 25 | 1554 | 1560 | | ? | 1459 | 1185 | 1732 | S | T | P |
| 25 | Urgent Community Response (UCR) Referrals | Aug 25 | 79.3% | 70.0% | | P | 81.6% | 71.1% | 92.1% | S | T | P |

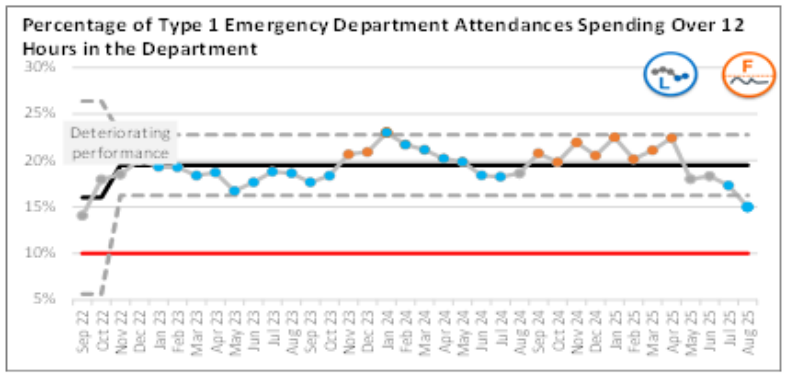
Summary icons key:



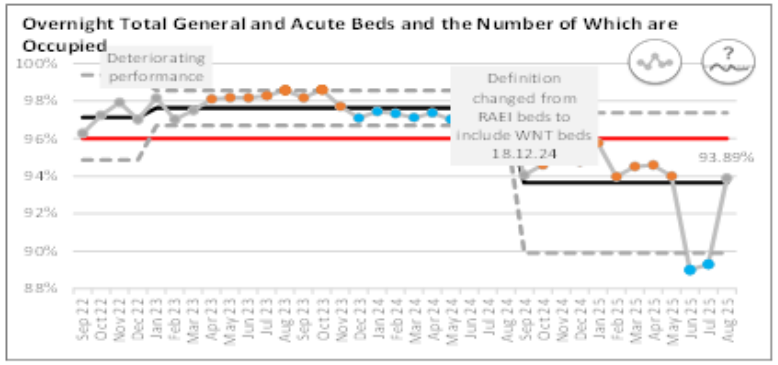
# Our Performance Insight Report : Urgent & Emergency Care M5 25/26



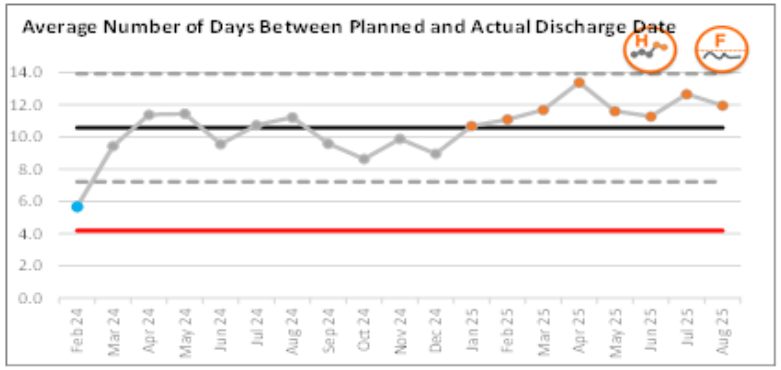

| Aug-25 |
|---|
| 77.0% |
| **Variance Type** |
| Special cause improving variation |
| **Target** |
| 76.0% |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |




| Aug-25 |
|---|
| 15.0% |
| **Variance Type** |
| Commmon cause variation |
| **Target** |
| 10.0% |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |




| Aug-25 |
|---|
| 93.9% |
| **Variance Type** |
| Special cause improving variation |
| **Target** |
| 96.0% |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |




| Aug-25 |
|---|
| 12.0 |
| **Variance Type** |
| Special cause concerning variation |
| **Target** |
| 4.2 |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |

| Summary: | Actions: | Assurance: |
|---|---|---|
| In August 2025, the Trust continued to face operational pressures across Urgent and Emergency Care (UEC) services but despite this managed to improve and sustain performance for 2 consecutive months.<br><br>• The acuity level of attendances increased, with 21.66% classified as high acuity, compared to 18% in July 2025<br>• 4-hour performance improved for 2 consecutive months reporting 77% in August 2025. This is the highest performance for 3 years.<br>• 12 hour waits improved significantly with August performance below the lower control limit at 15% | Improvement work continues through the Discharge and Flow Programme to recover UEC performance including a renewed focus on Ambulance Handover and commencement of the Ward Improvement Project. The Newton Europe Better Lives Programme continues to progress with the Admission and Admission Avoidance workstream and has moved into phase 2.<br><br>The ED improvement plan is to be linked to key quality and safety metrics, in addition the division are currently benchmarking pathways against the Emergency Care Pathways outlined in the new GIRFT guidance on Emergency Care Pathways. | 1. Weekly ED Assurance meetings<br>2. Weekly 12- hour performance review meetings<br>3. Implementation of 2-hourly ED huddle<br>4.Targeted work to improve the percentage of patients seen by a Doctor within 2-hours of arriving in the Emergency Department. Positive results in August saw an increase to 66.57% compared to 56.23% in June. |

# Our Performance Urgent & Emergency Care Narrative: M5 25/26

In August 2025, the Trust continued to face operational pressures across Urgent and Emergency Care (UEC) services but despite this managed to improve and sustain performance for 2 consecutive months.

- 8,246 attendances were recorded in August, of which 1,994 (24%) arrived by ambulance.
- The acuity level of attendances increased, with 21.66% classified as high acuity, compared to 18% in July 2025.
- 4-hour performance improved for 2 consecutive months reporting 77% in August 2025. This is the highest performance for 3 years.
- 12 hour waits improved significantly with August performance below the lower control limit at 15% , but remaining above the 10% target.

Ambulance handovers overall in statistical improvement with 60-minute waits almost eliminated on the back of the NWAS Handover 45 initiative, in august the average ambulance handover time was 23 minutes which is a significant improvement from the reported 34-minute handover reported in July. There was also statistical improvement in the percentage of patients seen by a doctor within 2 hours -66.57% compared to June 25 – 56.23%.

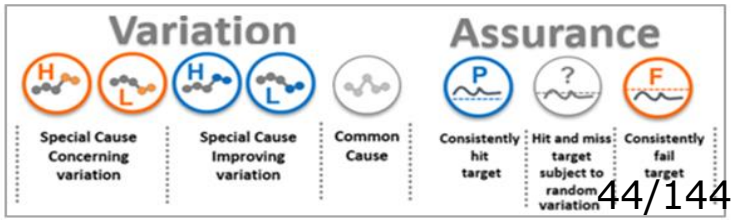
Improvement work continues through the Discharge and Flow Programme to recover UEC performance including a renewed focus on Ambulance Handover and commencement of the Ward Improvement Project. The Newton Europe Better Lives Programme continues to progress with the Admission and Admission Avoidance workstream and has moved into phase 2.

The improvement work is supported through the development of a UEC improvement plan, aligned to the seven key priorities outlined in the recent publication of the Urgent and Emergency Care Plan by NHS England

# Our Finance Performance Overview : M5 25/26

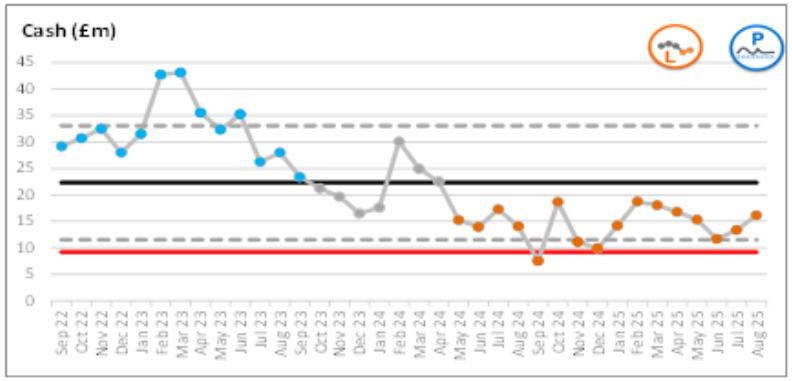
| | KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit | Data Quality Indicators: Sign-off & Review | Data Quality Indicators: Timely & Complete | Data Quality Indicators: Process & System |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Adjusted Financial Performance (£m) - Variance to Plan | Aug 25 | 0.0 | 0.0 | | ? | 0.3 | -4.2 | 4.8 | S | T | P |
| 2 | Cash (£m) | Aug 25 | 16.2 | 9.2 | L | P | 22.3 | 11.5 | 33.1 | S | T | P |
| 3 | API Income (£m) - Variance to Plan | Aug 25 | -0.7 | 0.0 | | ? | -0.3 | -1.5 | 0.9 | S | T | P |
| 4 | Total Cost Improvement Programme (CIP) (£m) - Variance to Plan | Aug 25 | -0.3 | 0.0 | L | ? | 0.3 | -1.9 | 2.5 | S | T | P |
| 5 | Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan | Aug 25 | -0.3 | 0.0 | | ? | -0.7 | -1.9 | 0.5 | S | T | P |
| 6 | Agency Expenditure (£m) | Aug 25 | 0.7 | 0.4 | L | F | 0.8 | 0.5 | 1.1 | S | T | P |
| 7 | Bank Expenditure (£m) | Aug 25 | 2.0 | 1.2 | L | F | 2.4 | 1.6 | 3.1 | S | T | P |
| 8 | Capital Expenditure (£m) - Variance to Plan | Aug 25 | -1.3 | 0.0 | L | ? | 1.2 | -3.0 | 5.4 | S | T | P |
| 9 | Better Payment Practice Code (BPPC) | Aug 25 | 95.0% | 95.0% | | ? | 93.5% | 87.6% | 99.3% | S | T | P |

Summary icons key:

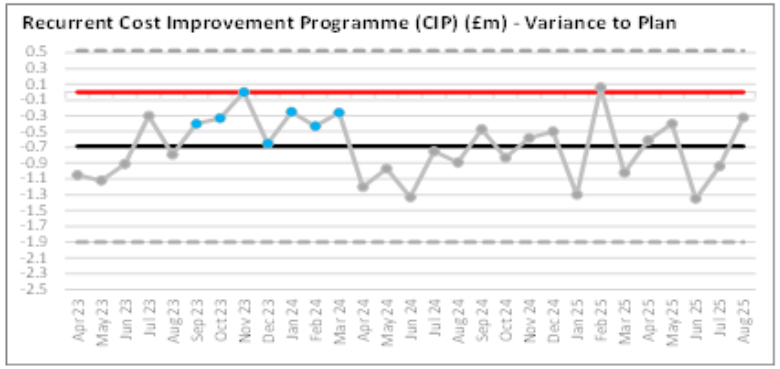



**The finance slides in the IPR should be viewed alongside the monthly finance report for wider context**

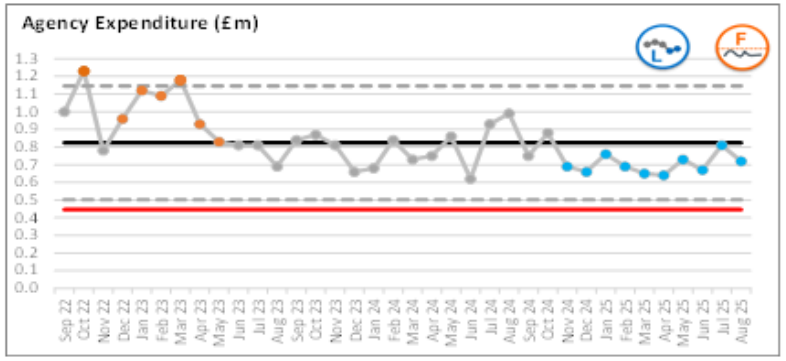
# Our Finance Performance Insight Report : M5 25/26



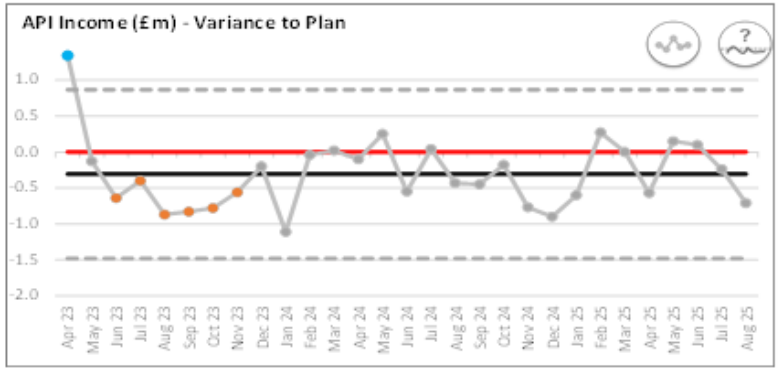

| Aug-25 |
|---|
| 16.2 |
| **Variance Type** |
| Special cause concerning variation |
| **Target** |
| 9.2 |
| **Target achievement** |
| Metric is consistently meeting the threshold/ target |




| Aug-25 |
|---|
| -0.3 |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 0.0 |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |




| Aug-25 |
|---|
| 0.7 |
| **Variance Type** |
| Special cause improving variation |
| **Target** |
| 0.4 |
| **Target achievement** |
| Metric is consistently missing the threshold/ target |




| Aug-25 |
|---|
| -0.7 |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 0.0 |
| **Target achievement** |
| Inconsistent performance compared to threshold/ target |

| Summary: | Actions: | Assurance: |
|---|---|---|
| 1. Closing cash at the end of August was £16.2m, an increase of £2.8m from July. There is a temporary benefit in month due to the pay award with employers' costs due next month. Our cash remains on a downward trajectory, with cash becoming a critical constraint.<br>2. Recurrent CIP slippage remains the primary driver of our adverse variance, but there has been improvement in month. The YTD slippage is £3.2m.<br>3. Agency spend in month is £0.7m, a £0.1m decrease compared to prior month, which is showing no change relative to the NHSE baseline (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.<br>4. Divisional elective API performance has declined compared to last month, resulting in a £0.7m adverse variance in month. YTD underperformance is £1.0m. Divisions are currently forecasting to recover this underperformance in year. | 1. Cash is being closely monitored, with a further update being presented to FIG in September. There is a recommendation to establish a Cash Steering Group.<br>2. 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". Further controls to be presented at Sep FIG, which will support financial recovery plans.<br>3. Agency expenditure continues to be closely monitored with grip and control measures in place, with variable pay being reviewed at the September FIG meeting. Temporary spend reduction links to CIP delivery.<br>4. Activity will be monitored at the Divisional Performance Reviews for the clinical divisions and has been flagged as a key line of enquiry by the CFO. | 1. Operational Cash Management Group, Finance and Performance Committee.<br>2. All CIP Huddles are now in place for each Division (CFO/ Deputy CEO led). Any particularly challenged divisions have been escalated to ETM (Surgery).<br>3. Executive Pay Control Group, Divisional Performance Reviews, Finance Improvement Group, Finance and Performance Committee<br>4. Divisional Performance Reviews, Elective Productivity and Capacity Programme Board. |

# Our Finance Performance Narrative : M5 25/26

| Description | Performance Target | Performance | SPC Variation / Assurance | Explanation |
|---|---|---|---|---|
| Revenue plan | Adjusted financial position: Achieve the financial plan for 2025/26. | Red | | We have held our YTD variance to plan for month 5, August. Our year-to-date position is an actual deficit of £1.9m, which is an adverse variance of £1.3m to the planned deficit of £0.6m. The month 5 position includes one-off benefits totalling £1.5m. Without these benefits, our position would have been £1.0m adverse to plan in month. External scrutiny on the deliverability of our position will continue with the NHSE assessment regarding Q3 deficit support funding to be based on month 5. |
| Cash & liquidity | Ensure financial obligations can be met as they become due. | Amber | | The cash balance as at 31st August 2025 is £16.1m, which is an increase of £2.8m from last month. 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. | Red | | Divisional elective API performance has declined compared to last month, resulting in a £0.7m adverse variance in month. Year to date underperformance is £1.0m which the divisions are currently forecasting to recover. |
| Cost Improvement Programme (CIP) | Deliver Total CIP of £38.4m | Red | | Recurrent CIP slippage remains the primary driver of our adverse variance, but there has been improvement in month. CIP of £3.3m has been delivered in month 5 which is £0.1m below plan. Year-to-date slippage is £3.2m. We need to recover the CIP slippage and accelerate delivery to achieve our 2025/26 financial plan. |
| | Deliver Recurrent CIP of £23.0m | Red | | |
| Agency expenditure | 30% reduction in agency spend. | Red | | Agency spend in month is £0.7m, a £0.1m decrease compared to prior month. Agency spend is showing no change 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 | Green | | Bank costs continue to increase. Bank spend is showing a 13% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE. |
| Capital expenditure | Achieve capital plan for 2025/26. | Amber | | Total capital expenditure in month 5 is £2.3m which is £2.0m behind plan. This Is due to the delay of PDC schemes whilst MOUs are awaited from NHSE. |
| Better Payments Practices Code (BPPC) | Pay 95% of invoices within 30 days. | Green | | BPPC performance in-month performance was 95.0% by volume and 98.8% by value. YTD performance was 94.2% by volume and 98.1% by value. |

| | |
|---|---|
| **Title of report:** | Financial reporting month 5 – Trust Finance Report |
| **Presented to:** | Board of Directors |
| **On:** | 1st October 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**

We have held our variance to plan for month 5, August, by delivering our plan in month. Our year-to-date position is an actual deficit of £1.9m, which is an adverse variance of £1.3m to the planned deficit of £0.6m. The month 5 position includes one-off benefits totalling £1.5m. Without these benefits, our position would have been £1.0m adverse to plan in month. External scrutiny on the deliverability of our position will continue with the NHSE assessment regarding Q3 deficit support funding to be based on month 5.

Recurrent CIP slippage remains the primary driver our adverse variance, but there has been improvement in month. CIP of £3.3m has been delivered in month 5 which is £0.1m below plan. Year-to-date slippage is £3.2m. We need to recover the CIP slippage to achieve our 2025/26 financial plan.

Divisional elective API performance has declined compared to last month, with a £0.7m adverse variance in month. This is primarily driven by under performance in Specialist Servies of £0.5m within Trauma and Orthopaedics, and a further £0.2m shortfall in Medicine, particularly in Gastroenterology. Surgery achieved their plan in month. Year to date underperformance has increased to £1.0m.

The cash balance as at 31st August 2025 is £16.1m, which is an increase of £2.8m from last month. There is a temporary benefit in month due to the pay award with employers' costs cash payments due next month. Our cash remains on a downward trajectory linked to the slippage on CIP delivery and static run rate, with cash becoming a critical constraint for operational decision making. A separate paper regarding cash is on the Finance and Performance Committee agenda.

Workforce in July is 6,983 WTE, which is an increase of 13 WTE on last month. The gap to the workforce plan is growing with the in-month position being 104 WTE above the plan of 6,879WTE. Pay expenditure is £1.2m adverse to plan in month which is associated with recurrent CIP underperformance.

Each quarter the NHSE region is asked to make a recommendation to the NHS England CEO and CFO about the awarding or withholding of deficit support funding (DSF) for each system. Their recommendation will reflect their assessment of whether the system is on track to deliver its plan. The month 5 financial position is pivotal in NHSE regional assessment of deficit support funding for the GM system for Q3. There is a set of national metrics will inform the decision, but NHSE is expected to take a broader view. At the time of writing, the decision for Q3 is not yet known.

The full year forecast scenarios are updated each month. The mid-case shows a base scenario deficit of £3.2m, which includes currently identified mitigations. A financial recovery plan is required to close the gap to best case and to ensure delivery of breakeven position in line with plan and our forecast to NHSE.

**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 4th September 2025, and the full finance report was reviewed at the Financial Improvement Group on 17th September 2025 and the Finance and Performance Committee on 30th September 2025.

**Wider implications**

There are no wider implications of this report.

**Recommendation(s)**

The Board is asked to note the month 5 financial position.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

# Trust Finance Report

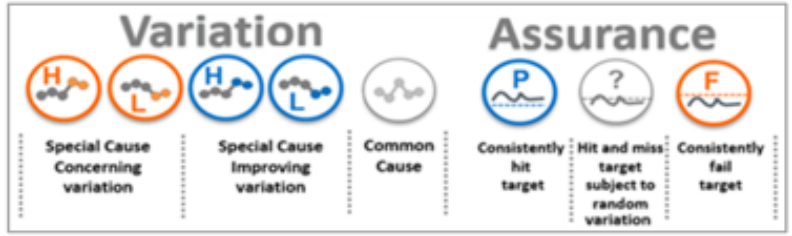
## Month 5 – August 2025

# Contents

## Main report



**Statistical Process Chart (SPC) Key**



# Key Performance Indicators

| Description | Performance Target | Performance | SPC Variation / Assurance | Explanation |
|---|---|---|---|---|
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| Cash & liquidity | Ensure financial obligations can be met as they become due. | Amber |  | The cash balance as at 31st August 2025 is £16.1m, which is an increase of £2.8m from last month. 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. | Red |  | Divisional elective API performance has declined compared to last month, resulting in a £0.7m adverse variance in month. Year to date underperformance is £1.0m which the divisions are currently forecasting to recover. |
| Cost Improvement Programme (CIP) | Deliver Total CIP of £38.4m | Red |  | Recurrent CIP slippage remains the primary driver of our adverse variance, but there has been improvement in month. CIP of £3.3m has been delivered in month 5 which is £0.1m below plan. Year-to-date slippage is £3.2m. We need to recover the CIP slippage and accelerate delivery to achieve our 2025/26 financial plan. |
| | Deliver Recurrent CIP of £23.0m | Red |  | |
| Agency expenditure | 30% reduction in agency spend. | Red |  | Agency spend in month is £0.7m, a £0.1m decrease compared to prior month. Agency spend is showing no change relative to the NHSE baseline (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE. |
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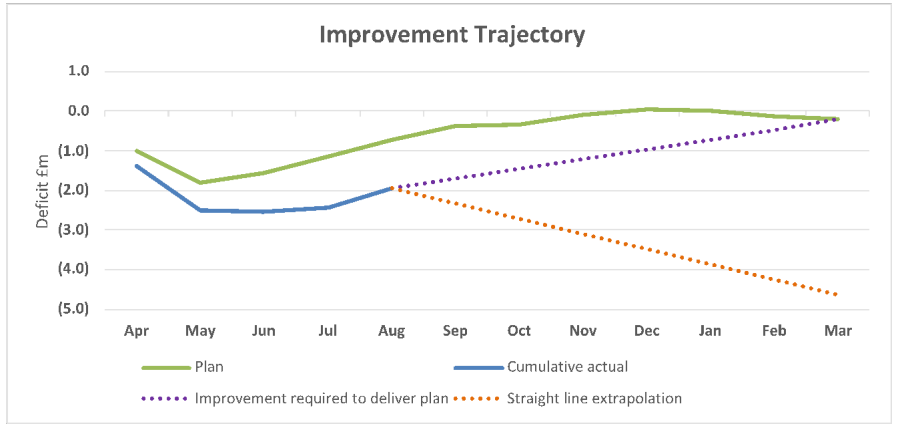
# Financial Performance

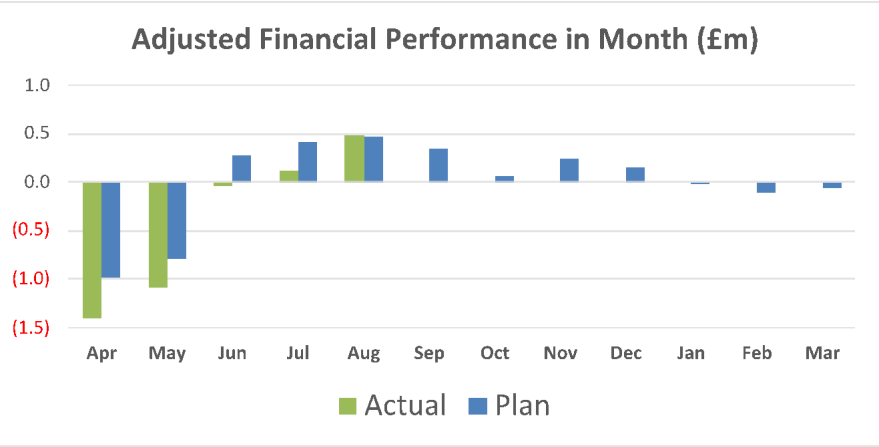
## Headlines

- In month, there is an actual surplus of £0.5m, which is **on plan.** The YTD deficit is £1.9m, which is £**1.3m adverse** to the planned deficit of £0.6m.
- Income is £47.5m, **adverse to plan £0.3m** mainly due to under performance on elective API activity £0.7m, offset by over performance on drugs and devices £0.3m.
- Pay is £34.0m, **adverse to plan £1.2m**, of which £0.8m is CIP slippage.
- Non pay is £12.7m, **favourable to plan £1.3m**. Includes £0.8m energy benefit associated with prior years, technical one-off benefits of £0.7m and CIP overperformance £0.4m.
- Actual CIP delivery is £3.3m in month, which is £0.1m behind the plan of £3.4m.

**Improvement Trajectory to Deliver Revenue Plan**

Based on the current run rate there needs to be a **£0.7m improvement each month** to March 2026 to deliver the 2025/26 plan.




| Key Financial Indicators | In Month (£000) | | | Year to Date (£000) | | | Full Year (£000) |
|---|---|---|---|---|---|---|---|
| | Actual | Plan | Var | Actual | Plan | Var | Plan |
| Income | 47,455 | 47,769 | (314) | 240,495 | 238,104 | 2,391 | 572,943 |
| Pay | (33,999) | (32,782) | (1,217) | (170,283) | (165,402) | (4,881) | (395,279) |
| Non Pay | (12,711) | (13,985) | 1,274 | (70,059) | (70,646) | 587 | (171,256) |
| Financing / Technical | (279) | (552) | 272 | (2,161) | (2,759) | 598 | (6,621) |
| Surplus / Deficit | 465 | 450 | 15 | (2,008) | (703) | (1,305) | (213) |
| Adjusted Financial Performance (AFP) | 484 | 468 | 15 | (1,931) | (613) | (1,317) | 0 |
| **Memo** | | | | | | | |
| Deficit support funding | (741) | (741) | 0 | (3,705) | (3,705) | 0 | (8,893) |
| AFP excluding deficit support funding | (258) | 468 | (726) | (5,636) | (613) | (5,023) | (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 | 449 | 422 | 27 | 1,761 | 2,103 | (342) |
| Surgery | 277 | 217 | 61 | 1,367 | 1,080 | 287 |
| Specialist Services | 868 | 1,593 | (724) | 7,507 | 7,939 | (432) |
| Community Services | 632 | 676 | (43) | 3,212 | 3,367 | (156) |
| Non Divisional Income | 44,000 | 43,865 | 135 | 221,097 | 218,634 | 2,463 |
| Finance | 13 | 13 | (0) | 57 | 67 | (10) |
| Digital Services | 7 | 7 | (1) | 22 | 37 | (15) |
| Dir of Strat & Planning | 161 | 136 | 25 | 877 | 679 | 198 |
| Chief Operating Officer | 0 | 0 | 0 | 0 | 0 | 0 |
| Human Resources | 62 | 96 | (34) | 294 | 481 | (187) |
| Medical Director | 56 | 74 | (17) | 417 | 368 | 48 |
| Estates & Facilities | 459 | 399 | 60 | 2,108 | 1,996 | 112 |
| Nurse Director | 133 | 183 | (50) | 518 | 513 | 5 |
| Trust Executive | 0 | (114) | 114 | 0 | (177) | 177 |
| GTEC | 159 | 163 | (5) | 797 | 816 | (19) |
| Corporate | 179 | 40 | 139 | 462 | 200 | 262 |
| **Total** | **47,455** | **47,769** | **(314)** | **240,495** | **238,104** | **2,391** |

## Headline

- Income is **£0.3m adverse** in month and **£2.4m favourable** YTD.

## Clinical divisions

- **Medicine**: Income is **on plan** in month. There is £0.1m under performance of Elective API income. This includes a £0.2m under performance predominantly within Gastroenterology offset by a coding benefit of £1.0m relating to prior months activity. Unbundled drugs and devices over performed by £0.2m and CDC income is £0.1m adverse in month.
- **Surgery**: Income is **£0.1m favourable** in month and this is predominantly due to Elective API income. The in-month position is £22k adverse but this is offset by a coding benefit of £0.1m relating to prior months activity.
- **Specialist Services**: Income is **£0.7m adverse** in month. This predominantly relates to an underperformance on Elective API income £0.5m within Trauma and Orthopaedics and £0.2m under performance on private patient income. CDC income is on plan in month.

## Other

- **Non-Divisional income**: **£0.1m favourable** in month. £0.2m is due to the inclusion of the limb salvage bespoke prosthesis recharge to Specialist Commissioning (£1.5m YTD). This recharge was not included in the Trusts Indicative Activity Plan (IAP) and discussions with commissioners are ongoing. The remaining £0.1m adverse variance is due to an under performance on CRU and Education income.
- **Trust Exec**: **£0.1m favourable** in month due to over performance on CIP.
- **Corporate**: Income is **£0.1m favourable** in month due to the MIAA Transport recharge which is offset with expenditure (WWL is procuring on behalf of GM).

# 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 | 1,524 | 1,528 | (4) | 990 | 1,006 | (16) | 7,258 | 7,947 | (689) | 4,859 | 5,231 | (372) |
| Medicine | Electives | 22 | 39 | (17) | 37 | 53 | (16) | 114 | 204 | (90) | 217 | 276 | (59) |
| Medicine | OP Proc New | 72 | 142 | (70) | 19 | 52 | (33) | 442 | 738 | (296) | 133 | 270 | (137) |
| Medicine | OP Proc FUP | 527 | 591 | (64) | 110 | 110 | (1) | 3,272 | 3,072 | 200 | 710 | 574 | 136 |
| Medicine | OPA New | 1,904 | 2,554 | (650) | 490 | 665 | (175) | 11,775 | 13,279 | (1,504) | 3,008 | 3,458 | (450) |
| Medicine | A&G | 542 | 276 | 267 | 117 | 59 | 57 | 2,298 | 1,378 | 920 | 494 | 296 | 198 |
| **Medicine Total** | | **4,591** | **5,129** | **(538)** | **1,762** | **1,946** | **(184)** | **25,159** | **26,617** | **(1,458)** | **9,421** | **10,106** | **(686)** |
| Specialist Services | Day Cases | 677 | 749 | (72) | 1,086 | 1,327 | (241) | 3,852 | 3,857 | (5) | 6,247 | 6,806 | (559) |
| Specialist Services | Electives | 326 | 364 | (38) | 2,409 | 2,704 | (295) | 1,810 | 1,875 | (65) | 13,809 | 13,945 | (136) |
| Specialist Services | OP Proc New | 879 | 871 | 8 | 144 | 146 | (2) | 5,077 | 4,528 | 549 | 846 | 757 | 90 |
| Specialist Services | OP Proc FUP | 1,293 | 1,283 | 10 | 187 | 180 | 6 | 7,569 | 6,672 | 897 | 1,065 | 937 | 128 |
| Specialist Services | OPA New | 2,955 | 3,110 | (155) | 628 | 655 | (27) | 16,203 | 16,174 | 29 | 3,425 | 3,404 | 21 |
| Specialist Services | A&G | 400 | 171 | 229 | 86 | 37 | 49 | 1,605 | 856 | 749 | 345 | 184 | 161 |
| **Specialist Services Total** | | **6,530** | **6,548** | **(18)** | **4,540** | **5,048** | **(509)** | **36,116** | **33,963** | **2,153** | **25,737** | **26,033** | **(296)** |
| Surgery | Day Cases | 984 | 1,008 | (24) | 1,410 | 1,373 | 37 | 4,956 | 4,861 | 95 | 6,464 | 6,513 | (49) |
| Surgery | Electives | 170 | 175 | (5) | 551 | 492 | 59 | 720 | 909 | (189) | 2,546 | 2,559 | (14) |
| Surgery | OP Proc New | 1,503 | 1,920 | (417) | 330 | 417 | (87) | 8,476 | 9,918 | (1,442) | 1,869 | 2,144 | (275) |
| Surgery | OP Proc FUP | 3,255 | 3,004 | 251 | 674 | 612 | 62 | 17,840 | 15,621 | 2,219 | 3,665 | 3,183 | 482 |
| Surgery | OPA New | 3,372 | 4,006 | (634) | 684 | 816 | (131) | 19,221 | 20,533 | (1,312) | 3,921 | 4,190 | (270) |
| Surgery | A&G | 288 | 107 | 181 | 62 | 23 | 39 | 951 | 536 | 414 | 204 | 115 | 89 |
| **Surgery Total** | | **9,572** | **10,221** | **(649)** | **3,711** | **3,732** | **(22)** | **52,164** | **52,377** | **(213)** | **18,669** | **18,704** | **(35)** |
| **Divisional ERF Totals** | | **20,693** | **21,898** | **(1,205)** | **10,012** | **10,727** | **(714)** | **113,439** | **112,957** | **482** | **53,827** | **54,844** | **(1,017)** |

## Elective API Performance

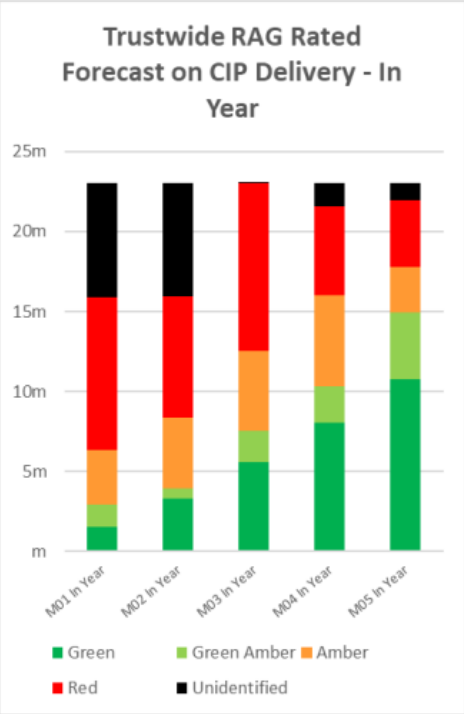
- In month 5, there is an **£0.7m adverse variance** to the elective API plan.
- Medicine are **£0.2m adverse** to plan in month predominantly due to Gastroenterology.
- Specialist Services are **£0.5m adverse** in month, predominantly within T&O.
- Surgery are on plan in month.
- Advice and Guidance income of £0.2m has been included in the position in month.

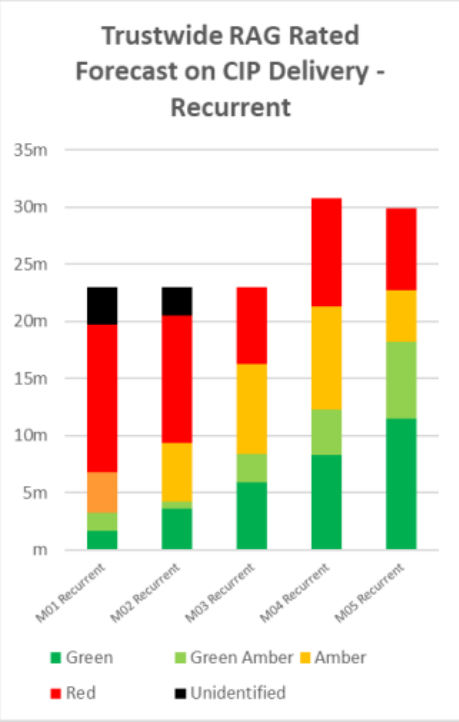
- Specialist Services £0.5m
- Medicine £0.2m

# Trust Wide CIP Delivery 2025/26

## 2025/26 CIP Delivery

- Total CIP delivered in Month 5 is £3.2m, which is £0.1m below plan: £1.8m is recurrent (54%) and £1.5m is non-recurrent (46%).
- The full value of recurrent CIP transacted has increased by £2.4m to £10.7m, however the recurrent delivery in the year to date position is £3.6m behind plan.
- At Month 5, £1.1m of the recurrent plan has slipped in year due to the delay in scheme start dates, which is mitigated non recurrently. There is a significant amount of risk within the identified value - 14% of the forecast is high risk.




The full year impact of the recurrent schemes is now £29.7m. This is due to a number of high value schemes being profiled for delivery later in the year.

A review of these schemes and expediting delivery is required to recover the position.

### Aug 2025 Reported Position (Rec)

| RAG | Value £'000 |
|---|---|
| | 1,085 |
| | 4,049 |
| | 2,935 |
| | 14,952 |
| CIP Total | 23,020 |

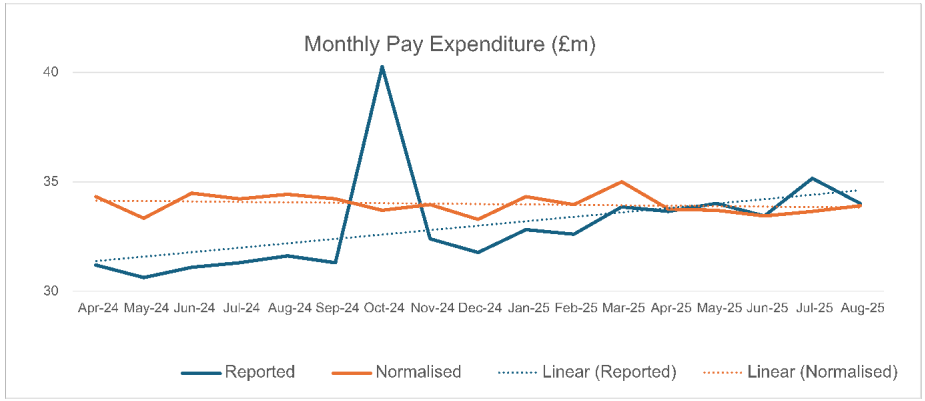
### July 2025 Reported Position (Rec)

| RAG | Value £'000 |
|---|---|
| | 1,473 |
| | 5,520 |
| | 5,426 |
| | 10,602 |
| CIP Total | 23,020 |

# Workforce

## Pay expenditure

- The in-month pay expenditure is £34.0m which is £1.2m above plan in month. This is due to unachieved CIP of £0.8m. The position includes the pay award paid in August (accounted for in July as per national guidance).
- The normalised pay expenditure has been rebased in line with 2025/26 rates and remains within the range seen since from Q4. Q1 normalised pay is £33.7m compared to the 2024/25 Q4 monthly average of £34.5m.




Pay £1.2m above plan in month

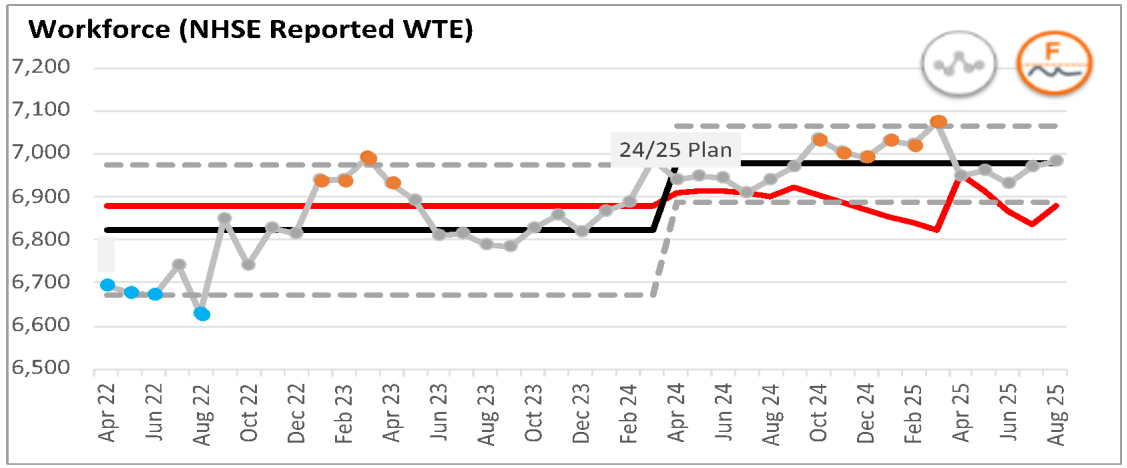
Normalised pay remains static c£33.6m

## Normalised quarterly average

| Q1 24/25 | Q2 24/25 | Q3 24/25 | Q4 24/25 | Q1 25/26 | M4-M5 25/26 |
|---|---|---|---|---|---|
| £34.1m | £34.3m | £33.7m | £34.5m | £33.7m | £33.9m |

## Workforce (WTE)

- Actual workforce 6,983 WTE in August. This is an increase of 13 WTE from last month and is 104 WTE above the workforce plan of 6,879 WTE.
- Substantive staffing has decreased by 1 WTE.
- Bank staffing has increased by 18 WTE.
- Agency has 4 WTE decrease compared to last month.

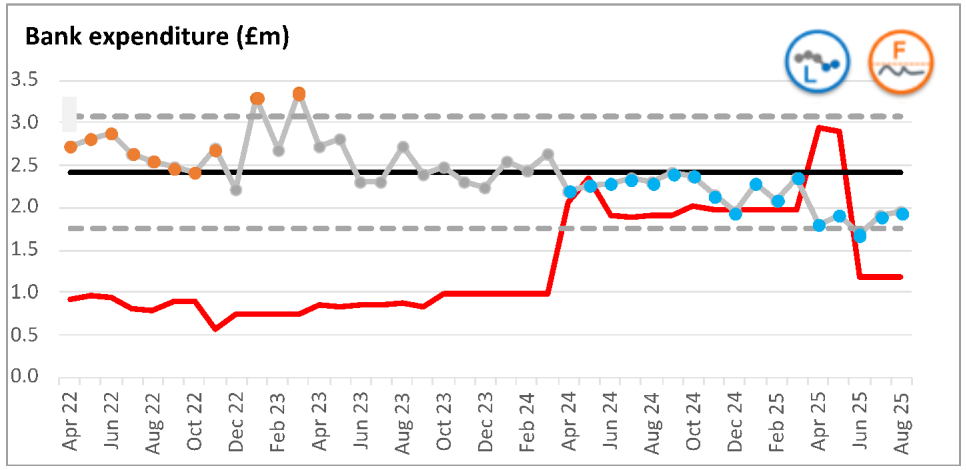



WTE above plan by 104 WTE (at an average WTE cost this equates to £0.4m in month)

# Bank & Agency Staffing

## Bank expenditure

- Bank costs were £1.9m in August, increasing on last month.
- Bank WTE increased by 18 WTE in line with spend.
- The chart still shows special cause improving variation due to the overall downward trajectory.
- In August, Medicine (£1.1m) and Surgery (£0.5m) continue to be the biggest users.
- Bank spend is showing a 13% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE.
- The bank plan reduced from month 3 associated with the increase in the CIP profile.

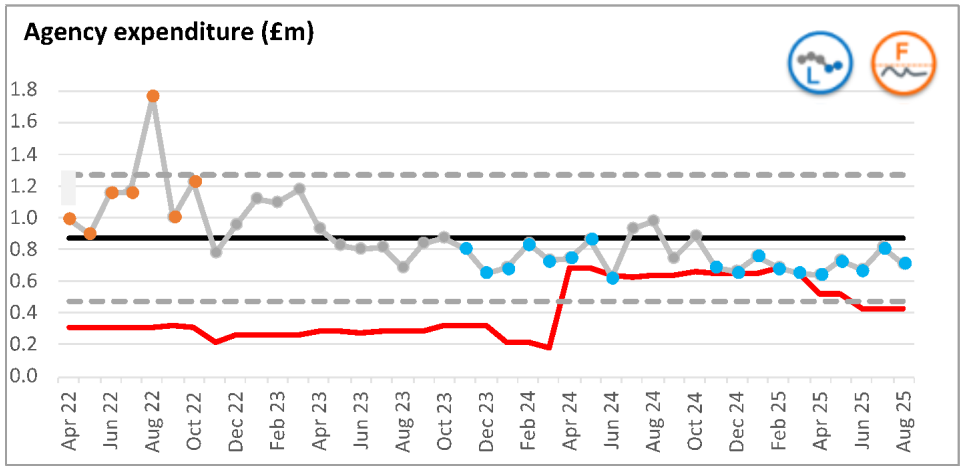



Bank expenditure increase in month

Reduced rates implemented from April 2025

## Agency expenditure

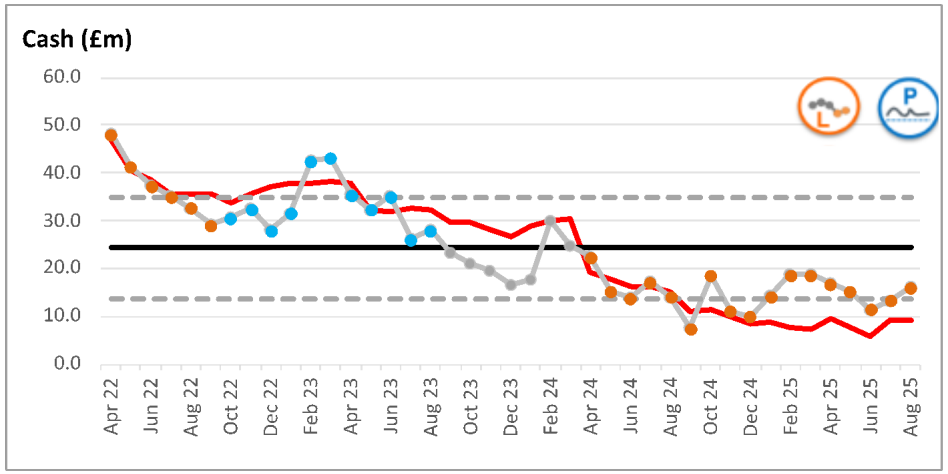
- Agency spend in month is £0.7m, a £0.1m decrease compared to prior month. The trend is still showing common cause improving variation as this is still within the typical process limits.
- There has been an increase in junior doctor agency usage following the GM rate standardisation in May.
- Medicine (£0.3m) continues to have the highest level of agency within the Trust.
- Agency spend is showing no change relative to the NHSE baseline (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.

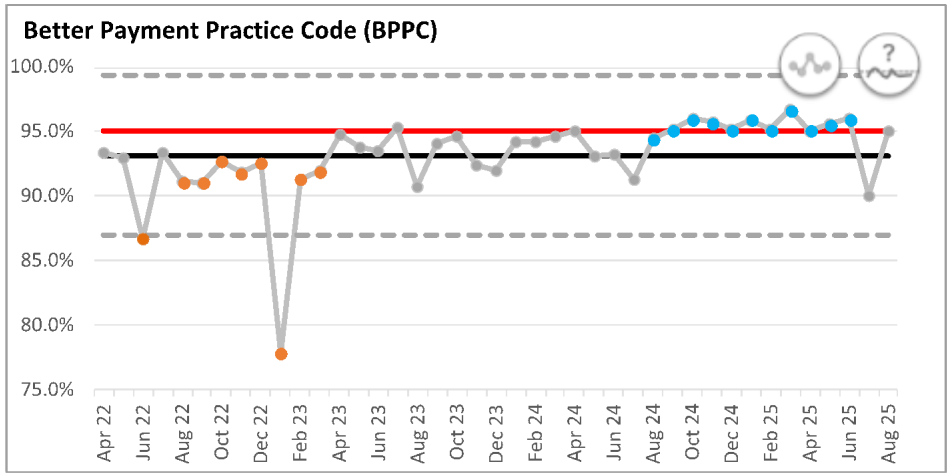



Slight decrease in Agency spend in month

Scrutiny remains high on agency spend

# Cash and BPPC




## Current cash position

- Closing cash at the end of August was £16.2m, increase of £2.8m from July. This is £6.8m above the plan submitted to NHSE, however it is £1.5m below the revised plan of £17.7m (when adjusted for actual opening balance). Contributing factors are:
- YTD deficit £1.3m more than plan, offset by the receipt of the backdated API stretch income, additional pay award funding, and a temporary benefit of the impact increased PAYE and pension contributions which are paid a month behind.
- Operating cash days at the end of August was 11.

## 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 will become critical towards the end of Q3.
- The monthly NHSE financial return has been updated to include a 4-month rolling cash forecast to flag any cash requirements ahead of formal cash support requests.

## Better Payment Practice Code (BPPC)

- The in-month performance returned to target in August following a temporary dip in July, which was caused by successful project to clear the PO notification backlog.
- The in-month performance was 95.0% by volume and 98.8% by value.
- The YTD performance was 94.2% by volume and 98.1% 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 | 1,777 | 2,706 | 930 | 8,609 | 10,597 | 1,988 | 14,117 | 61% |
| Over programming and over allocation | | | | | | | (672) | 0% |
| **Operational capital (CDEL)** | **1,777** | **2,706** | **930** | **8,609** | **10,597** | **1,988** | **13,445** | **64%** |
| **National funding (PDC)** | | | | | | | | |
| Solar Panels | 0 | 215 | 215 | 0 | 644 | 644 | 2,148 | 0% |
| Diagnostics prioritisation | 0 | 225 | 225 | 0 | 273 | 273 | 393 | 0% |
| UEC - Discharge Lounge capacity | 0 | 0 | 0 | 0 | 0 | 0 | 572 | 0% |
| Elective prioritisation - Theatres 5&6 | 0 | 131 | 131 | 0 | 131 | 131 | 1,050 | 0% |
| Estates Safety bids (Backlog Maintainance) | 82 | 387 | 305 | 1,120 | 1,381 | 261 | 2,744 | 41% |
| UEC (A&E Diagnostics) | 402 | 625 | 223 | 413 | 1,249 | 836 | 3,747 | 11% |
| 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% |
| RAAC - Leigh infirmary | 0 | 0 | 0 | 0 | 0 | 0 | 391 | 0% |
| EV Chargers | 0 | 0 | 0 | 0 | 0 | 0 | 12 | 0% |
| **Sub total national funding** | **484** | **1,583** | **1,099** | **1,533** | **3,679** | **2,146** | **12,507** | **12%** |
| **Total capital programme** | **2,260** | **4,289** | **2,028** | **10,142** | **14,275** | **4,133** | **25,952** | **39%** |

## Capital plan 2025/26

- Total capital programme for the financial year of £25.9m 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 £12.5m. In month we have received notification that a £12k bid for Electric Vehicle Chargers has been approved.

## Month 5 Headlines

- Total capital expenditure in month 5 is £2.3m which is £2.0m behind plan.
- Year to date, total capital expenditure is £4.1m behind plan.

## Operational CDEL

- Operational capital expenditure in month 5 is £1.8m which is £0.9m less than the plan of £2.7m.
- In month underspend is mainly due to the pharmacy robot scheme phasing not aligned with the scheme implementation scheduled for Q4.
- The YTD expenditure of £8.6m is £2.0m behind plan, due to the delay in the agreement of the Cranfield Road lease (£1.1m)
- The planning tolerance has been mitigated through identified scheme underspends and a VAT rebate from the prior year.

## PDC funded schemes

- Expenditure on PDC funded schemes is £0.5m in month, £1.0m behind plan and £1.5m year to date which is £2.1m behind the plan of £3.7m, this due to delays in receipt of MoUs and long lead in times between tendering and project commencement.
- Discharge Lounge is planned to commence in October subject to receipt of MoU from NHSE. The MoUs are required to drawdown the capital funding, therefore due to cash constraints, expenditure cannot commence prior to the drawdown.

# Full Year Scenarios

Bridge from straight line forecast to actual forecast of breakeven. This sets out the assumptions and mitigations identified within the mid case scenario .

| Straight line forecast - £4.6m deficit | Remove non-recurrent items and phasing adjustments -£2.7m | Key assumptions +£1.4m | Non-recurrent mitigations +£2.7m | Recovery plan +£3.2m | Mid-case scenario: Breakeven |
|---|---|---|---|---|---|
| •Extrapolated from £1.9m YTD deficit. | •Non recurrent items, extrapolated impact -£3.3m (includes one-off benefits £3.1m across month 3 to 5).<br>•Phasing adjustment for Newton Europe Better Lives consultancy £0.6m. | •Cash releasing CIP run rate improvement+£5.5m.<br>•Elective activity contribution +£1.0m.<br>•MARS severance -£1.0m.<br>•Energy/winter -£2.5m.<br>•Corporate financing -£1.4m<br>•Other items -£0.2m | • Non-recurrent mitigations /enhanced grip and control +£2.7m.<br>•The use of non-recurrent mitigations will extend the timeframe for financial sustainability. | •Recovery plan of £3.2m to be developed for the second half of the 2025/26 financial year. | •The current mid-case scenario is delivery of plan with a breakeven position.<br>•All other pressures to be mitigated within existing plan. |

**Key actions to achieve plan**

- Deliver CIP plan
- Deliver elective activity plan
- Recovery plan to be developed.
- Monthly run rate improvement of £0.7m required (from £0.4m YTD actual average deficit to £0.3m surplus per month)

**High level scenarios for full year forecast**

| Worst Case | Mid Case | Best Case |
|---|---|---|
| £8.0m deficit (£8.0m adverse to plan) | £3.2m base scenario deficit (£3.2m adverse to plan). Recovery plan required to close the gap to best case and to ensure delivery of **breakeven position** in line with plan and our forecast to NHSE. | Breakeven (on plan) |

The base scenario includes mitigations which are currently identified. All scenarios assume full receipt of DSF for Q3 and Q4.

# Risk Management and Mitigation

## Revenue position

**Recurrent CIP delivery**: Recurrent CIP delivery is materially behind plan; slippage to date will have to be recovered in year. WWL has improved its position in the weekly CIP returns. At Month 5, £1.1m of the recurrent plan has slipped in year due to the delay in scheme start dates, this is mitigated non recurrently. In month 5, all divisions are significantly behind plan.

**Deficit Support Funding**: Whilst this has been confirmed for GM ICS for Q2, the month 5 financial position is pivotal in NHSE regional assessment of deficit support funding for the GM system for Q3. There is a set of national metrics will inform the decision, but NHSE North West is expected to take a broader view. Indicative criteria noted in the box to the right.

**API activity**: Divisional elective API performance has deteriorated since last month. Year to date underperformance is £1.0m adverse which we are currently forecasting to recover.

**Prosthesis recharge**: Discussions are ongoing with NHSE Specialist Commissioning regarding the recharge for bespoke prosthesis expenditure. A project has identified additional expenditure in scope for pass through; however, this is above the activity plan agreed for the financial year.

**Industrial action**: Resident doctors participated in industrial action in July, with a cost of £0.3m incurred without any national financial compensation. The BMA are continuing to canvas members who are reported to be supportive of further industrial action. There is also a risk of industrial action for other staff groups.

**UEC funding**: GM ICB have confirmed that the UEC discharge and capacity allocation will remain unchanged for the 2025/26 financial year, however, it will be included in the commissioning intentions for 2026/27. A plan to mitigate the anticipated income reduction will be developed.

## 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 will become critical 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.

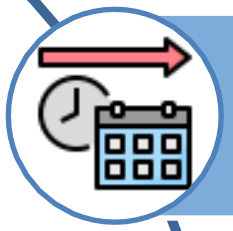
**Financial environment**: The financial environment for 2025/26 for both revenue and capital is highly constrained, and the Trust is operating at a deficit. These may impact on the ability of the Trust to deliver its strategic objectives.

**Deficit Support Funding Assessment:**

The DSF assessment will include several metrics and assurance areas:

- CIP fully developed or implemented
- Contracts signed and activity plans in place where required
- Evidence of progress with workforce reductions
- A robust assessment of risk to delivery of plan and appropriate mitigations, considered and approved by the Board for each organisation
- Evidence of improving run rate

# Forward look



Work is expected to commence on the Medium-Term Financial Plan imminently. NHSE guidance and allocations are anticipated in late September/early October. All providers are expected to submit a 5-year integrated delivery plan by the end of the calendar year (draft plans November, final plans December). This will set out the organisation's strategic approach to improving quality, productivity, and operational and financial performance. The foundation planning will focus on the underlying position and exit run rate for this financial year. At month 5, our forecast underlying run rate is a deficit of £8.1m, with the key assumptions being delivery of our financial plan in year and CIP full year effect in line with plan. There remains considerable risk to the delivery of this.

During August, NHS England's Deputy Chief Financial Officer outlined expectations for in-year financial management, including the need for a board-approved recovery plan with clear deliverables, milestones, metrics, risks, mitigations, and accountable clinical, operational, and executive SROs under robust governance. This will be developed during Q2-3 building on the high-level delivery plan produced at the end of Q1.

There is no further industrial action currently planned, but the BMA retains a legal mandate to strike until January 2026. Negotiations continue with the government and the BMA. Consultants and SAS doctors have responded to a ballot that revealed that 67 per cent of consultants and 82 per cent of Specialist, Associate Specialist and Specialty Doctors were willing to strike.

NHSE will undertake a qualitative assessment for Deficit Support Funding allocation for Q3 based on the month 5 position. This is awarded ay system level. It is expected this will include several metrics including having signed contracts, fully developed CIP plans, Financial and workforce performance relative to plan and an improving exit run rate position

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Partnerships Report |
| **Presented to:** | Trust Board |
| **On:** | 1st October 2025 |
| **Presented by:** | Richard Mundon, Director of Strategy and Planning |
| **Prepared by:** | Chris Clark, Director of Strategic Transformation |
| **Contact details:** | Email: chris.clark@wwl.nhs.uk |

**Executive summary**

The latest version of the NHS Foundation Trust Code of Governance (published in April 2023) requires the Trust to work effectively with our system partners and identifies several specific responsibilities for Trust Boards.

There have also been a few publications from NHS England over the last few months which have highlighted the importance of strong partnership arrangements as a key enabler to delivery of integrated and efficient services and in driving improvements in population health through an increased focus on prevention. These publications include:

- The NHS England 10 Year Health Plan, which highlights three radical shifts; from hospital to community; analogue to digital; and sickness (reactive care) to prevention; and
- The Planning Framework for the NHS in England, which promotes integrated, system-wide planning focused on population health, financial sustainability, and service transformation.

This is the latest biannual report to Trust Board highlighting the system partnership work that we are undertaking.

**Link to strategy**

Working effectively with our partners across the Wigan Locality, Greater Manchester and beyond is identified as a key part of *Our Strategy 2030*.

**Risks associated with this report and proposed mitigations**

No specific risks linked to this report. Risk to partnerships included within the Board Assurance Framework (see PR8)

**Financial implications**

No financial implications to this report.

**Legal implications**
No financial implications to this report.

**People implications**
No financial implications to this report.

**Wider implications**
None noted.

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

**Background**

The latest version of the NHS Foundation Trust Code of Governance (published in April 2023) highlighted an expectation that "*providers will work effectively on all issues, including those that may be contentious for the organisation and system partners, rather than focusing only on those issues for which there is already a clear way forward or which are perceived to benefit their organisation. The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver high quality care and effective use of resources*"[1].

This update to the code reflects the establishment of Integrated Care Systems (ICSs) on a statutory footing. Each ICS now has: an Integrated Care Board (ICB) which brings NHS bodies together locally to improve population health and care and manage the financial allocation; an Integrated Care Partnership (ICP) which is a statutory joint committee of the ICB and upper tier local authorities, with a focus on improving the health and wellbeing of the population. The ICP and ICB, along with place-based partnerships (such as our Healthier Wigan Partnership) and provider collaboratives, are tasked with bringing together all partners within an ICS.

The principles underpinning the new code has several elements that relate directly to the need to work in partnership as shown in the table below.

**Table 1 – Code of Governance Principles**

| | |
|---|---|
| **1.1** | Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust ***as part of the ICS and wider healthcare system in England***, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public. |
| **1.2** | The board of directors should establish the trust's vision, values and strategy, ***ensuring alignment with the ICP's integrated care strategy*** and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture. |
| **1.3** | The board of directors should give ***particular attention to the trust's role in reducing health inequalities in access, experience and outcomes***. |
| **1.4** | The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the ***trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners***, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions |
| **1.5** | For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and ***encourage collaborative working at all levels with system partners.*** |
| **1.6** | The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is responsible for ensuring effective workforce planning aimed at delivering high quality of care. |

There have also been a few publications from NHS England over the last few months which have highlighted the importance of strong partnership arrangements as a key enabler to delivery of integrated and efficient services and driving improvements in population health through an increased focus on prevention.

[1] NHS Foundation Trust Code of Governance – Paragraph 2.3

In July 2025 NHS England published the 10 Year Health Plan, which highlights three radical shifts, from:

- hospital to community;
- analogue to digital; and
- sickness (reactive care) to prevention.

Core to achieving these shifts, as set out in the 10 Year Health Plan, is development of a truly Neighbourhood Health Service, which is multi-disciplinary, prevention focussed and rooted in communities. Achievement of this will only come through effective working with our partners across the locality.

The 10 Year Health Plan also proposes reforming the NHS's operating model to give more power to local leaders and communities, with high performing Trusts having the opportunity to have greater freedom and the potential to become "integrated health organisations" that hold outcomes-based contracts for local populations. Whilst the policy details of how this will be implemented are still being developed nationally, it is again clear that accessing greater freedoms will only come through improving the services we provide our communities, which in turn will require effective partnership working to increase focus on prevention and provide integrated care.

In September 2025, the *Planning Framework for the NHS in England* was published. This marks a strategic shift in how services are planned and delivered introducing a rolling five-year planning horizon (2026/27-2030/31), which replaces the previous annual cycle, and promotes integrated, system-wide planning focused on population health, financial sustainability, and service transformation. This medium-term planning approach, with an emphasis on integrated planning across localities and systems, is a key enabler to delivery of the 10 Year Health Plan.

This report provides a summary update of the key ways in which we are seeking to work effectively as a system partner, specifically across Greater Manchester (GM) and the Wigan Locality.

**Alignment of Strategy**

As part of developing the Our Strategy 2030, the Trust engaged widely with partners across the Wigan locality alongside considering strategies at a Greater Manchester level. Our Strategy 2030 is focussed on delivery across our "4 Ps", one of which is Partnerships. Delivery of the Trust's strategy is then focussed on an annual basis as part of the corporate objective setting and supporting divisional plans. In addition to Our Strategy 2030, several other drivers are considered as part of setting the annual corporate objectives including: changes in national planning guidance and/or expectations; and any new partnership strategies as they emerge. In the current financial year we have a specific partnership objective: "to further strengthen existing partnerships and develop new ones, to complement and support our NHS and research activities" (CO8). Risks to achievement of this objective are monitored through the Board Assurance Framework (BAF).

**Participation in NHS Greater Manchester ICS**

All Executive Directors play an active role in their relevant sub-group or network across GM as well as the GM wide programme boards such as elective care or sustainable services, which track system wide

actions against priority areas. Several of the Executive Team have key roles within the GM Trust Provider Collaborative including the Chief Executive, who chairs the GM Elective Recovery Board, and the Deputy Chief Executive who chairs the GM Directors of Strategy group. We also continue to be closely involved in the processes to allocate capital funding across the GM ICS, with the Chief Finance Officer part of the GM Capital Resource Allocation Group (CRAG).

WWL was significantly involved at multiple levels throughout the organisation to ensure that our 2025/26 operational plan submission was consistent with planning assumptions within the GM ICS and that it contributes towards delivery of the GM ICS plan to meet national operational planning requirements. We are already fully engaged with the GM ICB to work towards development of our five-year plan for 2026/27 - 2030/31 in line with the requirements of the *Planning Framework for the NHS in England* through: the GM planning hub meeting and the GM Executive meetings (e.g. GM Directors of Strategy and GM Directors of Finance); and the Trust Provider Collaborative (TPC). Further opportunities to strengthen our clinical services, through working collaboratively with the other GM Trusts, will be considered through this planning round.

We are committed to the delivering key programmes in partnership with providers across GM including:

| | |
|---|---|
| **Pathology** | We have had a shared pathology for many years with Salford Royal (now part of the Northern Care Alliance). We are committed to building on this to develop a single pathology service for GM, through supporting Manchester Foundation Trust and the Northern Care Alliance to develop a best practice model for pathology. |
| **Procurement** | We are the strategic lead for developing a single procurement hub for GM, and an early adopter of the new model. |
| **Recruitment** | We are committed to supporting development of a single recruitment model for GM |

The potential impact of significant cost reductions that ICBs are being required to make on effective partnership working, given the disruption that this is likely to generate, is not yet clear. The operating model for the ICB, including how the ICB supports effective working in “place” (i.e. Wigan) has not yet been finalised. We do however continue to be actively involved wherever possible with partners in the ICB which will support us in mitigating this risk.

Our participation in GM programmes supports access to capital funding to deliver improvements in our services. Since the last partnerships report to Trust Board, the endoscopy service at Leigh has achieved accreditation from the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy (hosted by the Royal College of Physicians). This provides a national quality framework for endoscopy services and is a pre-requisite for delivering the Bowel Cancer Screening Programme. This supports earlier diagnosis, and an opportunity to reduce health inequalities both for residents of the Borough and GM. The capital work at Wigan is progressing well, with the new endoscopy unit expected to complete by November 2025. Following this we will be seeking JAG accreditation for Wigan which will support the delivery of Bowel Cancer Screening lists here too; increasing accessibility of screening and supporting a reduction in health inequalities given the variation in screening take up across the Borough.

**Collaboration with Bolton NHS Foundation Trust**

Our collaborative work with Bolton with oversight of projects to improve efficiency and service sustainability overseen by the Bolton and WWL Collaboration Board in line with the principles below that have previously been agreed and reported to Trust Board.

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

The table below outlines the key areas that we are working on together:

| | |
|---|---|
| **Microbiology** | Increasing attractiveness of Microbiology roles at WWL through ensuring access to Bolton's pathology laboratory, to support substantive recruitment and reduce premium spend |
| **Theatre utilisation** | Maximising theatre capacity for the benefit of our patients, with a specific focus on Bolton patients accessing capacity at Wrightington Hospital for orthopaedics and Leigh Infirmary for high volume low complexity general surgery. |
| **Workforce** | Review of opportunities for joint working across recruitment and payroll services to increase resilience, reduce costs, and align systems, in line with the single GM recruitment model. |
| **Digital** | Senior leadership collaboration sessions established, with review of opportunities for joint working being undertaken including the potential for a shared data centre. |
| **Finance & Procurement** | Sharing expertise where specialist knowledge can be pooled to provide resilience.<br>Early adopter and strategic lead for procurement collaboration across GM.<br>Progression of General Ledger harmonisation, in line with GM priority, using shared resource. |
| **Nursing, Midwifery & AHPs** | Senior leadership collaboration sessions established to share learning and identify opportunities, including consideration of joint posts where it makes sense to share expertise and leadership. |

**Healthier Wigan Partnership**

WWL Executives continue to play an active role in the Healthier Wigan Partnership Board which brings together key partners across the Wigan Locality including Wigan Council, WWL, the locality ICB team, Healthwatch and representation from the voluntary, community and faith sectors (VCFS). Key WWL stakeholders also contribute to the sub-groups to the Partnership Board.

Our commitment to increasing focus on prevention together is demonstrated by the recent joint appointment of a Consultant in Public Health with Wigan Council, bringing specialist expertise in epidemiology and health improvement into hospital services and supporting targeted action on health inequalities and embedding prevention within clinical pathways. The joint appointment will provide visible leadership across organisational boundaries, ensuring closer alignment of prevention, population health and acute care priorities, strengthening our shared use of data and intelligence and promoting workforce development.

We continue to be committed to the work of the Wigan Anchor Partnership, recognising that community wealth leads to strong community health (one of the fundamental "Progress with Unity" pillars). We know that a good job, access to education, a good place to live, connections to the community are important building blocks that can really improve the health and wellbeing of our residents. Through this partnership, we are actively engaged in supporting improvements in the socio-economics of the Borough by leveraging the economic clout we have as the largest employer and our significant spending power. To date the partnership has achieved significant progress supporting local people to access work, progress in their careers, created local jobs and run local buildings and facilities for the benefit of their community. We have also seen an increase in the value of non-pay spend with organisations based in Wigan and across GM.

Our "Better Lives" programme is now starting to deliver some tangible benefits through working collaboratively with Wigan Council and the ICB to support our residents to live independently and transform urgent and emergency care. The co-designed programme has three key aims:

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

We have much yet to do to sustainably embed new ways of working, and to achieve these aims. The signs are however encouraging. We have seen the second consecutive month of improvements in our four-hour emergency department performance, reaching 77% in August — the highest level in three years. The first phase of Better Lives, focussed on admissions avoidance is the most developed. Work has started over the last two months on the second phase which is focussed on discharging patients from hospital promptly and ensuring that we make the most of our reablement and rehabilitation services across the Borough. This will support increases in the number of patients who are able to return to their usual place of residence and reduce those going into long term care.

**Recommendation**

Trust Board is requested to note the contents of this report.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

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|---|---|
| **Title of report:** | University Hospital Status: Progress Report |
| **Presented to:** | Trust Board |
| **On:** | 1st October 2025 |
| **Item purpose:** | For Assurance |
| **Presented by:** | Prof Sanjay Arya, Consultant Cardiologist<br>Executive Medical Director and Responsible Officer |
| **Prepared by:** | Madeleine Jackson, Service Development Manager<br>Alison Robinson, Head of Research |
| **Contact details:** | E: Madeleine.Jackson@wwl.nhs.uk<br>E: alison.robinson2@wwl.nhs.uk |

**Executive summary**

Becoming a University Teaching Hospital has been a long-held ambition of the Trust. We have been working toward this ambition since 2021 with a project team which is chaired by Professor Sanjay Arya and comprises key members of WWL's Board, Research and Education Teams and Edge Hill University (EHU).

To become a University Teaching Hospital, the Trust must apply to the University Hospital Association (UHA) and there is a list of criteria that an organisation must meet to achieve University Hospital Status.

The project group were confident that the Trust would be able to apply to become a University Teaching Hospital in March 2026, having met all but one criteria 1ci (number of clinical academics) which is still in progress. However, we have been informed following NIHR grant financial reports for the previous financial year that unfortunately we are no longer achieving criterion 1ciii – i.e. we no longer meet the UHA criteria (average £200k) for RCF payments.

**Link to strategy and corporate objectives**

University Hospital status is a key priority within Our Strategy 2030.

**Risks associated with this report and proposed mitigations**

None

**Financial implications**

None

**Legal implications**

None

**People implications**

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

**Equality, diversity, and inclusion implications**

None

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

None

**Recommendation(s)**

This paper is to provide assurance that we are still working towards our aim of becoming a University Teaching Hospital and the Board is asked to note the progress made to date.

## Report

Becoming a University Teaching Hospital has been a long-held ambition of the Trust. We have been working toward this ambition since 2021 with a project group which is chaired by Professor Sanjay Arya and comprises key members of WWL's Board, Research and Education Teams and EHU.

To become a University Teaching Hospital, the Trust must apply to the University Hospital Association (UHA) and there is a list of criteria that an organisation must meet to achieve University Hospital Status.

The Education Team have gathered a wealth of evidence for the criteria listed under sections three, four, five and six. The RAG rated criteria can be found in appendix 1. We have kept criteria under sections three, four, five and six as amber pending review at the next project group meeting.

The project group were confident that we would be able to apply to become a University Teaching Hospital in March 2026.

However, we have been informed following NIHR grant financial reports for the previous financial year that we are no longer achieving criterion 1ciii Research Capacity Funding. The expenditure was lower than expected in the 2024-25 financial year, and the claim from the grant reduced in-year (with expenditure expected in the current financial year). This has directly impacted the level of Research Capacity Funding we are awarded for 2025-26, having previously achieved the >£200k average required (based on forecasted expenditure) and we are now only achieving £190k for the previous two years. Therefore, criterion 1ciii is no longer met, escalating the challenge to achieve the next successful NIHR grant.

An area which also remains a challenge is criterion 1ci "A core number of university principal investigators. There must be a minimum of 6% of the consultant workforce with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question." This has been a challenging criterion which requires a total of 13 consultants to meet it, which we are still working towards. See appendix 2 for the LIVE tracker, which shows progress around criterion 1ci. (6 already in post with others in the pipeline)

The group have developed a plan to mitigate against the challenges posed by criterion 1ci, and the group updates the tracker as individuals are discussed. These include:

| Planned actions | Progress |
|---|---|
| A review and change to new consultant recruitment and their job descriptions to ensure they have a clinical academic focus where appropriate and making it clear that the substantive employer would be EHU with an honorary contract with WWL when they go out to advert | New Appointments - two Clinical Academic Appointments – in the last year: Consultant in Diabetes and Microbiology following the Follett Principles with an integrated job plan. Others have been discussed e.g. two potentials in Haematology |
| Checking if non-medical consultants and education research colleagues are eligible | Non-medical consultants would be eligible. One is being discussed with EHU. Consultant Pharmacist/Frailty. |
| Checking if EHU Academics can be offered Honorary Clinical Contracts at WWL. | Previously, 1x HCC provided (Clinical Academic GP). 3 are in progress (Medical Education Research) – Critical Care, Dermatology, Anaesthesia. |
| Collaborating with our consultant colleagues, already in post, to develop their research portfolios and provide advice on contractual arrangements to enable them to become eligible principal investigators | FAQs relating to becoming a Clinical Academic are being drafted, consulting with University Hospitals Group to finalise for subsequent dissemination to consultants.<br><br>1x Consultant conversion achieved – Musculoskeletal.<br><br>WWL Consultants (8) have been approached and are considering transfer, and in consultation with EHU. Mainly derived from a Medical Education Research.<br><br>1 WWL Consultant transfer is in progress who is Chief Investigator for NIHR funded trial. |
| Developing a plan to maintain levels of REF returnable research, including an investment plan for the research investment fund | Research Investment review process in place should the request to pump-prime PAs to establish a strategic Clinical Academic post – on the proviso that new grant income would sustain the PAs going forward. |

It is possible that the University Hospital Association criteria may change again (as it did in 2021) by the end of this calendar year, however, we would still aim to meet the criteria. Clarification on this point will be provided in the next Board update.

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

# Appendix 1: University Hospital Association Criteria Checklist

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

## Appendix 2: Clinical Academic Appointments Live Tracker

LIVE tracker - clinical academic workforce S

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| **Title of report:** | Annual Report 2024-2025 |
| **Presented to:** | Board of Directors following Quality and Safety Committee |
| **On:** | 1 October 2025 |
| **Item purpose:** | [Information] |
| **Presented by:** | Kevin Parker-Evans Chief Nursing Officer |
| **Prepared by:** | Head of Patient Relations and PALS |
| **Contact details:** | T: 01942 773342 vicky.bolton@wwl.nhs.uk |

**Executive summary**

This annual report provides the Executive and Non-executive board with detailed analysis of the formal and informal complaints received into the Trust during the period of 1 April 2024 to the 31 March 2025[1]. This report provides data and assurance that the Trust has an appropriate complaints management process in place to ensure the standards are met in line with the NHS Complaints regulation (2009).

The annual report has been divided into formal complaints, Patient Advice and Liaison Services (PALs), compliments, and learning identified from these. There are key metrics associated with both formal and non-formal complaints identifying divisional performance against the management of complaints, the trends relating to the subject matter, which in this period highlights Clinical treatment, Communication, and Patient Care. There are also details of the PHSO involvement with the Trust ; results from the survey undertaken in respect of the complaints process will be presented separately as this is still in progress.

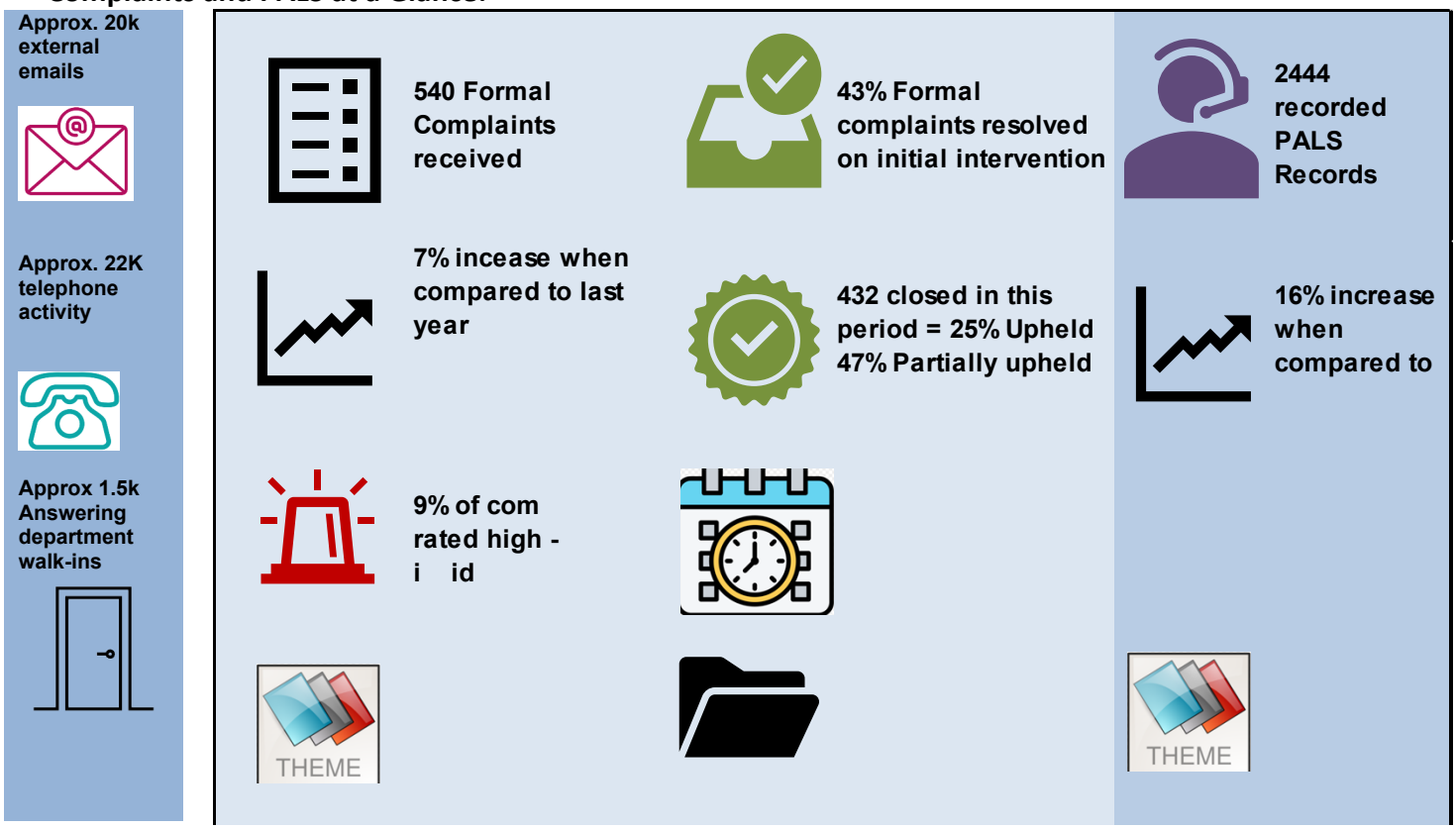
The overall Trust response rate for this period is 67%, which has not met the Trust's Performance Target. The Medicine and Urgent Care Division are experiencing difficulty in responding to complaints within 60 working days. The Chief Nurse has commissioned a supportive integrated governance and key stakeholder weekly review of complaints compliance, within the division which is helping to identify challenges. In addition, the introduction of a quarterly complaints panel where we deep dive into 3 division's responses to identify any learning. This is NED and Lived experience attended and is chaired by the Chief Nurse.

The Trust saw a 7% increase in formal complaints received and a 16% increase in the PALS activity, when compared to last year 2023/2024.

At the request of the Chief Nurse there has been an increased focus in the way in which plaudits and compliments are registered and held. The Head of Patient Relations implemented a web link for staff to enter any compliments received, this has resulted overall in a 85% increase in compliments when compared to last year

[1] As at 8 May 2025 – changes can be made due to consent, withdrawn complaint, late informal resolution, or other.

**Complaints and PALS at a Glance:**




**Patient Relation Successes 2024/2025**

| | | | | | |
|---|---|---|---|---|---|
| | 100% compliant with 3 day acknowlegement performance | | redesign of posters to ensure easy access to all | | Commencment of complaints Review Panel |
| | Actively supporting Ward Level complaints and exploring solutions together | | Family Liaison Officer supporting resolution meetings complaints/incidents | | increase in PALS - Listening and meeting the needs of our |
| | Trust wide web link to recoding compliments for all staff | | Ask Listen D commitme listening an | BSL | |
| | patient experience training, complaints writing | | developing communica module with the staff engagement team | | datix funcationality |

**Link to strategy**

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

**Risks associated with this report and proposed mitigations.**
The Division of Medicine and Urgent Care overall compliance to responding to complaints on time, is having an impact of the Trusts overall performance. The Chief nurse has implemented an enhanced closer support to the division with relation to complaints management

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

**Legal implications**
None identified.

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

**Equality, diversity and inclusion implications**
The Trusts Chief Nursing Officer has implemented a closer focus diversity and inclusion and ensuring equity with complaint responses. At the request of the Chief Nursing Officer thematic reviews of protected characteristics and ethnic groups will highlight if underrepresented groups escalate concerns and ensure that when they do they are answered accordingly.

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

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

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

1. Divisional teams were asked to note the contents of the report, In order to inform of the areas for improvements/focus on patient experience
2. Note the risks associated with achieving the proposals.

## 1. Formal Complaints

Table 1. outlines the top themes highlighted from formal complaints received, with the trend of the theme in comparison to 2024/2025

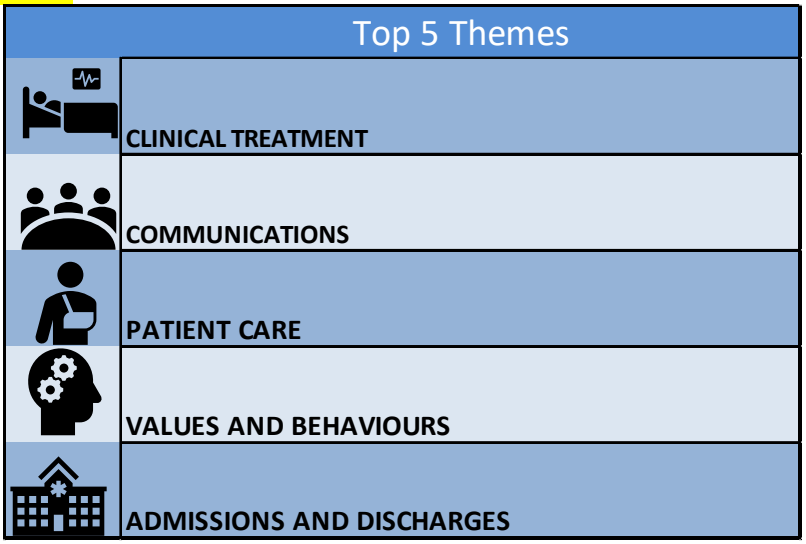



**Table 1.**

| | Total | Compared to 2023/2024 |
|---|---|---|
| CLINICAL TREATMENT | 229 | ↑ 19% |
| COMMUNICATIONS | 75 | ↑ 9% |
| PATIENT CARE | 50 | ↔ N/A |
| VALUES AND BEHAVIOURS (STAFF) | 46 | ↑ 4% |
| ADMISSIONS & DISCHARGES | 32 | ↓ 42% |
| WAITING TIMES | 29 | ↑ 52% |
| APPOINTMENTS | 27 | ↓ 23% |
| PRESCRIBING | 13 | ↑ 62% |
| TRUST ADMIN/POLICIES/PROCEDURES INCL PATIENT RECORD MANAGEMENT | 11 | ↑ 10% |

Of the 540 formal complaints, the main themes emerging from complaints received (the main matter raised within the formal complaint) are Clinical treatment 42%, Communication 14% and Patient Care 9%.

Looking at subject matter; Clinical Treatment and Communication featured in the top subjects in last year's data. Patient Care is again a prevalent subject but has neither increased nor decreased in this period. Noticeably Admissions and Discharges, and Appointments has decreased. In relation to Admissions and Discharges, there is an equal split of both Discharge and Admissions subject matter.

The subject of Appointments has decreased; with the majority of complaints involving Surgical and Specialist Services Divisions.

The subject Values and Behaviours has shown a slight increase when compared to last year, this is a subject that is closely linked to 'communications' subject, and therefore both subjects have been monitored over the year.

To provide assurance and support to both complainants and staff the Chief Nurse developed two new ways of working to support the reduction of values and behaviours themed complaints, a structured, documented

reflection template, supporting staff and their line manager, to understand if there is a skills and/or knowledge gap. A professional conduct panel: Nursing, Midwifery and AHP's involved in serious complaints, or those staff identified as being a trend within complaints and have completed the above exercise will be escalated to the professional conduct panel, whereby the panel can decide if there is further support and/or structured management required.

Meetings continue to be an effective way of responding to complaints and to support this process a new Chief Executive meeting template letter was introduced in January 2025. The content now includes a summary of the findings of the investigation and any improvements identified, with further details and discussion taking place within the meeting with the complainant at a later date. Of the 540 formal complaints received approximately 8% were responded to by holding a meeting.

In addition to the 540 formal complaints received, **21** other cases - other Trust's requiring information and Investigation outside of the NHS Regulations (over 1 year or more) were received; all 21 cases required a formal investigation and response. There were also **4** formal cases relating to Information Governance, 1 Human Resources formal complaint, and **9** Private Patient complaints.

**1a. Analysis of formal complaints recorded ethnicity and gender**

Of the 540 formal complaints received where the subject was recorded as 58% female and 42% male. The majority of our service users are White British, 93%. This is largely unchanged from last year.

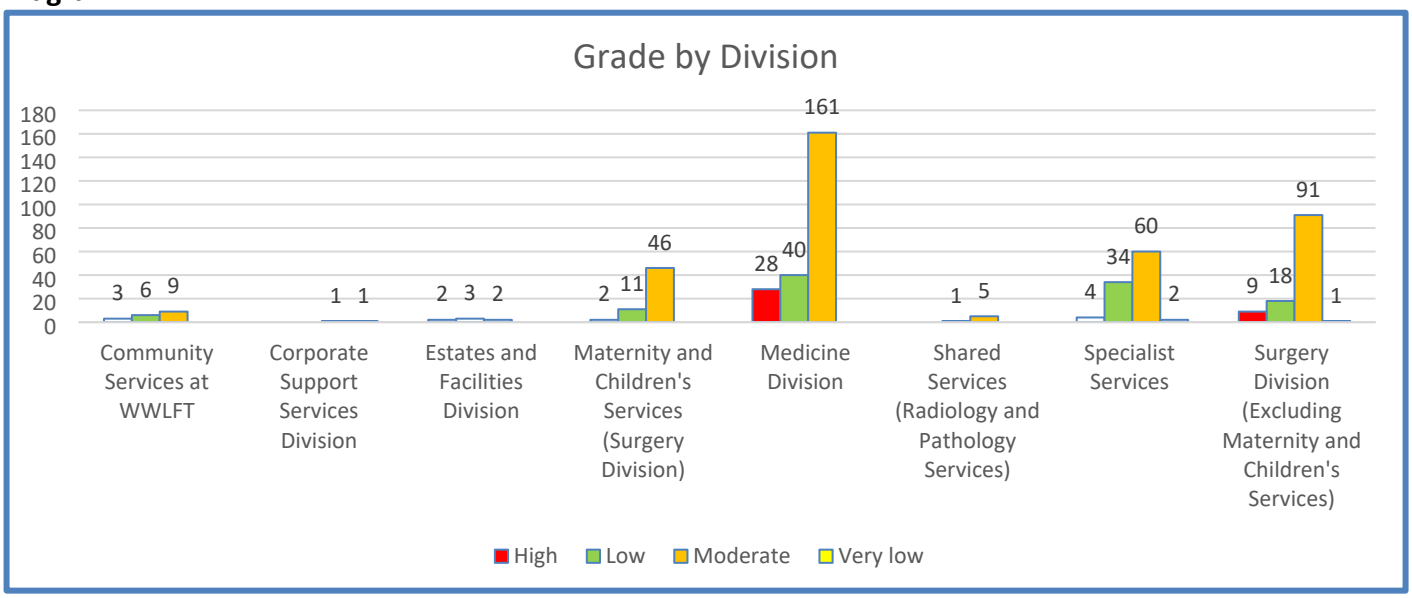
**Table 4 – subject of complaints by recorded ethnicity**

| Ethnicity Background | Numbers | Percentage |
|---|---|---|
| White British | 504 | **93%** |
| White Irish | 1 | **0.18%** |
| White – other white | 6 | **1.10%** |
| Mixed white and Asian | 1 | **0.18%** |
| Other Asian | 1 | **0.18%** |
| Black Caribbean | 1 | **0.18%** |
| Black African | 2 | **0.37%** |
| Other mixed | 2 | **0.37%** |
| Other ethnic category | 1 | **0.18%** |
| Not stated | 21 | **4%** |
| Total | 540 | |

The Patient Relations team support our community by asking at the point of contact if they require any assistance, any additional resources, or a particular text format for corresponding purposes. We promote the services of an independent advocacy service, such as ICA, and Healthwatch, who help and assist people with complaints. In addition to the work undertaken by the Inclusion and Diversity Service lead, who is helping the Trust to identify any barriers people may come across when accessing our services.

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

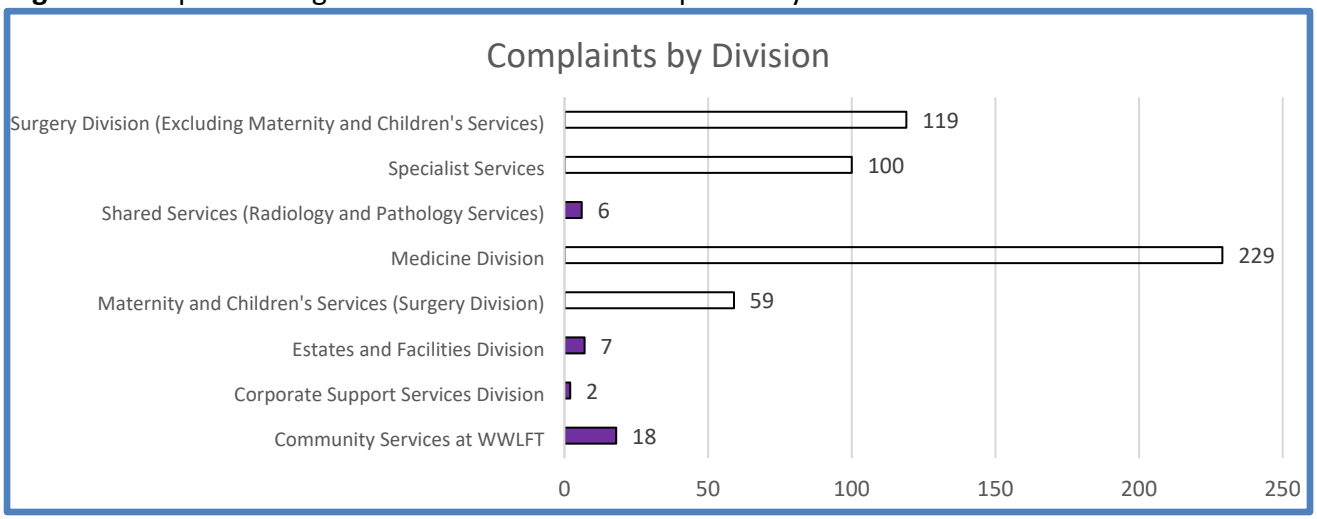
**Diagram 1.**




We will continue to link complaints to incident investigations which feed into complaint responses, when appropriate, ensuring that all questions raised by the patient, family or carer are answered fully and honestly Attending 'Learning from Patient Safety Events Group' also gives the team the opportunity to advise on cases where there are preferences on the way forward, or particular outcome is required. There are 160 incidents opened relating to the 540 complaints; the incident is either opened before the complaint is received, or divisional team will raise an incident on receipt of a formal complaint if it is considered that there is a potential incident raised by the complainant.

The team continue to work with the Patient Safety team, supporting families by acting as Family Liaison Officer. This role ensures we are providing updates and correspondence to families in a sensitive and compassionate manner which secures the confidence and trust of our patients and families, who have been informed an incident has been opened. The Chief Nursing Officer has supported Matrons to ensure de-escalation and management of complaints at a ward and departmental level is undertaken in real time. Matrons are being supported to be more visible across their wards and departments to support 'professional curiosity conversations' from both patients and their relatives.

**Diagram 2** Graph showing the number of formal complaints by Division




*Corporate Services now include Patient Flow/Discharge team

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

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

When a complainant remains unhappy with the response from the Trust, we ask that they let us know what they feel we have not responded to or what they do not agree with. Investigations may be re-opened for a number of reasons, including additional questions raised, further clarification or information. The Trust promotes meetings with clinicians/nursing staff to help resolve concerns at this stage, so that families or patients have the opportunity to directly speak to the clinicians/nursing staff involved in the care and treatment that has been provided following a formal investigation.

This reporting period received 30 reopened complaints (5%) of complaints responded to – compared to the reported figure in last year's report of 26 (5%). This is positive, as it means responses are of better quality and more adequately meeting the needs of the complainant. Appendix 6 shows reopened complaint investigations by division.

**1c. Trust Performance in responding to complaints (timescale)**

Whilst the NHS Regulations (2009) stipulate that we have 6 months in which to answer a complaint, good practice and early response demonstrates that we are listening and learning. **7** Medicine Division complaint cases received a 6-month letter, as per NHS Regulations, acknowledging their case had taken longer than 6 months to investigate and apologies were provided.

The Trust's overall response rate for 2024/2025 is 67%. This is a reduction in the Trust's compliance in responding to complaints; it is acknowledged that delayed responses can intensify a situation, risking further loss of confidence and Trust reputation. Corporate services now include Patient Flow/Discharge team.

**Diagram 3.** Outlines the Trust Performance Response Rate

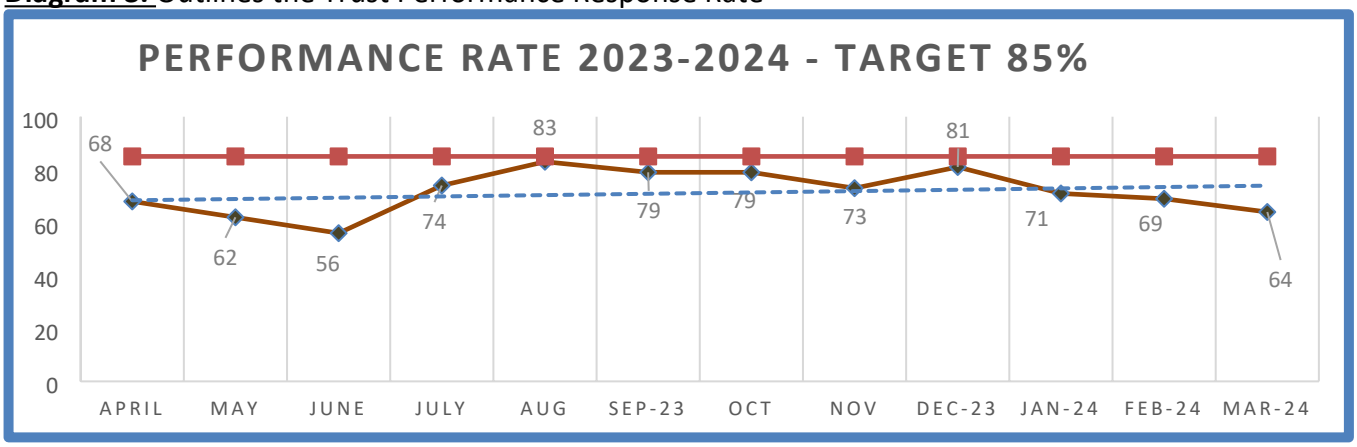



**Diagram 4 – shows the divisional response rate quarterly**

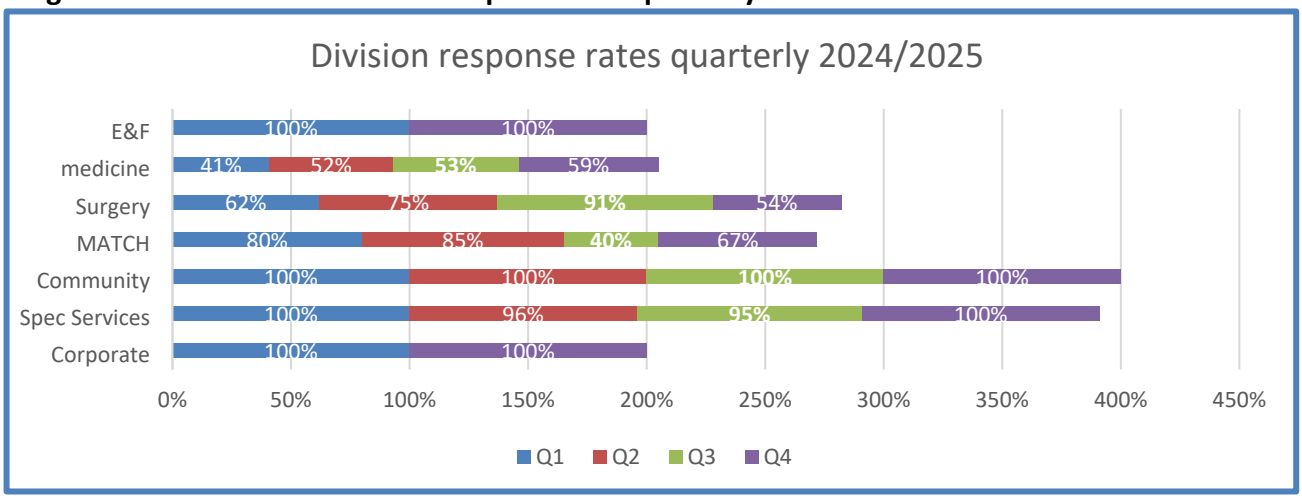


**Table 5 below shows Divisions overall compliance rate for the year.**

| Division | response rate |
|---|---|
| Medicine | 50% |
| Surgery | 70% |
| Maternity & Child Health | 69% |
| Specialist Services | 98% |
| E&F | 100% |
| Community Services | 100% |
| Corporate Services | 50% |

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

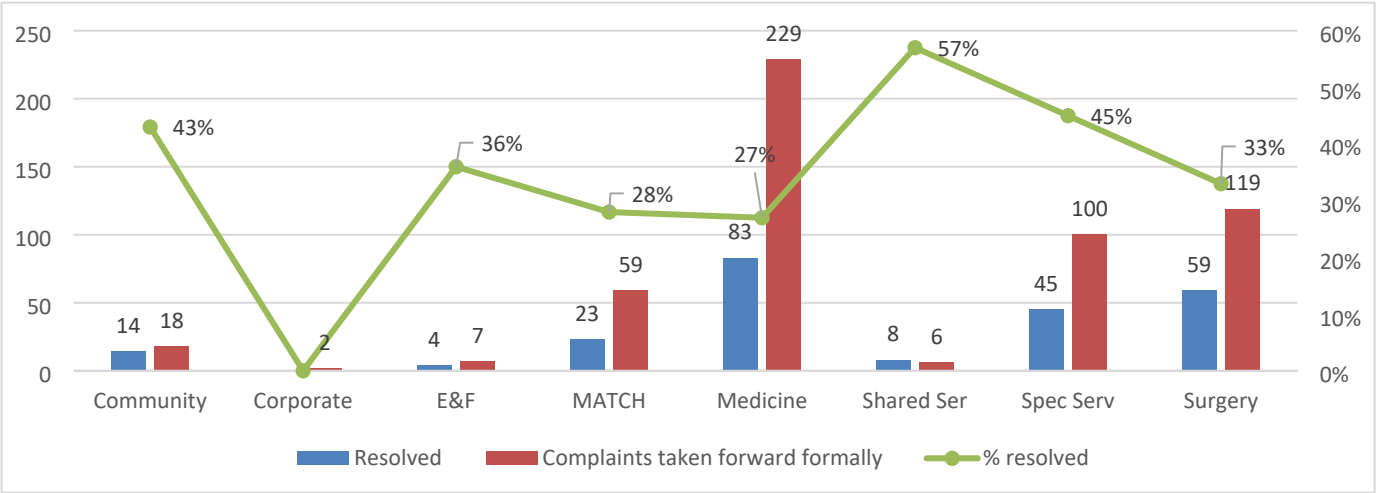
The Patient Relations team have provided training on how to respond to a complaint for 38 members of staff across divisions in this period (2024/2025) however there has been a lack of attendance and cancellations. The training will continue to embed and improve the quality of complaint management, how to respond to a complaint (providing suggested paragraphs and phrases) and increase confidence in responding in a timely manner, to improve this performance parameter. This will continue throughout the coming year. The team will be contacting those that have already attended the training to offer further support based on their requirements. Early look back on **reopened** cases shows no change from previous year, in particular there as been no increase.

Medicine Division receive most concerns and complaints, for this reason Patient Relations attend their Patient Experience group each week to target support where it is required. Patient Relations and the Datix Administrator last year utilised a module within Datix to further monitor and provide a tracker for the divisional governance teams to use for their agreed internal timescales. In addition, a task and finish set up by Patient Relations, identified functionalities that help divisional teams, such as electronic feedback/correspondence, case investigator section, and easy find complainant contact number to encourage divisional investigators to undertake the initial compassionate call.

**1d. Resolved Formal Complaints**

The percentage of those formal complaints deescalated is demonstrated in **Diagram 5.** for example: Community Services received 32 formal complaints and resolved 14 (43%). The role of staff resolving concerns at source is key to a positive and timely outcome, ensuring we maintain trust and provides confidence in our services. Good complaints management, by using an initial telephone call from the local team, has supported in de-escalating complaints at an earlier stage.

**Diagram 5. Formal complaints resolved and deescalated.**




**1e. Parliamentary and Health Service Ombudsmen (PHSO)**

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

Case 1 – Family feel that the discharge process for patient was not followed correctly. Family were not informed of discharge and patient was left in discharge lounge. The PHSO did not fully investigate this complaint but did ask our Trust to consider the offer of £200.00 to the complainant, and to provide evidence of learning

Case 2 - Patient unhappy with care and treatment provided in A&E when catheter inserted. The PHSO have recommended a local resolution meeting to resolve the continuing concerns.

There was an additional request for notes or further information regarding **4** cases, with no outcome provided presently. In addition, the PHSO informed the Trust of **2** cases they were not taking forward, **1** case that they are still investigating.

Demonstrating learning was an area that required development from the divisional teams. Patient relations were populating the 'improvement' field on Datix for completed responses, however some divisions are still not using this therefore we are revising at task and finish group starting again in Summer 2025, to address any challenges and barriers so that this can be done at divisional level ensuring improvements are owned by the area.

## 2. Recorded Concerns/PALs

Below are the top 5 themes from the PALS activity. With **Table 5.** outlining other subjects that have been used multiple times, for the year 2024/2025. Not all PALS queries are subjected because the team may provide information, support and guidance; admission or appointment queries, legal information, access to records requests, other Trust complaints/requests for information/report, Private Patients, and concerns dealt with by Human Resources. In total there was **2444** recorded PALS for this period (**16**% increase comparted to last year).

Appendix 5 shows PALS activity, including for example information/advice, other Trust concern, and Legal, and which divisions this activity relates to.

**Top Subjects**

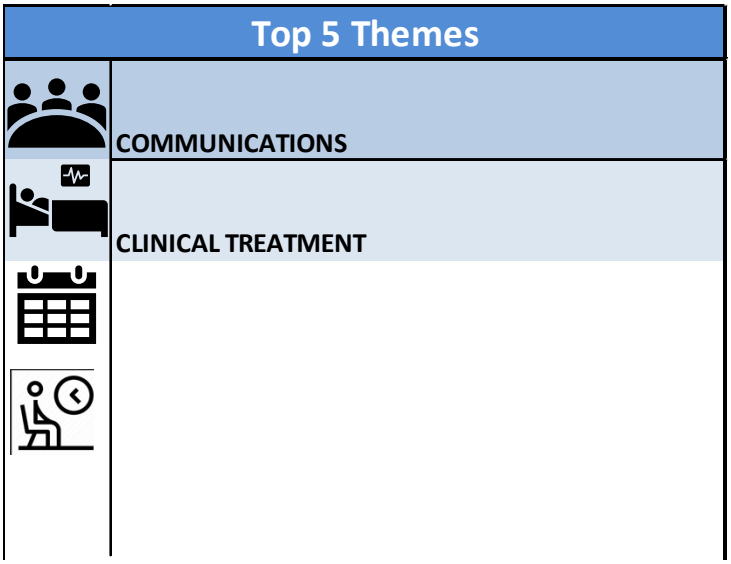



**Table 5.**

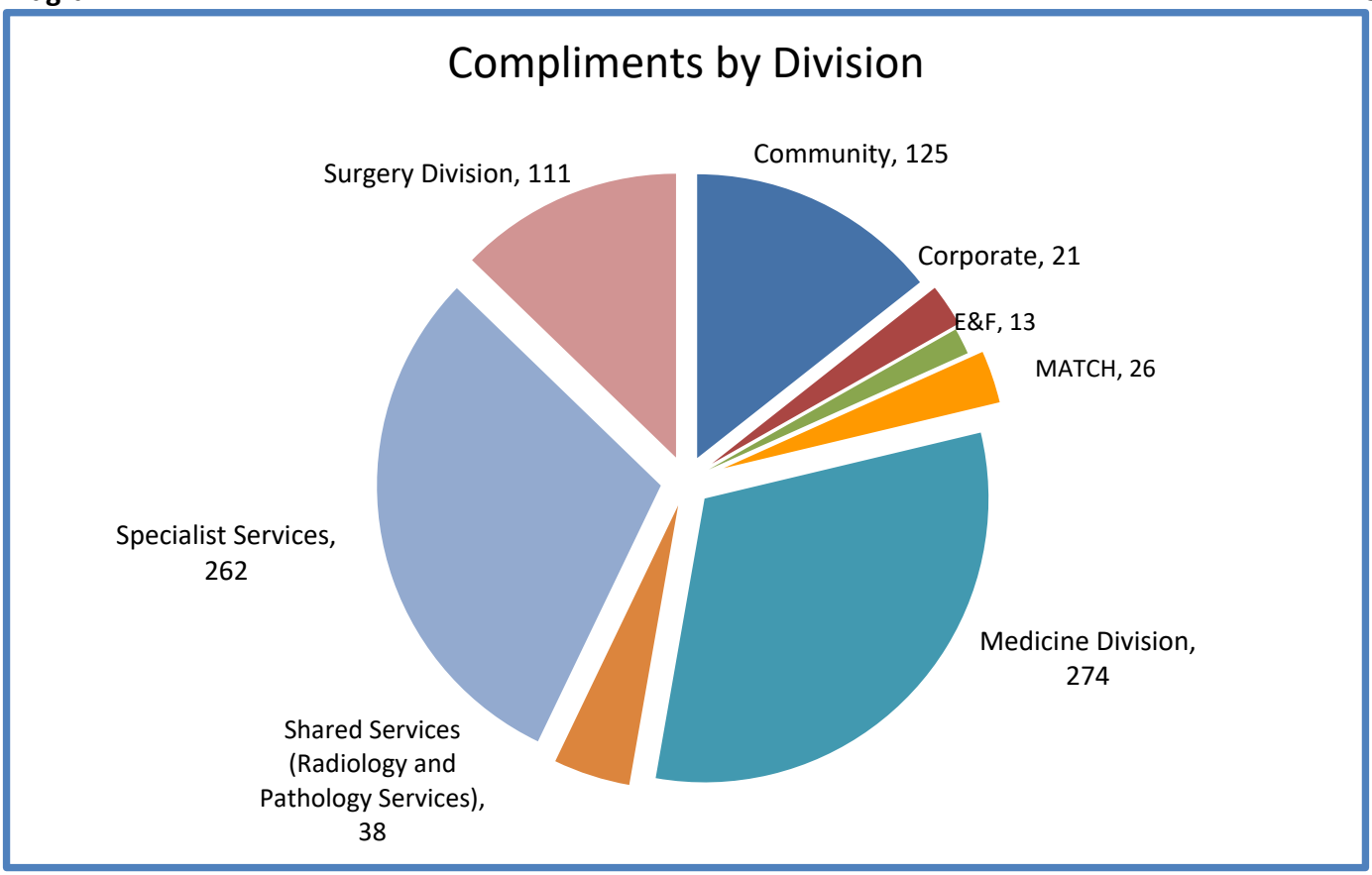
| | |
|---|---|
| COMMUNICATIONS | 388 |
| CLINICAL TREATMENT | 362 |
| APPOINTMENTS | 356 |
| WAITING TIMES | 256 |
| ADMISSIONS & DISCHARGES (EXCL DELAYED DISCHARGE DUE TO ABSENCE OF A CARE PACKAGE) | 160 |
| VALUES AND BEHAVIOURS (STAFF) | 88 |
| PATIENT CARE | 83 |
| PRESCRIBING | 48 |
| FACILITIES | 41 |

The subjects Communications, Clinical Treatments, and Admissions and Discharges are also prevalent in formal complaints, which are exactly the same subjects as reported last year. However, without the PALS team's intervention and early action/resolution these subjects would have been added to the formal complaints, putting more pressure within the divisions to manage the compliance and the complaints process. Whilst Admissions and Discharges is in the top 5 it is reported to have shown a reduction in the formal complaints data, this demonstrates that the PALS team use of collaborative working, focusing on solutions and managing patient's, relatives, and carers expectations, is more person centred, regaining trust and confidence in the services we provide, resulting in a positive feedback experience.

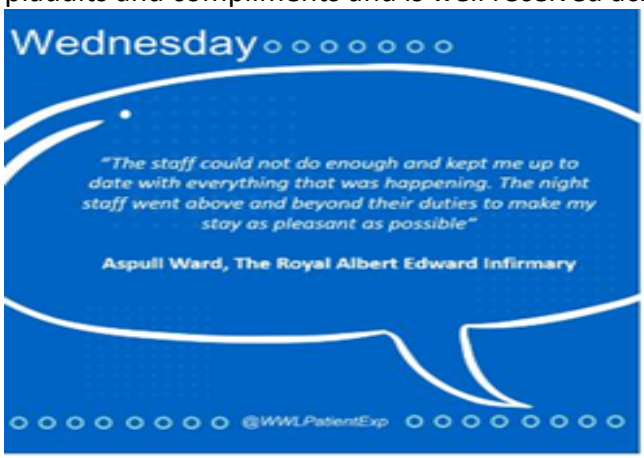
**2a. Compliments and Plaudits**

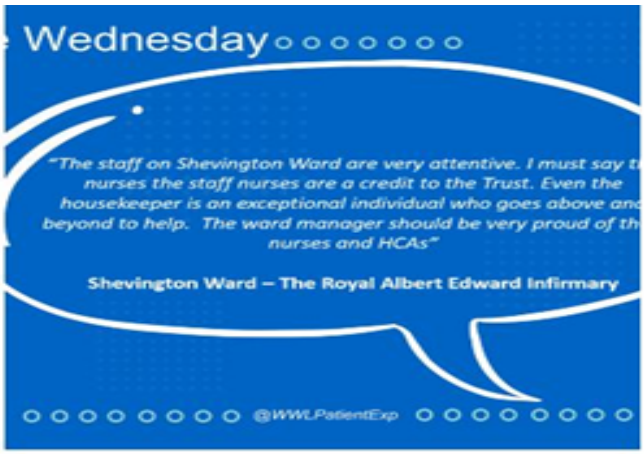
**Diagram 5.** Outlines compliments per division. The Chief Nurse has directed via the Chief Nurse start of the week the importance of managing, receiving and documenting plaudits and compliments and it anticipated that as this data increases it can be triangulated to provide substantial assurance with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

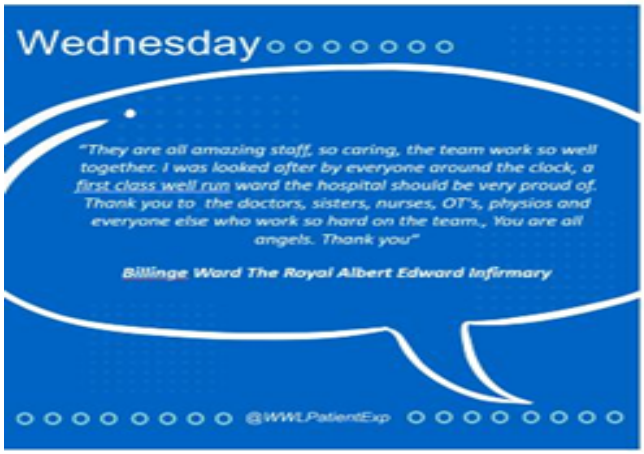
**Diagram** **5.**

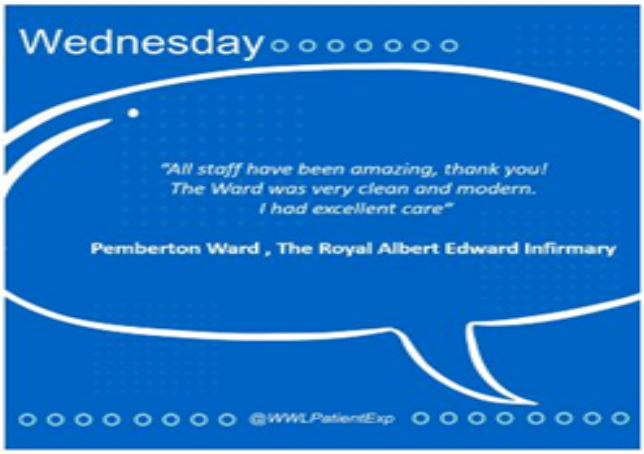



Wellbeing Wednesday is popular with our community, using social media as a platform to feedback thanks, plaudits and compliments and is well received across the teams.



**2c. Learning from complaints**

Learning from complaints is fundamental in improving the quality of care and delivery of services by understanding the experiences and needs of our patients. Trust wide shared learning, celebrating success and lived experience subject matter experience involvement are key to the delivery of a robust patient experience and patient relations strategy.

The patients voice when acting upon complaints is essential, and by welcoming complaints in a positive way, this is a valuable insight, and promotes a learning culture. The Chief Nurse is encouraging senior divisional representatives to facilitate open and transparent face to face approach to managing complaints as a first line offer. The Chief nurse has also facilitated a number of complex complaint meetings during this quarter, which have been well received.

The Associate Chief Nurse for Harm Free Care, Patient Quality and Experience in appointed in August 2024 by the Chief Nursing officer is working in close collaboration with the Patient Relations Team, Patient Experience, and Integrated Governance teams. The Associate Chief Nurse has created a lived experience forum, panel and representation with the management of complaints.

In respect of learning from the subjects; there is work ongoing with groups and after action reviews from across the Trust such as Deteriorating Patient, Discharge Improvement, Lost to follow up, Category Pressure Ulcer, Lost Property, LD Autism and Neurodiversity, Smoke Free Hospital.

The patient relations team have created a complaints review panel process which will provide annually a review of 18 complaints across all divisions with bi-monthly meetings. The complaints are reviewed by an independent panel which includes a lived experience representatives, Healthwatch, ICB and will supportively scrutinise the response, any learning will be reviewed to ascertain whether this has been embedded, and improved patient experience. Following an initial kick off meeting in November, the process was refined and since then a further panel meeting took place which received positive feedback. The feedback and learning from these panel meetings will be shared in the Patient Experience and Engagement meetings twice yearly.

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

**3. Department survey**

During the year surveys regarding the complaints process, and outcome/satisfaction to a response is undertaken; this report will be provided as an addendum at a later date.

4. **Summary from this year and Priorities for 2025/2026**

The Patient Relations team will focus on early resolution of complaints, even with the PALS activity increase, solutions have been provided ensuring satisfactory conclusion to concerns received. Training continues to be provided, and the team encourage investigators to get in touch to have one to one support and training on a regular basis. The department has continued their proactive role in the PALS service, everyone is welcome to contact the department whether they are a patient, relative, carer or member of staff, as a friendly welcome is given to all. We respond to many requests for information and advice and signpost all who access our service in the right direction. The department answers the door to many issues, including call outs to the 'initial responder bleep team', aid people to establish where their appointment is, security

involvement, and our community members who need to have a listening ear, and wanting support during a difficult time. The workflow is unpredictable and can be pressured, but we will continue to endeavour to support our community and help patients to become involved in their own healthcare; *'if we don't know, we will find out who does'*.

The Team empower staff to work with us proactively to resolve concerns at source. Over the past year we have presented to departments on how we learn from complaints, and what strategies can be undertaken to resolve issues, as well as highlighting to staff wellbeing support available in the Trust. Themes and trends continue to be consistent and so a focused approach is required in relation to learning from complaints and Trust wide shared learning, which is regularly updated on the intranet.

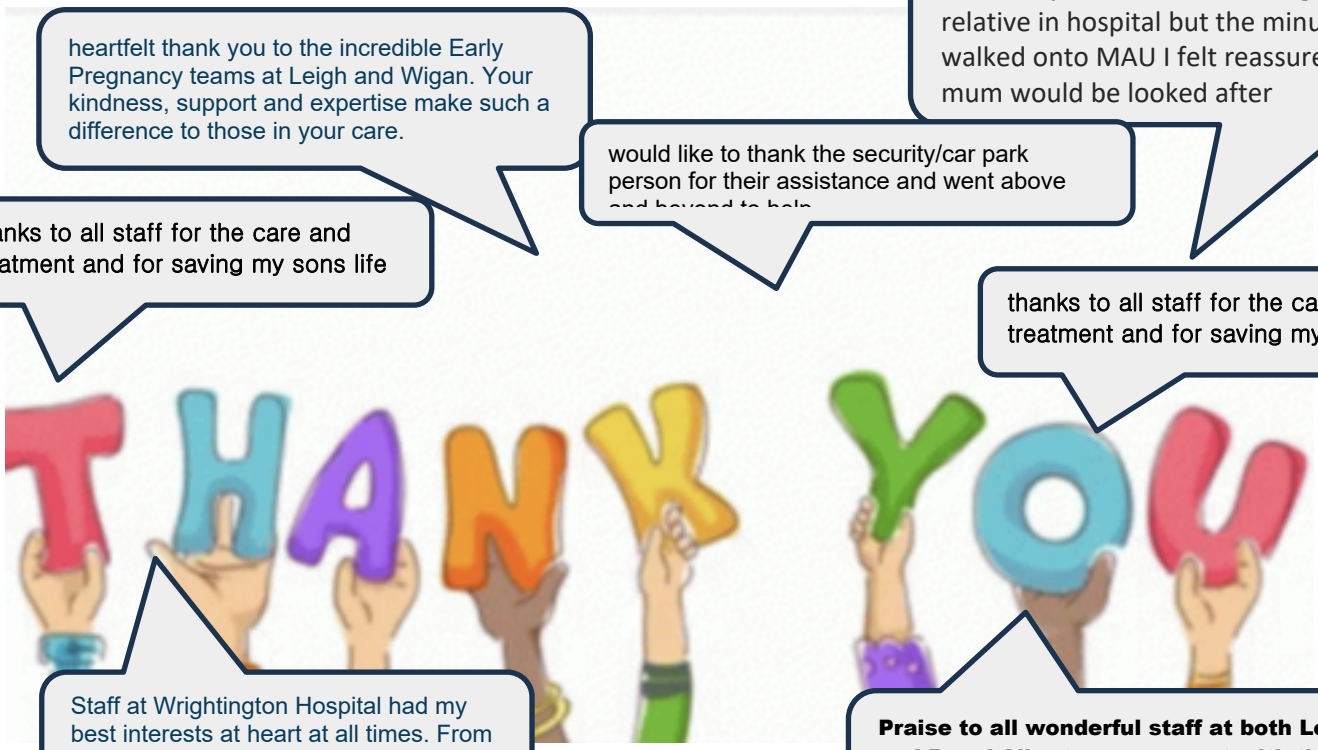
There has been an increase in the number of compliments and plaudits received following new ways of working led by the patient relations team.

The team will continue to improve our accessibility to ensure our community is provided with a fair inclusive culture, addressing questions and problems quickly. Datix now includes Armed Forces selection box for each complaint.

We will continue to support the ED team during time of pressure and will restart the bespoke complaints and compliments awareness sessions on wards and areas. The team support the volunteers on a regular basis, particularly when a relative or friend is trying to locate their loved one. Occasionally the team do get involved in incidents outside of the department office, due to the area being a public thoroughfare, and because of their active participation in supporting our community and the compassion they have for promoting a caring environment.

**Appendix 1** outline a number of plaudits received into the Trust during 2024/2025

**Appendix 1.**


heartfelt thank you to the incredible Early Pregnancy teams at Leigh and Wigan. Your kindness, support and expertise make such a difference to those in your care.
It is a very anxious time leaving your relative in hospital but the minute I walked onto MAU I felt reassured my mum would be looked after
would like to thank the security/car park person for their assistance and went above
thanks to all staff for the care and treatment and for saving my sons life
thanks to all staff for the care and treatment and for saving my sons life
THANK YOU
Staff at Wrightington Hospital had my best interests at heart at all times. From the professional and caring experience, I received it was 100% positive.
Praise to all wonderful staff at both Leigh and Royal Albert we were met with the same amazing staff, who again were professional, friendly, & approachable.

**Appendix 2**
**Learning from closed complaints 2024/2025:**

**Medicine – Communication/Patient Care**
**NG tube insertion training:** Nutritional Nurse to provide education sessions in regard to identifying patients that are not suitable for NG tube insertion and the importance of record keeping following procedures.

**White boards behind a patient's bed:** audit to ensure boards provide the correct information for Speech and Language therapists recommendations, and staff to ensure this is checked before offering beverages.

**Training for modified diets:** Clinical Nurse Educator to train new staff on modified diet and fluids, this includes refresher training for existing staff.

**Dysphagia Training:** Clinical Nurse Educator to upskill staff in Dysphagia Screening (basic swallowing assessment) to ensure patient's safety.

**Specialist Services – Communication**
**Rheumatology Telephone Line change:** A revised staffing model to be implemented to ensure that the Rheumatology telephone line is staffed Monday – Friday mornings and afternoons. Answerphone messages to be reviewed regularly throughout the day and messages deleted to allow capacity for more patients to leave messages

**Medicine – Waiting times**
**Communication in Pharmacy:** Posters have been developed and displayed in the Pharmacy waiting room to encourage patients to come forward to speak to a member of staff if they have been waiting for longer than 30 minutes.

**Medicine – Clinical Treatment**
**Awareness of Patients Chemotherapy Pathway**: In conjunction with the Oncology team, training sessions delivered to Emergency Care staff for patients who have recently or are undergoing chemotherapy should the patient need access to emergency care.

**Surgery – Prescribing**
**Development of Pregnancy Flow Chart for PID (Pelvic Inflammatory Disease):** A new flow chart in the process to provide clear information to support prevention.

**Medicine – Communication**
**Communication:** Complaint sessions on the ward facilitated by the patient relations team to highlight themes in complaints and give staff insight to why communication is important to patient care.

**Surgery – Waiting times**
**Managing Patient Expectations:** Surgical Clinical Cabinet to discuss the importance of managing patient expectations around waiting times to be seen.

**Maternity and Child Health - Trust Admin/Policies and Procedures**
**Patient Information Leaflet:** implement a patient information leaflet regarding NAI (None Accidental Injury) to ensure families are fully informed of the processes in place.

**Maternity and Child Health – Clinical Treatment**
**Midwifery community Training:** Maternity education team to support community midwives in wound care, including assessment of caesarean section wounds healing.

**Specialist Services – Communications**
**Patient Information Leaflet review:** The Preoperative Assessment department will be updating their patient information leaflet to clarify the preoperative assessment process in more detail – this will clarify that when additional investigations are required the patient would not hear from the Trust further until the investigations are complete.

**Ask do listen, feedback, concerns and complaints.**
To improve experiences and outcomes for children and adults who are autistic or have a learning disability, their families and carers, NHS England are taking forward a service development improvement plan (SDIP) for all providers who offer services to people with a learning disability, autism or both (including children and young people). The Patient Relations department has used the resources provided by Ask Listen Do, to improve the posters, leaflets, and the Trust's Patient Relations' part of the Trust website to make it easier for people, families and paid carers to give feedback, raise concerns and complaints. Posters will include top 5 languages other than English (Kurdish, Arabic, Romanian, Farsi, Polish – which were the most interpreted during 2023/2024). The Patient Relations Department has also scripted and created with the interpreter service a video included on the Trust's website explaining the PALS service in BSL. As the team receive many requests for access to records, which are dealt with by Information Governance (IG); we asked IG to also look at an easy read form, which has now been completed.

The Deputy Chief Nurse was direct by the Chief Nurse to lead and develop this aspect and the 'Learning Disability/autism/Neurodiversity effectiveness group' was launched and the first meeting took place in September 2024.

**Family Liaison Officer (FLO)**

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

- **Independent Complaints Review Panel**

The first meeting for this panel commenced on 22 November 2024. The meetings are chaired by the Chief Nurse and colleagues external to the Trust from the ICB and Healthwatch will be regularly attending in addition to Lived Experience Partners and Non-Executive Director representatives will ensure the objectivity of the meetings. The first meeting was well attended and involved a review of the three closed complaints which were identified. This was an initial meeting and, with further scheduled bi-monthly through the year. Feedback from these meetings will be shared with the Divisions and in a twice-yearly report to Corporate Patient Experience and Engagement Group.

- **Compliments**

The roll out of the web intranet link to all staff has been a success – the electronic forms allows a staff member to complete the name of the patient the compliment relates to and the area. The team later revalidate the entry and subject the compliment.

- **Communication**

**Training** - The team are taking forward training for OSC security and car parking staff, so that they are involved in what type of complaints and concerns are received, providing skills on de-escalation and resolution. This has also been identified for our Volunteers across the Trust.

**Consultant Appraisal meeting –** at the request from the Medical Director, a senior urology consultant presented a detailed view of complaints handling - the subject matter of what our Trust receives, and skills and how to resolve complaints fairly and efficiently; focusing on key steps – actively listening, clear communication, and the meaning of an apology.

**WWL Learning Hub** – the team are working with the Learning and Development team to implement a module where a series of questions will be asked about how you would deal with a concern. There will be a minimum score in order to pass the module, and appropriate answers/actions are provided, as well as advice and support directed to the staff member.

**Chatbot** – the team have liaised with the IT implementation team to discuss the concept of a chatbot on the Trust website for frequently asked questions, which may help and assist our community, and may alleviate delays in obtaining information with the option of still being able to speak to a staff member in the team.

**Complaints drop in sessions**

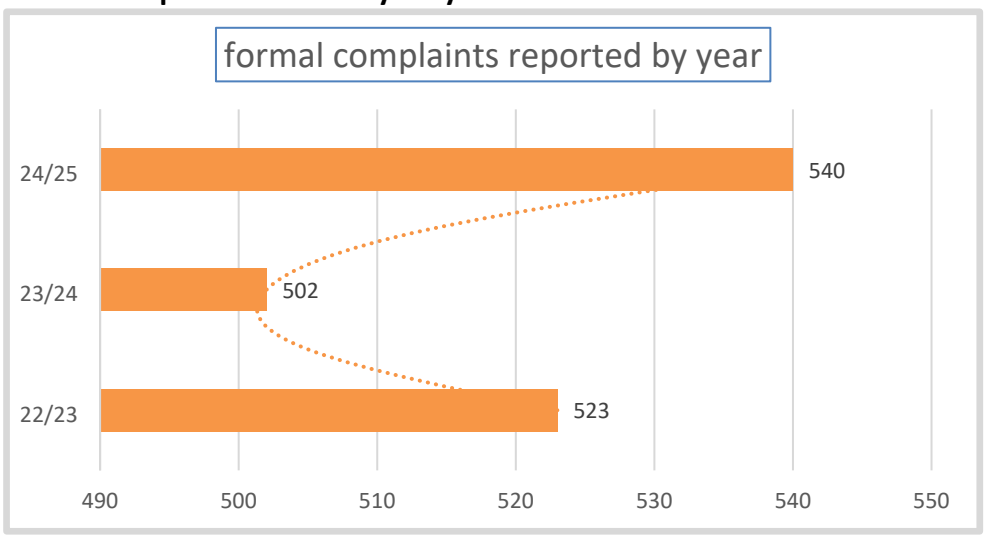
The team have offered Trust complaint investigators to drop into the department to help write responses, advise on resolution meetings, and provide general support that is required.

**Winstanley Ward trial**

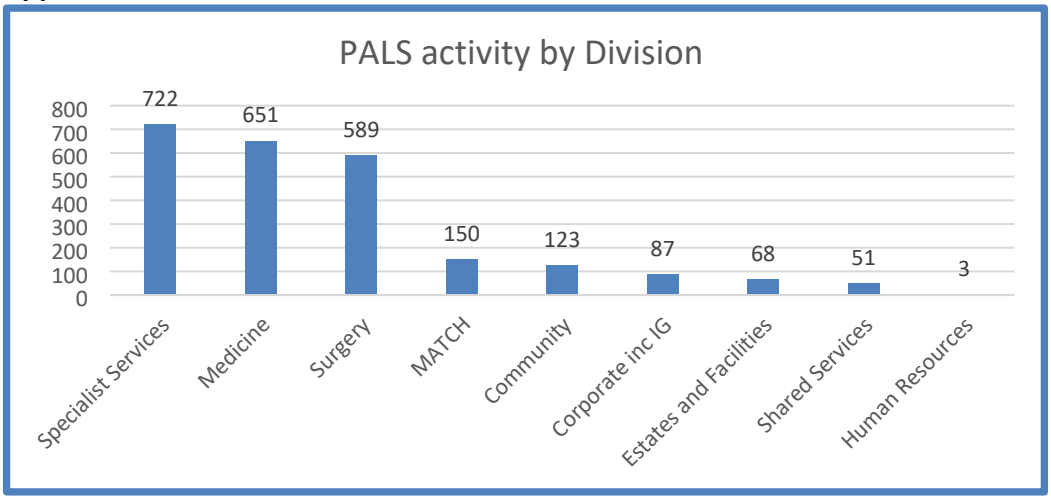
The Ward Consultant has identified a gap in relaying information to relatives of our loved ones; emphasized during a resolution meeting with the Ward Consultant and Head of Patient Relations. Therefore, supported by the Ward Leader a poster has been devised to highlight 'positive engagement', encouraging our relatives to request a discussion about their loved one, with their loved one and named consultant.

**Appendix 4**

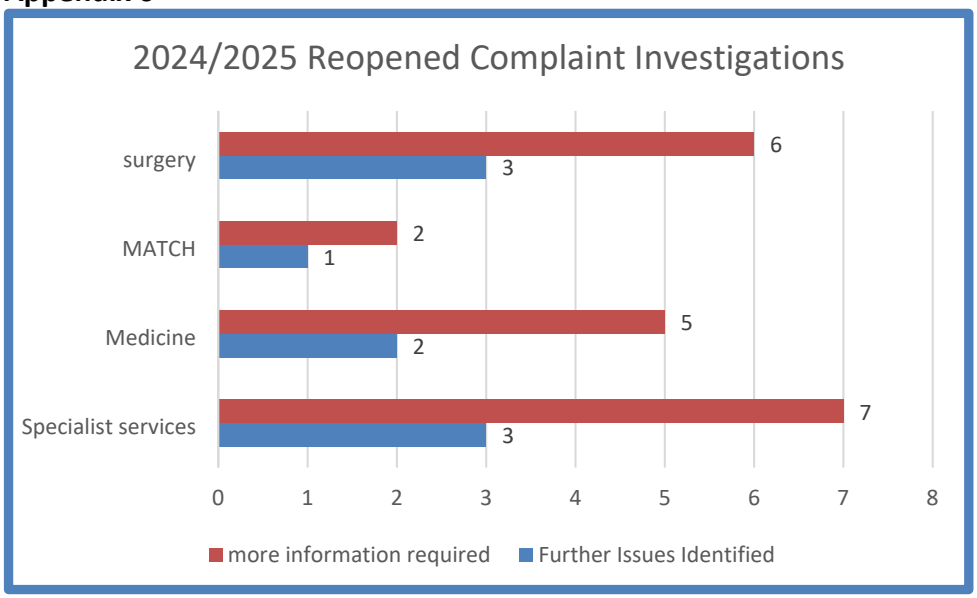
**Formal complaints received yearly*[2]**




**Appendix 5**




**Appendix 6**




[2] As at 8 May 2025 – for year 2024/2025 this figure can change, because the Trust is working on 60 working days, de-escalation/retraction can be made to complaints at the complainants request or agreement


**Donation of Handmade Angel Gowns**

We would like to thank retired Palliative Care Nurse, Mrs Janette Hilton, for her kind donation of 'Angel Gowns' for our tiniest patients. The 'Angel Gowns' have been made from her 2008 wedding dress and she has created them during her spare time.

Mrs Hilton recycled her wedding dress to give something back to the community and she hopes that her kind gesture, brings comfort to families. The Neonatal and Maternity services are in much need of these beautiful gowns for babies who are stillborn to wear on their final journey.

Colleagues from Paediatric Emergency Care, Bereavement Midwives and Patient Relations were delighted to receive the gowns and to thank Mrs Hilton for her act of generosity.

| | |
|---|---|
| **Title of report:** | CNST Update Report |
| **Presented to:** | Trust Board |
| **On:** | 01. 0ctober 2025 |
| **Presented by:** | Kevin Parker-Evans Chief Nurse & DIPC |
| **Prepared by:** | Cathy Stanford Divisional Director of Midwifery and Child Health |
| **Contact details:** | T: 01942 773107 E: cathy.stanford@wwl.nhs.uk |

## Link to strategy and corporate objectives

This summary provides an update on CNST progress additional to the quarterly updates received within the Perinatal Quality Surveillance Report. It provides oversight and assurance to the Board that there are effective systems in place to achieve compliance with Year 7 of The MATERNITY Incentive Scheme

## Risks associated with this report and proposed mitigations.

Non-compliance will trigger escalation

## Financial implications

Failure to meet the maternity and Perinatal Incentive Scheme 10 Safety Standards will result in the financial loss of at least 10% refund of scheme contributions

## Legal implications

N/A

## People implications

Key responsibilities of individuals and systems are included within the published standards. Lack of compliance may lead to patient safety incidents.

**Equality, diversity, and inclusion implications**

All are considered within each metric

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

None

**Recommendations)**

The Board are requested to note the summary of compliance as outlined below and note that the Maternity and Neonatal services are on track to achieve compliance against the standards.

Additionally they are asked to note non-compliance against PMRT Training for MNVP leads for Safety action 7 which does not affect the overall compliance against the standards if escalated to the Trust Board, LMNS and ICB. Compliance must be achieved against this particular element by the end of March 2026.

## Executive Summary

Timetable

| Date | Description | Purpose |
|---|---|---|
| 28th April 2025 | National Launch of CNST Year 7 | Introduction to the requirements for Year 7 |
| 12th May 2025 | GM presentation of CNST Year 7 | Q&A opportunity with NHS Resolutions |
| 14th July 2025 | Safety Action 7 | Q&A opportunity with MNVP Lead/NHS Res |
| 29th August 2025 | CNST Progress | Providers to update on expected compliance at 3 March 2026 |
| 1st September 2025 | Safety Action 7 | Q&A opportunity with MNVP Lead |
| 2nd September 2025 | Safety Action 3 | New QI projects to be registered with Trust QI / Service Improvement Team |
| 16th September 2025 | Safety Action 3 | Providers continuing projects from Year 6 to present to the LMNS their progress. |
| 30th November 2025 | End of the Compliance Period | |
| 15th December 2025 | Maternity providers to submit all CNST evidence to LMNS | |
| 26th February 2026 | Declaration Form & Assurance Letter to be emailed to LMNS | |
| 3rd March 2026 - 12 noon | CNST Year 7 Declaration Submission | |

### CNST Maternity Incentive Scheme (MIS) – Year Seven

- **Purpose**: To support safer maternity care across acute Trusts delivering maternity services.
- **Eligibility**: Applies to all acute Trusts that are members of the CNST and provide maternity services.
- **Incentive Structure**:
    - Trusts that **achieve all 10 maternity safety actions**:
        - Recover their CNST MIS fund contribution.
        - Receive a share of any **unallocated funds**.
    - Trusts that **do not meet all 10 actions**:

        - Do **not** recover their contribution.
        - May receive a **smaller discretionary payment**, subject to an annual cap.
- **Submission Requirements**:
    - Deadline: **12 noon, 3rd March 2026**.
    - Submit completed **Board declaration form** to:

      ✉ nhsr.mis@nhs.net
    - Conditions:
        - All 10 safety actions must be achieved.
        - A joint presentation to the Trust Board by:
            - Director/Head of Midwifery
            - Clinical Director for Maternity Services
        - Trust Board must authorise the **CEO** to sign the declaration.
        - Declaration must be signed by:
            - **Trust CEO** (no substitutes)
            - **ICS Accountable Officer (AO)**

To be eligible for payment under the scheme, Trusts must:

1. **Achieve all 10 maternity safety actions.**
2. **Present to the Trust Board**:
    - A joint presentation detailing progress on safety actions.
    - Delivered by the **Director/Head of Midwifery** and **Clinical Director for Maternity Services**.
3. **Board Approval**:
    - Trust Board must authorise the **Chief Executive Officer (CEO)** to sign the declaration form.
    - The form **must be signed by the CEO** — signatures from other Trust members will not be accepted.

4. **ICS Assurance**:
    - The CEO must ensure the **Integrated Care System (ICS) Accountable Officer (AO)** is fully informed.
    - Both the **CEO and AO must sign** the declaration form to confirm full assurance and agreement with the submission.

**Assurance Process**

To understand the Maternity Providers' position and progress of the ten safety actions, the LMNS requested that the CNST progress form and relevant evidence, was submitted to the LMNS by 29 August 2025.

CNST progress will also be discussed at LMNS Assurance visits which will take place in November 2025. The outcomes of the progress form, initial evidence submissions and the assurance visits will be reported to the Maternity and Neonatal System Group, Performance Oversight Meeting (POM) and Clinical Effectiveness and Governance Committee (CEG) meeting.

The CNST Assurance Panel will be engaged to oversee the assurance process and review evidence. Membership of the CNST Assurance Panel will include:

- LMNS Consultant Clinical Lead
- LMNS Safety Lead Midwife
- LMNS Assistant Director
- LMNS Workforce Lead
- ICB Maternity Assurance Lead
- ICB Quality and Assurance Representative
- Maternity and Neonatal Voices Partnership (MNVP) Representative
- Northwest Neonatal Operational Delivery Network (NNODN) Representative
- Locality Lead Representative

Maternity providers must submit all CNST evidence for all Safety Actions except for Safety Action 6, to the LMNS to be reviewed by the CNST Assurance Panel. Safety Action 6 evidence will be submitted to the Strategic Clinical Network and assurance provided to the LMNS.

Maternity providers will also be required to submit particular evidence for sign off by the LMNS and/or ICB

Assurance meetings will be held via Microsoft teams in late 2025 and early 2026 with maternity providers and the CNST Assurance Panel, in advance of the final sign off process.

**WWL remains on track to achieve all 10 Safety Actions. Evidence will be reviewed by the LMNS after the submission deadline of the 15 December 2025 has been reached**.

This will be uploaded into the NHSFutures portal, and the team will meet with the review panel to discuss and agree if compliance can be declared.

**Overview of progress on MIS year 7 safety action requirements**

*Mandated Safety Action Requirements:

| Safety Action | Red | Amber | Green | Blue | Total Requirements |
|---|---|---|---|---|---|
| 1 | 0 | 0 | 7 | 0 | 7 |
| 2 | 0 | 0 | 2 | 0 | 2 |
| 3 | 0 | 2 | 3 | 0 | 5 |
| 4 | 0 | 5 | 13 | 0 | 18 |
| 5 | 0 | 1 | 10 | 0 | 11 |
| 6 | 0 | 1 | 7 | 0 | 8 |
| 7 | 0 | 2 | 1 | 0 | 3 |
| 8 | 0 | 0 | 21 | 0 | 21 |
| 9 | 0 | 1 | 8 | 0 | 9 |
| 10 | 0 | 1 | 8 | 0 | 9 |
| Total | 0 | 13 | 80 | 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 7** was discussed following a MNVP webinar with all Maternity Leads and, it was decided that a scoping exercise was required to understand what governance/ quality and safety meetings the MNVP's were expected to attend in each individual service. This will assist the MNVP lead and LMNS in understanding any gaps in MNVP provision and understanding individual Trusts position for CNST year 7.

To be fully compliant for Safety Action 7 MNVP leads must attend Perinatal Mortality Review meetings. However, training has not yet been rolled out across the region for MNVP leads, therefore they are unable to attend.

If non-compliance is declared for SA7 escalation is required through the trust board, LMNS, ICB and Regional team. To facilitate this in the timeline outlined in CNST, it was suggested in the meeting that non-compliance is escalated to Trust Boards in good time to allow onward escalation.

MNVP's are required to be commissioned and function in line with the MNVP guidance by the end of the Three-Year Delivery Plan (March 2026) and it is an expectation that Trusts will be compliant by this time. The WWL MNVP Lead is commencing her training in the coming weeks, but this will not demonstrate compliance.

WWL have completed the scoping tool along with all regional providers and as with all other providers we do not meet this requirement therefore **Non-compliance needs to be declared, and the Board are asked to note this within the minutes**

**If escalation occurs, then compliance can still be declared on the Trust Board declaration form.**

ICB's are expected to develop an action plan with the Trust in response to the escalation and monitor progress through agreed governance processes and via a risk register.

| | |
|---|---|
| **Title of report:** | Perinatal Quality Oversight Model briefing summary |
| **Presented to:** | Trust Board |
| **On:** | 01. 0ctober 2025 |
| **Presented by:** | Kevin Parker-Evans Chief Nurse & DIPC |
| **Prepared by:** | Cathy Stanford Divisional Director of Midwifery and Child Health |
| **Contact details:** | T: 01942 773107 E: cathy.stanford@wwl.nhs.uk |

**Link to strategy and corporate objectives**

This summary provides the recommendations of the Perinatal Oversight Model to advise the Board of what should be included within Maternity reporting via the quarterly Perinatal Quality Surveillance report which provides oversight and assurance to the Board that there are effective systems of clinical governance and monitoring of safety for Maternity and Neonatal services. It is a CNST requirement linked to Safety Action 9

**Risks associated with this report and proposed mitigations.**

Non-compliance will trigger escalation

**Financial implications**

Failure to meet the maternity and Perinatal Incentive Scheme 10 Safety Standards will result in the financial loss of at least 10% refund of scheme contributions

**Legal implications**

N/A

**People implications**

Key responsibilities of individuals and systems are include within the published document.

**Equality, diversity, and inclusion implications**

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

None

**Recommendations)**

The Board are requested to note the recommendations as outlined below.

## Perinatal Quality Oversight Model (PQOM)

### Executive Summary

Following the introduction of the Perinatal Quality Surveillance Model in December 2020, a revised framework—the Perinatal Quality Oversight Model (PQOM)—was published in August 2025. This updated model clarifies the roles and responsibilities of provider trusts, Integrated Care Boards (ICBs), and regional and national teams.

The PQOM has been developed in response to the growing need for proactive identification of trusts requiring support, aiming to intervene before serious issues arise. It provides a consistent and structured approach to the oversight of NHS perinatal services, ensuring that the necessary data and insights are collected to drive continuous service improvement.

While provider trusts and their boards remain ultimately responsible for the quality and improvement of the services they deliver, the PQOM supports both trusts and ICBs in fulfilling their duties. It also offers a mechanism for the escalation of emerging risks, trends, or issues that cannot be resolved locally or would benefit from wider system-level sharing and learning.

### Role of the provider trust

Under the Perinatal Quality Oversight Model (PQOM), provider trusts retain statutory responsibility for ensuring that maternity and neonatal services are:

- Safe, effective, and efficient
- Delivered in a way that actively addresses health inequalities
- Aligned with Integrated Care System (ICS) strategies and plans through effective system-wide collaboration

Trusts are expected to undertake dynamic monitoring of service quality, supported by clinically relevant data. This should be informed by key performance indicators, patient outcomes, and broader insights, including:

- Identification of opportunities for learning from patient safety incidents, regardless of severity
- Use of data to inform continuous improvement and proactive risk management

**Perinatal Board Safety Champions**

The Perinatal Board Safety Champions role is central to driving quality improvement, supporting staff, and ensuring that safety remains a core priority at board level. These champions play a key role in:

- Building strong multi-disciplinary partnerships
- Promoting positive cultures that support safe and compassionate care
- Ensuring that mothers and babies receive the safest care possible by embedding best practice across services

**Board Oversight for Perinatal Quality and Safety**

To ensure robust governance and oversight of perinatal quality and safety, each trust should have the following structures and processes in place:

1. **Board Safety Champion (Non-Executive Director)**
   A designated Non-Executive Director (NED) should work visibly alongside the board safety champion for perinatal services (covering midwifery, obstetrics, and neonatology). Their role is to provide objective, external challenge and scrutiny.
2. **Frontline Safety Champions**
   Identified frontline safety champions from midwifery, obstetrics, and neonatal services should meet regularly with the board safety champion(s) to share insights, escalate concerns, and support continuous improvement.
3. **Quarterly Board-Level Review of Perinatal Safety Intelligence**
   The trust board—or a delegated sub-committee—must review perinatal safety intelligence at least quarterly. These discussions should demonstrate professional curiosity and be used to drive shared learning across the organisation. Key areas for discussion include:

- Ongoing monitoring of service performance and long-term trends
- Concerns raised by staff and service users
- Progress against local improvement plans, including actions under the Patient Safety Incident Response Framework (PSIRF)
- For neonatal incidents, collaboration with the Neonatal Operational Delivery Network (ODN) and the Integrated Care Board (ICB) to identify and manage risks.

4. **Board Reporting**

Board Reporting A member of the perinatal leadership team should present a formal report to the board, providing context and analysis. Specific content can be agreed locally, but it is recommended that the report includes as a minimum the following measures to be reviewed quarterly.

1. Findings of review of all perinatal deaths using the real time data monitoring tool with actions

2. Findings of review of all cases eligible for referral to Maternity and Neonatal Safety Investigations (MNSI) programme with actions

3. Report on:

a. themes and actions from patient safety incidents

b. training compliance for all staff groups in maternity and neonatal critical care related to the core competency framework and wider job essential training (%)

c. minimum safe staffing in maternity and neonatal services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing. Planned cover versus actual

4. Service user voice feedback – themes

5. Staff feedback from frontline champion and walkabouts – themes

6. Maternity and Neonatal Safety Investigations (MNSI) programme, NHS Resolution, Care Quality Commission (CQC) or other organisation with a concern with or request for action made directly to the trust

7. Coroner Reg. 28 made directly to trust, where applicable

8. Progress in achievement of Maternity Incentive Scheme – 10 safety actions 9. Proportion of midwives responding ‘agree’ or ‘strongly agree’ to whether they would recommend their trust as a place to work or receive treatment (reported annually)

10. Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as ‘excellent’ or ‘good’ (reported annually)

**Data should be disaggregated by ethnic group and deprivation level (based on the mother’s postcode)—to support the identification and investigation of potential health inequalities.**

**The Trust Board currently receive the Perinatal Quality Surveillance report quarterly, this is also shared at Divisional Governance forums, Quality and Safety Committee and the Safety Champions Forum, whilst this report covers most of the new recommendations it will need to strengthen the detail around points 3c 9&10.**

**Sharing with the Integrated Care Board (ICB)**

Provider trusts are expected to share safety and quality intelligence with their Integrated Care Board (ICB) throughout the commissioning cycle. This includes:

- Escalating risks where mitigating actions are not delivering the required improvements within agreed timeframes
- Identifying opportunities for shared learning across the system
- Contributing to system-wide improvement by addressing common issues or contributory factors to poor outcomes through the trust’s Patient Safety Incident Response Plan (PSIRF)

This collaborative approach ensures that emerging risks are addressed proactively and that learning is disseminated across the wider maternity and neonatal system.

**Sharing with the Neonatal Operational Delivery Network (ODN)**

In line with the Neonatal Critical Care Service Specification and trust contracts, provider trusts must have a clear process for sharing patient safety concerns with their Neonatal ODN.

This includes:

- Proactive engagement on quality and workforce issues

- Participation in ODN governance processes, including attendance at relevant meetings
- Escalation of concerns to the ICB or NHS England's regional specialised commissioning function, where appropriate

This ensures that neonatal safety and quality issues are addressed collaboratively and consistently across the regional network.

**Service User Voice**

The **Maternity and Neonatal Voices Partnership (MNVP) Lead** is a key stakeholder in supporting safety and quality within maternity and neonatal services. They should be actively involved in relevant trust meetings, including:

- Safety champion meetings
- Governance meetings
- Perinatal quality meetings
- Audit and assurance meetings

Their role is to provide scrutiny from a service user perspective, helping to improve transparency, accountability, and oversight of service quality. MNVP leads should contribute insights gathered through:

- Surveys
- Walkabouts
- Other engagement activities conducted by the MNVP

To ensure meaningful involvement, MNVP leads must receive timely follow-up on any risks or concerns they raise, including information on actions taken to address identified safety issues. Their input is essential in shaping services that are responsive to the needs and experiences of women, families, and communities.

**The MNVP Lead attends all the above meetings except clinical audit, and this will be addressed going forward.**

| | |
|---|---|
| **Title of report:** | Neonatal staffing Review August **2025** |
| **Presented to:** | Trust Board |
| **On:** | 1 October 2025 |
| **Item purpose:** | Information / approval |
| **Presented by:** | Kevin Parker-Evans Chief Nurse/ DIPC |
| **Prepared by:** | Cathy Stanford Divisional Director of Midwifery and Child Health |
| **Contact details:** | T: 01942 773107 E: Cathy.stanford@wwl.nhs.uk |

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

**Risks associated with this report and proposed mitigations.**
Achieving National recommendations

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

**Legal implications**
There are no direct legal implications with this report.

**People implications**
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

## Executive summary

### Annual Neonatal Unit Staffing Review – 2025

In accordance with Safety Action 4 of the Maternity and Neonatal Incentive Scheme (MNIS) Year 7, all NHS Trusts are required to undertake an annual review of Neonatal Unit staffing. This review must be benchmarked against the recommendations of the Neonatal Nurses Association and the British Association of Perinatal Medicine (BAPM). A key requirement of this process is submission of the findings to both the Local Maternity and Neonatal System (LMNS) and the Northwest Neonatal Operational Delivery Network (NWNODN), with oversight and formal sign-off by the Trust Board.

This 2025 report outlines the methodology used for the nursing staffing review at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL), including the application of the nationally recommended staffing tool and a subsequent gap analysis. The findings provide assurance of safe staffing levels within the Neonatal Unit.

The national vision for neonatal services, as set out in the *Neonatal Critical Care Review Service Specification* (March 2024), is to deliver a seamless, responsive, and multidisciplinary service centred around the needs of newborn babies and the active involvement of families in their care. The inclusion of Allied Health Professionals (AHPs) has been recognised as essential, not only for supporting neurodevelopment during critical early life stages, but also for improving long-term outcomes and enhancing family cohesion.

Neonatal Critical Care is delivered through Operational Delivery Networks (ODNs), closely aligned with maternity services via LMNSs.

WWL is commissioned to provide care as a Local Neonatal Unit (LNU), which encompasses all services provided by Special Care Units (SCUs), with additional capabilities including:

- Neonatal care in line with national guidelines and professional standards for singleton births from 26+6 weeks gestation (or 27+6 weeks for multiple births), where birth weight is anticipated to be above 800g.
- Provision of high dependency and special care for the local population.
- Ongoing care for babies repatriated from other neonatal units requiring continued high dependency or special care.

- Post-operative care for babies repatriated from surgical Neonatal Intensive Care Units (NICUs).
- Support for network referrals from units unable to provide high dependency or special care due to capacity or network guidelines.

**Current Nurse Vacancy Position (Staffing figures correct at 08.08.2025)**

| | Band 5/6 | Band 7 | Band 8a and above | Total |
|---|---|---|---|---|
| **Clinical Vacancies** | **0** | **0** | **1** | **1** |
| **Upcoming vacancies in next 3 months** | **1.60** | **0** | **0** | **1.60** |
| **Additional Quality Roles (Not currently funded** | **5.58 wte** | | | |

**Recommendation(s)**

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

# Report

## Background

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

## Service Specification

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

- Intensive Care 1:1 staff-to-baby ratio[a]
- High Dependency 1:2 staff-to-baby ratio[a]
- Special Care 1:4 staff-to-baby ratio[b]
- Transitional Care 1:4 staff to baby ratio[b] (babies will be cared for alongside their mother either on a dedicated TC or PN bed). (TC is based on The Maternity Post Natal Ward)

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

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

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

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

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

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

**Neonatal units require key contributions from an essential group of Allied Health Professionals (AHPs), These are essential to champion the need to view neonatal care that looks forward to improving longer term outcomes for babies and their families.** (Neonatal Critical Care Service Specification March 2024)

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

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

**Methodology**

This paper outlines the annual staffing and skill mix review and the further requirements for Neonatal services to work towards the integration of Allied Health Professionals into the Multi-disciplinary team to enhance care and provide a holistic approach to neonatal care that is fully supportive of Family Integrated Care (FiCare).

The Neonatal Nursing Workforce Tool (2020) has been adapted from the CRG Workforce Calculator (Dinning) Tool (2013) and has been developed with the National Lead Nurses Group. **(See Appendix 1)**

Staffing requirements within the Neonatal Unit are calculated using the BAPM workforce planning tool, based on an 80% occupancy rate and incorporating a 25% uplift. This tool provides neonatal nurse managers with a consistent and evidence-based method for determining nursing establishment needs, aligned with national standards including:

- NHS Improvement (2018)
- NHSE Neonatal Service Specification E08 (2015)
- Department of Health (DH) (2009)
- BAPM (2010)
- NICE (2010)

These standards collectively advocate for an appropriately sized and skilled workforce, with the necessary leadership and competencies to deliver high-quality care for babies requiring medical and surgical interventions.

In line with DH (2009) guidance:

- A minimum of 70% of the nursing establishment must be ‘Qualified in Specialty’ (QIS).
- Each shift must include a supernumerary team leader, in addition to the staff directly caring for babies.

**Sickness Absence**

Sickness levels within the Neonatal Unit have been notably high across all staff grades. For Q4 of 2024/25, the overall sickness rate stood at 13.9%. However, more recent data from July 2025 indicates a positive trend, with sickness rates reducing to:

- **6%** among registered staff
- **8%** among unregistered staff

This improvement is being closely monitored and supported through ongoing workforce wellbeing initiatives.

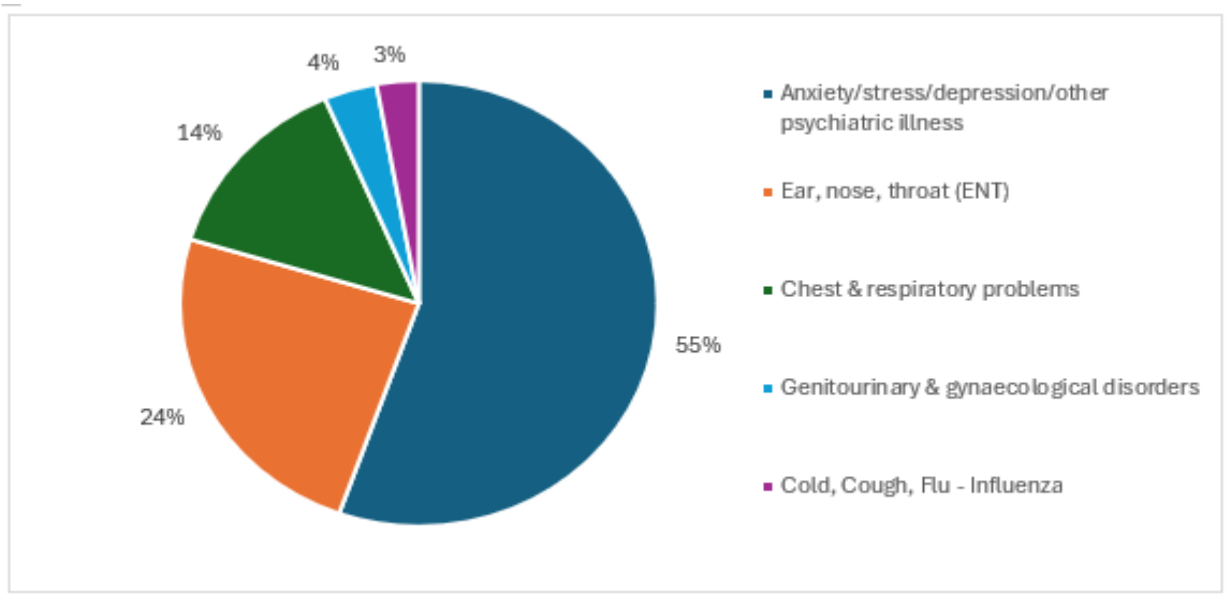
The most frequently reported reason for sickness absence across all staff grades continues to be anxiety, depression, or other psychiatric illnesses.

A comprehensive range of support measures is in place to promote staff wellbeing. Staff are routinely signposted to the Wellbeing Team and Occupational Health services, ensuring timely access to appropriate support. In addition, Wellbeing Champions are available across the organisation to provide peer support and promote a culture of wellbeing.

Robust adherence to sickness absence procedures is maintained, with HR support provided throughout. Roster management has also been reviewed to ensure shift patterns are not overly demanding, and roster rules are actively applied to safeguard staff health and wellbeing.

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

| Reason | Hours | % |
|---|---|---|
| Anxiety/stress/depression/other psychiatric illness | 370.5 | 55% |
| Ear, nose, throat (ENT) | 162 | 24% |
| Chest & respiratory problems | 93 | 14% |
| Genitourinary & gynaecological disorders | 24 | 4% |
| Cold, Cough, Flu - Influenza | 19 | 3% |




**Tier 1 Medical Staffing shortfalls**

Historically, there has been a shortfall in the Tier 1 rota, which did not meet the recommendations outlined in Safety Action 4 of the Maternity and Perinatal Incentive Scheme. To address this, the Division implemented a strategic plan to recruit Advanced Neonatal Nurse Practitioners (ANNPs), aimed at both mitigating Tier 1 rota gaps and enhancing senior clinical support within the Neonatal Unit.

As a result of this initiative, the Neonatal Unit now benefits from the presence of three fully trained and operational Neonatal Advanced Clinical Practitioners (ACPs) and two Advanced Nurse Practitioners (ANPs). This staffing model ensures consistent 24/7 Tier 1 coverage by either a dedicated ACP or Tier 1 doctor, exclusively for the Neonatal Unit.

**With this enhanced and sustainable workforce in place, Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) can now declare full compliance with MIS Safety Action 4, with no further action plans required.**

The Tier 2 and Tier 3 medical staffing rotas continue to be fully covered.

**Neonatal Out-Reach**

Support for neonatal outreach, in-reach, or community services should be delivered by an integrated hospital-community neonatal team or a clearly identifiable group of specifically trained community health professionals.

The newly published *Neonatal Outreach Service: A BAPM Framework for Practice* (May 2025) highlights that professionals supporting neonates and their families during the

transition to home require a highly specialised skill set. This includes advanced capabilities in assessment, observation, intervention, evaluation, and interpretation of clinical findings—particularly for preterm and high-risk infants in the home environment.

Staff providing this care must possess clinical training and expertise in neonatal settings, underpinned by robust theoretical and evidence-based knowledge. They should feel confident and competent in delivering consistent, appropriate advice to parents and carers. This includes ensuring families receive clear, relevant information prior to discharge, with details of any arrangements outlined in the baby's care plan to support continuity of care at home.

Units should facilitate opportunities for parents and carers to meet the community team who will be supporting them post-discharge, ensuring a smooth and reassuring transition from hospital to home.

The framework outlines **12 key recommendations** for services to work towards, aimed at ensuring all outreach services are safe, high-quality, compassionate, and responsive to the evolving needs of babies and families.

These recommendations will be reviewed in detail with the Neonatal Team and NWNODN. Any resulting actions will be addressed or escalated as appropriate. However, these actions fall outside the scope of this staffing review.

**Training and Development**

**Professional Competence, Education and Training:**

• Appropriate and specific training programmes for all trained and untrained staff are in place with regular neonatal specific update training where required.

• A minimum of 70% (special care) and 80% (high dependency and intensive care) of the nursing and midwifery establishment hold NMC registration.

• A minimum of 70% of registered neonatal nursing establishment hold a post registration qualification in specialised neonatal care (QIS)

• A minimum of 70% of registered neonatal nursing establishment hold Newborn Life Support Accreditation.

• All registered neonatal nursing establishment have been assessed yearly and have attended the inhouse British Association of Perinatal Medicine (BAPM) Neonatal Airway Safety/Difficult Airway Training Day to comply with the new BAPM Neonatal Airway Safety Standard.

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

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

**Summary**

The Chief Nurse and Board are asked to review the findings of the annual neonatal staffing review in alignment with MIS Year 7 requirements.

**Key Findings:**

- **Leadership Staffing:**
  The neonatal unit at WWL has the appropriate level of leadership staffing in place, as per budgeted establishment.
- **Staffing Shortfalls:**
  Gaps remain within the **Allied Health Professional (AHP)** and **Nurse Quality roles**, as highlighted in the Neonatal Critical Care Review.
- **Interim Measures:**
  Collaboration with the Community Division is ongoing to identify sustainable support for these roles. In the meantime, AHP services are provided on a reduced, ad hoc basis to ensure babies receive some level of input, supporting improved care and outcomes.
- **Financial Implications:**
  Full implementation of the recommended AHP roles would require an investment of **£444k**. These roles are considered aspirational and represent a future goal for service development.
- **Nurse Quality Roles:**
  Full implementation would require an additional **5.14 WTE nurses**. Currently, these roles are supported through protected time, dependent on staffing levels.
- **Nurse Staffing Overview:**
  - Vacancies remain minimal, with low attrition and turnover.
  - Active recruitment is ongoing, including the Child Health Matron post.

    - Two Band 5 nurses are expected to leave next quarter, with one staff member returning from maternity leave.
    - No additional nurse staffing is requested at this time, as activity and acuity are in line with current establishment.
- **Future Considerations:**
  Should additional funding become available, it is recommended to:
    - Increase establishment to meet Quality and AHP role recommendations.
    - Apply a **25% uplift** to support mandatory training requirements.
- **Workforce Tool Insights:**
  Activity within the unit has decreased over the past year, attributed to:
    - The **MatNeoSIP collaborative** focus on optimising preterm birth outcomes.
    - The presence of a **Transitional Care Bay** on the maternity ward, reducing the need for neonatal unit admissions.

This trend reflects a national shift, and all unit's cot base is currently under review as part of the wider Neonatal Critical Care Review.

Sickness levels within the Neonatal Unit have been notably high across all staff grades. In Q4 of 2024/25, the overall sickness rate reached 13.9%. However, more recent data from July 2025 shows a positive downward trend, with sickness rates reducing.

This improvement is being closely monitored and supported through ongoing workforce wellbeing initiatives.

The most commonly reported reason for sickness absence across all staff groups remains anxiety, depression, or other psychiatric illnesses.

To address this, a comprehensive suite of wellbeing support measures is in place. Staff are routinely signposted to the Wellbeing Team and Occupational Health Services for timely and appropriate support. In addition, Wellbeing Champions are available across the organisation to provide peer support and foster a culture of wellbeing.

There is robust adherence to sickness absence procedures, with active HR involvement. Roster management has been reviewed to ensure shift patterns are not overly demanding, and roster rules are consistently applied to safeguard staff health and wellbeing.

**Please see appendix 1 for the Neonatal workforce tools demonstrating activity, requirements and compliance against the recommendations.**

**Appendix 3 identifies the aspirational AHP roles and the current shortfalls**

**References**

British Association of Perinatal Medicine A Framework for Neonatal Transitional Care (October 2017)

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

Neonatal Nursing Workforce Tool (2020)

A workforce strategy for Northwest Neonatal Units 2021-2026.

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

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK. (November 2022)

Neonatal Critical Care Service Specifications NHS England Specialist Commissioning. (March 2024)

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

Neonatal Outreach Service A BAPM Framework for Practice (May 2025)

Maternity (Perinatal) Incentive Scheme NHS Resolution Year 7 (April 2026)

**Appendix 1 Neonatal Workforce Tool**

# Neonatal Nursing Workforce Tool (2020): Wigan

| Input unit details | | | |
|---|---|---|---|
| Trust | Wrightington, Wigan and Leigh NHS Foundation Trust | | |
| Unit | Wigan | | |
| Designation | LNU | | |
| Completed by | Cathy Stanford | | |
| Date completed | 15.08.2025 | | |
| Activity period | Average 2022/23, 23/24 & 24/25 | Days in period | 365 |

| Input activity (HRG 2016) | | |
|---|---|---|
| | Activity | Declared cots |
| HRG 1 (IC) | 114 | 1 |
| HRG 2 (HD) | 774 | 3 |
| HRG 3 (SC) | 1,800 | 10 |
| **Total** | **2,688** | **14** |

| Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY | | |
|---|---|---|
| | Budget | In post |
| Total QIS | 20.78 | 21.70 |
| Total Non QIS | 6.12 | 6.12 |
| Total Non Reg | 3.69 | 2.92 |
| **Total** | **30.59** | **30.74** |

| Activity (HRG 2016) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Activity | *For calculations* | | Declared cots | Occupancy for period | Cots required to meet activity at average 80% occupancy | Variance: declared cots against required |
| | | *80% of daily activity* | *WTE (6.07 / BAPM)* | | | | |
| HRG 1 | 114 | *0.4* | *6.07* | 1 | 31.23% | 1 | 0 |
| HRG 2 | 774 | *2.7* | *3.04* | 3 | 70.68% | 3 | 0 |
| HRG 3 | 1,800 | *6.2* | *1.52* | 10 | 49.32% | 6 | 4 |
| **Total** | **2,688** | | | **14** | **52.60%** | **10** | **4** |

| Nursing workforce (WTE) DIRECT PATIENT CARE ONLY | | | | | |
|---|---|---|---|---|---|
| *NB total nurse staffing required to staff declared cots = 36.42, of which 25.49 (70%) should be QIS* | | | | | |
| | Current position | | Required to meet activity at average 80% occ | Variance: budget against required | Variance: in post against required |
| | Budget | In post | | | |
| Total nursing staff | 30.59 | 30.74 | 25.84 | 4.75 | 4.90 |
| Total reg nurses | 26.90 | 27.82 | 23.03 | 3.87 | 4.79 |
| Total QIS | 20.78 | 21.70 | 16.48 | 4.30 | 5.22 |
| Total non-QIS | 6.12 | 6.12 | 6.55 | -0.43 | -0.43 |
| Total non-reg | 3.69 | 2.92 | 2.81 | 0.88 | 0.11 |
| Reg nurses as % nursing staff | 87.9% | 90.5% | 89.1% | | |
| QIS as % reg nurses | 77.2% | 78.0% | 71.6% | | |

| DIRECT PATIENT CARE | | | | |
|---|---|---|---|---|
| **Role Title** | **Band** | **WTE Budget** | **WTE in post** | **Head Count in post** |
| Supernumerary shift Leader. (Sister / Charge Nurse) | 7 | 6.38 | 6.4 | 8 |
| Deputy Sister / Charge Nurse | 6 | 5.38 | 5.34 | 6 |
| Staff Nurse QIS | 5 QIS | 14.74 | 15.42 | 19 |
| **Subtotal QIS** | | **26.5** | **27.16** | **33** |
| Staff Nurse Non-QIS | 5 NON-QIS | 3.84 | 3.84 | 4 |
| **Subtotal non-QIS** | | **3.84** | **3.84** | **4** |
| Nursing Associate | 4 | 0 | 0 | 0 |
| Nursery Nurse | 4 | 0 | 0 | 0 |
| Healthcare Support Worker | 3 | 2.69 | 1.92 | 3 |
| **Subtotal non-Reg** | | **2.69** | **1.92** | **3** |
| **TOTAL DIRECT PATIENT CARE** | | **33.03** | **32.92** | **40** |

| ADDITIONAL DATA | | | | |
|---|---|---|---|---|
| | **From** | **To** | **WTE** | **Head Count** |
| **New Starters** | 01/01/2025 | 31/03/2025 | 1 | 1 |
| **Leavers** | 01/01/2025 | 31/03/2025 | 0 | 0 |
| **Net Gain / Loss** | 01/01/2025 | 31/03/2025 | **1** | **1** |
| **Turnover** | 01/01/2025 | 31/03/2025 | **0%** | **0%** |
| **Current vacancies (WTE)** | 01/01/2025 | 31/03/2025 | **0.32** | |
| **Maternity Leave (WTE) in quarter** | 01/01/2025 | 31/03/2025 | 1.0 | |
| | | | **WTE** | **Rate (%)** |
| **Sickness days (WTE) in quarter** | 01/01/2025 | 31/03/2025 | 6.20635 | **13.9%** |
| | | | **WTE** | **Hours used** |
| **Bank Usage (WTE) in quarter** | 01/01/2025 | 31/03/2025 | **2.8** | 1328 |
| **Agency Usage (WTE) in quarter** | 01/01/2025 | 31/03/2025 | **0.0** | 0 |

| ADVANCED NEONATAL NURSE PRACTITIONER DATA | | | | |
|---|---|---|---|---|
| | **Band** | **WTE Budget** | **WTE in post** | **Head Count in post** |
| Trainee ANNP | 7 | 0 | 0 | 0 |
| ANNP | 8a | 3 | 3 | 3 |
| Senior ANNP | | | | |
| Enhanced Neonatal Nurse Practitioner | | | | |

## Medical Staffing - LNU

| Tier 1 separate rota compliance 24/7 | | | | | |
|---|---|---|---|---|---|
| In Budget | In post | Vacancy | Ideal WTE | Difference budget v ideal | Projected cost* |
| 8 | 8 | 0 | 8.0 | 0.0 | |
| **Tier 2 rota compliance 12h per day** | | | | | |
| In Budget | In post | Vacancy | Ideal WTE | Difference budget v ideal | Projected cost* |
| 8 | 8 | 0 | 8.0 | 0.0 | |
| **Tier 3 compliance** | | | | | |
| | | | | | Yes/No |
| Significant geographical separation between neonatal and paediatric units | | | | | no |
| | | | | | |
| In Budget | In post | Vacancy | Ideal WTE | Difference budget v ideal | Projected cost* |
| 7 | 7 | 0 | 7.0 | 0.0 | |

## NURSING QUALITY ROLES

| Role Title | Band | WTE Budget | WTE in post | Ideal | Difference budget v | Projected cost* |
|---|---|---|---|---|---|---|
| LEADERSHIP ROLES | | | | | | |
| Senior/Lead Nurse | | | | | 0 | |
| Matron | 8a | 0.5 | 0.5 | 1.00 | 0.50 | £58,487.00 |
| Ward Manager | 7 | 1 | 1 | 1.00 | 0 | £50,273.00 |
| Other Senior role (please specify) | | | | | 0 | |
| QUALITY ROLES | | | | | | |
| Governance Lead Nurse* | 7 | 0.2 | 0.32 | 0.27 | 0.0688 | £13,513.38 |
| Practice Development/Education Lead* | 7 | | | 1.06 | 1.06 | £53,289.38 |
| Clinical Educator | 6 | | | | 0 | £0.00 |
| Infant Feeding Lead | | | | | 0 | |
| Family Integrated Care Lead | 7 | 0 | 0 | 0.54 | 0.5376 | £27,026.76 |
| Family Integrated Care Nurse | | | | | 0 | |
| Other Family care/developmental care role | | | | | 0 | |
| Bereavement/Palliative Care Lead | 7 | 0 | 0 | 0.27 | 0.2688 | £13,513.38 |
| Professional Nurse Advocate (PNA) | | | | | 0 | |
| QI in perinatal optimisation lead | | | | | 0 | |
| Safeguarding Children | | | | | 0 | |
| Discharge Planning role | | | | | 0 | |
| Infection control lead | | | | | 0 | |
| ENNP | | | | | 0 | |
| Other | | | | | | |
| Neonatal Digital Nurse | 7 | | | 1.00 | | £50,273.00 |
| Totals | | 1.7 | | 5.14 | 2.44 | £266,375.91 |
| Direct Nursing shortfall | | | | | | £0.00 |
| Total nursing workforce (headcount) | 53 | | | | | |
| Birthrate | 2421 | | | | | |

**The Blue highlighted roles are those that are currently being focused on with the Neonatal service specification as priority areas.**

CS August 2025

**Appendix 3**

## Allied Health Professional Recommended roles

**Recommended Allied Health Professional roles based on activity and cot base at WWL.**
**These are aspirational posts / best practice for units to be working towards. The below tables identify WWL shortfalls against National recommendations and what the projected cost of implementation would be.**

### PHYSIOTHERAPISTS

| Banding | In Budget | In post | Vacancy | Ideal | Difference budget v ideal | New positions required | Projected cost* |
|---|---|---|---|---|---|---|---|
| 8a | | | 0 | 0.78 | -0.58 | | £0.00 |
| 7 | 0.2 | 0 | 0.2 | | | 0.58 | £29,158.34 |
| 6 | | | 0 | | | | £0.00 |
| Totals | 0.2 | 0 | 0.2 | | | 0.58 | £29,158.34 |

This is for inpatient and declared TC cots only and does not include outreach or follow up

### DIETITIANS

| Banding | In Budget | In post | Vacancy | Ideal | Difference budget v ideal | New positions required | Projected cost* |
|---|---|---|---|---|---|---|---|
| 8a | | | 0 | 0.7132 | -0.7132 | | £0.00 |
| 7 | | | 0 | | | 0.71 | £35,693.83 |
| 6 | | | 0 | | | | £0.00 |
| Totals | 0 | 0 | 0 | | | 0.71 | £35,693.83 |

This is for inpatient and declared TC cots only and does not include outreach or follow up

### OCCUPATIONAL THERAPISTS

| Banding | In Budget | In post | Vacancy | Ideal Standard | Difference budget v ideal | New positions required | Projected cost* |
|---|---|---|---|---|---|---|---|
| 8a | | | 0 | 0.78 | -0.58 | | £0.00 |
| 7 | 0.2 | 0 | 0.2 | | | 0.58 | £29,158.34 |
| 6 | | | 0 | | | | £0.00 |
| Totals | 0.2 | 0 | 0.2 | | | 0.58 | £29,158.34 |

This is for inpatient and declared TC cots only and does not include outreach or follow up

### SPEECH AND LANGUAGE THERAPISTS

| Banding | In Budget | In post | Vacancy | Ideal | Difference budget v ideal | New positions required | Projected cost* |
|---|---|---|---|---|---|---|---|
| 8a | | | 0 | 0.54 | -0.34 | | £0.00 |
| 7 | 0.2 | 0.2 | 0 | | | 0.34 | £23,334.54 |
| 6 | | | 0 | | | | £0.00 |
| Totals | 0.2 | 0.2 | 0 | | | 0.3 | £23,334.54 |

This is for inpatient and declared TC cots only and does not include outreach or follow up

| QUALIFIED PSYCHOLOGIST | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Banding | In Budget | In post | Vacancy | Ideal | Difference budget v ideal | New positions required | Additional hub post | Projected cost* |
| 8c | | | 0 | 0.70 | -0.50 | | 0.4 per 3 units | £0.00 |
| 8b | | | 0 | | | | | £0.00 |
| 8a | 0.2 | 0 | 0.2 | | | 0.50 | | £20,411.50 |
| 7 | | | 0 | | | | | £0.00 |
| Totals | 0.2 | 0 | 0.2 | | | 0.50 | | £20,411.50 |
| This is for inpatient and declared TC cots only and does not include outreach or follow up | | | | | | | | |

* It is not a requirement to provide the projected cost, but it is advisable to complete the local costing,

| PHARMACIST | | | | | | | |
|---|---|---|---|---|---|---|---|
| Banding | In Budget | In post | Vacancy | Ideal | Difference budget v ideal | New positions required | Projected cost* |
| 8c | | | 0 | 0.72 | -0.62 | | £0.00 |
| 8b | | | 0 | | | | £0.00 |
| 8a | | | 0 | | | 0.20 | £11,697.40 |
| 7 | 0.1 | 0.1 | 0 | | | 0.42 | £28,825.02 |
| Totals | 0.1 | 0.1 | 0 | | | 0.62 | £40,522.42 |

| Projected Costs | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Direct Nursing | Quality Nursing | TC & Outreach | Physio | Dietitan | OT | SALT | Psychologist | Pharmacist | ANNP | Medical |
| £0.00 | £266,375.91 | £0.00 | £29,158.34 | £35,693.83 | £29,158.34 | £23,334.54 | £20,411.50 | £40,522.42 | £0.00 | £0.00 |

| Total |
|---|
| £444,654.88 |

| | |
|---|---|
| **Title of report:** | Maternity Dashboard and Optimisation Report |
| **Presented to:** | Trust Board |
| **On:** | 1St October 2025 |
| **Item purpose:** | Information |
| **Presented by:** | Kevin Parker-Evans (Chief Nurse and 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 3 consecutive months

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

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

**Link to strategy and corporate objectives**

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

**Risks associated with this report and proposed mitigations.**

The August dashboard has highlighted that there are some areas for increased observation. Delay in category 1 and 2 CS has been flagging for several months. Whilst a snapshot audit was completed recently regarding CS, a real time weekly audit is being carried out and will continue for the coming months. This is being undertaken by the hot week consultant and the labour ward lead. All metrics are continually observed for any themes or trends by the governance team.

As many of the figures recorded are small numbers, they cannot be assessed for any themes immediately. Themes will usually be assessed over time using larger numbers of data.

**Financial implications**

N/A

**Legal implications**

N/A

**People implications**

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

**Equality, diversity, and inclusion implications**

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

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

None

**Recommendation(s)**

The board are asked to note the August 2025 dashboard and overview of indicators as outlined below.

**Report**

**August 2025 Exception report - Maternity**
**Summary**

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

- There were 43 validated midwifery red flags reported in August, eleven for delayed or cancelled time critical activity, thirteen for missed or delayed care (e.g. obs), sixteen for delay of 2+ hours between admission and commencing IOL, two for delay in providing pain relief and one for the coordinator being unable to remain supernumerary.
- We are now validating red flag 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 unable to remain supernumerary for one shift in August.
- 1:1 care is validated at 100% in August.
- There were 2 Maternity complaints received in August, and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

**PSII Commissioned Incidents**

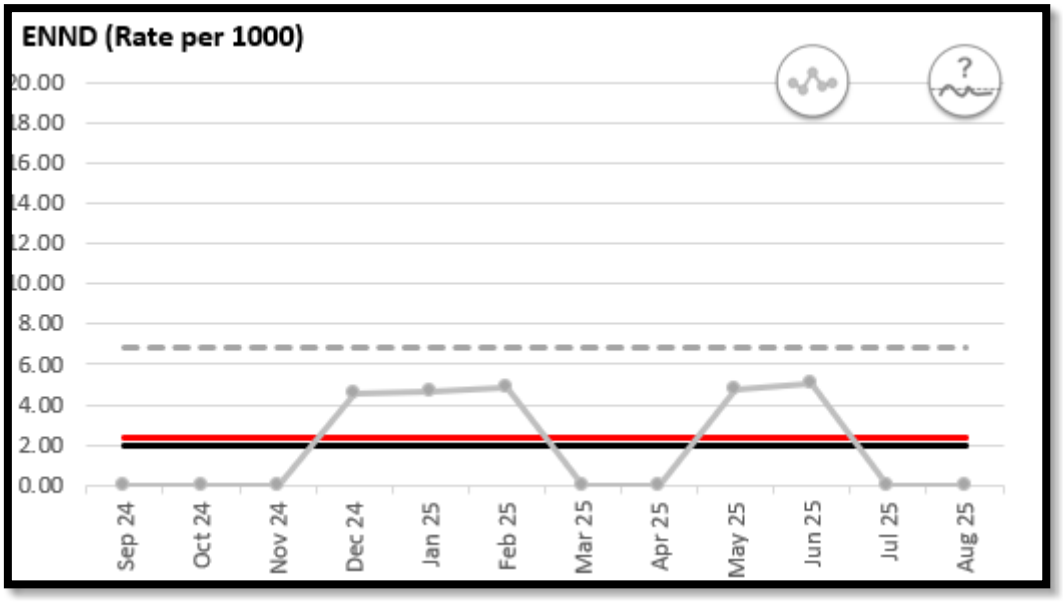
There was one PSII Commissioned incidents reported in August. This was a mother who had a peri cardiac arrest in theatre.

**StEIS reported incidents**

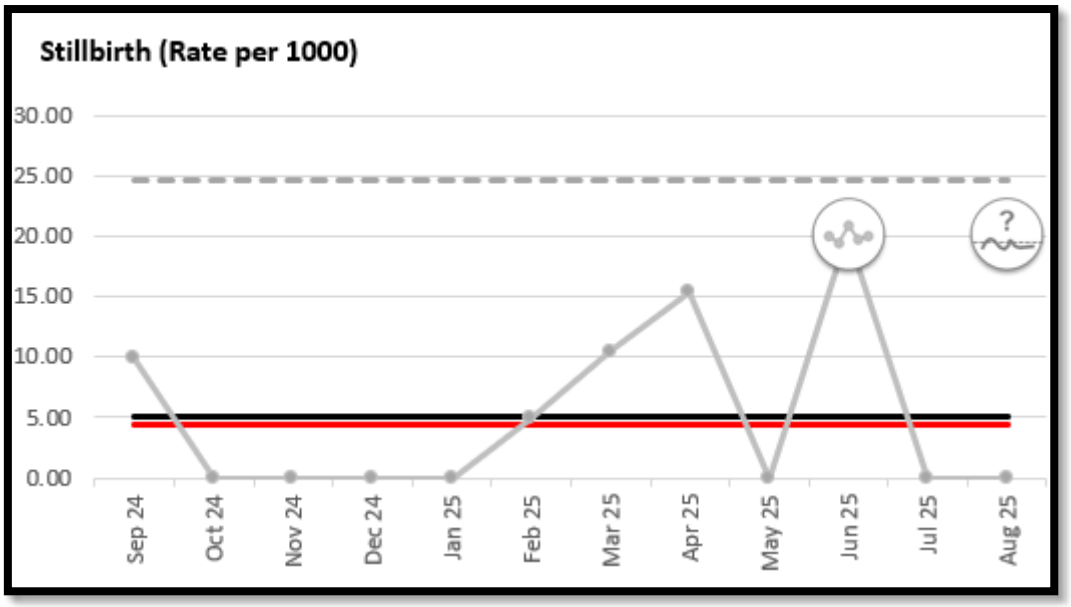
There were no StEIS reported incidents in August.

**Green**

**Number of Neonatal Deaths (rate per 1000).**
The figure is recorded as a rate per 1000. There were no ENNDs in August. 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 no stillbirths in August. Any learning from the spike in June will be fed back once all the reviews are completed. All cases also undergo a PMRT review. The below SPC chart shows how WWL compare with the 2024 average from GM (red line).



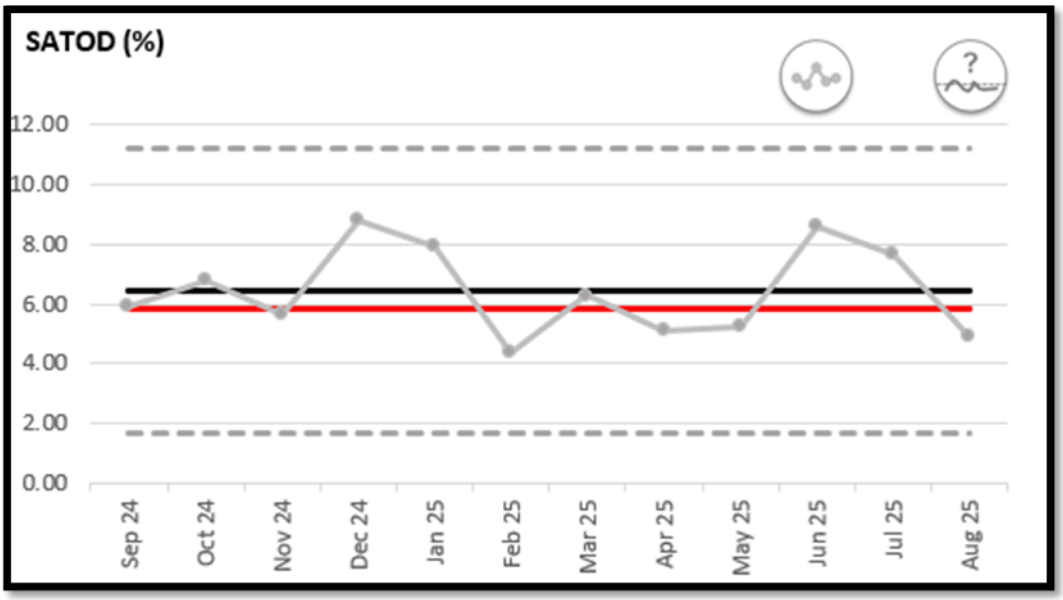

**Skin to skin contact (%)**
This metric continues at green levels after a slight drop into amber levels in March. Work continues to improve this metric with antenatal education and Midwifery training. The infant feeding team have been asked to attend the pregnancy circles which are commencing in Hindley 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 have been at green and normal levels since. Work continues to ensure that women are booked early, the ideal being before 10 weeks.

**Induction of Labour (IOL) – (%).**
These levels have fluctuated over the past few months. June saw a spike into red levels, but the figure has returned to green levels in August. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes, with no outlying themes and trends noted.

**Women readmitted within 28 days of Delivery (rate per 1000).**
There was 1 maternal readmission to the obstetric unit in August. This admission was for a possible infection. No omissions in care were noted.

**Smoking at the time of Delivery (SATOD) (%).**
This sees a significant improvement from the spike in June. 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 below SPC chart shows our % SATOD rates in com parison to the 2024 average from GM (red line).

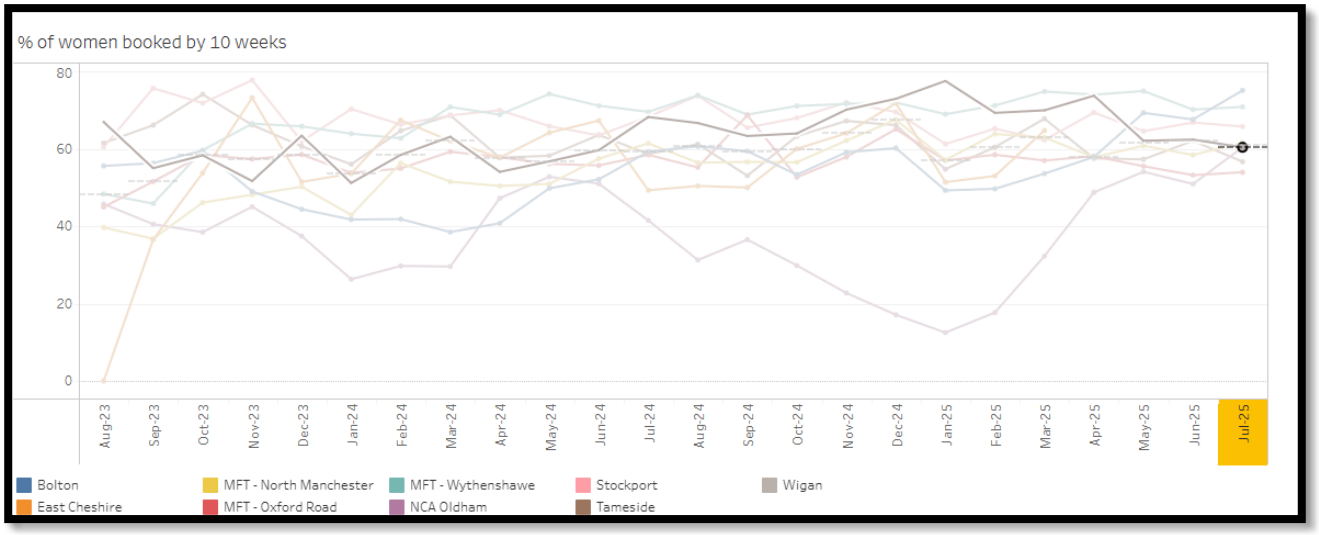



**1:1 care in labour (%).**
There were no women in August reported to have not had 1:1 care.

**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.

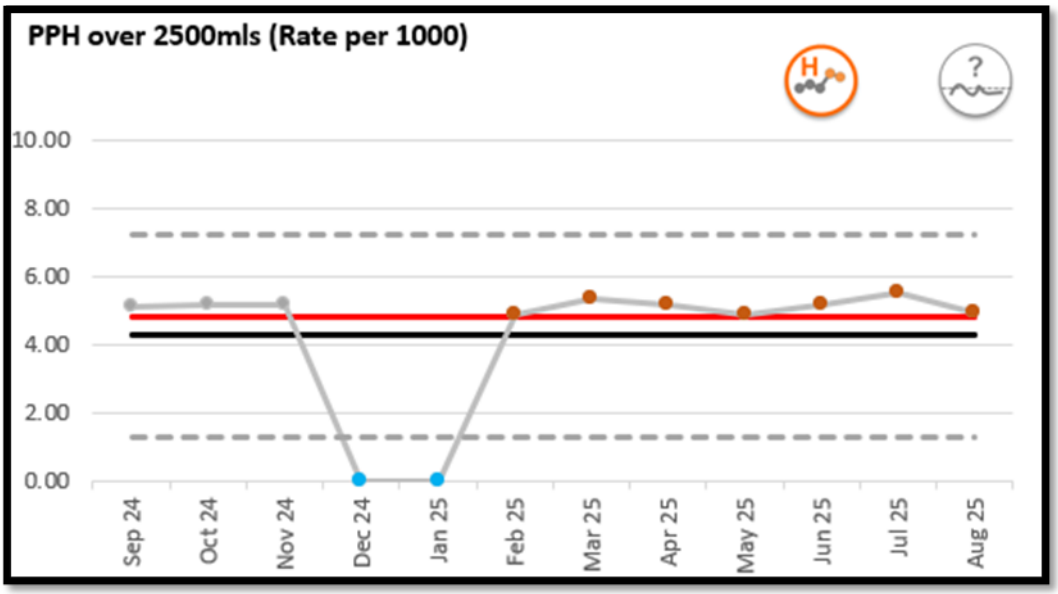
**Amber**

**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.

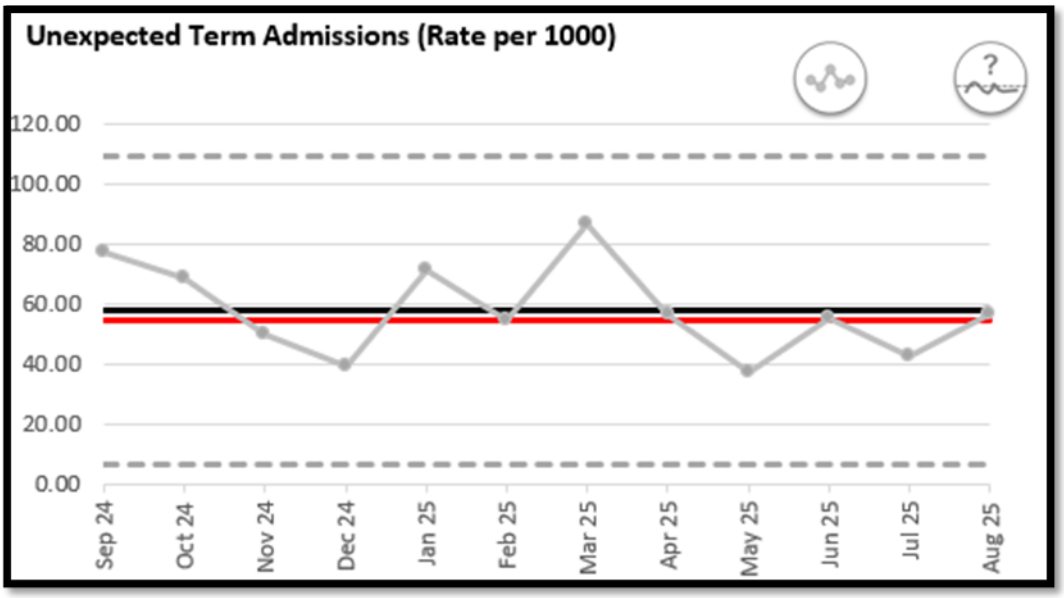



**Category 2 Caesarean Sections with no Delay in Decision to Delivery interval (%).**
Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and delivery. In August there were 3 women out of 20 who had an interval time of more than 75 mins. The times where there was a delay ranged from 85 minutes to 168 minutes. This metric is being reviewed with a deep dive audit. The initial results of this audit indicate discrepancies between the written notes and what is recorded on Euroking. It has been agreed in Safety Champions that this audit should be ongoing for a while for increased assurance.

**PPH over 2500mls (rate per 1000).**
There was one woman who had a PPH of over 2500mls in August. 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.



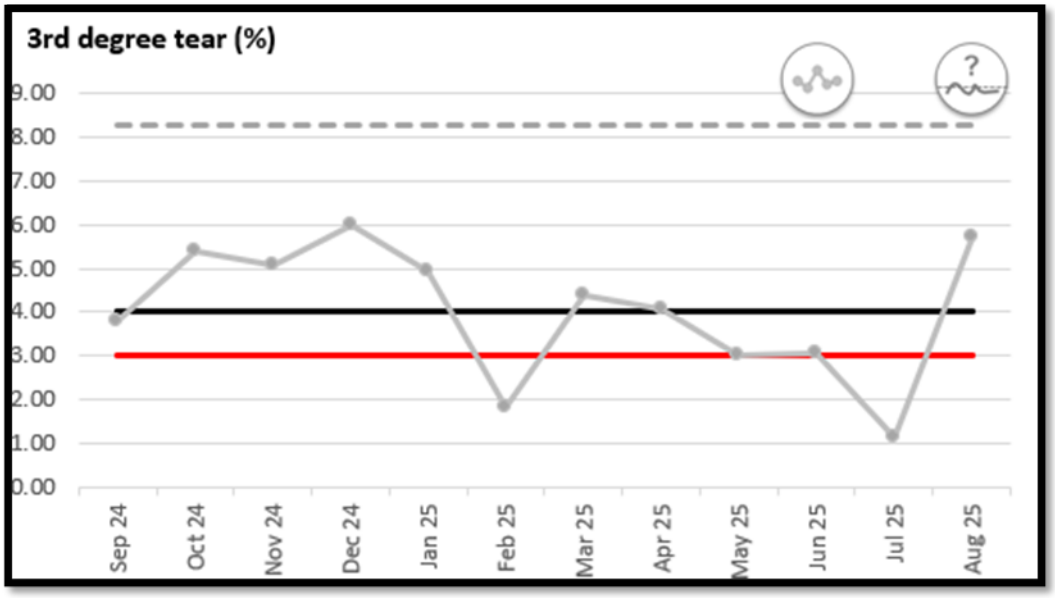

**Term admissions to NNU (rate per 1000).**
This figure is recorded as rate per 1000 and equates to 11 babies in July. This metric had been beginning to see a downward trend. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate and to try to improve the figures in this metric. The below is an SPC chart showing our rates in comparison to the 2024 GM average (red line).




**Red**

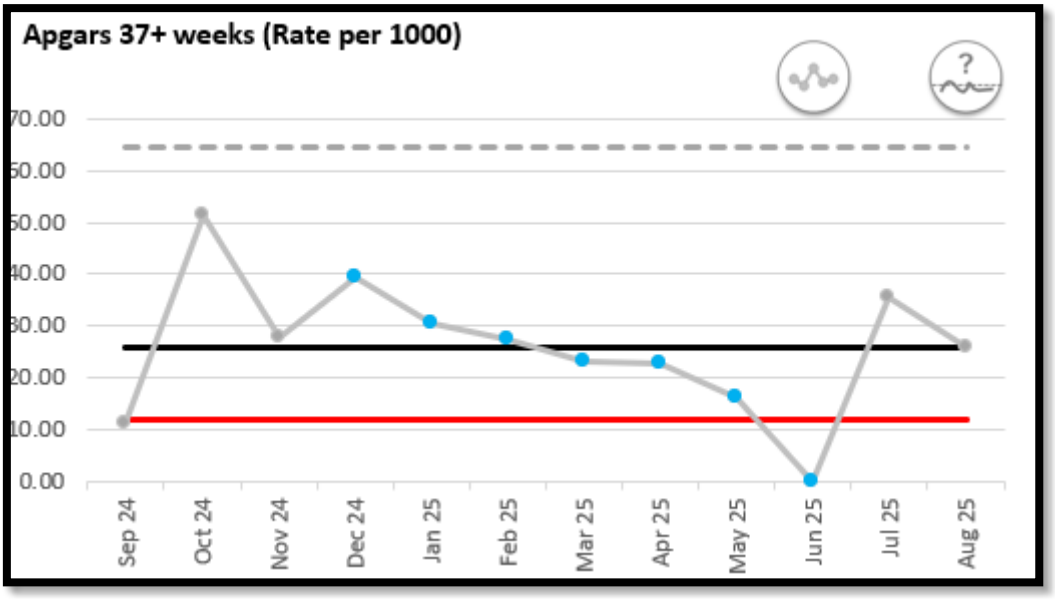
**3rd / 4th degree tear (%)**.

The figure is recorded as a rate per 1000. There were 6 woman who had a 3rd degree tear and one with a 4th degree tear in August. 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.




**All infants with Apgar's less than 7 (rate per 1000)**.

This metric fell to zero in June but sees a spike into red levels in July and August. We had been seeing a downward trend in the rates for this metric. The rate per 1000 in August equates to 5 babies. A themed analysis of these babies will be carried out by the governance team and any findings fed back. The below SPC chart shows how our figures compare to the 2024 GM average (red line) and demonstrate the improvement following the focused work that has been undertaken around training and documentation.

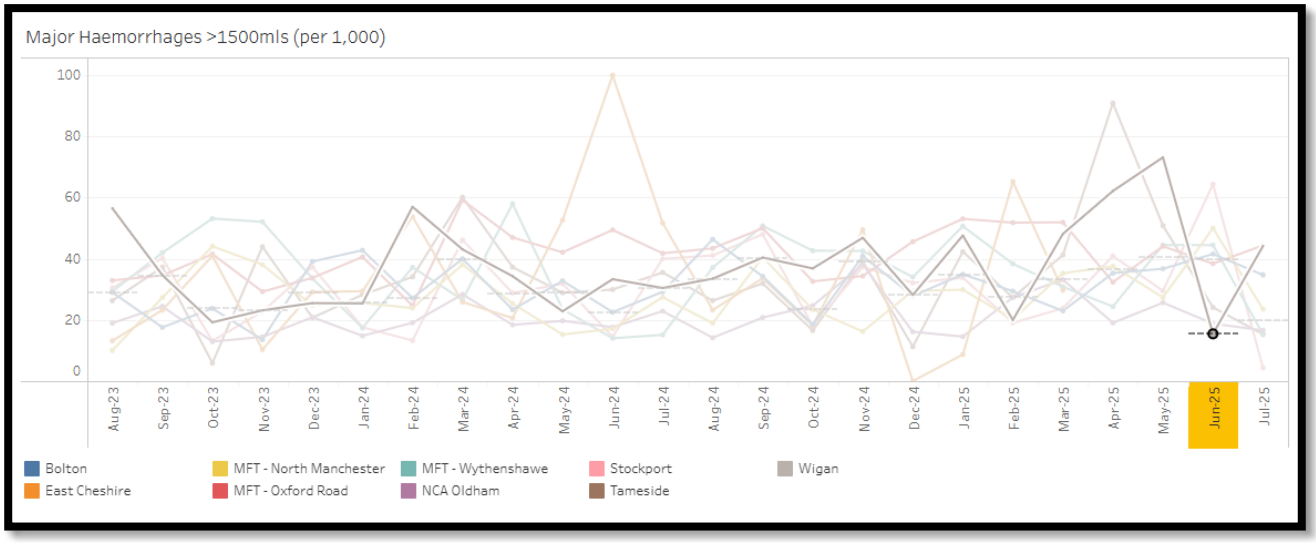



**Category 1 Caesarean Sections with no Delay in Decision to Delivery interval (%).**
Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and delivery. The figures pulled from Euroking for August show that 4 out of 17 women had an interval of more than 30 minutes. The times where there was a delay ranged from 35 to 46 minutes. This metric is being reviewed with a deep dive audit. The initial results of this audit indicate discrepancies between the written notes and what is recorded on Euroking. The manual audit for Cat 1 sections showed that just one woman had a delay. It has been agreed in Safety Champions that this audit should be ongoing for a while for increased assurance.

**Supernumerary Shift Coordinator**
This had remained green for the past 4 months. August sees the figure dip into red levels as there was one shift where the shift coordinator was unable to remain supernumerary due to high activity and acuity.

**<u>Other areas not RAG rated</u>**

**PPH 1500mls – 2500mls**
The figure shown on the dashboard is shown as a rate. The rate in July equates to 8 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.



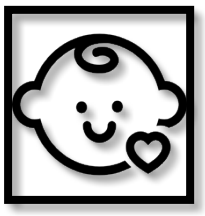

**Conclusion**

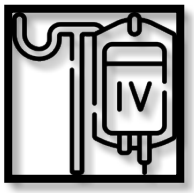
Normal variation and fluctuations are noted with the figures this month and positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show green and amber indicators but do show several red areas which will be observed going forward. Persistently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

**The below relates to 2 mothers who delivered 3 babies.**

- There were 2 babies not born in an appropriate care setting. Twins were delivered due to an abnormal antenatal CTG.
- 2 babies born < 30 weeks gestation (Twins)
- 1 babies born < 34 weeks gestation.

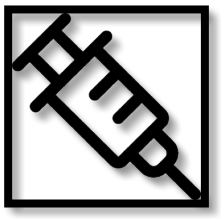


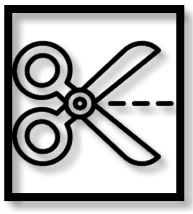



100% of mothers received MgS04 24hrs prior to delivery

33% of babies received steroids within 7 days of delivery (< 34 weeks).

- 1 mother received a full course.
- 1 mother (twins) received a partial dose and went on to have a Cat 1 CS before the 2nd dose could be administered.

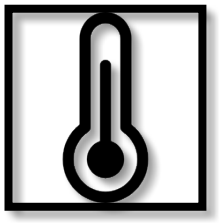




33% received optimal cord management (< 34 weeks).

- 1 baby received delayed cord clamping at delivery.
- X2 did not receive delayed clamping due to their condition at birth.

66.6% of babies had a Normothermic Temperature (36.5-37.5C) on admission to NNU, measured within one hour of birth (< 34 weeks).

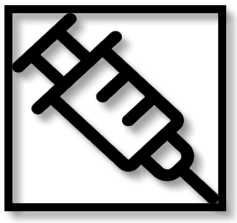


- 2 babies had a normothermic temperature taken within an hour of birth.
- 1 baby had a temp of 36.1.

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

- 2 babies were transferred out after delivery so unable to audit.
- 1 Baby received EBM within 24 hrs of birth

100% received Intrapartum Antibiotics >4 hrs prior to delivery (< 34 weeks)



- 1 received Intrapartum Antibiotics
- 2 N/A (twins) 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 | Aug | Sep | Oct | Nov | Dec | 2025 Q1 | Q2 | Q3 | Q4 | YTD | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity | Bookings (Total bookings) | | | | 245 | 228 | 233 | 198 | 248 | 242 | 250 | 189 | | | | | 706 | 688 | | | | |
| | 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% | 60.40% | 70.37% | | | | | 72.27% | 66.08% | | | | |
| | 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% | 90.40% | 95.77% | | | | | 92.76% | **92.95%** | | | | |
| | Registerable births | | | | 214 | 205 | 191 | 195 | 209 | 198 | 183 | 205 | | | | | 610 | 602 | | | | |
| | Planned home births (as % of all births) | | | | 0.93% | 0.00% | 1.05% | 1.03% | 0.96% | 2.02% | 0.00% | 1.95% | | | | | 0.66% | **1.33%** | | | | |
| | Unplanned home births (as % all births) – BBA | | | | 0.93% | 0.49% | 0.52% | 0.51% | 0.48% | 1.01% | 1.09% | 0.49% | | | | | 0.65% | **0.67%** | | | | |
| | NVD (as % of total births) | | | | 40.65% | 46.34% | 41.88% | 42.05% | 38.76% | 42.42% | 37.70% | 43.41% | | | | | 42.96% | 41.08% | | | | |
| | Instrumental deliveries (as % of total births) | | | | 6.54% | 7.32% | 5.76% | 8.21% | 8.61% | 7.07% | 9.84% | 7.80% | | | | | 6.54% | **7.96%** | | | | |
| | Total number of Caesarean Sections (all categories – as % of total births) | | | | 53.74% | 46.34% | 52.36% | 64.62% | 52.15% | 50.00% | 51.91% | 47.80% | | | | | 50.81% | **55.59%** | | | | |
| | Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour | | | | 3 | 6 | 6 | 6 | 6 | 4 | 2 | 5 | | | | | 15 | 16 | | | | |
| | Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour | | | | 19 | 21 | 22 | 20 | 24 | 15 | 21 | 15 | | | | | 62 | 59 | | | | |
| | Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS | | | | 9 | 11 | 14 | 15 | 14 | 7 | 11 | 19 | | | | | 34 | 36 | | | | |
| | Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour | | | | 4 | 1 | 1 | 2 | 2 | 1 | 0 | 2 | | | | | 6 | 5 | | | | |
| | Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour | | | | 11 | 5 | 6 | 7 | 7 | 8 | 8 | 4 | | | | | 22 | 22 | | | | |
| | Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS | | | | 15 | 8 | 7 | 2 | 8 | 12 | 8 | 6 | | | | | 30 | 22 | | | | |
| | Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy | | | | 32 | 26 | 23 | 26 | 27 | 32 | 29 | 29 | | | | | 81 | 85 | | | | |
| | Robson Group 6: Nulliparas; single breech pregnancy | | | | 5 | 2 | 4 | 3 | 6 | 4 | 3 | 3 | | | | | 11 | 13 | | | | |
| | Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus) | | | | 5 | 2 | 2 | 3 | 0 | 3 | 5 | 1 | | | | | 9 | 6 | | | | |
| | Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus) | | | | 6 | 5 | 7 | 4 | 8 | 6 | 2 | 6 | | | | | 18 | 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 | 1 | 4 | | | | | 0 | 3 | | | | |
| | Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus) | | | | 6 | 8 | 8 | 7 | 7 | 6 | 5 | 4 | | | | | 22 | 20 | | | | |
| | Number successful VBAC | | | | 6 | 4 | 8 | 5 | 3 | 2 | 2 | 2 | | | | | 18 | 10 | | | | |
| | % 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% | 88.89% | 76.40% | | | | | 71.86% | **68.99%** | | | | |
| | % 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% | 79.17% | 85.00% | | | | | 77.23% | **71.04%** | | | | |
| | Number of Caesarean Section at Full Dilatation | | | | 8 | 2 | 8 | 6 | 10 | 2 | 6 | 3 | | | | | 18 | 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% | 37.16% | 34.15% | | | | | 36.37% | 40.57% | | | | |
| | Number of women induced when RFM is the only indication <39 weeks | | | | 0 | 3 | 0 | 0 | 2 | 0 | 0 | 1 | | | | | 3 | 2.00% | | | | |
| | Number of women induced for Suspected SGA | | | | 7 | 9 | 2 | 10 | 5 | 4 | 9 | 4 | | | | | 18 | 19% | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number of In-utero transfers in from other units | | | | 4 | 7 | 2 | 2 | 2 | 4 | 3 | 5 | | | | | 13 | 8% | | | | |
| | Number of In-utero transfers out to other units | | | | 2 | 2 | 6 | 4 | 0 | 0 | 2 | 4 | | | | | 10 | 4% | | | | |
| | Average Postnatal Length of Stay | | | | 1.7 | 1.7 | 1.9 | 1.7 | 1.7 | 1.5 | 1.7 | 1.8 | | | | | 1.76 | 1.63 | | | | |
| 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% | 1.15% | 5.71% | | | | | 4.05% | 3.73% | | | | |
| | Of which 4th degree tears (number) | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | | | | 0 | 0 | | | | |
| | PPH 1500 – 2500 mls (Rate per 1000) | | | | 46.73 | 19.51 | 47.12 | 61.54 | 71.77 | 15.15 | 43.72 | 43.90 | | | | | 37.79 | **49.49** | | | | |
| | PPH > 2500mls (Rate per 1000) | Under 4 | Above 6 | | 0.00 | 5.00 | 5.35 | 5.18 | 4.88 | 5.15 | 5.52 | 4.95 | | | | | 3.45 | 5.07 | | | | |
| | Number of Women Requiring Level 2 Critical Care | | | | 2 | 2 | 2 | 0 | 1 | 2 | . | . | | | | | 6 | **3** | | | | |
| | Number of Women Requiring Level 3 Critical Care | | | | 0 | 0 | 0 | 0 | 0 | 0 | . | . | | | | | 0 | **0** | | | | |
| | Number of Blood Transfusions > 4 Units | | | | 0 | 0 | 0 | 0 | 0 | 0 | . | 0 | | | | | 0 | 0 | | | | |
| | Number of Maternal deaths | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | | | | |
| | Number of women re-admitted within 28 days of delivery (Rate per 1000) | Under 25 | Above 35 | | 23.36 | 24.39 | 26.18 | 10.26 | 9.57 | 15.15 | 10.93 | 4.88 | | | | | 24.64 | 11.66 | | | | |
| | Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis (Number) | | | | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 1 | | | | | 2 | 0 | | | | |
| Neonatal Morbidity and Mortality | Total stillbirths (as rate per 1000) | Under 3.5 | Above 4 | | 0.00 | 4.88 | 10.47 | 15.38 | 0.00 | 20.20 | 0.00 | 0.00 | | | | | 5.12 | 11.86 | | | | |
| | Stillbirths (excluding MTOP as rate per 1000) | | | | 0.00 | 4.88 | 5.24 | 15.38 | 0.00 | 15.15 | 0.00 | 0.00 | | | | | 3.37 | 10.18 | | | | |
| | Number of stillbirths (excluding MTOP) | | | | 0 | 1 | 1 | 3 | 0 | 3 | 0 | 0 | | | | | 2 | 6 | | | | |
| | Early neonatal deaths (as rate per 1000) | Under 1 | Above 1.77 | | 9.35 | 4.88 | 0.00 | 5.13 | 4.78 | 5.05 | 0.00 | 0.00 | | | | | 4.74 | 4.99 | | | | |
| | Early neonatal deaths (excluding MTOP as rate per 1000) | | | | 4.67 | 4.88 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | 3.18 | 0 | | | | |
| | Number of Early Neonatal Deaths (excluding MTOP) | | | | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | | | | | 3 | 1 | | | | |
| | Number of babies born below 37 weeks | | | | 18 | 21 | 14 | 15 | 22 | 18 | 18 | 11 | | | | | 53 | 55% | | | | |
| | Shoulder Dystocia (as % of total births) | | | | 1.87% | 0.98% | 1.57% | 0.51% | 0.96% | 1.01% | 0.55% | 0.49% | | | | | 1.47% | 0.83% | | | | |
| | Number of singleton babies born under 27 weeks | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | | | | |
| | Number of multiple babies born under 28 weeks gestation | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | | | | | 0 | 0 | | | | |
| | Number of above babies where transfers out not facilitated | | | | N/A | N/A | N/A | N/A | N/A | 0 | N/A | 2 | | | | | 0 | 0 | | | | |
| | % of Mothers who delivered under 34 weeks who received AN steroids | | | | 25% | 50% | 50% | 40% | 40% | 43% | 33% | 33% | | | | | 42% | 41 | | | | |
| | % of Mothers who delivered under 34 weeks who received AN Magnesium Sulphate | | | | 25% | 8% | 0% | 20% | 40% | 14% | 100% | 100% | | | | | 11% | 25 | | | | |
| | % of Mothers who delivered under 30 weeks who received AN Magnesium Sulphate | | | | N/A | 100% | N/A | N/A | N/A | N/A | 100% | 100% | | | | | 100.00% | N/A | | | | |
| | Number of mothers who delivered under 34 weeks who received a partial dose of steroids | | | | 1 | 1 | 0 | 1 | 2 | 1 | 1 | 1 | | | | | 2 | 4 | | | | |
| | 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 | 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% | 86.89% | 89.27% | | | | | 85.38% | 85.72% | | | | |
| | % 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% | 44.44% | 45.45% | | | | | 70.95% | 38.10% | | | | |
| | 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 | 36.59 | 25.77 | | | | | 26.97 | 12.88 | | | | |

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Term Admissions to NNU (births >_ 37 weeks gestation) - Rate per 1000 | Under 54 | Above 65 | | 71.43 | 54.64 | 86.21 | 37.40 | 37.43 | 55.56 | 42.68 | 56.70 | | | | | 70.76 | 51.61 | | | | |
| | Number of babies re-admitted with 28 days of birth | | | | 16 | 18 | 18 | 19 | 16 | 14 | 13 | 9 | | | | | 52 | 49 | | | | |
| | Number of babies born < 3rd centile | | | | 13 | 5 | 8 | 7 | 9 | 12 | 4 | 12 | | | | | 26 | 28.00% | | | | |
| | Number of babies born < 3rd centile >_ 38 weeks | | | | 6 | 1 | 1 | 2 | 5 | 3 | 3 | 6 | | | | | 8 | 10 | | | | |
| Public Health | % women smoking at time of booking (as % of total bookings) | | | | 7.76% | 3.95% | 14.16% | 7.58% | 6.45% | 6.20% | 10.40% | 4.76% | | | | | 8.62% | 6.74% | | | | |
| Public Health | % 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% | 7.65% | 4.88% | | | | | 6.21% | 6.33% | | | | |
| Public Health | 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% | 77.05% | 77.56% | | | | | 74.05% | 78.92% | | | | |
| Public Health | 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% | 58.00% | 66.00% | | | | | 62.97% | 61.04% | | | | |
| 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% | 98.83% | 100.00% | | | | | 99.24% | 100.00% | | | | |
| Workforce | Percentage of shifts where shift Co-ordinator able to remain supernumerary | | Under 100% | | 100% | 100% | 98.39% | 100% | 100% | 100% | 100% | 98.38% | | | | | 99.00% | 100.00% | | | | |
| Workforce | Diverts: Number of occasions unit unable to accept admissions | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | | | | 0 | 0 | | | | |
| Workforce | Number of vacancies | | | | 1.82 | 2.22 | 1.94 | 6.04 | 7.97 | 5.84 | 6.49 | 5.81 | | | | | 1.99 | 6.61 | | | | |
| Workforce | Midwife : Birth Ratio | | | | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | | | | | | | | | | |
| Workforce | Prospective Consultant hours on Delivery Suite | | | | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | | | | | 180 | 180 | | | | |
| Workforce | Number of Midwifery Red Flags Reported | | | | 8 | 5 | 7 | 20 | 17 | 6 | 24 | 42 | | | | | 21 | 43 | | | | |

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | NHS EPRR Core Standards Framework 2025 |
| **Presented to:** | Trust Board of Directors |
| **On:** | 1st October 2025 |
| **Item purpose:** | Information |
| **Presented by:** | Accountable Emergency Officer |
| **Prepared by:** | Head of Resilience |
| **Contact details:** | T: 0300 707 3858 E: mark.taylor1@wwl.nhs.uk |

**Executive summary**
This paper is a report from the annual NHS Core Standards for EPRR self-assessment for 2025. This year the Trust has self-assessed as **Substantially Compliant** against the 62 applicable core standards in the framework, this maintains the compliance rating from 2024. This process has identified the areas in which the Trust have improved in over the last 12 months and also the areas that still require improvement and which will form the 2025 NHS Core Standards for EPRR improvement action plan for the next 12 months.

**Link to strategy and corporate objectives**
None

**Risks associated with this report and proposed mitigations**
None

**Financial implications**
None

**Legal implications**
There are legal implications linked to this in that the Trust are not currently fully complaint with statutory duties as set out in the Civil Contingencies Act and NHS EPRR Core Standards Framework. However, an improvement plan is being developed to move back to a compliant status by September 2026.

**People implications**
None

**Recommendation(s)**
The Trust Board of Directors are asked to acknowledge the contents of this report, the maintenance of the substantially compliant rating, acknowledge the process timeline and the communication expected from NHSE, along with a potential request for further information should NHSE not agree with the self-assessment.

The WWL Way

**Report Purpose:**
NHS England requires all NHS organisations to annually assess their ability to meet their Emergency Preparedness, Resilience & Response (EPRR) statutory obligations. This assurance is sought each autumn, and Trust Management Team and Boards are to be made aware of the level of preparedness achieved. This report shows the results of our self-assessment for 2025.

**Self-Assessment Statement:**
The self-assessment for 2025 shows that overall WWL is substantially compliant with the EPRR Core Standards for 2025, having fully completed 58 out of the 62 standards required (equating to 94%). In addition, the Trust is partly compliant in 4 standards, and there are Zero standards where we have no level of compliance (see diagram below). The areas where we are not fully compliant relate mainly to:

- Business Continuity (DPST compliance, BCMS KPI's and performance reporting, providers/suppliers BC plans)
- Hazmat/CBRN (Hazmat Training)

**Dashboard:**

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

| Core Standards | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Governance | 6 | 6 | 0 | 0 |
| Duty to risk assess | 2 | 2 | 0 | 0 |
| Duty to maintain plans | 11 | 11 | 0 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 4 | 4 | 0 | 0 |
| Response | 7 | 7 | 0 | 0 |
| Warning and informing | 4 | 4 | 0 | 0 |
| Cooperation | 4 | 4 | 0 | 0 |
| Business Continuity | 10 | 7 | 3 | 0 |
| Hazmat/CBRN | 12 | 11 | 1 | 0 |
| CBRN Support to acute Trusts | 0 | 0 | 0 | 0 |
| Total | 62 | 58 | 4 | 0 |

| Overall assessment: | Substantially compliant |
|---|---|

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

- July to August Trust undertakes self-assessment
- 23/09/25 AEO Informed of initial self-assessment outcome
- 23/09/25 Full report to AEO for sign-off
- 23/09/25 ETM Report sent to COO
- 30/09/25 Board Report sent to Co. Secretary
- 30/09/25 Submit self-assessment to GM-ICB
- 01/10/25 Report presented to public board meeting
- 14/10/25 Assurance visits to Trust by GM EPRR
- 20/11/25 LHRP Review of GM Assessments
- 28/11/25 GM Submission into LHRP

The Head of Resilience, on behalf of the Accountable Emergency Officer has scrutinised the self-assessment and identified the following areas for improvement against which a 12-month action plan will be developed, overseen by the EPRR Group, to ensure compliance to the standards in 2025.

- DSPT compliance
- Update EPRR policy to include key performance indicators and more regular reporting to Board
- Update provider/supplier assurance framework and BC arrangements
- Increase CBRN training for A&E staff

**APPENDIX 1: Trust Statement of Compliance**

## Greater Manchester Local Health Resilience Partnership (LHRP)
## Emergency Preparedness, Resilience and Response (EPRR) Assurance 2025-2026

## STATEMENT OF COMPLIANCE

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

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

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

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

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

_____

Signed by the organisation's Accountable Emergency Officer

23/09/2025

Date signed

| 25/09/2025 | 01/10/2025 | _____ |
|---|---|---|
| Date of Board/governing body meeting | Date presented at Public Board | Date published in organisation's Annual Report |

**Greater Manchester Local Health Resilience Partnership (LHRP)**
**Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026**

## STATEMENT OF COMPLIANCE

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

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

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

| Overall EPRR assurance rating | Criteria |
|---|---|
| **Fully** | The organisation is 100% compliant with all core standards they are expected to achieve.<br><br>The organisation's Board has agreed with this position statement. |
| **Substantial** | The organisation is 89-99% compliant with the core standards they are expected to achieve.<br><br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
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I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan.

_____

Signed by the organisation's Accountable Emergency Officer

Click here to enter a date.

23/09/25

| 25/09/2025 | 01/10/2025 | Click here to enter a date. |
|---|---|---|
| Date of Board/governing body meeting | Date presented at Public Board | Date published in organisation's Annual Report |