Board of Directors - Public Meeting

Wed 04 June 2025, 13:45 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

1 min

18. Declarations of Interest

Information *Mark Jones*

Verbal item

18.1. Register of directors' interests

Information *Mark Jones*

18.1. Directors DoIs - Jun 2025.pdf (3 pages)

1 min

19. Minutes of the previous meeting

Approval *Mark Jones*

19. Minutes_Board of Directors - Public Meeting _020425 (1).pdf (9 pages)

2 min

20. Action Log

Discussion *Mark Jones*

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

5 min

21. Staff Story

Information

Video to be shared during the meeting.

5 min

22. Chair's comments

Information *Mark Jones*

15 min

23. Chief Executive's report

Information *Mary Fleming*

23. CEO Board Report_May 2025 v2.pdf (5 pages)

30 min

24. Integrated performance report

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

24. Board of Directors IPR M1 2526.pdf (4 pages)

24a. Board of Directors IPR M1 2526.pdf (25 pages)

15 min

25. Finance report Month 12 and Month 1

Information *Tabitha Gardner*

25. Board Cover Sheet - Trust Finance Report March 2025.pdf (2 pages)
25a. Trust Finance Report 24-25 March Month 12 Board.pdf (14 pages)
25b. Board Cover Sheet - Trust Finance Report Apr 2025.pdf (2 pages)
25c. Trust Finance Report 25-26 April Month 1 Board.pdf (14 pages)

30 min

26. Committee chairs' reports

Information *Non Executive Directors*

26.1. Quality and Safety

Information *Francine Thorpe*

26.1. AAA QSmay25.pdf (2 pages)

26.2. Finance and Performance

Information

26.2. AAA - FP - May 2025.pdf (2 pages)

26.3. People Committee

Information *Mark Wilkinson*

26.3. People Committee - Apr 2025 AAA.pdf (2 pages)

26.4. Audit Committee

Information *Simon Holden*

26.4. AAA - Audit Committee - 8 May 2025.pdf (2 pages)

26.5. Research Committee

Information *Clare Austin*

Verbal update due to close proximity of the meeting.

10 min

27. National Staff Survey update

Information *Juliette Tait*

Verbal item

5 min

28. Reflections on equality, diversity and inclusion

Discussion *Mark Jones*

Verbal item

10 min

29. Chair's closing remark

Information *Mark Jones*

Verbal item

Consent Agenda

0 min

30. Fit and proper persons annual report

Information

30 F&PP annual report.pdf (4 pages)

0 min

31. Maternity Dashboard Reports

Information

31. Maternity Dashboard report April 25.pdf (10 pages)
31a. Maternity Dashboard - Feb 25.pdf (3 pages)
31b. May 25 Neonatal Dashboard.pdf (3 pages)
31c. Perinatal Quality Surveillance Q4 24-25 Jan-Mar 25 (For June Board).pdf (33 pages)
31d. - Wrightington Leigh and Wigan Maternity Letter 2025-05 Baby Friendly Gold progress monitoring.pdf (2 pages)
31e. Baby Friendly Gold report Wrightington Leigh and Wigan 2025-04.pdf (18 pages)

0 min

32. Date, time and venue of the next meeting

Information

06 August 2025, 1.15pm, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

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

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

	Wife employed by Lancashire County Council public health department Son works for Mersey and West Lancs NHS FT
THORPE, Francine	Independent Chair, Salford Safeguarding Adults Board

EXECUTIVE DIRECTORS	
Name	**Declared interests**
ARYA, Sanjay	Clinical private practice, Beaumont Hospital and WWL. Undergraduate Clinical Lead in Cardiology, Edge Hill University. Contracted to act as Principle Investigator for Triage Heart Failure Study Medtronic Company (in association with Manchester Foundation Trust). Honorary position on the Advisory Panel at Bolton University Medical School Director and Chair of the Hospital Doctors' Forum, British International Doctors' Association (CRN: 01396082) Director, Highbank Grange (Bolton) Residents Association Limited (CRN: 04300183) Spouse is General Practitioner in Bolton
BRENNAN, Sarah	Nil declaration
TAIT, Juliette	Nil declaration
FLEMING, Mary	Nil declaration
GARDNER, Tabitha	Governor, Aspiring Learners Academy Trust Spouse is Director at Manchester University NHS FT
MILLER, Anne-Marie	Spouse is director of Railway Children Charity and Railway Children Trading Company Limited
MUNDON, Richard	Nil declaration
PARKER-EVANS, Kevin	Spouse is Head of Safeguarding and Designated Adult safeguarding nurse for NHS Greater Manchester (Stockport Locality) Honorary Senior Clinical Lecturer at Edge Hill University

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

Board of Directors - Public Meeting

Wednesday 2 April 2025, 14:00 - 16:15

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Board members

Mark Jones (Chair), Sanjay Arya (Medical Director), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Sarah Brennan (Chief Operating Officer), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Simon Holden (Non-Executive Director), Mary Moore (Non-Executive Director), Richard Mundon (Deputy Chief Executive), Kevin Parker-Evans (Chief Nurse), Juliette Tait (Chief People Officer), Francine Thorpe (Non-Executive Director), Mark Wilkinson (Non-Executive Director)

Absent: Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Aydin Djemal (Development Non-Executive Director), HAMEEDA KHAN-DAVEY (Development Non-Executive Director)

In attendance

Jonathan Kerry (Interim Deputy Place Lead (Wigan)), Steve Parsons (Interim Director of Corporate Governance)

Meeting minutes

59. Declarations of Interest

Information

Mark Jones

Verbal item

59.1. Register of directors' interests

Information

Mark Jones

The Board noted the circulated paper on declared interests, and the following were drawn to attention-

- Mary Moore had retired as a Non-Executive Director of Stockport Hospital NHS Foundation Trust;
- The entry regarding the employment of Claire Austin's son could now be retired

No declarations of interest in the business expected to be considered at the meeting were drawn to the Board's attention.

13.1. Directors DoIs - Apr 2025.pdf

60. Minutes of the previous meeting

Approval

Mark Jones

The minutes of the Board's public session held on 5th February 2025 were APPROVED as a true and accurate record of the proceedings.

14. Minutes_Board of Directors - Public meeting_050225.pdf

61. Action Log

Discussion

Mark Jones

The following updates were noted-

- In relation to progress towards University Hospital status, it was noted that the University Hospitals Association had now moved to be hosted by NHS Providers; it was anticipated that the move would be accompanied by a review of the required standards to achieve University Hospital status, which the Trust could influence. Particular attention was drawn to the work of colleagues in the research team, who were

continuing to develop the Trust's research portfolio; and the retirement of Professor Maya as the Director of Research, and the appointment of Professor Watts as his successor. The Trust remained on course to seek this accreditation in March 2026; more detailed information could be provided to Directors outside of the Board meeting.

The Board then noted the updated action log.

15. Public Board Action Log 2025.pdf

62. Research Story

Information

The Board received a video presentation regarding the SOFFT research project, led by the Trust, which had reviewed the potential of new potential treatment for elbow-related fractures. Whilst final results were yet to be published, the research was likely to drive positive changes in patient experience and recovery.

Following the video presentation, the Board noted that the research was something that started with the team at the Wrightington site, but it was important to acknowledge the contribution from colleagues at Edge Hill University and the links between them and the Trust.

63. Chair's report and stakeholder update

Information

Mark Jones

The Chair drew the following to the Board's attention-

a. There had been major changes announced at a national level, with the intention to merge NHS England into the Department of Health and Social Care with significant reductions in posts; and also the requirement for ICB's to reduce their corporate staffing by 50%, both to be delivered by September 2025. The Chair drew the Board's attention to the past experience of Sir James Mackey, the incoming Chief Executive of NHS England.
b. As Directors were aware, there had been serious concern at the initial financial submissions which had combined to a national position of £6 billion deficit; Sir James had been clear that this was unacceptable, and since then the position had improved. There was also a continuing and increased focus on the delivery of quality and safe services to patients: and an expectation that there will be deepened co-operation at system level whilst Boards took accountability for provision of services and their standards.
c. The newly-published Performance Assessment framework made clear that oversight of performance would be firmly located with NHS England, with Integrated Care Boards having other responsibilities. This was likely to be a positive for this Trust, providing opportunities for innovation and showing it was a "can-do" organisation.
d. With the Chief Executive and the Deputy Chair, he would be visiting Wrightington later in the day to engage in some blue-sky thinking with the Orthopaedic Consultants, around what could be developed to improve both productivity and quality. He considered that the Trust and its senior medical teams needed to drive innovation and 'consider how to do the impossible'.
e. There had recently been discussions with senior colleagues from Greater Manchester and NHS England North-West Region, including a visit by the Regional Director; which had given very positive feedback.
f. The presentation shown on the agenda in relation to the Trust's Charity would now be taken at the April Away-day.

The Board noted the update from the Trust Chair.

64. Chief Executive's report

Information

Mary Fleming

The Chief Executive drew attention to the following points-

a. She reminded the Board that there had been a commitment to achieving 71% performance against the 4-hour-wait target; for March 2025, the Trust had achieved performance of 73.1%. This would now be the basis of the planned forward progress towards achieving the national expectation of 78% by the end of

March 2026. The Board's attention was also drawn to other areas of improved performance, particularly that the Trust had no patients waiting for longer than 104 weeks at the end of March 2025. She congratulated staff of their hard work to deliver this; and noted that the Trust needed to continue to improve performance through 2025-2026.

b. The Chief Executive was pleased to be able to advise the Board that the Trust had been awarded the 'cleanest Acute hospital' award for the second year running; and congratulated all the colleagues who enabled the award to be achieved.
c. The Board's attention was drawn to the recently-published results from the NHS national Staff Survey exercise from 2024, which showed the Trust as remaining top in a number of categories across Greater Manchester. However, participation rates in the Staff Survey remained disappointingly low; work was being undertaken to learn from other Trusts that had shown improvement in participation rates, and Trust leadership would be seeking to work with medical leadership and staff side colleagues.
d. Related to the work on the Staff Survey, the Chief Executive also intended to re-institute the prior arrangements where Executive colleagues met face-to-face in small group settings with colleagues at all levels, to listen and learn.
e. Attention was drawn to the recent opening of the new operating theatre at Leigh by Jo Platt MP. This supported the increased activity at Leigh, and it was also pleasing to be able to advise the Board that 100% of diagnostic tests were now being delivered within the national standard. It was also pleasing that Theatre 12 at Wrightington was now operational.
f. The Trust had been very pleased to be able to dedicate the recently-opened Clinical Research lounge to Bill Coward, OBE, who had led in this area for many years and developed the research portfolio.
g. The Board welcomed the news that the Trust had been awarded £2 million to install over 3,500 solar panels across our sites, which would be a significant contribution to achieving the agreed Green Strategy.
h. As shown later in the Board papers, the financial performance to the end of February 2025 (Month 11) had been encouraging, but there remained a significant ask to achieve the full-year plan which colleagues were continuing to work hard to achieve. This showed why the Trust needed to focus on and deliver transformation. The Chief Executive took the opportunity to advise the Board that there was now agreement with the Integrated Care Board that enabled the Trust to formally accept the control total.

The Board noted the update from the Chief Executive.

18. CEO Board Report_Apr 2025_FINAL.pdf

65. Integrated performance report

Information

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

The Deputy Chief Executive introduced the IPR, and ran the Board through the holistic narrative which set out the key points for the consideration of the Board. He also noted a small correction to the changes for Whole-Time Equivalents that had been mis-typed in the report.

The following points were discussed from the report-

a. A query was raised regarding mortality performance shown in SHMI, which still seemed to be above the desirable level although it was improving. The Board noted there had been substantial improvement in this area, shown both in SHMI and HSMR; but the SHMI remained above the 100 level, so the ambition that the Trust had set for itself had not been achieved as yet. All cases were subject to detailed review, and there were no indicators of concern that should be drawn to the Board's attention.
b. In respect of the CIP programme for 2025-2026, a question was raised regarding the phasing of the programme given the increased monitoring of delivery from NHS England. The Board were advised that the Trust was in the process of finalising the Cost Improvement Programme plan, which would be at the level the level of £37.7 million for 2025-2026, or 6.9% of turnover; most of the requirement had been identified, with the intention that plans for delivering all of the requirement would be identified by Easter 2025, which would include the potential effects on workforce. NHS England had announced that Trusts would be subject to weekly monitoring of their delivery of the submitted CIP target, starting from 1st April 2025, which meant immediately starting delivery would be important. The Trust was also working on a number of opportunities to develop collaborations with other partners.
c. The Board's attention was also drawn to the recent announcement that Trusts would be expected to

implement 50% savings in corporate costs, for re-investment in front-line services; detailed information on the expectation was expected shortly from NHS England.

d. The Board welcomed the continued improvement in the use of Virtual Ward provision, and enquiry was made as to the ability to use this for more pathways. The Board were advised that work was in progress to review further pathways that could utilise this model, including opportunities for ‘step-up’ care as well as ‘step-down’ provision. There was also work to embed the technology as part of the partnership offer with Wigan Borough Council. The Trust’s work had been recognised as an example of good practice across the NHS, particularly in respect of ‘step-up’ provision.

The Board then noted the Integrated Performance Report, and the performance of the Trust to the end of February 2025.

19. Board of Directors IPR M11 2425 FINAL.pdf
19a. M11 2425 Integrated Performance Report FINAL.pdf

65.1. Better Lives Programme update

Jonathan Kerry from the NHS Greater Manchester attended to provide the Board with an update on the partnership’s work; and drew attention to the following-

a. He reminded the Board of the background that had led to the development of the Healthy Wigan Partnership, involving the Trust, the Borough Council and other partners. The partnership had agreed the ‘Progress with Unity’ plan to develop and improve services together, with the opportunities to improve the health of local communities shown in the ‘traffic lights’ page in the circulated presentation.
b. The aim of the partnership was to improve the health experience of local communities by working with them to identify positive changes in their local environments; and during the previous year the partnership had come together to progress work against the four agreed priorities. This had been an approach that had shown significant success in a number of communities across the Borough to date.
c. Attention was drawn to the case study included within the presentation, which showed what had been achieved through engagement with communities in West Leigh.
d. Turning to the Better Lives programme, Sarah Brennan reminded the Board of the proposals and the timetables for implementation; the programme was now showing positive results in reducing attendances for urgent and emergency care; and also the avoidance of lengthy stays for patients. The programme was facilitating Same Day Emergency Care (SDEC) to discharge patients into the community and follow-up appointments; together with work to support primary care with referral in to SDEC and urgent and emergency care. The programme was also focused on ensuring that today’s work was undertaken today, and accelerating appropriate recalls.
e. Key Performance Indicators for the Better Lives programme had recently been agreed, with respect to the initial programmes; and was moving to having a focus to support discharges and flow. There was also work being undertaken to support patients in need of intermediate care, through support in their own home, being undertaken with system partners. This would also enable capacity for better elective care.
f. A system-level dashboard had just been implemented, which would simplify the delivery of care in a joined-together fashion between partners together with enabling some foresight of challenges which would improve responsive planning. A number of other changes were being progressed to improve working between and with partners, with the focus on the benefit of the patient/ service user and those supporting them.
g. The Chief Nurse drew the Board’s attention to other items delivered through the partnership since its inception-
    - An education and skills partnership had been put into place, including the recent appointment of a joint Clinical Fellow with Edge Hill University. This was the first such appointment in the country, and had been provided through Continuing Professional Development funds.
    - Work was being progressed on providing care closer to home, with a view to having a preceptorship programme in place for September 2025.
    - The Borough’s public health Infection Prevention and Control team had merged with the Trust’s provision, so there was a single team for the Borough; this would support enabling patients to return to care homes, and provide mitigation of risks.
    - Working with Wigan College, the Trust was developing a ‘grow your own talent’ programme, leading into the Trust’s Healthcare Assistant programme; with the aim of it being expanded to

include partners at the Council and within the care home sector from September 2025.

The following points were discussed from the presentation-

a. Directors welcomed the really uplifting presentation and progress shown, which showed the potential for the Trust and its partners to work together and make positive differences to the community.
b. Enquiry was made as to a data-set for the outcomes of the programmes, together with an observation that a surprisingly high number of the overall 'traffic lights' were red. The Board noted the continuing discussions on ensuring cross-impacts on communities could be recognised appropriately, and also on funding shifts to reflect this; together with the need to address the underlying drivers of community problems, rather than just the consequences. It was noted that a new Consultant in Public Health was being jointly appointed in May 2025, who would be able to drive action across these areas within the Borough.
c. The Board recognised the work that had gone into the development of the comprehensive set of Key Performance Indicators (KPI's) shared with the Board; and noted that, with the publication of the 10-year plan for the NHS later in the year, it would be necessary to review and update a range of KPI's to reflect the priorities set out nationally.
d. A query was raised regarding the recognition of the positive effects of green spaces within the Borough; the Board noted that these were being utilised as a resource to support communities, particularly through social prescribing by GP's. There was also continuing work with organisations such as Wigan Youth Zone on their effective utilisation.
e. Enquiry was made as to the data being used to track effects on discharge and flow across the Trust; it was confirmed each programme had metrics that were collected and regularly analysed, together with attention to terminology to make it more appropriate. It was suggested that a relevant case study should be presented as a patient story to the Board.
f. Work was being undertaken across the Borough to bring partners together, to think differently about how their budgets worked and to support resources being allocated together to be more effective. This needed to be taken further, to extend to items such as capital support and allocations, and to enable communities to change their responses to health inequalities.
g. It was confirmed that, through their Scrutiny Committee, the Borough Council saw similar information to that the Board was discussing; and that it was also provided to forums such as GP Networks.

The Board then-

i. Noted the presentation;
ii. Thanked Mr Kerry for attending and supporting the Board's discussion.

19.1. WWL Board - System Priorities Update - 02 April 2025.pdf

66. Board Assurance Framework

Information

Steven Parsons

The Board considered the circulated report, and discussed the following points-

a. Directors noted that the data for some of the metrics related to BAF risks had not yet been finalised for the full year 2024-2025, which meant giving consideration to an end-of-year report was more challenging.
b. It was suggested that risks CO1 and CO3 needed further review by the Quality and Safety Committee, given no further actions were identified but the data was limited. It was noted that CO1 had now progressed to working with care homes, and CO3 would be reviewed by the Committee at its next meeting as part of the regular order of business.
c. On risk CO2, a query was raised about progress given the potential high impact. The Board were advised that the position was improving compared to April 2024, but it was impacted by the availability and priorities within the capital programme; an update was scheduled for the next Quality and Safety Committee meeting.
d. The Board were advised that it was anticipated that the 2025-2026 corporate objectives would come to the June Board meeting, which could include items within the Better Lives programmes; some of the related risks would be closed, but others would be transferred into the new year. Attention was drawn to the national changes in approach to workforce matters, which would lead to changes under the People

strategic objective.

e. Attention was drawn to the reduction in the risk rating for the Zero Carbon risk, reflecting the additional capital that had become available to support this area of work.

The Board then noted the position on BAF risks, and the year-end update on the risks.

20. BAF Report Board April 2025 final.pdf

67. Committee chairs' reports

Information

Non Executive Directors

67.1. Quality and Safety

Information

Francine Thorpe

Mrs F Thorpe drew the Board's attention to the following from the Committee's circulated report-

a. The Committee had received the quarterly patient safety report, and had requested that further work was undertaken on safety standards and procedures, to give greater assurance.
b. There had been a 'deep dive' undertaken into the Community Division, and in particular the position for paediatric audiology. There was some assurance given the work that was continuing in concert with Greater Manchester, but risks to compliance with the Trusts' obligations; the Committee would continue to be following this area.
c. The Learning from Deaths report had been considered, highlighting improvements in systems and learning.
d. Mrs M Moore updated the Board on the recent Maternity Champions meeting; it had been generally positive. The Board noted that the next set of maternity standards for NHS Resolution had been published during the week, and that Year 7 students were being brought into the Trust today.

The Board noted the report from the Quality and Safety Committee.

21.1. AAA.QS - March 2025.pdf

67.2. Finance and Performance

Information

Julie Gill

Mrs J Gill drew the following key matters from the circulated report to the attention of the Board-

a. Following the discussions at the Committee, and then at the Board, agreement had been reached with the Integrated Care Board on a financial plan for 2025-2026. This would include some £37.7 million in efficiency savings.
b. The Committee had noted the positive progress shown by Trauma and Orthopaedics through the course of the year in meeting their set targets for performance.
c. There had been encouraging assurance from the 'deep dive' into the Community Division.

The following points were discussed from the report-

a. The Chair noted that the expected discussion on how better to align the work of the various Board Committees would now be held at the Board's away-day later in the month. The intention was to enable the Non-Executive Directors to have a greater level of oversight and assurance; a short paper would be provided to support the discussions.

The Board then noted the report from the Finance and Performance Committee.

21.2. AAA - F&P March 25.pdf

67.3. People Committee

Information

Mark Wilkinson

Mr M Wilkinson drew out the following points from the Committee's report-

a. The Committee would be reviewing a revised People Dashboard at its next meeting: it was anticipated

that this would give greater visibility at a Divisional level, to provide greater assurance to the Committee.

b. The detailed outcomes of the 2024 national Staff Survey would be considered at the April 2025 meeting, with the intention of the plan for improvement to come through the June/ July 2025 round of meetings. There would also be a discussion at the Board's away-day later in the month.

The Board noted the report from the People Committee.

21.3. AAA - People Committee - Feb 2025.pdf

67.4. Audit Committee

Information

Simon Holden

Mr S Holden drew the Board attention to the following from the Committee's work-

a. There had been Limited Assurance ratings for two Internal Audit reviews, into Enhanced Care and Employee Relations/ Retention of Documents. The action plans had been reviewed with the relevant Executive Directors, and the Committee had assurance that improvement could be expected.
b. There was a range of positive assurances as outlined in the report, including three Internal Audit reviews.
c. Attention was drawn to a typographical error in the report, which should indicate a materiality limit of 2%.

The Board noted the report from the Audit Committee.

21.4. AAA - Audit Committee - 20 Feb 2025.pdf

67.5. Research Committee

Information

Clare Austin

Prof. C Austin presented the report, drawing the Board's attention to the matters reported.

The Board noted the report.

21.5. AAA - Research - Mar 2025.pdf

68. Finance Report

Information

Tabitha Gardner

The Chief Finance Officer presented the report, setting out the position at the end of February 2025 (Month 11), and noted the following key items-

a. It had been a positive performance in the month, with the Trust being £700,000 ahead of the plan for the month. The current expectation was that the plan would be met by the end of March.
b. Divisional Cost Improvement Plans were on plan overall, but were not delivering the planned level of recurrent savings within that.
c. There had been a successful month for Trauma and Orthopaedics within the Elective Recovery Fund- they had achieved the financial target, although slightly behind on performance targets.
d. The Trust was behind plan on workforce spending; the pay position was being closely monitored, but it was remaining static across the Trust despite the vacancy control measures that had been implemented.

The Board noted the financial position for the end of February 2025 (month 11).

22. Trust Finance Report 24-25 February Month 11 Board.pdf
22. Trust Finance Report February 2025.pdf

69. Partnerships report

Information

Richard Mundon

The paper was presented in compliance with the requirements of the *Code of Governance for NHS Provider Trusts*, and there were no particular matters to draw to the Board's attention.

The Board noted the paper.

23. Trust Board - Partnerships Report April 2025 FINAL (no highlights).pdf

70. 7-day services report

Information

Sanjay Arya

The Medical Director presented the report, noting the following points-

a. The report was presented in line with the national expectation that Boards would annually review the provision of seven-day services, outlined in National Quality Board documents. The report was based on an audit exercise against the national standards.
b. There were not specific matters that needed to be drawn to the Board's attention; there were some areas that were the subject of ongoing work, but it could be confirmed that all relevant patients had received a review by a senior medical colleague if not a Consultant.

The following points from the report were discussed-

a. A query was raised regarding the inclusion in the exercise of patients with extended waits for admission; it was confirmed that these were not included in the audit process as not within the definition in the national guidance, but it would be the case that they had senior review appropriately. Attention was drawn to the changes in practice since the guidance was issued in 2013, and the consequent impact on assurance levels; and that the standards might benefit from being reviewed.
b. It was noted that the time of day could impact, as there were quieter times where Consultants were more available.

The Board noted the annual update on seven-day services.

24. Seven Day Services Audit 2024-25.pdf

71. Reflections on equality, diversity and inclusion

Discussion

Mark Jones

It was suggested, arising from the earlier discussion on system working, that the 'place' system should have an eye towards these issues and the related questions of deprivation when determining both priorities and looking at outcomes.

Consent Agenda

72. Risk appetite statement FY 2025/26

Approval

Steve Parsons

Without objection the Risk appetite statement was **APPROVED** by the Board.

26. Risk Appetite 25-26 v3.pdf

73. Use of the Common Seal

Information

The Board received and noted the contents of the report.

27. Use of the common seal.pdf

74. Gender pay gap report

Information

The Board received and noted the contents of the report.

28. Gender Pay report for board.pdf

75. Modern Slavery and Human Trafficking statement

Approval

Without objection the Board **APPROVED** the Modern Slavery and Human Trafficking statement.

29. Modern slavery statement 2025-2026.pdf

76. Maternity Dashboard Reports

Approval

The Board received and noted the contents of the reports.

30. Maternity Dashboard report February 25.pdf
30a. Maternity Dashboard - Feb 25.pdf
30b. Neonatal Dashboard - Feb 25.pdf

77. Audit Committee annual report

Information

The Board received and noted the contents of the report.

31. Audit Committee annual board report and cover sheet.pdf

78. Date, time and venue of the next meeting

Information

04 June 2025, 1.15pm, Trust Headquarters

Action log: April 2025

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Feb 2025	21.3	People Committee AAA	Circulate the People and Culture Strategy to board members.	J Tait	4 Jun 2025	
4 Dec 2024	193.4/24	People Committee AAA	Consider whether anything additional can be done to support Board members to speak up where they have concerns.	J Tait	4 Jun 2025	27/25 saw an additional request for input on how staff can be encouraged to give their name when reporting.
4 Dec 2024	194/24	Workforce Race Equality Standard and Workforce Disability Equality Standard (WRES and WDES)	Consider whether any other Board focussed updates should/could be provided wider than the assurance given to the People Committee.	J Tait	4 Jun 2025	
5 Feb 2025	*24/25*	*Safe Nurse Staffing Bi-annual review*	*Provide assurance on the staffing of escalated areas for the People Committee.*	*K Parker Evans*	*Referred to People Committee.*	---

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	4th June 2025
Item purpose:	Information
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy and corporate objectives

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with this report.

Equality, diversity, and inclusion (EDI) implications
There are no EDI implications in this report.

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

Recommendation(s)

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

Key Achievements in 2024/25

Financial Sustainability

This year, we made significant strides in improving our financial future. We managed to deliver a £0.8m deficit, hitting our financial target for the year. This achievement means we're on the right track financially, allowing us to invest more in patient care. Our Cost Improvement Programme (CIP) saved us £27.4m, with £13.2m of that being ongoing savings. These savings are crucial as they enable us to reinvest in critical services and innovations. Additionally, we improved our underlying financial position by £7m, setting us up for the aim of achieving sustainability by 2027/28. We're building a solid foundation for the future.

Urgent & Emergency Care (UEC)

In Urgent & Emergency Care, we've made good progress. Our Discharge and Flow Programme advanced multiple workstreams, including ward improvements and faster ambulance handovers. This means quicker admissions for patients and less waiting time. The BetterLives Programme, a tripartite agreement between three partners continued to reduce hospital pressures through admission avoidance and community-based care, enhancing patient experiences and outcomes. We also sustained compliance with the four-hour national care standard in March 2025, ensuring timely care for patients. One of our proudest achievements is reducing corridor use by over 50% and de-escalating two previously bedded areas, making A&E a safer and more comfortable place for patients and a better working environment for staff.

Elective Care

Managing long waits has been a challenge, regardless we supported Greater Manchester by providing the most mutual aid, which in turn supported the system in addressing long waiting times for patients within struggling specialties. We achieved eradication of 104 week waits and we're working hard to clear 65+ week waits by March 2025, despite facing challenges such as junior doctor strikes throughout the year. This effort demonstrates our commitment to reducing waiting times and improving patient access to care.

Mortality Metrics

Our focus on quality care is reflected in our mortality metrics. We've kept our Hospital Standardised Mortality Ratio (HSMR) consistently below 100 since April 2023, showing our commitment to high-quality care. Our Summary Hospital-level Mortality Indicator (SHMI) has also seen continuous improvement over the past 18 months, reflecting safer care delivery.

Workforce Recognition

Celebrating our staff is a priority. During Nursing and Midwifery Week, we shared stories and recognized six HCAs with National Chief Nursing Officer Awards. It's great to see our staff being appreciated both locally, regionally and nationally.

The event also honoured the contributions of our diverse workforce, with support from the Caribbean and African Health Network. Diversity makes us stronger.

The board will see a progress update on the work that has been undertaken with regards to supporting our Global Majority Nurses following on from their concerns last year. The implementation of the Global Majority Practice Development Nurse and the Chief Nursing Officer Clinical Fellow programme are new but influential roles in integrating our workforce, resulting in the work that has been undertaken winning a Royal College of Nursing Diversity Improvement Award. I am delighted to tell you that Gideon Agbemafle, our Global Majority Practice Development Nurse, has recently been appointed as the North West Black and Minority ethnic strategic advisory Group fellow representing the North West region on this national platform, reporting to the Chief Nursing Officer for England.

We have made significant progress with the development of our workforce of the future, supporting our ambitions as an Anchor Institute and one of the highest employers across the Borough. We have introduced some new and exciting collaborative roles that are not only new to the locality but are gaining national recognition for system working across health, social care and education. We have appointed a Joint Sector Clinical Fellow, a shared role (hosted by WWL) with Edge Hill University that will support the development of the health and social care education programme for learners. This will lead to the development of rotational learner placements and WWLs Practice Education Facilitator (PEF) Team providing educational in reach to the placements. We have also appointed a dual trained nurse and social worker in this exciting role which has had interest and support of the National Chief Nursing Officer for social care.

Working with our social care colleagues, we have supported the Nursing Associate role within care home settings. WWL have 'gifted' underspent Apprentice levy to social care colleagues, enabling them to embrace and introduce the Nursing Associate role with WWL's PEF supporting their education and competencies and rotational placements. By September there will be 10 Student Nursing Associates across this health and social care circuit.

Working with our colleagues at Wigan Youth Zone and Public Health we have identified a unique opportunity to work in partnership in providing an enhanced health and social care offer for our children and young people. WWL and the Youth Zone will have a dual hosted role working across the Youth Zone and WWL's Paediatric Emergency Care Centre and Rainbow Ward to develop pathways to support the Youth Zone being used by our children and young people. The role will also integrate health services into the Youth Zone becoming the base of specialist staff and clinics such as smoking cessation and a vaccination offer at the 'Babyzone'

Patient Safety

Patient safety remains at the forefront of our efforts. We introduced Martha's Rule Pilot, which includes wellness questionnaires and rapid review rights for families concerned about patient deterioration. This initiative empowers families and enhances patient safety. We're now expanding this initiative wider to improve patient outcomes and responsiveness.

Looking Ahead to 2025/26

As we look to the future, our goals are clear. We're aiming for 76% compliance with the four-hour A&E standard and reducing 12+ hour waits to under 10%. No more long waits! We're also working to eliminate corridor care entirely and have specialty-led recovery plans to reduce waiting times and improve access.

Our BetterLives journey to Phase 2 will focus on intermediate care, reducing hospital dependency and supporting independent recovery post-discharge. We're also strengthening our bid for University Teaching Hospital status through joint Consultant-Clinical Academic roles with Edge Hill University.

Our People & Culture Strategy includes a three-year vision to embed a values-led culture, inclusive leadership, and staff wellbeing. Key initiatives include Trust-wide values-based recruitment, a new leadership development programme, reducing the gender pay gap in senior clinical roles, delivering our Anti-Racist strategy, and hosting listening events to shape the future of WWL.

Financially, we're targeting a balanced position with £38.4m in CIP savings (6.5%), including £23.0m recurrent. Our transformation programmes will focus on elective productivity, corporate transformation, commercial opportunities, discharge and flow, and organisational redesign.

Conclusion

WWL has built a strong foundation through resilience, innovation, and teamwork. As we move into 2025/26, our focus remains on delivering outstanding care, engaging our people, and transforming our services to meet the needs of our communities.

Title of report:	M1 25/26 Integrated Performance Report
Presented to:	Board of Directors Meeting
On:	4th June 2025
Item purpose:	Information
Presented by:	Deputy Chief Executive
Prepared by:	Principal Data Analyst, Data Analytics and Assurance
Contact details:	BIPerformanceReport@wwl.nhs.uk

Executive summary

The latest month, for M1 April 25 update of the Trust's Integrated Performance Report (IPR) is presented to the Board of Directors.

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

Unfortunately, we had a never event in month 1, which was appropriately investigated. However, harms were generally low and both the key mortality metrics continued to show sustained improvement.

The Summary Level Mortality Index (SHMI) showed further improvement to 104.49 and the Hospital Standardised Mortality Ratio (HSMR) remains below the 100 indexed standard.
Whilst our performance on category 2 pressure ulcers is not at the standard to which we aspire, there has been a month on month improvement since February.

Our performance on complaint responses improved to 71.7%, which is still below our expected standards, but the focus through fortnightly meetings and lightning learning seems to be gaining traction.

Potential harms continue to be a focus during sustained pressure and particularly during periods of escalation. Escalation spend has reduced in month1 by £120k compared to month12. This is multifactorial including the sustained closure of inpatient escalation areas (DL & AAA) and the implementation of a more robust utilisation of the Safe Care module, supporting the deployment of staff to support any interim opening of non-inpatient escalation capacity (corridor). There has been

a significant change in the way in which nurse staffing and temporary staffing is being managed; there is no forward planning of nurse staffing for escalation areas.

The continued challenges of patient flow has also impacted on patient moves. Whilst our performance has improved a little, we are seeing 38 patients transferring between wards more than 5 times compared to our standard of less than 32, it is worth noting that this is a new indicator recently implemented by the CNO and senior Nursing and Midwifery leadership team for IPR reporting.

There has been a slight increase in sick absence in month 1 to 5.7%. Whilst operational pressures will be a factor, the underlying reasons are more complex, and we are ensuring through our People and Culture Strategy that our workforce are supported to enable them to stay well and productive. Short term sickness absence rates have reduced from 2.6% to 2.4% - this is, in part, due to seasonal variation, but also reflects the additional support HR have been provided to ensure timely return to work interviews and a focus on repeated periods of short-term episodes

We remain non-complaint with appraisals at 80.9% against our 90% standard. As previously reported, this is a result of cumulative winter pressures but is now routinely a focus of divisional performance reviews. With medical staff, appraisal and job planning will be linked to pay progression from July. We also recognise that our clinical support workforce is the most challenging to reach for appraisal completion, so the CNO has identified a more accessible and creative way for groups of staff to have a development discussion involving bringing groups of staff together in a group appraisal scenario.

We achieved 71.5% against our 4-hour Accident and Emergency wait standard of 76%, sustaining the improvement in month 12. However, we saw a deterioration in 12-hour waits in month 1 to 22.4% against a standard of 10%. Bed occupancy numbers are below target, but the inclusion of Wrightington beds masks the continued pressure on the Royal Albert Edward Infirmary site. The long waits within the Emergency Department and overall occupancy could be related to the number of single sex breaches which are predominately ICU step downs, who were not transferred to an inpatient bed in line with the single sex guidance and timeframe.
The percentage of patients who do not meet the criteria to reside is still high at 32.5% and currently a deteriorating position. Phase 2 of Better Lives will focus on intermediate care at home and the intermediate care bed base within the community alongside discharge, so we would expect to see an improvement in these metrics over the next few months.

From an elective perspective, we saw improvements in the overall number of patients waiting, but still predict breaches against our 52 and 65-week wait standards. The 52-week waiters show a continuing improvement and continue to be tracked on a daily basis. Disappointingly, we still have 65-week breaches due to complexity and patient choice and primarily in dermatology/plastics and ENT. This performance has triggered placement in tier 2 for electives by NHS England and the associated scrutiny.
Our 6-week diagnostic performance dipped very slightly in month 1 but is still on an improving trend. The challenges on non-obstetric ultrasound (NOUS) capacity continue and we are working with Bolton on the provision of mutual aid in this modality. We have also seen challenges with magnetic resonance imaging (MRI) and dual-energy X-ray absorptiometry (DEXA) modalities within month.
In month 1 we are reporting a variance in revenue plan of £0.4m. This is driven by slippage on both cost improvement plans (CIP) and activity. Whilst this is a cause for concern, especially with £7.1m CIP still to be identified, the control total and activity plans were only agreed very late in the planning

process and local delivery plans are still being developed. Cash at £16.8m is below plan and is being tracked closely as liquidity depends upon cash releasing CIPs being delivered and access to additional cash, whilst not currently predicted, is much more challenging in 2025/26. Capital spending, against our total capital plan of £26m, remains broadly on plan at month 1.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations

There are no risks currently associated with the report.

Financial implications

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

Legal implications

None currently identified.

People implications

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

Equality, diversity and inclusion implications

None currently identified.

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

Executive Team Meeting 22.5.25 and 29.5.25

Recommendation(s)

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

Report

Please see the attached M1 25/26 IPR report.

Appendices

None.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

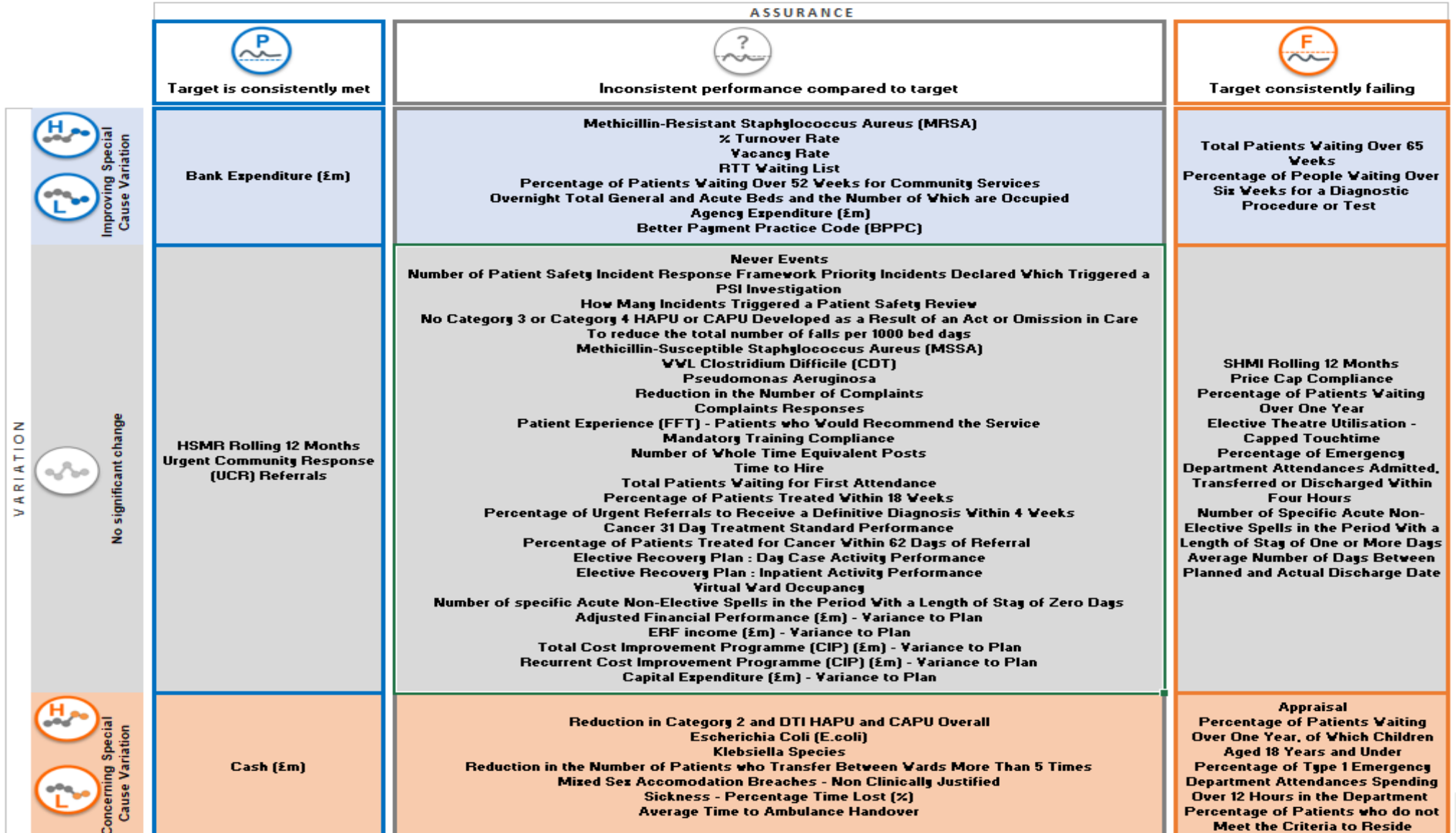
25/26 Integrated Performance Report

Meeting presented to:

Board of Directors 4.6.25

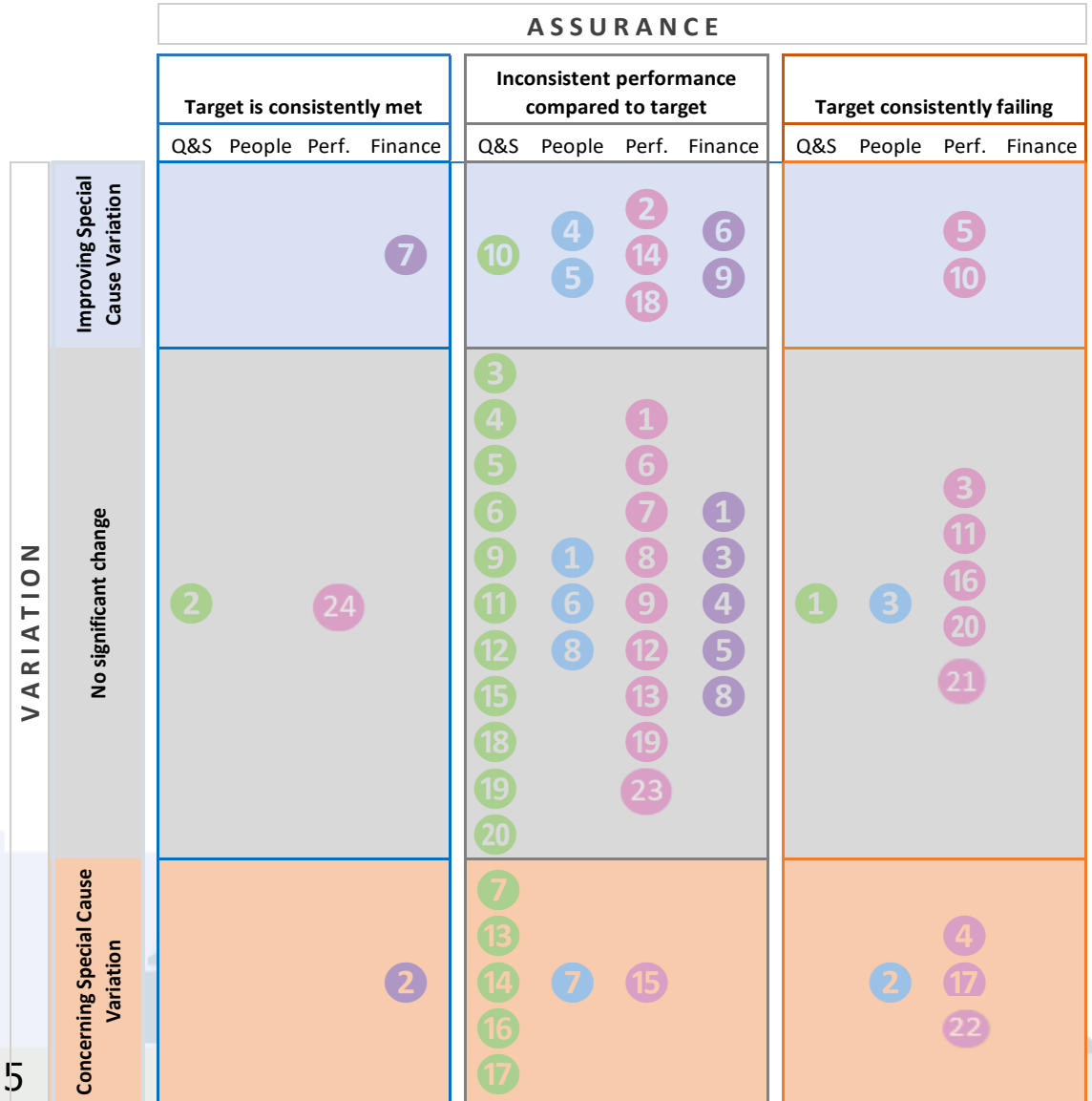
Contents

Trust Matrix : M1 25/26



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

Trust Matrix : M1 25/26



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

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

1. Mandatory Training Compliance
2. Appraisal
3. Price Cap Compliance
4. % Turnover Rate
5. Vacancy Rate
6. Number of Whole Time Equivalent Posts - Variance to plan
7. Sickness - Percentage Time Lost (%)
8. Time to Hire

1. Total Patients Waiting for First Attendance
2. RTT Waiting List
3. Percentage of Patients Waiting Over One Year
4. Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under
5. Total Patients Waiting Over 65 Weeks
6. Percentage of Patients Treated Within 18 Weeks
7. Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks
8. Cancer 31 Day Treatment Standard Performance
9. Percentage of Patients Treated for Cancer Within 62 Days of Referral
10. Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test
11. Elective Theatre Utilisation - Capped Touchtime
12. Elective Recovery Plan : Day Case Activity Performance
13. Elective Recovery Plan : Inpatient Activity Performance
14. Percentage of Patients Waiting Over 52 Weeks for Community Services

15. Average Time to Ambulance Handover
16. Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours
17. Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department
18. Overnight Total General and Acute Beds and the Number of Which are Occupied
19. Virtual Ward Occupancy
20. Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days
21. Average Number of Days Between Planned and Actual Discharge Date (Excludes patients discharged on discharge ready date)
22. Percentage of Patients who do not Meet the Criteria to Reside
23. Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days
24. Urgent Community Response (UCR) Referrals

1. Adjusted Financial Performance (£m) - Variance to Plan
2. Cash (£m)
3. ERF income (£m) - Variance to Plan
4. Total Cost Improvement Programme (CIP) (£m) - Variance to Plan
5. Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan
6. Agency Expenditure (£m)
7. Bank Expenditure (£m)
8. Capital Expenditure (£m) - Variance to Plan
9. Better Payment Practice Code (BPPC)

Trust Holistic Narrative : M1 25/26 Page 1 of 2

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Continued on next slide

Trust Holistic Narrative : M1 25/26 Page 2 of 2

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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

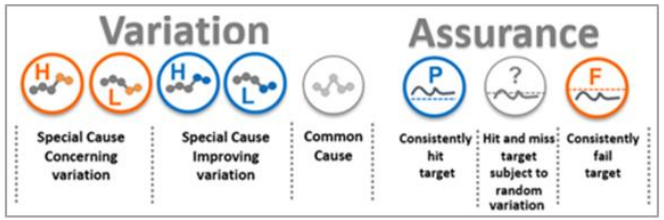
Each of the metrics within the IPR have been assessed to the scoring framework outlined below.
We assess the Sign off and Review process, whether the data is Timely and Complete and assess the Process and System around the data. We score this as per the table below and include an assessment on each of 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
		Metric definition been agreed and sense checked by a senior leader in the DAA team		2	2	3 = Amber
		Metric definition been agreed and sense checked by clinical and/or operational SRO		3	3	4 - 6 = Green
	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
		Minor changes to the reported data at the next snapshot	Less than 10% tolerance changes expected to previously reported data.	2	2	3-4 = Amber
		No changes to the reported data at the next snapshot	No changes made to previously reported data.	3	3	5 - 6 = Green
	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
		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	3-4 = Amber
		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	5 - 6 = Green
	System	Data is collected outside of a proper digital system e.g. spreadsheet or manual report	Data is recorded outside of a recognised digital system	1	1	
		Data is split over multiple digital systems or recorded data is not structured	Data is split over multiple digital systems or recorded data is not structured	2	2	
		A digital system is used to record structured data	A digital system is used to record structured data	3	3	

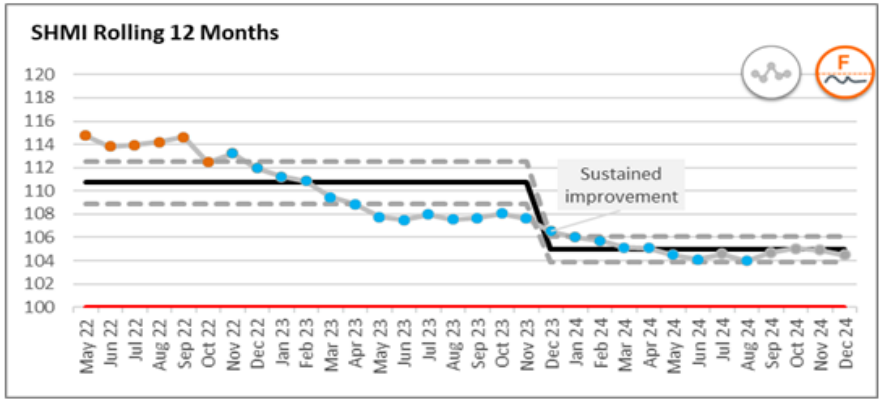
Quality & Safety Overview 1 of 2: M1 25/26

	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	SHMI Rolling 12 Months	Dec 24	104.49	100		F	104.98	103.85	106.11	S	T	P
2	HSMR Rolling 12 Months	Dec 24	91.51	100		P	91.57	89.22	93.91	S	T	P
3	Never Events	Apr 25	1	0		?	0	0	2	S	T	P
4	Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation	Apr 25	1	4		?	3	0	9	S	T	P
5	How Many Incidents Triggered a Patient Safety Review	Apr 25	9	33		?	27	0	54	S	T	P
6	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care	Apr 25	0	0		?	1	0	3	S	T	P
7	Reduction in Category 2 and DTI HAPU and CAPU Overall	Apr 25	39	34	H	?	29	8	49	S	T	P
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	Apr 25	8.6	6.1		?	7.0	4.4	9.6	S	T	P

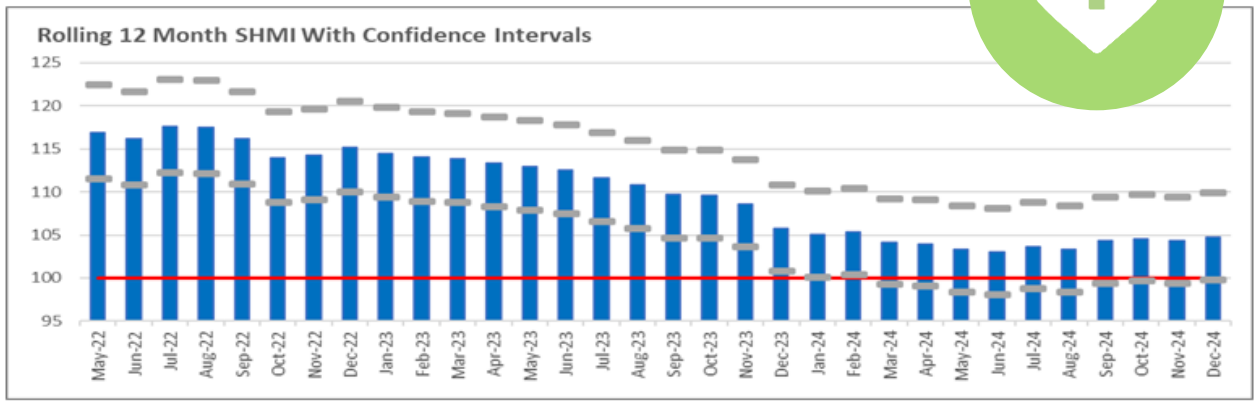
Summary icons key:

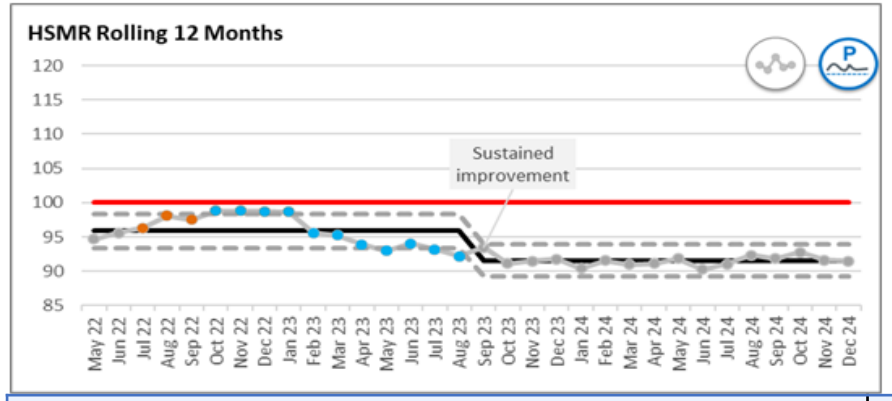


Quality & Safety Insight Report 1 of 2: M1 25/26

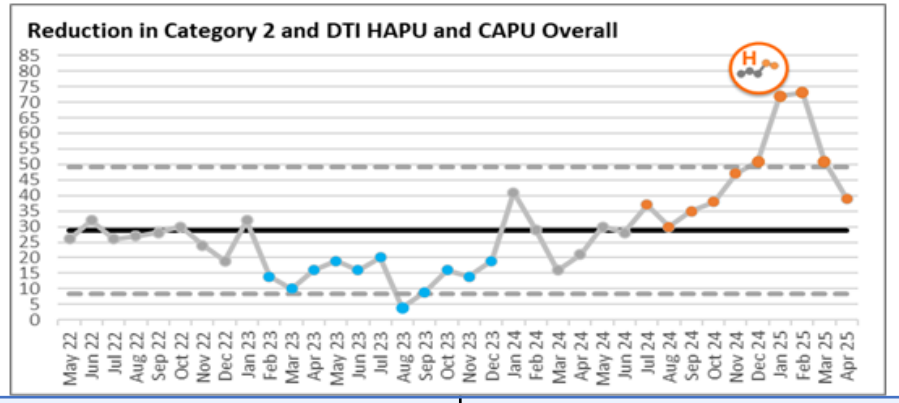


Dec-24
104.49
Variance Type
Common cause variation
Threshold
100
Target achievement
Metric is constantly failing the threshold





Dec-24
91.51
Variance Type
Common cause variation
Threshold
100
Target achievement
Metric is constantly achieving the threshold



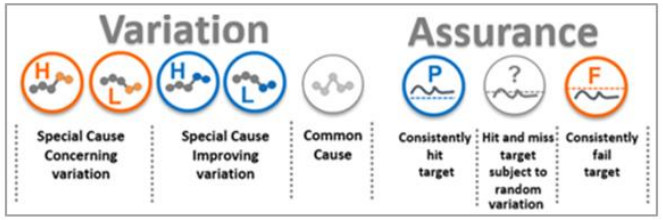
Dec-24
0.39
Variance Type
Special cause concerning variation points
Threshold
Target achievement

Summary:	Actions:	Assurance:
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. **Pressure Ulcers** This metric to identify a reduction in category 2 pressure	**SHMI** Continue improvement plans to ensure that patients are appropriately managed Work with system partners to ensure appropriate discharge placements for patients **Pressure Ulcers**	**SHMI** SHMI is currently within national expected range 'funnel plot' and has been so for many months. Both SHMI and HSMR are continuing to fall and are now better than some other similar sized GM Trusts **Pressure Ulcers**

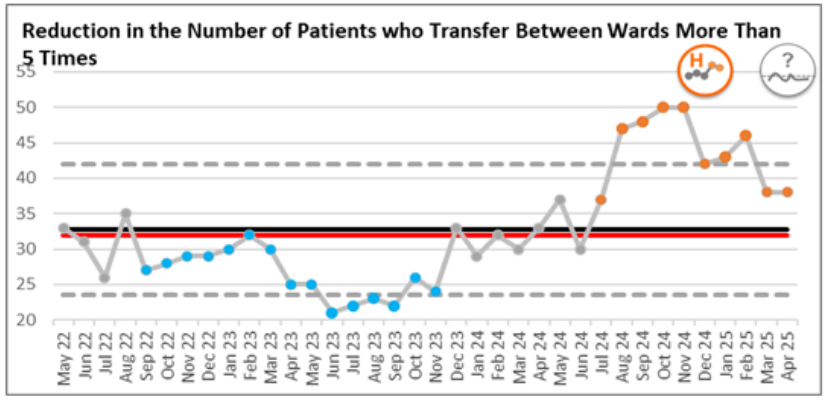
Quality & Safety Overview 2 of 2: M1 25/26

	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)	Apr 25	0	0			0	0	0	S	T	P
11	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Apr 25	2	0			1	0	5	S	T	P
12	WWL Clostridium Difficile (CDT)	Apr 25	5	5			6	0	17	S	T	P
13	Escherichia Coli (E.coli)	Apr 25	5	4			2	0	4	S	T	P
14	Klebsiella Species	Apr 25	1	1			1	0	2	S	T	P
15	Pseudomonas Aeruginosa	Apr 25	0	0			0	0	1	S	T	P
16	Reduction in the Number of Patients who Transfer Between Wards More Than 5 Times	Apr 25	38	32			33	24	42	S	T	P
17	Mixed Sex Accomodation Breaches - Non Clinically Justified	Apr 25	35	19			13	2	24	S	T	P
18	Reduction in the Number of Complaints	Apr 25	44	40			42	21	62	S	T	P
19	Complaints Responses	Apr 25	71.7%	90.0%			66.0%	40.2%	91.7%	S	T	P
20	Patient Experience (FFT) - Patients who Would Recommend the Service	Apr 25	86.6%	90.0%			87.1%	80.8%	93.3%	S	T	P

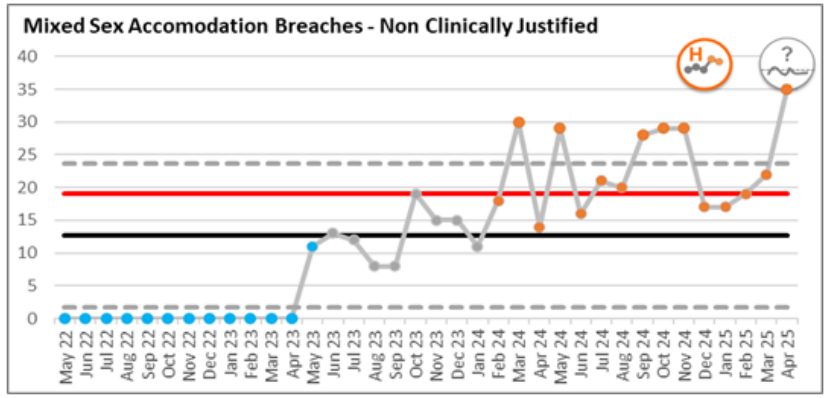
Summary icons key:



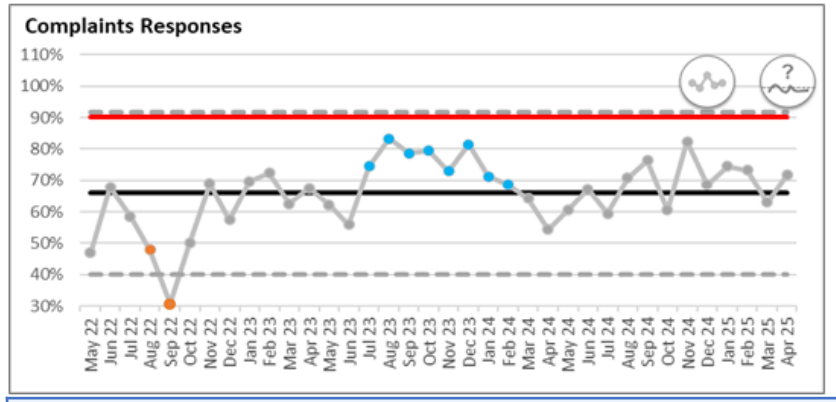
Quality & Safety Insight Report 2 of 2: M1 25/26



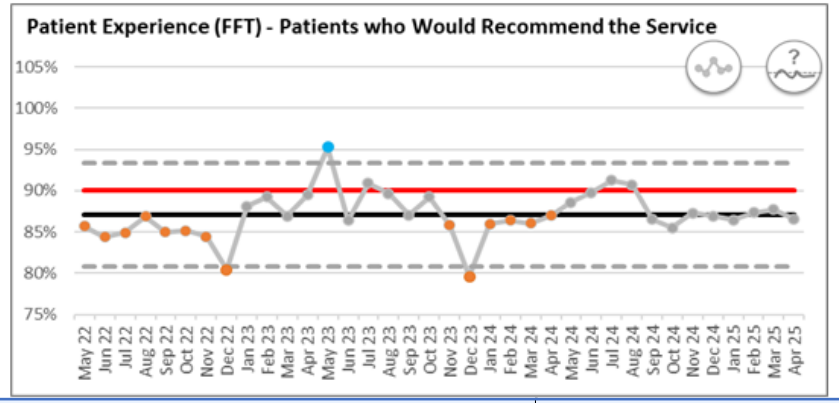
Apr-25
38
Variance Type
Special cause concerning variation points
Threshold
32
Target achievement
Inconsistent performance compared to threshold



Apr-25
35
Variance Type
Special cause concerning variation points
Threshold
19
Target achievement
Inconsistent performance compared to threshold



Apr-25
71.7%
Variance Type
Common cause variation
Threshold
90%
Target achievement
Inconsistent performance compared to threshold



Apr-25
86.6%
Variance Type
Common cause variation
Threshold
90%
Target achievement
Inconsistent performance compared to threshold

Summary:

Transfers
The Trust is actively avoiding multiple moves for patients as this increases multiple safety risks for those patients

Complaints
The current response rate is not at the level required, although higher than previous years

Mixed Sex Accommodation Breaches
Although this has increased since previous years

Actions:

Transfers
'Red to Green' and bed meetings happen daily meeting reviews patients, part of this reviews any patient moves and is actively working to reduce the numbers of moves

Complaints
Lightning learning and focussed education to empower frontline teams to manage concerns better and work towards reducing the number of complaints made

Mixed Sex Accommodation Breaches
Work has been ongoing to better identify actual incidents and a robust process of assessment as to the appropriateness of those breaches

Assurance:

Transfers
Whilst the numbers reduced in March and April 2025, there will be work across the year to actively reduce these numbers significantly to see a reduction

Complaints
There has been a continued reduction in 'second bites' those complainants who return to us following their final responses

Mixed Sex Accommodation Breaches
There is a better reporting culture of incidents

Quality & Safety Narrative: M1 25/26

SHMI / HSMR
The Trust most up to date SHMI from Dec 2024 is 104.49 which is still well within the 'funnel plot' for expected range. It should be noted that this data is December 2024 and will be updated as received.

Incidents
In month 1 (March 2025), the Trust escalated 1 incident as a PSII. This related to a patient who was identified hydronephrosis, prompting a referral to the urology team, who requested a left-sided nephrostomy. Unfortunately, the intervention radiology team performed the procedure on the right side. This error influenced clinical decision making. Whilst the patient did pass away the following day, it was determined that the death was not directly related to the wrong site procedure.

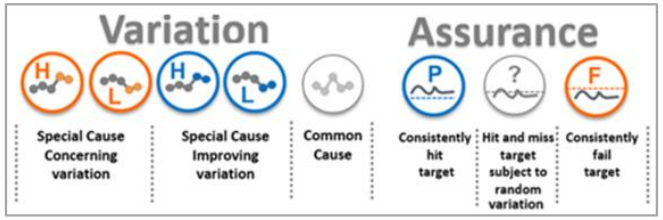
Complaints
The Trust has begun the financial year at 71.1%. Complaints fortnight meetings continue with the Executive Chief Nurse and Divisional Directors of Nursing to provide support and scrutiny. Lightning learning and support from the Patient Relations Team is continuing to support and empower all staff to manage concerns.

Holistic Summary
Complaints and incidents are reviewed weekly within the Learning from Patient Safety Events Group and any that are linked are noted here to ensure that there is cross working to support patients who have made a complaint that are also linked to adverse events.

Our People Overview : M1 25/26

	KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	Mandatory Training Compliance	Apr 25	95.1%	95.0%			94.9%	94.1%	95.7%	S	T	P
2	Appraisal	Apr 25	80.9%	90.0%	L	F	81.8%	80.8%	82.9%	S	T	P
3	Price Cap Compliance	Apr 25	28.1%	60.0%		F	31.5%	19.7%	43.3%	S	T	P
4	% Turnover Rate	Apr 25	8.6%	8.5%	L		8.7%	8.4%	9.1%	S	T	P
5	Vacancy Rate	Apr 25	4.0%	5.0%	L		6.0%	4.9%	7.1%	S	T	P
6	Number of Whole Time Equivalent Posts - Variance to plan	Apr 25	-4.02	0.00			90.58	-43.04	224.20	S	T	P
7	Sickness - Percentage Time Lost (%)	Apr 25	5.7%	5.0%	H		5.5%	4.7%	6.2%	S	T	P
8	Time to Hire	Apr 25	60.5	65.0			57.9	47.4	68.4	S	T	P

Summary icons key:



Our People Narrative : M1 25/26

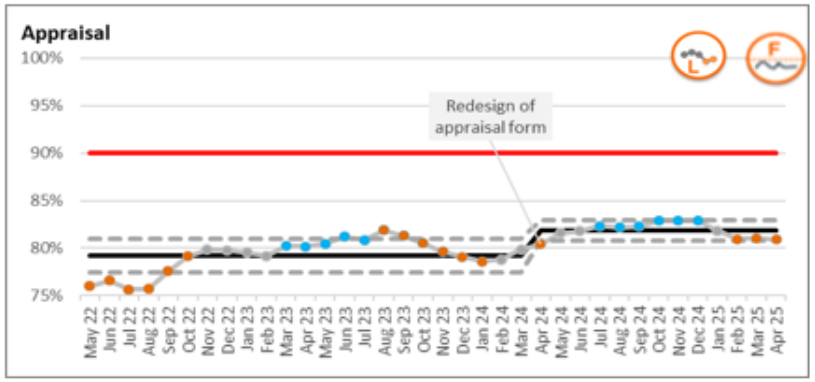
Appraisals – at 80.9% the appraisal rate remains below the Trust target of 90%. Divisions are continuing to work through plans to increase compliance, which is being closely monitored through Divisional Assurance meetings. The appraisal process has been updated to incorporate the new Trust values, and further work is under way to improve the appraisal process, following feedback from the 2024 National Staff Survey.

Price cap compliance – at 28.1% price cap compliance remains significantly below the target of 60%. This is primarily caused by medical agency locum shifts, which are above the NHSE price cap. There is ongoing scrutiny of medical agency shifts through the Medical Vacancy Control Group, renegotiation of agency commission rates where possible, continued recruitment to permanent vacancies, converting agency workers to the bank and development of agency tiering, all of which are designed to reduce improve price cap compliance.

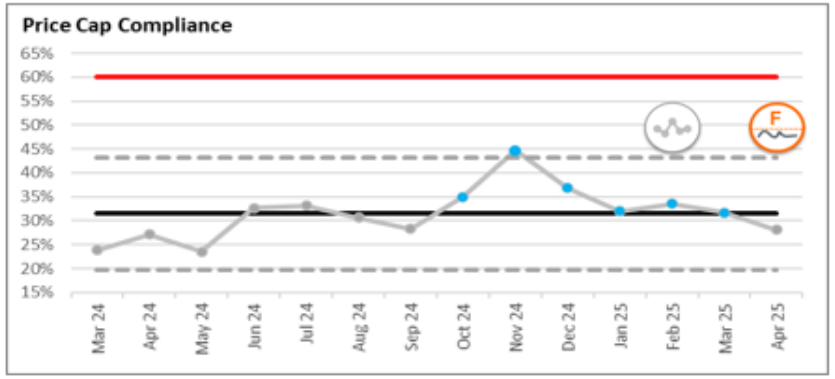
WTE – overall total workforce WTE (substantive, bank and agency WTE) was 4.02 WTE below plan in April 25. Reductions were noted in levels of both bank and agency WTE in April, although bank WTE was 10.65 WTE above plan, partly due to the use of bank workers as an alternative to agency workers. Substantive staff in post was 25.6 WTE above the month 1 plan. Divisions are continuing to refine their workforce plans and close scrutiny continues through Divisional Assurance meetings, Finance Improvement Group and Transformation Board. Vacancy controls also remain in place through the Executive level Establishment Control Group. A further MARS scheme will run during May 25, to support a reduction in WTE.

Sickness – At 5.7% in-month sickness absence remains above the Trust target of 5%. Long term absence increased in April from 2.9% to 3.3%, offset by a reduction in short term absence from 2.6% to 2.4%. Main reasons for absence recorded remain consistent with previous months (anxiety/stress/depression 30%, musculoskeletal 11%, cough/cold/flu 7%, gastrointestinal problems 6%). The sickness absence task and finish group remains active, with implementation of the action plan ongoing. The new workplace adjustments guidance and health passport to support staff with long term conditions is due to launch shortly. The new Wellbeing Policy is currently being finalised, which is anticipated will support a reduction in absence.

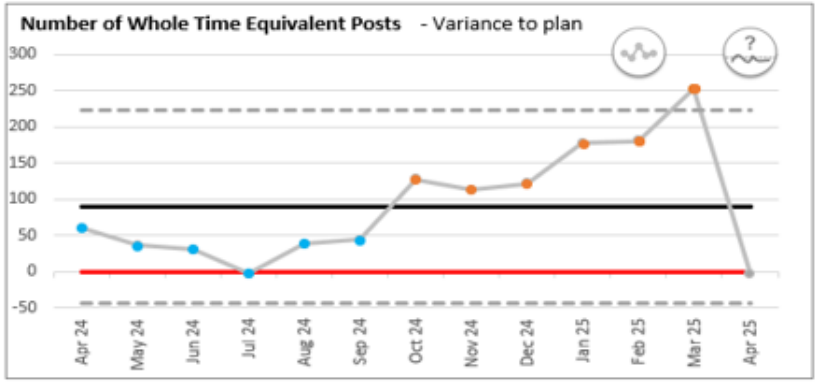
Our People Insight Report : M1 Month Year



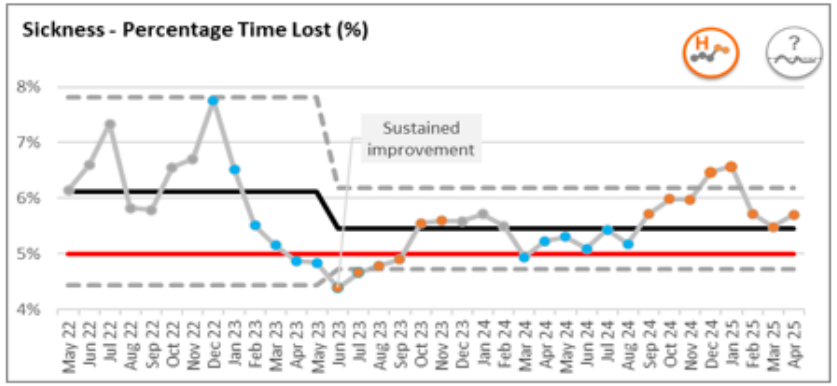
Apr-25
80.9%
Variance Type
Special cause concerning variation points
Target
90%
Target achievement
Metric is constantly failing the target



Apr-25
28.1%
Variance Type
Common cause variation
Target
60%
Target achievement
Metric is constantly failing the target



Apr-25
-4.02
Variance Type
Commom cause variation
Target
0
Target achievement
Inconsistent performance compared to target

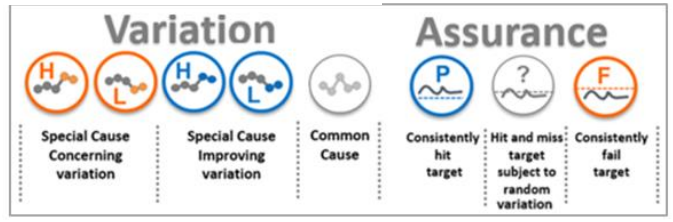


Apr-25
5.7%
Variance Type
Special cause concerning variation points
Target
5%
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
1. At 80.9% appraisal rates continue to remain below the target of 90%, and are at a similar point to April 24 2. Price cap compliance is significantly below the target, and has not achieved it at any point in the previous 12 months 3. With continued grip and control measures in place, the total workforce WTE in April was 4.02WTE below the planned workforce, although substantive staff in post was above plan 4. The sickness absence rate in April increased slightly, and at 5.7% remains above the target. The absence rate has not been below the target since March 2024	1. Continued monitoring of appraisal completion rates through monthly Divisional Assurance Meetings. Divisions through plans to improve compliance 2. Scrutiny of shifts above agency cap through Executive Medical Vacancy Control meeting, chaired by the Medical Director. Actions ongoing to recruit to posts substantively to reduce use of agency, and to introduce agency tiering 3. Executive approval of posts, and Executive level Vacancy Control Panel remains in operation. Ongoing work to reduce bank and agency usage through more robust controls. Development of divisional and Trustwide transformation and CIP schemes 4. Launch of workplace adjustments and health passport to support staff with long term health conditions. Action plan in place through Sickness Absence Task & Finish group, to keep staff well in work, and support a return to work at the earliest opportunity	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 Assurances Meetings and People Committee 2. Price cap compliance monitored through Executive Medical Control Group and People Committee 3. WTE reported and monitored through Divisional Assurance meetings, Finance Improvement Group and People Committee 4. Oversight also via Divisional Assurance Meetings, Wider Leadership Team Meeting and People Committee, along with Sickness Absence T&F Group

Our Performance Overview – Elective Care : M1 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	Apr 25	31830	31463		?	32569	31384	33755	S	T	P
2	RTT Waiting List	Apr 25	50421	52765	L	?	51362	49147	53578	S	T	P
3	Percentage of Patients Waiting Over One Year	Apr 25	3.8%	2.4%		F	4.1%	3.3%	4.8%	S	T	P
4	Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under	Apr 25	0.6%	0.3%	H	F	0.4%	0.3%	0.6%	S	T	P
5	Total Patients Waiting Over 65 Weeks	Apr 25	95	0	L	F	244	35	454	S	T	P
6	Percentage of Patients Treated Within 18 Weeks	Apr 25	65.5%	65.0%		?	61.9%	57.6%	66.2%	S	T	P
7	Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks	Mar 25	85.5%	75.0%		?	81.4%	75.0%	87.9%	S	T	P
8	Cancer 31 Day Treatment Standard Performance	Mar 25	96.7%	96.0%		?	92.4%	84.9%	99.9%	S	T	P
9	Percentage of Patients Treated for Cancer Within 62 Days of Referral	Mar 25	78.2%	75.0%		?	78.5%	68.6%	88.3%	S	T	P
10	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test	Apr 25	18.0%	5.0%	L	F	18.5%	13.0%	24.0%	S	T	P
11	Elective Theatre Utilisation - Capped Touchtime	Apr 25	79.5%	85.0%		F	81.3%	78.8%	83.9%	S	T	P
12	Elective Recovery Plan : Day Case Activity Performance	Apr 25	92.1%	100.0%		?	97.0%	84.3%	109.7%	S	T	P
13	Elective Recovery Plan : Inpatient Activity Performance	Apr 25	85.7%	100.0%		?	102.2%	79.0%	125.4%	S	T	P
14	Percentage of Patients Waiting Over 52 Weeks for Community Services	Apr 25	0.0%	0.0%	L	?	0.0%	0.0%	0.1%	S	T	P



Our Performance Elective Care Narrative : M1 25/26

The total RTT waiting list shows a favorable position against the target, however the percentage of patients waiting above one year is higher than the target and this correlates with the position in relation to the over 65 week waits of which there were 95 in April and which the plan was to be 0. It is anticipated that this position will be lower in May, however a significant reduction is required to reach the <than 1% of waiters over 52 weeks by 31st March 2026. Detailed specialty recovery plans are being reviewed on a weekly basis with the COO.

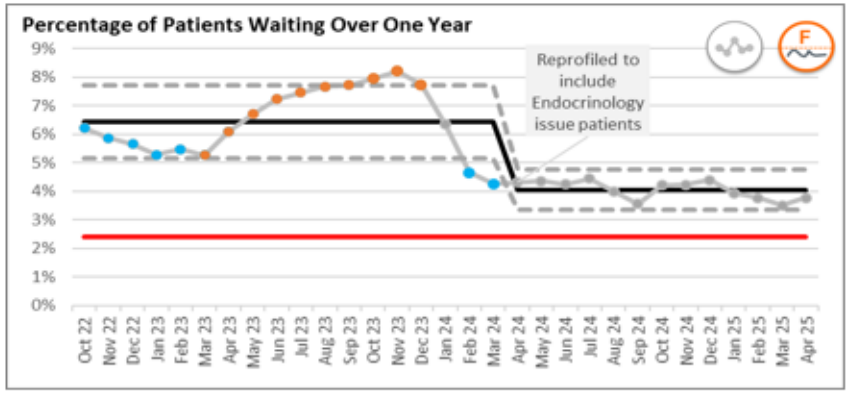
The cancer 62-day performance continues to exceed the 75% target at 78.2% and this is consistently monitored to ensure that patients are seen in a timely manner and cancer elective activity is protected from the pressures experienced in relation to urgent and emergency care and elective cancellations The cancer faster diagnosis standard was above the 75% target at 85.5%. There are challenges moving forward in relation to endoscopy capacity which may impact the cancer performance. There is a detailed action plan within the medicine division with divisional transformation support to address this challenge and to make achievement of performance in this area more sustainable.

Work is continuing in relation to the percentage of patients waiting less than 6 weeks for diagnostics, particularly in relation to NOUS and this has shown a significant deterioration in month which is largely due to the lack of non-obstetric ultrasound capacity. Challenges with DEXA and MRI capacity have also impacted in month. Both the MRI and DEXA capacity are anticipated to resolved in a timely way with a new MRI scanner being available at Wrightington in the next few weeks and weekend clinics for DEXA, however, the NOUS capacity challenges are more difficult to mitigate due to changes to payrates which are in line with steps which have been taken for nursing staff and across the GM footprint and also the availability of higher paid work within the independent sector. Conversations are ongoing with Bolton to support the delivery of the required activity.

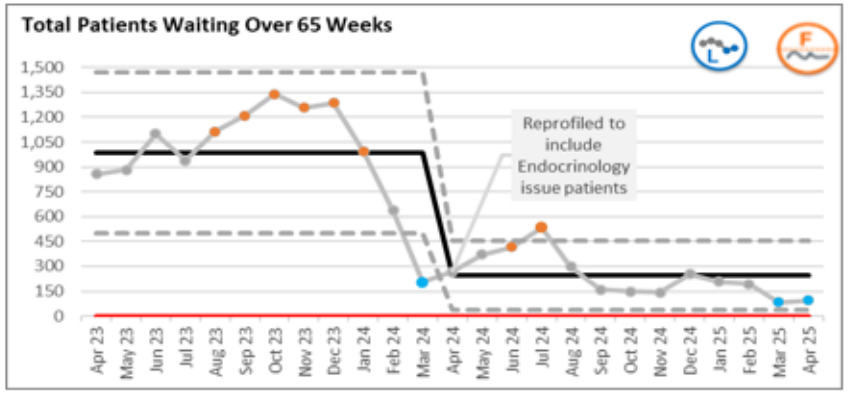
Work continues via the internal Trust Elective Recovery Board and with GIRFT in relation to capped touch time and inpatient and day case performance.

Community services continue to have 0% of patients waiting over 52 weeks.

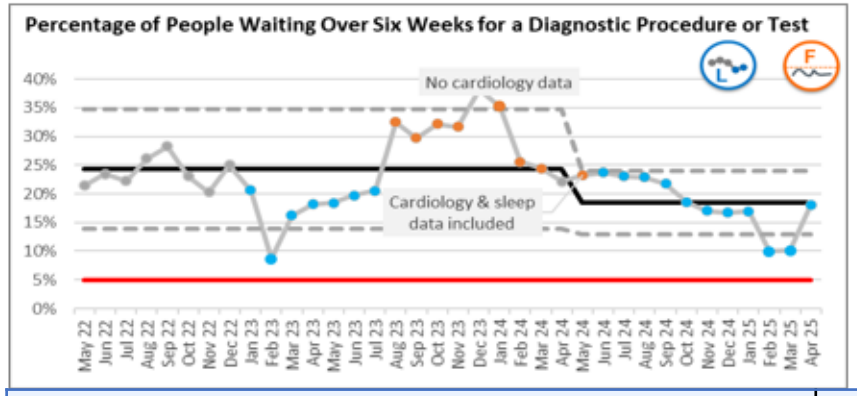
Our Performance Insight Report : Elective Care M1 25/26



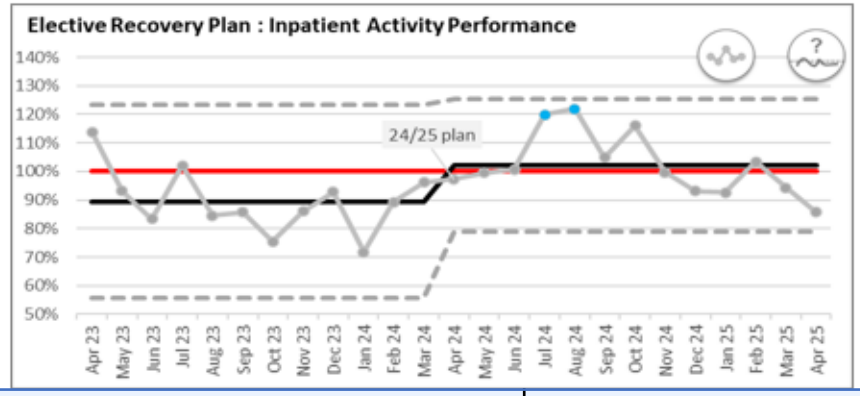
Apr-25
3.8%
Variance Type
Common cause variation
Target
2.4%
Target achievement
Metric is constantly failing the target



Apr-25
95
Variance Type
Special cause improving variation
Target
0
Target achievement
Metric is constantly failing the target



Apr-25
18.0%
Variance Type
Special cause improving variation
Target
5%
Target achievement
Metric is constantly failing target

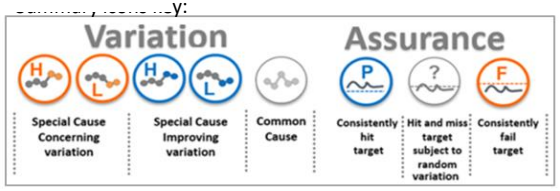


Apr-25
85.7%
Variance Type
Common cause variation
Target
100%
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
1. The overall number of 52-week breaches has reduced in month and now stands at 2098 [a reduction of 773]. 2. The number of 65-week capacity breaches has reduced from previous month. The total month end forecast has increased from the last GM submission to 56 due to an increase in the number of pt choice and complexity patients. Pressure areas remain as plastics/dermatology along with ENT. 3. The most challenged modality is Non-Obstetric Ultrasound (NOUS). The 6-week position has deteriorated following the removal of the LPV and additional capacity. 4. The inpatient activity plan was not met in month	1. There will now be a weekly PTL meeting for each Division to present and go through individual recovery plans. 2. There will now be a weekly PTL meeting for each Division to present and go through individual recovery plans. 3. Maintained insourcing capacity and maximising all internal capacity. Working towards collaboration with Bolton to support additional capacity. Exploring contractual options re the AQP contract. 4.Targetted action plans to maximise all available capacity to achieve plan	1. Weekly long waits week mtg with COO to go through each service area. 2. Weekly long waits week mtg with COO to go through each service area. 3. Currently due to deteriorating position there is low assurance of a robust recovery plan. 4. Daily tracking of activity at a divisional level working towards a 6-4-2 position to maximise all capacity and address the day case/inpatient mix.

Our Performance Overview – Urgent & Emergency Care: M1 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
15	Average Time to Ambulance Handover	Apr 25	00:47:27	00:38:00	H	?	00:41:56	00:20:16	01:03:36	S	T	P
16	Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours	Apr 25	71.5%	76.0%		F	69.2%	65.5%	73.0%	S	T	P
17	Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department	Apr 25	22.4%	10.0%	H	F	19.8%	16.8%	22.8%	S	T	P
18	Overnight Total General and Acute Beds and the Number of Which are Occupied	Apr 25	94.6%	96.0%	L	?	96.8%	95.3%	98.2%	S	T	P
19	Virtual Ward Occupancy	Apr 25	65.5%	80.0%		?	70.4%	46.8%	94.1%	S	T	P
20	Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days	Apr 25	1807	1439		F	1924	1670	2177	S	T	P
21	Average Number of Days Between Planned and Actual Discharge Date (Excludes patients discharged on discharge ready date)	Apr 25	6.8	0.0		F	6.6	4.7	8.6	S	T	P
22	Percentage of Patients who do not Meet the Criteria to Reside	Apr 25	32.5%	12.5%	H	F	27.1%	21.0%	33.3%	S	T	P
23	Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days	Apr 25	1296	1560		?	1424	1162	1686	S	T	P
24	Urgent Community Response (UCR) Referrals	Apr 25	80.3%	70.0%		P	85.8%	76.1%	95.6%	S	T	P



Our Performance Urgent & Emergency Care Narrative: M1 25/26

The time to average handover has exceed the required performance of 38:00 minutes at 47.27 minutes. This can be correlated to several of the other indicators including:

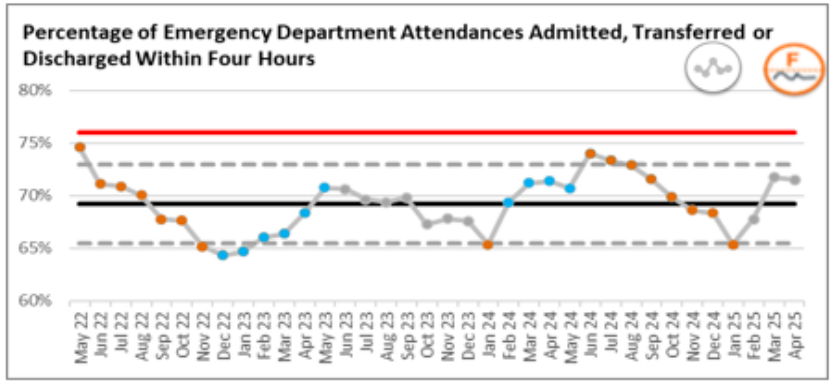
- Percentage of 12 hour waits in the department
- Number of specific acute non elective spells in the period with a Length of Stay (LOS) of one or more days
- Number of days between planned and actual discharge date
- Percentage of patients who do not meet the Criteria to Reside (CtR)

As the flow in the Emergency Department (ED) department is reduced, the ability to see patients in a timely way diminishes and more patients are admitted to hospital than initially required Then the 4-hour, 12-hour care standards and the timely handover of ambulances are also impacted.

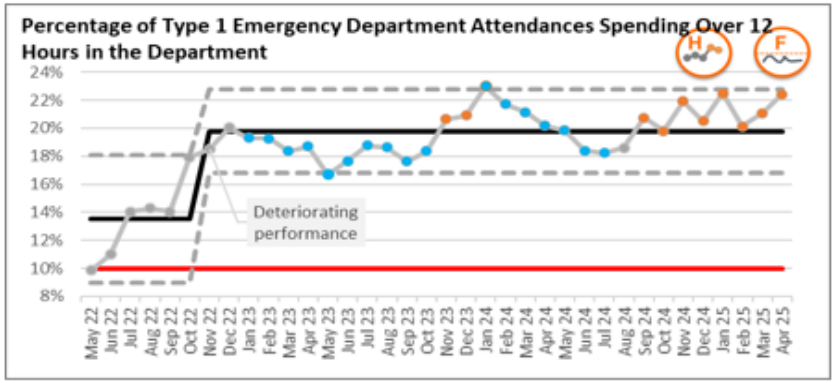
Phase 2 of the BetterLives programme will start to look at the utilisation of our Intermediate Care (IMC) at home service and also the intermediate care bed base as well as the internal discharge processes which should support the reduction in the No Criteria to Reside (NCTR) numbers and support patients to return to the own homes in a timely way.

The urgent community response team has been supporting the Community Admissions Avoidance Team (CAAT) practitioner at the front door and has still maintained the urgent 2-hour response times.

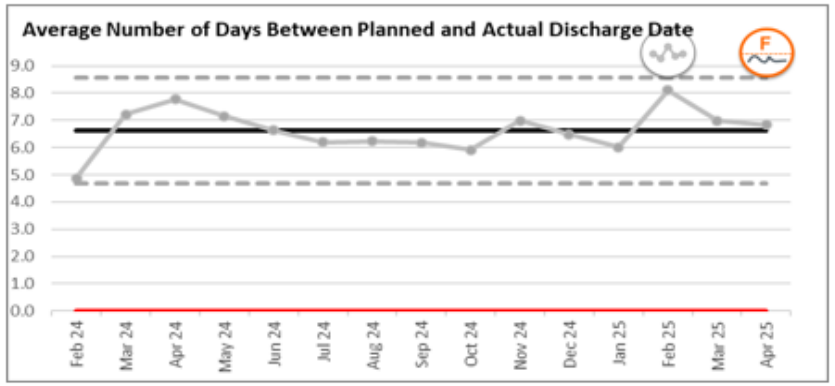
Our Performance Insight Report : Urgent & Emergency Care M1 25/26



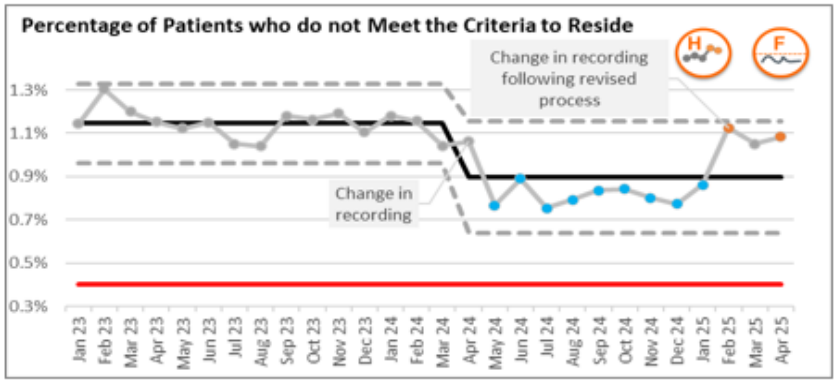
Apr-25
71.5%
Variance Type
Common cause variation
Target
76.0%
Target achievement
Metric is constantly failing the target



Apr-25
22.4%
Variance Type
Concerning special cause variation point
Target
10.0%
Target achievement
Metric is constantly failing the target



Apr-25
6.8
Variance Type
Common cause variation
Target
0
Target achievement
Metric is constantly failing the target



Apr-25
1.1%
Variance Type
Concerning special cause variation point
Target
40.0%
Target achievement
Metric is constantly failing the target

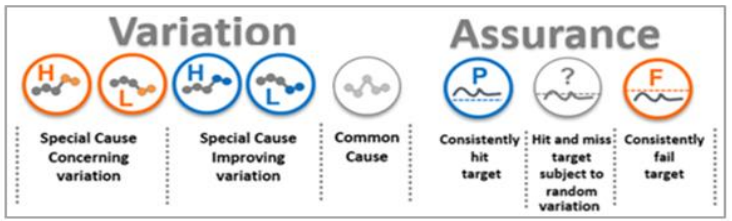
Summary:	Actions:	Assurance:
1. Continued improvement against the 4 hour national care standard has been maintained, however there is some way to go to consistently achieve the 4 hour national care standards target. 2. The percentage of over 12 hour waits in the department has increased this month to 22.4% which can be tracked against a deteriorating position against the NCTR numbers. 3. The average number of days between planned and actual discharge date has fallen slightly in month, however this metric is consistently failing the target. 4. The percentage of patients who do not meet the criteria to reside has increased in month and is consistently failing the target.	1. Daily monitoring of the A&E national care standards within the bed meetings and the division and actions are taken to improve performance on an hourly and daily basis. 2. Work is ongoing to improve discharge processes to create a better flow to support the reduction of 12 hour stays in the department as well as ensuring that the internal professional standards and actions are taken to ensure that patients are seen in a timely way to reduce the likelihood of a 12 hour stay in department. 3. This metric requires the delivery of improved discharge planning as soon as a patient is admitted to the hospital and this work is being picked up via phase 2 of the BetterLives programme, working with partners particularly the council to support earlier planning. 4. Work is being undertaken via the Discharge and Flow programme and the BetterLives programme to support the reduction in NCTR.	1. Being monitored via the Bed Meetings, Medicine Triumvirates meetings, Weekly Performance Meetings and Divisional Assurance Meetings. 2. Being monitored via the Bed Meetings, Medicine Triumvirates meetings, Weekly Performance Meetings and Divisional Assurance Meetings. 3. Actions being monitored via the Discharge and Flow Board and also the Better Lives Delivery Oversight Group. 4. Actions being monitored via the Discharge and Flow Board and also the Better Lives Delivery Oversight Group.

Our Finance Performance Overview : M1 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	Apr 25	-0.4	0.0		?	0.1	-3.7	3.8	S	T	P
2	Cash (£m)	Apr 25	16.8	9.6	L	P	24.8	13.8	35.8	S	T	P
3	ERF income (£m) - Variance to Plan	Apr 25	-0.6	0.0		?	-0.3	-1.4	0.8	S	T	P
4	Total Cost Improvement Programme (CIP) (£m) - Variance to Plan	Apr 25	-0.6	0.0		?	0.1	-1.9	2.1	S	T	P
5	Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan	Apr 25	-0.6	0.0		?	-0.6	-1.3	0.1	S	T	P
6	Agency Expenditure (£m)	Apr 25	0.6	0.5	L	?	0.9	0.5	1.3	S	T	P
7	Bank Expenditure (£m)	Apr 25	1.8	2.9	L	?	2.5	1.8	3.2	S	T	P
8	Capital Expenditure (£m) - Variance to Plan	Apr 25	-0.1	0.0		?	0.0	-2.0	1.9	S	T	P
9	Better Payment Practice Code (BPPC)	Apr 25	96.7%	95.0%	H	?	93.1%	87.0%	99.2%	S	T	P

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

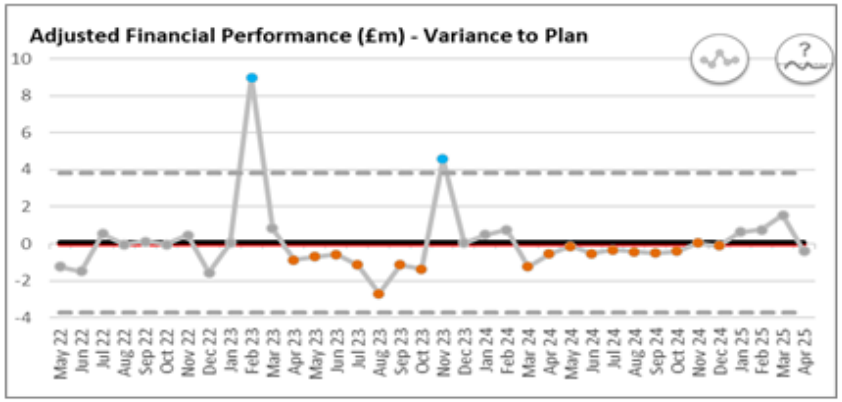
Summary icons key:



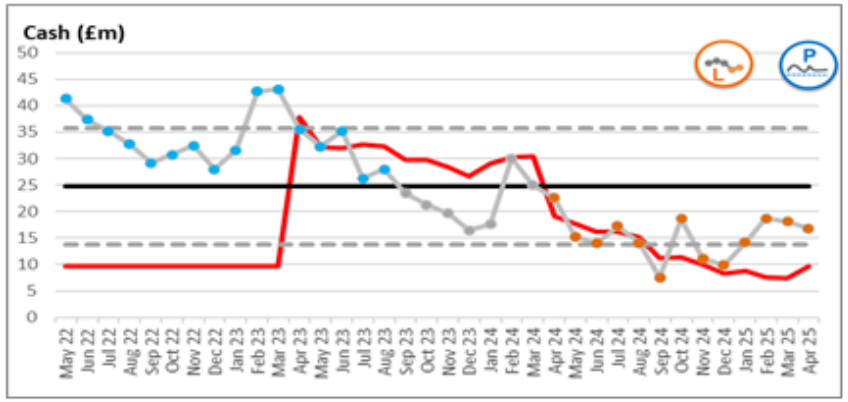
Our Finance Performance Narrative : M1 25/26

Description	Performance Target	Performance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Red	For month 1, we are reporting an actual deficit of £1.4m, which is this is £0.4m adverse to the planned deficit of £1.0m. This relates to CIP slippage and ERF activity.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber	The cash balance as at 30 April 2025 is £16.8m, which is a decrease of £1.2m from last month. The cash plan is based on delivery of the revenue and efficiency plans and remains challenging for 2025/26.
ERF Income	Achieve the elective activity plan for 2025/26.	Amber	Our internal income plan is £7.9m higher than the notified GM ICB ceiling for the full year – we are awaiting confirmation from the ICB regarding the additional income being approved. In month 1 the Trust is £0.6m behind the internal ERF plan.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Red	Total CIP delivered in Month 1 is £1.6m, which is £0.6m below plan: £0.4m is recurrent (22%) and £1.2m is non-recurrent (78%). The recurrent delivery is £0.6m behind plan. As at month 1, there is £7.1m unidentified in the recurrent plan.
	Deliver Recurrent CIP of £23.0m	Red	
Agency expenditure	30% reduction in agency spend.	Red	Our agency plan reflects the NHSE planning requirement to reduce expenditure by 30% on the month 8 2024/25 forecast outturn. In month 1, we are £0.1m above the plan of £0.5m. Agency spend in month is £0.6m and has been relatively static for the last few months.
Bank expenditure	10% reduction in bank spend	Amber	Our bank plan reflects the NHSE planning requirement to reduce expenditure by 10% on the month 8 2024/25 forecast outturn, plus a further £2.0m stretch associated with the difficult decisions. In month 1, bank expenditure was £1.8m which is a 13% reduction on the 2024/25 average baseline.
Capital expenditure	Achieve capital plan for 2025/26.	Green	Capital expenditure in month 1 is £2.3m, which £0.1m behind the plan of £2.4m. There is 21% agency reduction on Month 8 2024/25 – ahead of the NHSE targeted reduction of 10%.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Green	BPPC performance to end of April is 95.3% by volume and 99.2% by value.

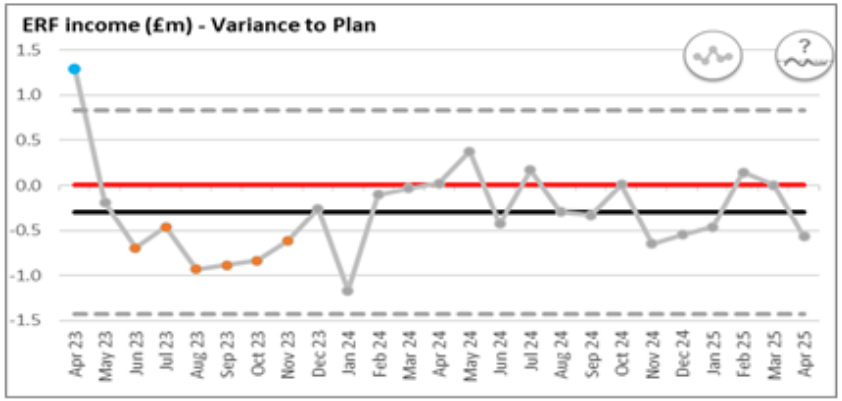
Our Finance Performance Insight Report : M1 Month Year



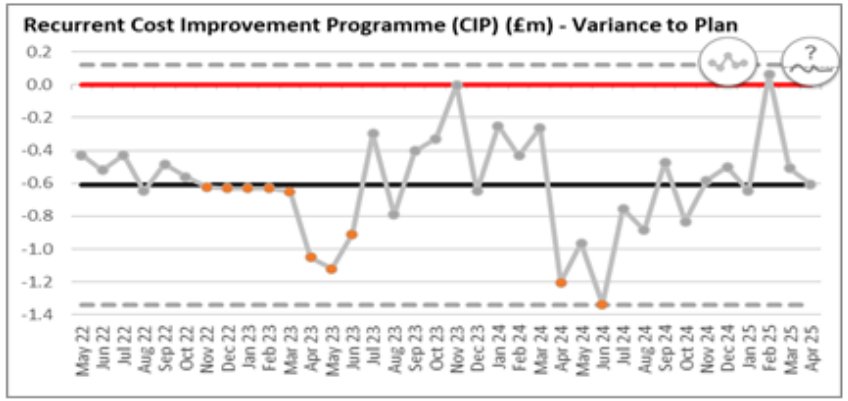
Apr-25
-0.4
Variance Type
Common cause variation
Target
0.0
Target achievement
Inconsistent performance compared to target



Apr-25
16.8
Variance Type
Concerning special cause variation point
Target
9.6
Target achievement
Metric is constantly achieving the target



Apr-25
-0.6
Variance Type
Common cause variation
Target
0.0
Target achievement
Metric is constantly failing the target



Apr-25
-0.6
Variance Type
Common cause variation
Target
0.0
Target achievement
Inconsistent performance compared to target

Summary:

1. April is the first month of the new 2025/26 financial year. We have agreed a breakeven revenue plan for the year with GM ICB and NHSE. For month 1, we are reporting a deficit of £1.4m, which is £0.4m adverse to the planned deficit of £1.0m. This relates to CIP slippage and ERF activity.
2. The cash balance as at 30 April 2025 is £16.8m, which is a decrease of £1.2m from last month. The cash plan is based on delivery of the revenue and efficiency plans and remains challenging for 2025/26.
3. In month 1 we are £0.6m below the ERF plan, with underperformance in Specialist Services, Surgery and Medicine.
4. For month 1, CIP of £1.6m was delivered against the plan of £2.2m, which is a shortfall of £0.6m. The shortfall is all against the recurrent target with £0.4m delivered against the target of £1.0m.

Actions:

1. ERF underperformance and CIP slippage to be escalated via the divisional assurance meetings; this will need to be recovered in year to meet the financial plan.
2. Cash is being closely monitored. Based on the current run rate, the forecast indicates that cash support may be required towards the end of Q2.
3. ERF underperformance to be escalated via the divisional assurance plans with an improvement trajectory required.
4. Divisions have implemented action plans for all Monthly CIP meetings to facilitate transparency and assurance around progress – to be reported through Performance Review Meetings.

Assurance:

1. Divisional Assurance Meetings, Finance Improvement Group, Executive Team Meeting, Finance and Performance Committee
2. Cash Management Group, Finance and Performance Committee.
3. ERF is monitored at the Elective Recovery programme board and the divisional assurance meetings, both held monthly.
4. Divisional Assurance Meetings, Finance Improvement Group, Executive Team Meeting, Finance and Performance Committee

Agenda item: [25]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Trust finance report for March 2025 (Month 12)
Presented to:	Board of Directors
On:	4th June 2025
Item purpose:	Information
Presented by:	Tabitha Garder, Chief Finance Officer
Prepared by:	Senior Finance Team
Contact details:	E: Heather.Shelton@wwl.nhs.uk

Executive summary

The presentation provides the full finance report on the Trust financial position for month 12 (March 2025), subject to final sign off by our external auditors.

Please see slide 3 for key messages and slide 4 for key performance indicators.

Link to strategy

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

Financial implications

There are no direct financial implications as it is reporting on the financial position (it is reporting on the financial position).

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Equality, diversity and inclusion implications

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

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

The finance flash metrics report was reviewed by ETM on 10th April 2025. The full finance report was reviewed by Wider Leadership Team on 6th May 2025 and the Finance and Performance Committee on 27th May 2025.

Wider implications

There are no wider implications of this report.

Recommendation(s)

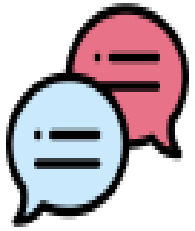
The Board are asked to note the contents of this report.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Trust Finance Report

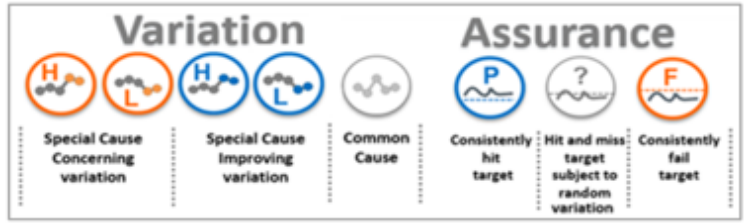
Month 12 – March 2025

Contents



Main report

Statistical Process Chart (SPC) Key



Key Financial Messages

We have delivered the revenue position agreed with GM and NHSE for the 2024/25 financial year of a £0.8m deficit, subject to final sign off by the Trust's external auditors, KPMG. At the year end, we are reporting a technical deficit of £28.4m which includes land and buildings impairments of £27.5m; these are excluded from the measure of system performance.

Divisional CIP was on plan in March which brings the YTD delivery to £27.4m, which is £0.1m above plan full year. Recurrent full year delivery is £13.2m which is £5.9m behind plan. This was supported by non-recurrent schemes in-year.

There has been an improvement in divisional ERF performance; this was on plan in March for the second consecutive month. Surgery and Medicine were above plan in month, and the under performance in Specialist Services reduced. Full year ERF performance was £2.0m below plan.

The closing cash balance is £18.1m, which is a decrease of £0.7m from last month. The non-recurrent deficit funding (£13.4m) means that cash support was not needed in 2024/25, but cash remains challenging going into the new financial year.

Workforce in March is at 7,075 WTE, the highest it has ever been and an increase of 54 WTE on last month. At the end of the financial year workforce was 253 WTE above the plan of 6,822 WTE. Pay expenditure is above plan £1.7m adverse in month (£5.2m adverse full year), excluding the central pensions notional adjustment. There has been an increase in temporary staffing WTE and expenditure on bank compared to last month.

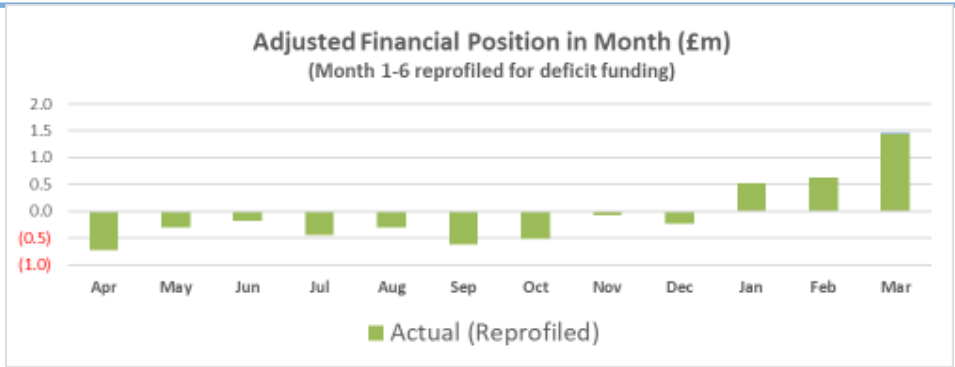
Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Red		The Trust has delivered the agreed 2024/25 revenue plan, subject to sign off by the external auditors, KPMG. The technical deficit for the year was £28.4m which includes impairments £27.5m of impairments arising from re-valuation of the Trust land and buildings (£14.0m) and impairment of the Community Health Investment Plan properties (£13.5m). These are excluded from the adjusted financial position of £0.8m deficit which is the measure used to assess system performance.
	Adjusted financial position: Achieve the financial plan for 2024/25.	Green		
ERF Income	Achieve the elective activity plan for 2024/25.	Amber		Elective activity is on plan in month 12 and £2.0m behind plan for the full year. This includes Advice & Guidance income of £1.4m which has been included for diverted activity.
Agency	To remain within the agency ceiling set by NHSE.	Green		Agency expenditure is £0.7m in month 12, similar to last month. This is below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure. This reflects 1.9% of total pay spend in month and 2.4% full year.
Escalation	Sustained reduction in escalation spend for 2024/25.	Green		Reported escalation costs for March was £0.4m. Total escalation spend decreased by £0.1m in month with no escalation of AAA, DL or SDEC overnight during the month. 1:1 enhanced care spend increased slightly compared with last month but is in line with average spend.
Capital expenditure	Achieve capital plan for 2024/25.	Green		We have delivered our agreed capital expenditure for the 2024/25 financial year. Total capital expenditure for the year was £23.2m. There is an agreed underspend of £0.9m against plan, which relates to leases and was agreed with GM ICB to support the system position.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Green		There is a closing cash balance of £18.1m for March 2025 which a decrease of £0.7m from last month and £10.7m above plan (which excluded the non-recurrent deficit funding). This is due to timing differences in the receipt and payment of invoices. This includes £13.7m revenue deficit support and additional PDC capital allocation of £1.9m.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Amber		Total CIP delivered in year £27.4m, which is £0.1m above plan. Of this, £11.4m is recurrent with a full year effect of £13.2m (£5.9m below the plan of £19.1m).
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Amber		BPPC performance to end of March is 94.7% by volume and 96.3% by value, which is a slight improvement to previous months.

Financial Performance

Headlines

- **We have delivered our planned deficit of £0.8m (adjusted financial performance) for the 2024/25 financial year, subject to external audit.**
- The month 12 position was a surplus of £1.4m. ERF activity was on plan for the second consecutive month and there was a benefit from year end income settlements.
- CIP delivered in full for 2024/25, however the recurrent full year effect is lower than planned.
- The technical deficit for the year was £28.4m which includes impairments of £27.5m transacted in month 12. This related to the external re-valuation of the Trust land and buildings £14.0m and impairment of the Community Health Investment Plan (CHIP) properties £13.5m. The re-valuation was the full 5 year valuation, with interim years based on a desktop exercise.
- Income and pay include the notional central pension employers contribution of £21.1m, with no impact to the bottom line.



Deficit walk to Adjusted Financial Performance

- The technical deficit in our annual accounts is £28.4m.
- Our Adjusted Financial Performance (AFP), which is the measure used to assess system performance (akin to the control total) is £0.8m deficit.
- Specific technical adjustments are excluded from the AFP. This includes certain impairments and the impact of donated assets.

Key Financial Indicators	In Month (£000)			Full Year (£000)		
	Actual	Plan	Var	Actual	Plan	Var
Income	70,768	46,011	24,757	581,007	550,200	30,807
Pay	(55,016)	(32,158)	(22,858)	(412,107)	(385,714)	(26,393)
Non Pay	(41,557)	(13,482)	(28,075)	(191,963)	(159,465)	(32,498)
Financing / Technical	(227)	(502)	276	(5,319)	(6,029)	710
Surplus / Deficit	(26,032)	(132)	(25,900)	(28,382)	(1,008)	(27,374)
Adjusted Financial Performance	1,438	(116)	1,554	(815)	(815)	(1)

Income

Division	In Month (£000)			Full Year (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	614	400	214	5,117	4,509	607
Surgery	1,772	217	1,555	7,643	2,602	5,042
Specialist Services	1,467	1,603	(136)	15,115	18,505	(3,390)
Community Services	665	587	78	7,239	7,048	191
Non Divisional Income	43,770	42,223	1,547	509,278	504,663	4,614
Finance	10	11	(1)	194	137	57
Digital Services	57	7	50	113	87	26
Dir of Strat & Planning	194	230	(36)	2,629	2,759	(130)
Chief Operating Officer	0	0	0	0	0	0
Human Resources	12	1	11	262	11	251
Medical Director	220	52	168	1,282	621	661
Estates & Facilities	467	459	8	5,363	5,514	(151)
Nurse Director	116	65	52	1,281	775	506
Trust Executive	10	26	(15)	64	309	(245)
GTEC	182	195	(13)	2,168	2,534	(365)
Corporate	21,212	(65)	21,278	23,259	127	23,132
Total	**70,768**	**46,011**	**24,757**	**581,007**	**550,200**	**30,807**

Headline

- Income is £24.8m favourable in month and £30.8m favourable full year.

Medicine

- Medicine's income is £0.2m favourable in month due to over performance of £0.1m on ERF income and £0.2m over performance on Education income following a transfer from Non-Divisional Income. This is offset by £0.1m under performance on CDC income.

Surgery

- Surgery's income is £1.6m favourable in month due to £0.6m over performance on ERF income, £0.3m over performance on Education income relating to prior months which is offset in Non-Divisional income. Surgery also received an additional £0.4m ICB income in month for several schemes.

Specialist Services

- Specialist Services' income is £0.1m adverse in month due to under performance of £0.6m on ERF offset by £0.1m over performance on unbundled drugs and devices and £0.4m over performance on income related to the Major Revision Centre funding.

Non – Divisional Income

- Non-Divisional income is £1.6m favourable in month primarily due to full and final year end settlements. £0.6m favourable due to review of drugs challenges and prior year ERF settlements. £0.4m favourable due to CDC performance. £0.6m benefit due to Lancs ICB API drugs and £0.6m due to GM ICB contribution to Community Paediatrics and Dermatology service. This is offset by £0.2m under performance due to Long COVID clawback and £0.6m under performance on Education income due to re-allocations to Divisions.

Corporate

- £21.3m favourable in month due to a notional pension income offset with expenditure.

Divisional ERF Activity and Income v Final Plan

ERF Performance

- In month 12 the Trust is breakeven to the internal ERF plan and £2.0m adverse for the full year inclusive of advice & guidance income which has been allocated out to Divisions.
- Specialist Services are £0.6m adverse in month and £5.1m adverse for the full year predominantly within Trauma & Orthopaedics, this is a result of not utilising all available theatre sessions.
- Surgery have overperformed against their plan by £0.5m in month and are £3.0m favourable full year.
- Medicine are on plan in month and £0.1m above plan for the full year.
- Advice and Guidance income of £1.4m for the full year has been included in the financial position and has been allocated out to Divisions.
- The Trust over performed on the GM ceiling by £0.3m and therefore have been under paid for this activity but have benefited by £0.8m due to under performing against the Low Volume Activity (LVA) activity which is blocked at the baseline value.

		In Month Activity			In Month (£000)			Full Year Activity			Full Year (£000)		
Division	POD	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,582	1,679	(97)	1,026	1,083	(57)	18,049	20,306	(2,257)	11,828	13,100	(1,272)
Medicine	Electives	13	27	(14)	33	43	(10)	420	327	93	619	515	105
Medicine	OP Proc New	47	196	(149)	13	68	(55)	1,497	2,373	(876)	485	819	(334)
Medicine	OP Proc FUP	601	363	238	132	72	59	7,618	4,393	3,225	1,434	876	558
Medicine	OPA New	2,394	2,266	128	595	552	43	28,430	27,407	1,023	7,076	6,672	403
Medicine	A&G				57		57				686		686
Medicine Total		**4,637**	**4,531**	**106**	**1,856**	**1,817**	**39**	**56,014**	**54,806**	**1,208**	**22,127**	**21,981**	**146**
Specialist Services	Day Cases	756	865	(109)	1,247	1,445	(198)	8,566	9,517	(951)	14,241	15,675	(1,434)
Specialist Services	Electives	403	461	(58)	2,933	3,352	(419)	4,412	4,986	(574)	32,020	36,224	(4,203)
Specialist Services	OP Proc New	811	846	(35)	132	140	(8)	10,776	10,237	539	1,722	1,691	31
Specialist Services	OP Proc FUP	1,172	1,068	104	160	146	14	16,060	12,912	3,148	2,188	1,770	418
Specialist Services	OPA New	3,240	3,241	(1)	659	665	(7)	37,476	39,198	(1,722)	7,666	8,049	(384)
Specialist Services	A&G				36		36				434		434
Specialist Services Total		**6,382**	**6,481**	**(99)**	**5,167**	**5,749**	**(581)**	**77,290**	**76,850**	**440**	**58,271**	**63,409**	**(5,137)**
Surgery	Day Cases	1,091	828	263	1,458	1,089	368	10,657	10,009	648	14,176	13,158	1,018
Surgery	Electives	167	119	48	516	459	57	2,056	1,443	613	5,914	5,553	360
Surgery	OP Proc New	1,738	1,681	57	370	358	12	21,548	20,327	1,221	4,499	4,328	170
Surgery	OP Proc FUP	3,462	3,036	426	662	564	98	41,115	36,720	4,395	7,939	6,816	1,123
Surgery	OPA New	3,926	4,052	(126)	787	804	(17)	49,053	49,012	41	9,756	9,720	36
Surgery	A&G				23		23				280		280
Surgery Total		**10,384**	**9,716**	**668**	**3,815**	**3,273**	**542**	**124,429**	**117,512**	**6,917**	**42,563**	**39,575**	**2,988**
Divisional ERF Totals		**21,403**	**20,728**	**675**	**10,839**	**10,839**	**(0)**	**257,733**	**249,168**	**8,565**	**122,962**	**124,966**	**(2,004)**

Overperformance

- Surgery £3m YTD
- Medicine £146k YTD

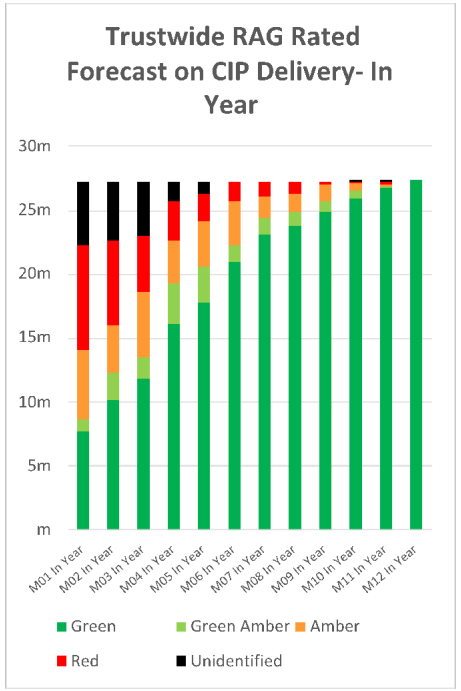
Underperformance

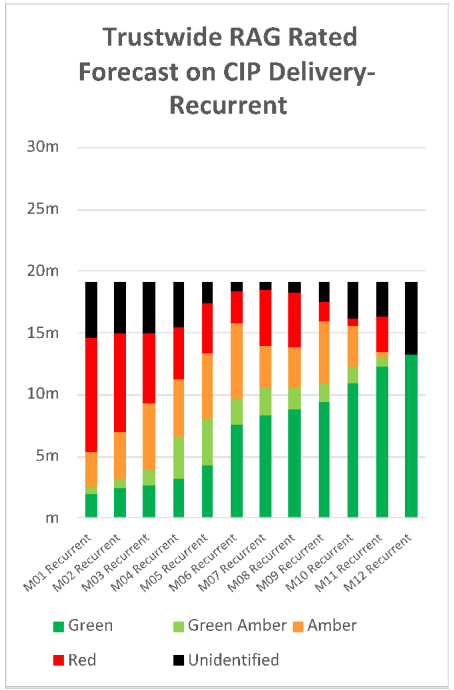
- Specialist Services £5.1m YTD

Trust Wide CIP Delivery 2024/25

2024/25 CIP Plans

- Total CIP delivered in year £27.4m, which is £0.1m above plan.
- Of this, £11.4m is recurrent with a full year effect of £13.2m (£5.9m below the plan of £19.1m).





March 2025 Reported Position

RAG	Value £'000
	-
	-
	-
	27,410
CIP Total	27,410

- £27.4m identified, £13.2m recurrent

February 2025 Reported Position

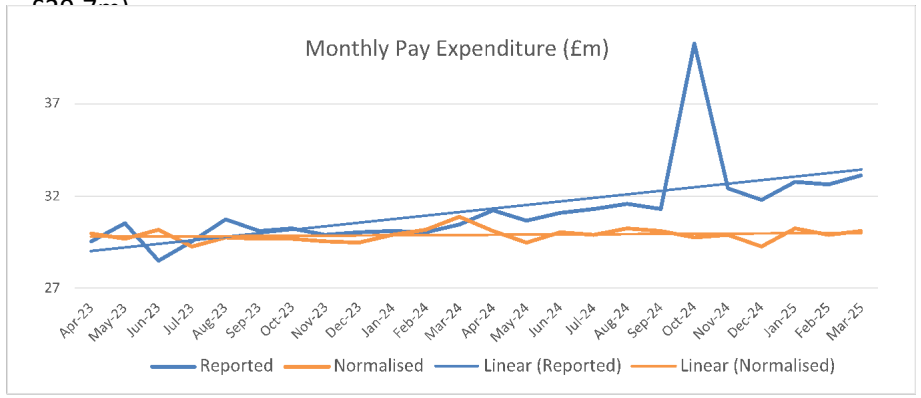
RAG	Value £'000
	26
	246
	183
	26,845
CIP Total	27,300

- £27.3m identified, £16.3m recurrent

Workforce

Pay expenditure

- The in-month pay expenditure is £33.8m which is £1.7m above plan in month, and £5.2m adverse to plan YTD. This excludes the £21.0m central employers' notional pensions accounting adjustment that takes place at year end which is offset with income and has nil impact on trust bottom line.
- MARS severance payments of £0.3m were made in Month 12 with a further £0.2m provision made for employees approved to leave under the scheme after 31st March 2025. Total severance costs in 2024/25 were £0.7m, due to generate recurrent savings of £0.9m.
- Normalised pay expenditure has increased marginally in Q4 24/25 but remains within the typical range. The Q4 monthly average is £30.1m (compared to the Q3 average of



Pay £0.4m below plan in month

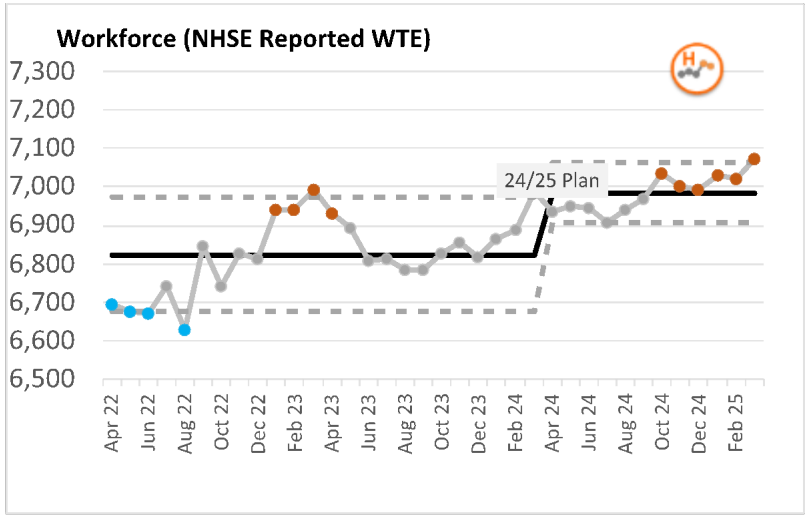
Normalised pay remains static

Normalised quarterly average

Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
£29.9m	£29.6m	£29.5m	£30.3m	£29.8m	£30.0m	£29.7m	£30.1m

Workforce (WTE)

- Actual workforce 7,075 WTE in March; this is the highest workforce ever for the Trust. There is an increase of 54 WTE from last month and is 253 WTE above the workforce plan of 6,822 WTE.
- Substantive staffing has increased by 13 WTE.
- Bank staffing has increased by 41 WTE in Surgery (theatres and wards) and Medicine (Medical and Nursing staff – not associated with escalation)
- Agency remained static compared to last month.
- There were a total of 26 employees approved for MARS, which will have an associated reduction of 18.8 WTE (split 14.3 WTE in 2024/25 and 4.5 WTE in 2025/26).



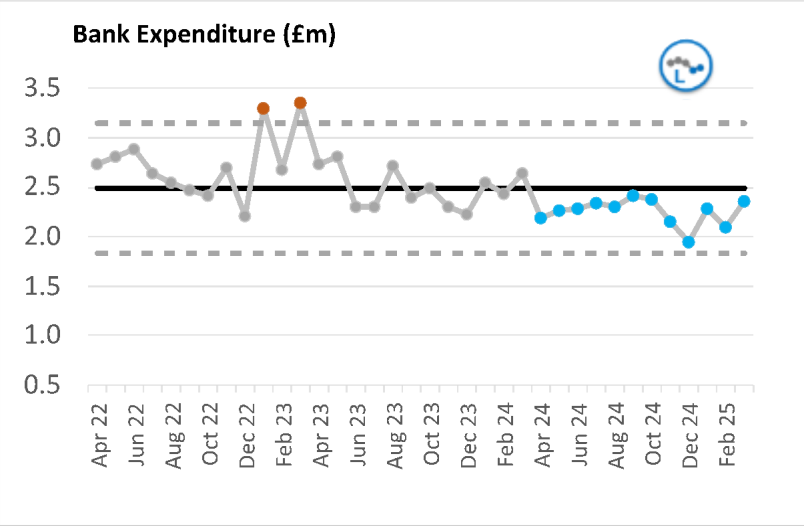
WTE increasing with March the highest month ever reported

WTE above plan by 253 WTE

Temporary Staffing

Bank expenditure

- Bank costs were £2.6m in March, a £0.5m increase from the prior month. This can be seen across Medicine and Surgery divisions.
- Standardised bank rates based on AfC top of scale applied from 1st December 2024, removing the premium cost.
- Bank WTE also increased by 41 WTE compared to the prior month.
- The chart is showing a special cause improving variation.
- In month 12, Medicine (£1.2m) and Surgery (£0.5m) continue to be the biggest users.

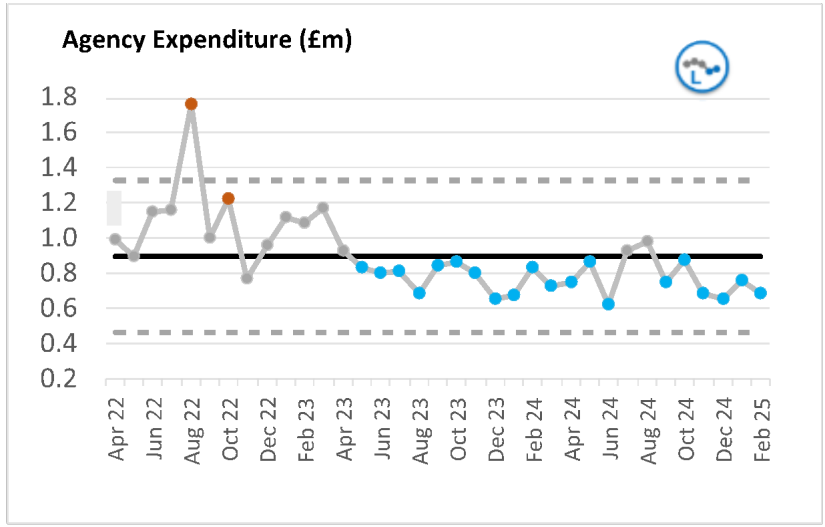


Bank expenditure increased in month

Standardised rates implemented from December

Agency expenditure

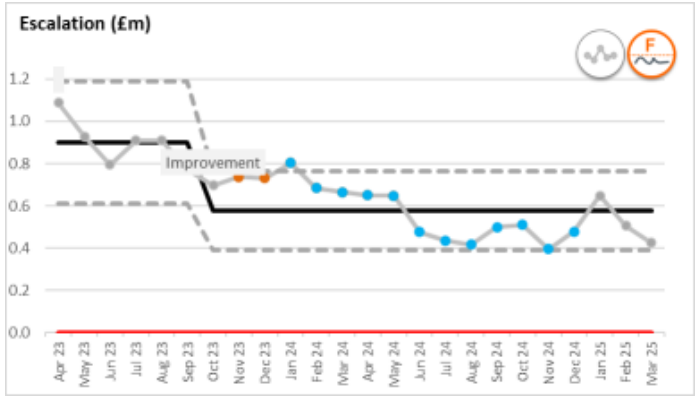
- Agency spend in month is £0.6m, no movement from the prior month, therefore the trend is showing special cause improving variation as this is still within the typical process limits.
- There was no material change in agency expenditure despite the standardisation of NHSP bank rates from 1st December 2024.
- Agency spend in month is 1.2% of the total pay spend, which is below the NHSE agency ceiling set at 3.2%. The final agency % of total pay spend for the full year is 2.2%
- Medicine (£0.4m) continues to have the highest level of agency.



Below the NHSE agency ceiling, however scrutiny remains high

Escalation – Medicine Division

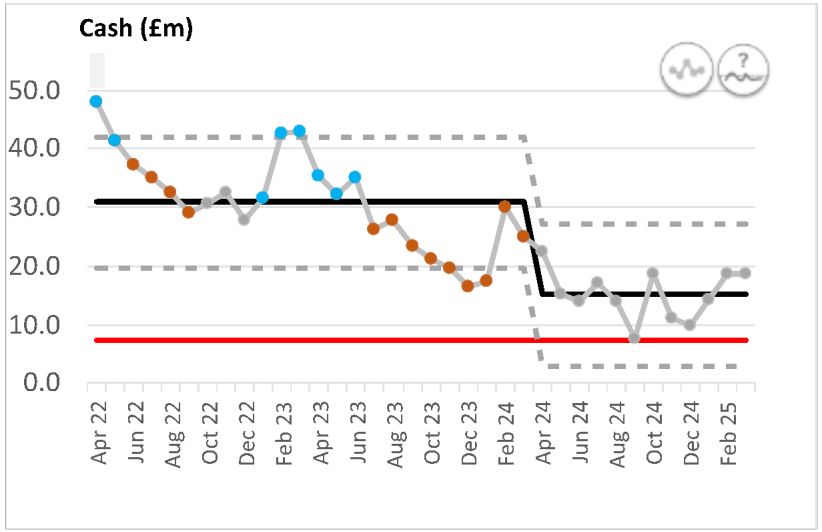
Area	2023/24 (£000)	M1 Actual (£000)	M2 Actual (£000)	M3 Actual (£000)	M4 Actual (£000)	M5 Actual (£000)	M6 Actual (£000)	M7 Actual (£000)	M8 Actual (£000)	M9 Actual (£000)	M10 Actual (£000)	M11 Actual (£000)	M12 Actual (£000)	YTD total (£000)
A&E Rota Issues	3,248	128	147	103	103	103	103	103	103	103	103	103	103	1,304
Paeds rota issues	1,014	67	67	67	67	67	67	67	67	38	38	38	38	689
Acute Rota Issues	809	51	51	51	51	28	21	21	21	21	21	21	21	374
Acute Outliers	517	26	26	26	26	26	26	26	12	12	12	12	12	244
Outlier Additional Doctor	0									5	21	5	10	41
AAA	129	79	77	68	0	0	0	7	15	51	51	49	0	397
Discharge Lounge	157	53	46	18	24	14	26	19	35	43	29	0	1	309
Corridor	1,748	71	31	15	41	21	78	98	60	54	118	87	79	753
Corridor - Extra Medics	0									21	34	31	30	116
Waiting room	374	31	31	31	31	31	31	31	31	31	31	31	31	372
1:1 Enhanced Care	1,724	123	154	84	87	125	79	86	50	61	143	89	100	1,181
Wrightington Escalation	0									36	12	0	0	49
SDEC Overnight	0										35	41	1	76
BWN Decant Costs	0						67	51						119
Total	**9,721**	**629**	**630**	**463**	**430**	**415**	**498**	**509**	**394**	**477**	**648**	**506**	**425**	**6,024**
Winter Business Cases	570	140	140	148	148	148	148	148	148	148	148	148	148	1,760
Grand Total	**10,291**	**769**	**770**	**611**	**578**	**563**	**646**	**657**	**542**	**625**	**796**	**654**	**573**	**7,784**

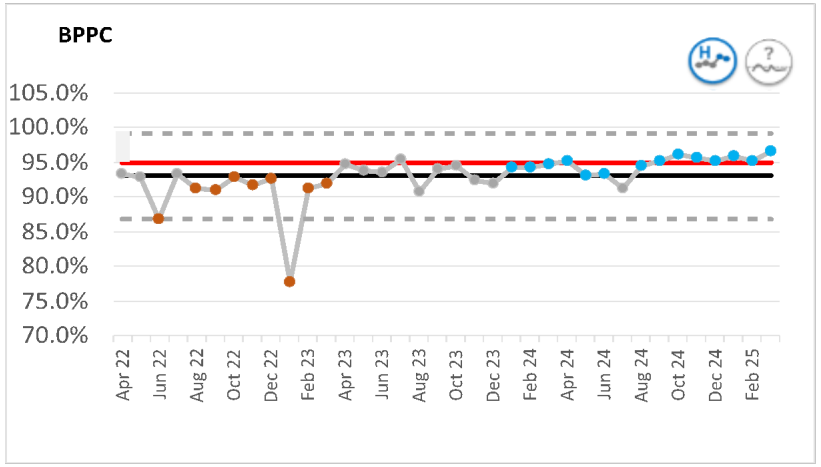


Headlines

- Total escalation spend decreased by £81k in month with no escalation of AAA, DL or SDEC overnight during the month.
- 1:1 enhanced care spend increased slightly compared with last month but is in line with average spend.
- Total escalation spend was £6.0m for the 2024/25 financial year (excluding the winter business cases).

Cash and BPPC





Cash position

- Closing cash at the end of March 2025 was £18.1m, a decrease of £0.7m from February. This is due to timing differences in the receipt and payment of invoices. £5.2m of PDC allocation was drawn down in the month.
- The closing cash balance is £10.7m above the plan of £7.7m largely due to the provider deficit funding, pay award funding, additional PDC funding, variance to the revenue plan and other timing differences in payment of invoices.
- Deficit funding support of £13.7m has been received, the final balance of £1.0m was received in March.
- Additional PDC Cash of £1.9m received in March.
- The cash position will be monitored closely going into the new financial year, as the current run rate indicates cash support would be required from Q2.

Better Payment Practice Code (BPPC)

- The in-month performance was 96.5% by volume and 98.5% by value.
- YTD performance 94.7% by volume which is slightly under target, and 96.3% by value which is above target.

Capital

Overall plan

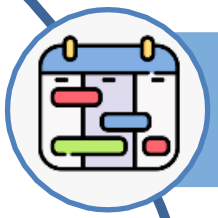
- **Opening capital programme: £21.0m**
- Internal CDEL **£9.2m**
- PDC **£8.2m**
- Leases **£3.5m**
- Funding for additional PDC schemes received in year of £3.9m
- Lease expenditure of £0.8m released in year to support system overcommitment.
- PDC cash backed capital incentive funding of £1.9m received in March
- Expenditure on back log maintenance (£0.8m) and Theatre 12 (£1.1m) transferred from operational CDEL to PDC for against capital incentive.
- **Closing capital programme: £23.2m**
- Internal CDEL**: £7.4m**
- PDC **£14.0m**
- Leases: **£2.6m**

Key points

- Achievement of capital programme for both CDEL and PDC funded schemes.
- Expenditure on leases £0.9m below plan as per agreement with ICB to support system overcommitment. This includes £0.8m for the renewal of the SSDU lease for Cranfield Road which has been deferred to 2025/26.

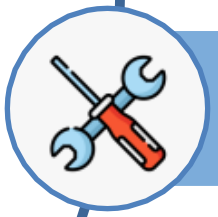
	In Month (£000)			Full Year (£000)		
Scheme	**Actual**	**Plan**	**Var**	**Actual**	**Plan**	**Var**
Operational capital (CDEL)	(1,228)	1,014	2,242	7,371	7,371	(0)
Lease expenditure (IFRS16)	1,053	0	(1,053)	1,761	2,655	894
Sub total internally funded	**(175)**	**1,014**	**1,189**	**9,132**	**10,026**	**894**
National funding (PDC)						
Theatre 11, Wrightington	8	0	(8)	1,325	1,325	0
Endoscopy	1,202	543	(659)	6,886	6,886	0
RAAC Eradication Programme	170	121	(49)	711	711	(0)
Transnasal Endoscopy	267	0	(267)	267	267	(0)
LED Lighting	472	540	68	2,362	2,362	0
I-refer Clinical Descision Support (CDS)	162	162	(0)	162	162	(0)
Paediatrics at Leigh	365	0	(365)	400	400	0
Capital Incentive Programme						
Backlog maintenance	797	797	0	797	797	
Theatre Reurbishments	1,119	1,119	0	1,119	1,119	
Sub total national funding	**4,563**	**3,282**	**(1,281)**	**14,029**	**14,029**	**0**
Total capital programme	**4,388**	**4,296**	**(92)**	**23,161**	**24,055**	**894**

Forward look



Executive level discussions have continued across GM ICS in respect of system plans for 2025/26. The WWL Board of Directors agreed a move to our control total for the revenue plan, which is a breakeven plan inclusive of £8.9m non-recurrent deficit funding. Several conditions were negotiated to support delivery of this plan, including additional capital and support for our surgical hubs.

CIP plans for 2025/26 are being developed across the divisions. An increase to the CIP target for 2025/26 was agreed by the Board as part of the improvement to meet the control total. This target is £38.5m, of which 60% is recurrent, and represents 6.5% of influenceable spend.



Capital planning for 2025/26 is continuing both internally and across the GM system. Capital allocations have been confirmed, and prioritisation of the remaining envelope will take place over April and May, with oversight from the Capital Strategy Group.

The new Chief Executive of NHSE issued a letter on 1st April 2025 outlining the requirement to reduce corporate cost growth seen since 2018/19. Providers have been set a target to reduce this by 50% by quarter 3; the WWL target reduction is £8.8m. Providers are required to plans on how this will be achieved by the end of May 2025.

Agenda item: [25]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Trust finance report for April 2025 (Month 1)
Presented to:	Board of Directors
On:	4th June 2025
Item purpose:	Information
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Senior finance team
Contact details:	E: Heather.Shelton@wwl.nhs.uk

Executive summary

The presentation provides the full finance report on the Trust financial position for month 1 (April 2025).

Please see slide 3 for key messages and slide 4 for key performance indicators.

Link to strategy

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

Risks associated with this report and proposed mitigations

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?

The finance flash metrics were reviewed by ETM on 8 May 2025. The full report has been to Finance and Performance Committee on 27 May 2025 and Financial Improvement Group on 2 June 2025. The latter is a change in governance from 2024/25 where previously the full report went to Wider Leadership Team.

Wider implications

There are no wider implications of this report.

Recommendation(s)

To note the finance report for the month 1 financial position.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Trust Finance Report

Month 1 – April 2025

Contents

Main report

Statistical Process Chart (SPC) Key

Key Financial Messages

April is the first month of the new 2025/26 financial year. We have agreed a breakeven revenue plan for the year with GM ICB and NHSE. For month 1, we are reporting a deficit of £1.4m, which is £0.4m adverse to the planned deficit of £1.0m. This relates to CIP slippage and ERF activity.

The CIP target for 2025/26 is £38.4m (6.5% of influenceable spend). For month 1, CIP of £1.6m was delivered against the plan of £2.2m, which is a shortfall of £0.6m. The shortfall is all against the recurrent target with £0.4m delivered against the target of £1.0m. There is a phasing increase from month 3 (to £3.4m) recognising the CIP stretch agreed in April.

In month 1 we are £0.6m below the ERF plan, with underperformance in Specialist Services, Surgery and Medicine.

The cash balance as at 30 April 2025 is £16.8m, which is a decrease of £1.2m from last month. The cash plan is based on delivery of the revenue and efficiency plans and remains challenging for 2025/26.

Workforce in April is at 6,948 WTE, this is a decrease of 127 WTE on last month and is 4 below the workforce plan of 6,952 WTE. Bank expenditure and WTE have decreased compared to last month. NHSP bank rates were standardised to midpoint from 1 April 2025, with bank staff eligible to receive the AFC pay award once confirmed.

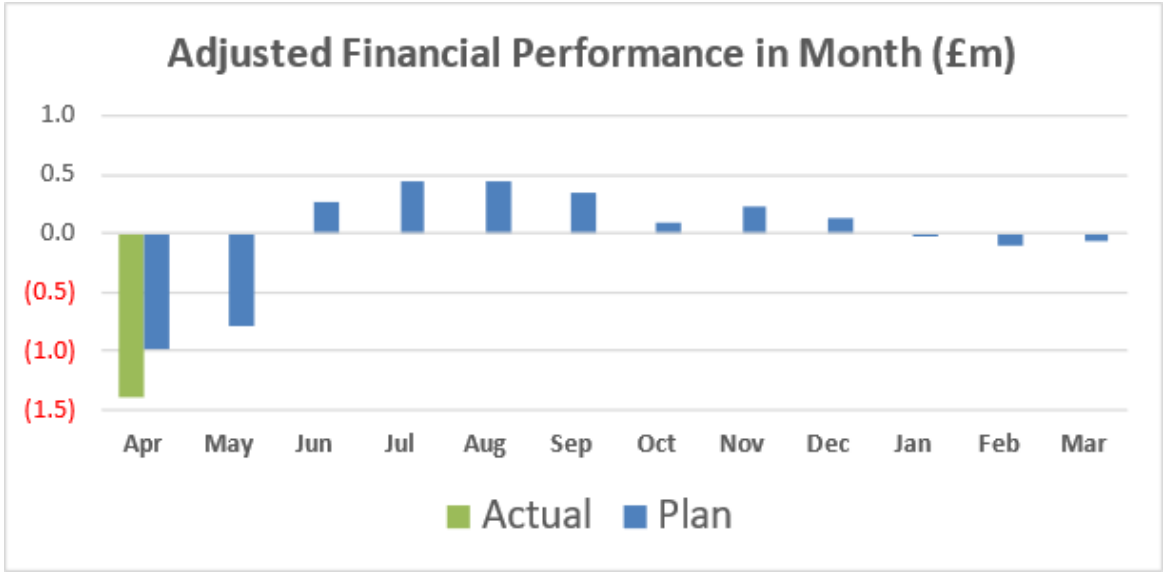
Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Red		For month 1, we are reporting an actual deficit of £1.4m, which is this is £0.4m adverse to the planned deficit of £1.0m. This relates to CIP slippage and ERF activity.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		The cash balance as at 30 April 2025 is £16.8m, which is a decrease of £1.2m from last month. The cash plan is based on delivery of the revenue and efficiency plans and remains challenging for 2025/26.
ERF Income	Achieve the elective activity plan for 2025/26.	Amber		Our internal income plan is £7.9m higher than the notified GM ICB ceiling for the full year – we are awaiting confirmation from the ICB regarding the additional income being approved. In month 1 the Trust is £0.6m behind the internal ERF plan.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Red		Total CIP delivered in Month 1 is £1.6m, which is £0.6m below plan: £0.4m is recurrent (22%) and £1.2m is non-recurrent (78%). The recurrent delivery is £0.6m behind plan. As at month 1, there is £7.1m unidentified in the recurrent plan.
	Deliver Recurrent CIP of £23.0m	Red		
Agency expenditure	30% reduction in agency spend.	Red		Our agency plan reflects the NHSE planning requirement to reduce expenditure by 30% on the month 8 2024/25 forecast outturn. In month 1, we are £0.1m above the plan of £0.5m. Agency spend in month is £0.6m and has been relatively static for the last few months.
Bank expenditure	10% reduction in bank spend	Amber		Our bank plan reflects the NHSE planning requirement to reduce expenditure by 10% on the month 8 2024/25 forecast outturn, plus a further £2.0m stretch associated with the difficult decisions. In month 1, bank expenditure was £1.8m which is a 13% reduction on the 2024/25 average baseline and meets the expected planning reduction.
Capital expenditure	Achieve capital plan for 2025/26.	Green		Capital expenditure in month 1 is £2.3m, which £0.1m behind the plan of £2.4m. There is 21% agency reduction on Month 8 2024/25 – ahead of the NHSE targeted reduction of 10%.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Green		BPPC performance to end of April is 95.3% by volume and 99.2% by value.

Financial Performance

Headlines

- Our revenue plan for 2025/26 financial year is breakeven. This includes £8.9m of non-recurrent deficit support (our control total).
- In April (month 1), we have an actual deficit of £1.4m**,** which is **£0.4m adverse** to the planned deficit of £1.0m.
- Income is £46.6m, **£0.4m adverse to plan** due primarily to ERF underperformance across the clinical divisions
- Pay expenditure is £33.7m, **£0.4m adverse to plan.** This is due to slippage on CIP.
- Non pay expenditure is £13.9m, **£0.5m favourable to plan**. Non pay expenditure is lower than the 2024/25 Q4 run rate.
- The Trust CIP target is £38.4m for 2025/26. In month 1, the Trust delivered CIP of £1.6m, which **is £0.6m adverse** to the plan of £2.2m.



Key Financial Indicators	In Month (£000)			Full Year (£000)
	Actual	Plan	Var	Plan
Income	46,635	47,020	(385)	568,926
Pay	(33,668)	(33,222)	(446)	(391,663)
Non Pay	(13,925)	(14,382)	456	(171,256)
Financing / Technical	(459)	(418)	(41)	(6,221)
Surplus / Deficit	(1,418)	(1,002)	(415)	(213)
Adjusted Financial Performance (AFP)	(1,399)	(985)	(415)	0
Memo: Deficit support				
Non-recurrent deficit dupport	(741)	(741)	0	(8,893)
AFP excluding non-recurrent deficit support	(2,141)	(1,726)	(415)	(8,893)

Income

Division	In Month (£000)		
	Actual	Plan	Variance
Medicine	239	419	(179)
Surgery	142	213	(71)
Specialist Services	1,345	1,580	(236)
Community Services	636	678	(41)
Non Divisional Income	43,227	43,271	(43)
Finance	10	13	(3)
Digital Services	3	7	(4)
Dir of Strat & Planning	215	132	83
Chief Operating Officer	0	0	0
Human Resources	62	96	(34)
Medical Director	91	57	34
Estates & Facilities	381	399	(18)
Nurse Director	79	83	(3)
Trust Executive	0	(131)	131
GTEC	145	163	(18)
Corporate	60	40	20
Total	**46,635**	**47,020**	**(385)**

Headline

- Income is £0.4m adverse in month.

Medicine

- Medicine's income is £0.2m adverse in month due to an under performance of ERF income predominantly within Gastroenterology.

Surgery

- Surgery's income is £0.1m adverse in month due to over performance on education income and private patient income offset by under performance of ERF income of £0.2m.

Specialist Services

- Specialists Services income is £0.2m adverse in month due to an under performance of ERF income predominantly in Trauma and Orthopaedics.

Non – Divisional Income

- Non-Divisional income is £43k adverse in month predominantly due to education income which has been offset with an over performance in Surgery.

Trust Executive

- £0.1m favourable in month due to over delivery on CIP relating to bank interest.

Divisional ERF Activity and Income v Internal Plan

Division	POD	In Month Activity			In Month (£000)		
		Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,401	1,528	(127)	928	1,006	(78)
Medicine	Electives	11	39	(28)	34	53	(19)
Medicine	OP Proc New	90	142	(52)	30	52	(22)
Medicine	OP Proc FUP	603	591	12	133	110	23
Medicine	OPA New	2,270	2,554	(284)	583	665	(82)
Medicine	A&G	0	0	0	58	58	0
Medicine Total		**4,375**	**4,854**	**(479)**	**1,767**	**1,944**	**(178)**
Specialist Services	Day Cases	740	746	(6)	1,181	1,304	(123)
Specialist Services	Electives	364	369	(5)	2,713	2,752	(39)
Specialist Services	OP Proc New	926	871	55	145	146	(0)
Specialist Services	OP Proc FUP	1,006	1,283	(277)	151	180	(29)
Specialist Services	OPA New	2,973	3,110	(137)	626	655	(29)
Specialist Services	A&G	0	0	0	37	37	0
Specialist Services Total		**6,009**	**6,380**	**(371)**	**4,853**	**5,074**	**(221)**
Surgery	Day Cases	804	881	(77)	1,087	1,158	(71)
Surgery	Electives	131	175	(44)	412	492	(80)
Surgery	OP Proc New	1,566	1,904	(338)	358	411	(54)
Surgery	OP Proc FUP	3,429	3,004	425	703	612	91
Surgery	OPA New	3,674	3,935	(261)	749	804	(54)
Surgery	A&G	0	0	0	24	24	0
Surgery Total		**9,604**	**9,899**	**(295)**	**3,333**	**3,501**	**(168)**
Divisional ERF Totals		**19,988**	**21,133**	**(1,145)**	**9,953**	**10,519**	**(567)**

ERF Performance

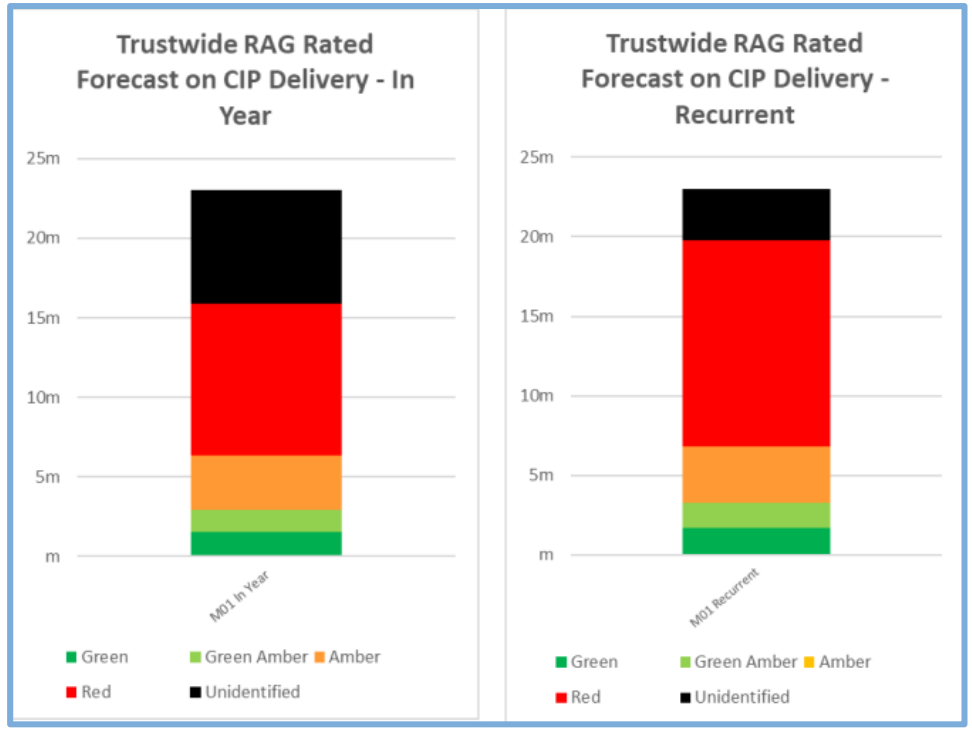
- Our internal income plan is £7.9m higher than the notified GM ICB ceiling for the full year – we are awaiting confirmation from the ICB regarding the additional income being approved.
- In month 1 the Trust is £0.6m behind the internal ERF plan.
- Specialist Services are £0.2m adverse in month which is predominantly within Trauma & Orthopaedics.
- Surgery are £0.2m adverse in month which is predominantly in Ophthalmology, Oral Surgery and Breast Surgery .
- Medicine are £0.2m adverse to plan in month predominantly due to Gastroenterology .
- Advice and Guidance income of £0.1m has been included in the position; this requires confirmation from the ICB.

- Medicine £0.2m
- Specialist Services £0.2m
- Surgery £0.2m

Trust Wide CIP Delivery 2025/26

2025/26 CIP Delivery

- Total CIP delivered in Month 1 is £1.6m, which is £0.6m below plan: £0.4m is recurrent (22%) and £1.2m is non-recurrent (78%).
- The recurrent delivery is £0.6m behind plan.
- There is £7.1m unidentified in the recurrent plan.
- Recurrent CIP identified is £15.9m (69%) against a plan of £23.0m.
- The plan for month 2 will be £2.2m (same as month 1) and from month 3 will be £3.4m per month for the remainder of the year



April 2025 Reported Position (Rec)

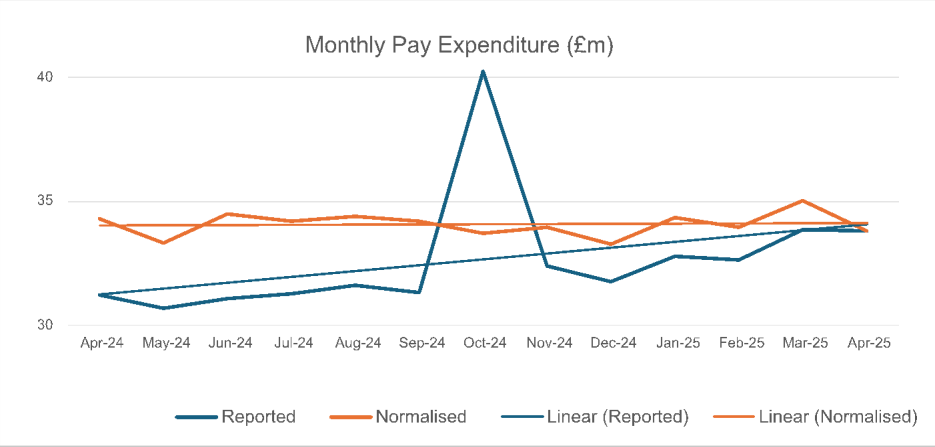
RAG	Value £'000
	7,136
	9,541
	3,393
	2,949
CIP Total	23,020

- £15.9m Recurrent CIP identified

Workforce

Pay expenditure

- The in-month pay expenditure is £33.7m which is £0.4m above plan in month.
- The position includes a 2.8% pay award accrual for 2025/26 for substantive and bank staff, in line with national planning guidance, £0.8m.
- There is also an increase in employers' national insurance contributions from 1 April 2025. This is an increase of £0.7m and is within our plan. Both the pay award assumption and national insurance increase are funded via the uplift to national tariff.
- The normalised position has been restated to 2025/26, meaning 2024/25 has been uplifted in line with the 2025/26 planning assumptions for pay inflation.



Pay £0.4m above plan in month

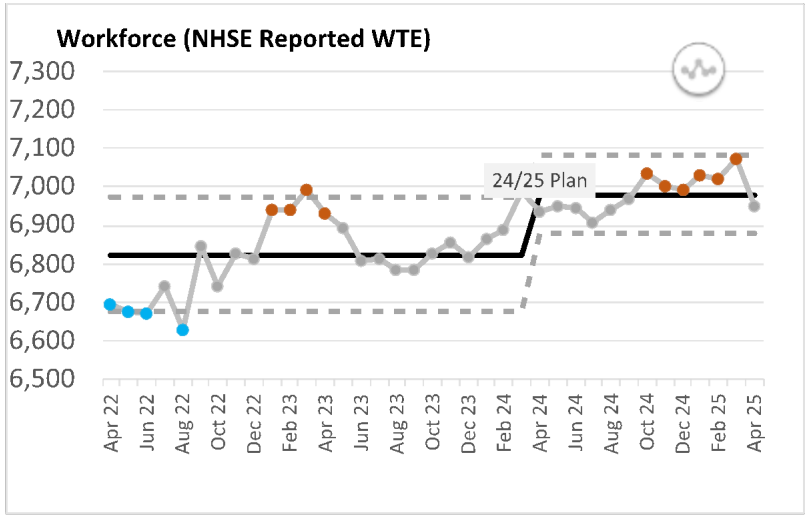
Normalised pay has returned to the Q3 2024/25 average

Normalised quarterly average

Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	M1 25/26
£34.1m	£34.3m	£33.7m	£34.4m	£33.8m

Workforce (WTE)

- Actual workforce 6,948 WTE in April. This is a decrease of 127 WTE from last month and is 4 WTE below the workforce plan of 6,952 WTE.
- Substantive staffing has decreased by 41 WTE, mainly in Specialist Services and Surgery.
- Bank staffing has decreased by 77 WTE across all the clinical divisions.
- Agency has 8 WTE decrease compared to last month in, largely found in Medicine.
- The workforce staff in post (SIP) plan assumes an overall reduction of 266 WTE over the year, from March 2025 (7,032 WTE) to March 2026 (6,765 WTE). This includes an assumed reduction of 200 WTE associated with CIP.



4 WTE below staff in post plan for April

Annual plan reduction of 266 WTE

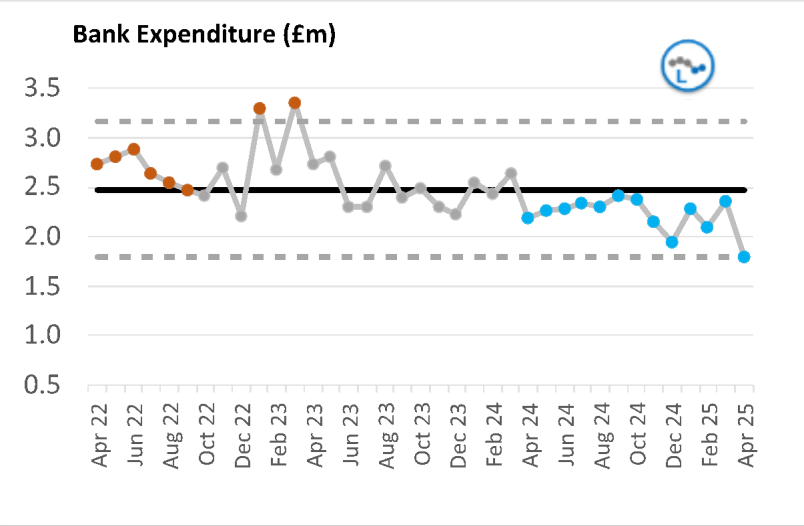
Bank & Agency Staffing

Bank expenditure

- Bank costs were £1.8m in April, a £0.8m improvement from the prior month. This can be seen across all the clinical divisions. This is primarily due to reduced demand (usage) but there is also a positive impact from the standardised of rates to AfC middle of scale applied from 1st April 2025.
- The AFC pay award has been accrued for NHSP bank staff now rates are aligned.
- Bank WTE decreased by 77 WTE compared to the prior month.
- The chart is showing a special cause of an improving variation.
- In April, Medicine (£1.0m) and Surgery (£0.4m) continue to be the biggest users.
- There is 13% bank reduction on 2024/25 average used as the baseline for NHSE monitoring.

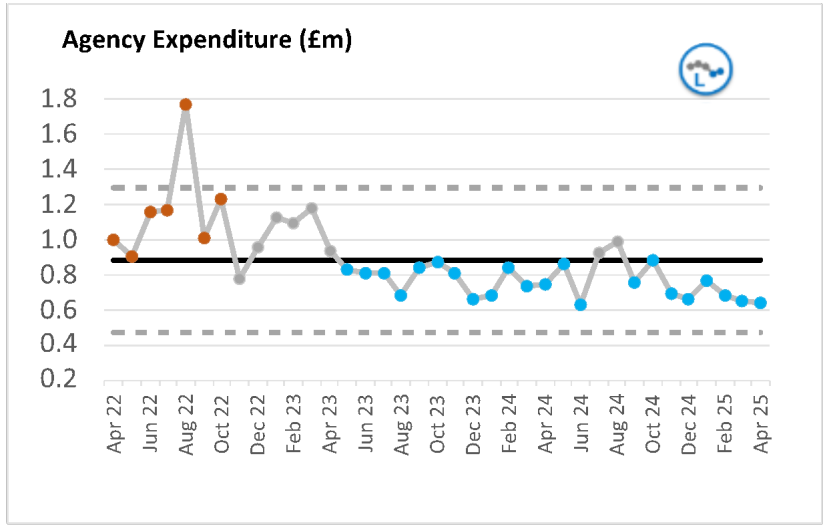
Agency expenditure

- Agency spend in month is £0.6m and has been relatively static for the last few months.
- The trend is showing common cause improving variation as this is still within the typical process limits.
- Medicine (£0.4m) continues to have the highest level of agency within the Trust.
- Our agency plan reflects the NHSE planning requirement to reduce expenditure by 30% on the month 8 2024/25 forecast outturn. In month 1, we are £0.1m above the plan of £0.5m.



Bank expenditure decreased in month

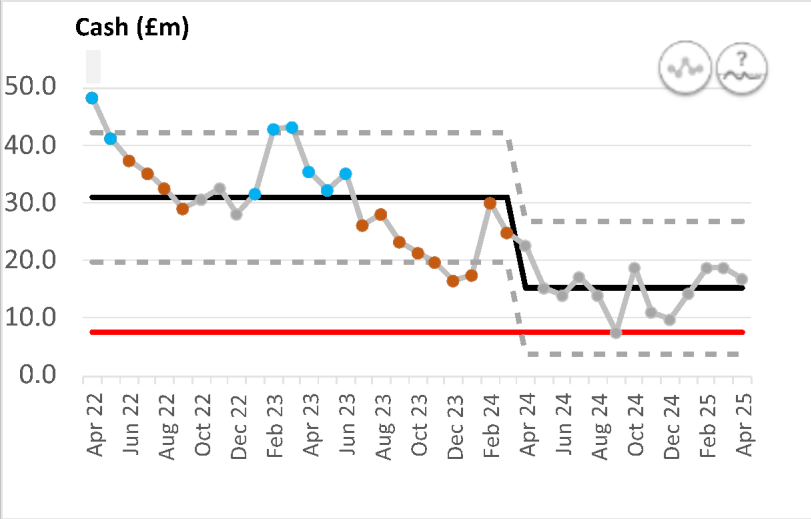
Standardised midpoint rates applied from April 2025

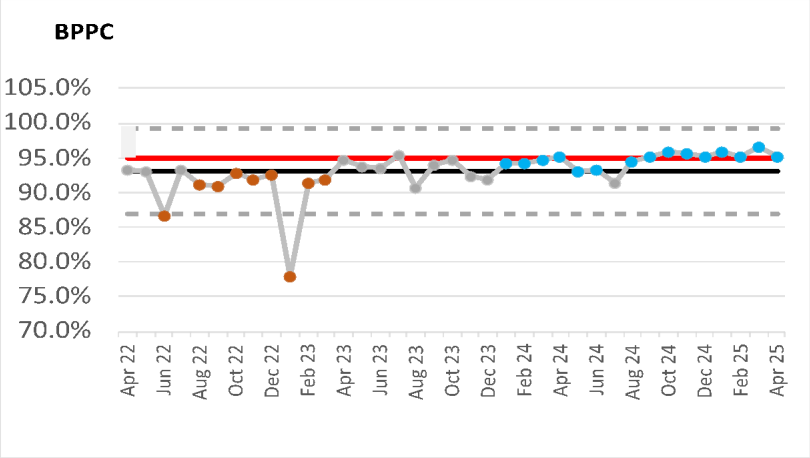


Above plan based on NHSE target reduction

Improving variation since last financial year

Cash and BPPC





Current cash position

- Closing cash at the end of April was £16.8m, a decrease of £1.2m from the previous month. This is due to timing differences in the receipt and payment of invoices.
- The closing cash balance is £7.2m above the plan of £9.6m. This is due to 2024/25 closing balance of £18.1m being £8.4m above the opening cash plan of £9.7m, which was based on the month 11 forecast position.
- Whilst receipts of cash income were on plan, cash expenditure payments were £1.0m more than plan.
- The current operating days metrics show we have cash equivalent to 11 days.

Cash forecast

- The cash plan assumes delivery of the revenue, efficiency and capital plans in full. However,. based on the current run rate, the forecast indicates that cash support may be required towards the end of Q2
- It is expected to be much harder in 2025/26 to access any external cash support, with NHSE using this as a lever to drive financial improvement. NHSE have recently advised that the cash support process for April has been put on hold. Organisations requiring cash support are to look at cost recovery and cash management processes to minimise cash risk.

Better Payment Practice Code (BPPC)

- The in-month performance was 95.3% by volume and 99.2% by value, therefore achieving the target of 95.0%.

Capital

Scheme	In Month (£000) Actual	Plan	Var	Full Year (£000) Plan	YTD Actual of Full Year Plan (%)
Operational capital (CDEL)	1,892	2,028	137	14,117	13%
Sub total internally funded	**1,892**	**2,028**	**137**	**14,117**	**13%**
National funding (PDC)					
Solar Panels	0	0	0	2,148	0%
Diagnostic equipment: Echo Machines	0	0	0	135	0%
Diagnostic equipment: Head up tilt test	0	0	0	48	0%
Diagnostic equipment: Sapce lab analysers	0	0	0	90	0%
UEC: Discharge Lounge refurbishment	0	0	0	572	0%
Elective: Theatres 5&6 refurbishment	0	0	0	1,050	0%
Estates Safety: Backlog Maintainance	0	0	0	2,294	0%
Estates Safety: Staff car park	450	450	0	450	100%
UEC: A&E Diagnostics	0	0	0	3,747	0%
UEC: SDEC	0	0	0	1,341	0%
Sub total national funding	**450**	**450**	**0**	**11,875**	**4%**
Total capital programme	**2,342**	**2,478**	**137**	**25,992**	**9%**

Month 1 Headlines

- Capital expenditure in month 1 is £2.3m, which £0.1m behind the plan of £2.4m.

Capital plan 2025/26

- Total capital plan for the financial year of £26.0m made up of:
  - Internal operational CDEL £14.1m.
  - PDC £11.9m.
  - 5% planning tolerance £0.7m included within £14.1m which will need to be managed in year.

Operational CDEL

- Capital expenditure in month 1 is £1.9m which £0.1m behind the plan of £2.0m.
- Expenditure includes £0.7m on endoscopy and £1.1m on digital schemes, both in line with the plan.

PDC funded schemes

- Expenditure of £0.5m in month on the surface staff car park at Freckleton Street, linked to the multi storey car park project.
- Confirmation received from NHSE that national panel have approved our PDC funded schemes, except for the SDEC configuration (£1.3m) where further work is being done to define the scope of the scheme.

Risk Management and Mitigation

Revenue position

Recurrent CIP delivery: Month 1 recurrent CIP of £0.4m delivered against the plan of £1.0m. This slippage of £0.6m will need to be recovered within this financial year. There is an increase in the plan from June associated with the agreed CIP stretch.

ERF activity: In month 1 there was underperformance of £0.6m against the ERF plan. A step change in activity is required to deliver our plan.

ERF cap: The totality of the activity plan currently has a value greater than the proposed ERF cap by £7.9m for GM ICB and discussions have been held with GM regarding the additional requirement and is currently going through their governance process.

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

Inflation: Our 2025/26 plan is based on the national inflationary assumptions. There is a risk that actual inflation exceeds this in non-pay. The pay award has yet to be confirmed and is going though the pay review body process.

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, the forecast indicates that cash support may be required towards the end of Q2. Cash management strategies will be implemented to mitigate short term cash shortages.

Business rules: A potential change in the business rules had been signalled which may impact the non-recurrent deficit funding arrangements. At the time of writing, further clarity is awaited.

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.

Forward look

The PDC capital bids are going through the governance and approval process, with business cases being developed for NHSE. This includes the A&E diagnostics development, estates safety and theatre 5 & 6 refurbishment.

Following communication from NHSE in April 2025 regarding the requirement to reduce corporate cost growth since 2018/19, further analysis has been undertaken, and this will be progressed via the Corporate Transformation Board.

The identification and work up of CIP schemes is a Trust wide priority to reduce the unidentified balance. Programme charters are being finalised, following which QIAs and project timescales will be progressed.

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	14th May 2025
Chair:	Francine Thorpe

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

ALERT

- An external review of the Trusts provision for patients with a learning disability, autism or who identify as being neuro-diverse was received. This included a gap analysis against the national learning disability improvement standards for Trusts. Whilst some areas of good practice were highlighted, twelve recommendations for improvement were noted. Actions are being overseen by the Learning Disability/Autism and Neurodiversity Effectiveness Group. An update to the committee has been scheduled.
- A report was received in relation to the application of National Safety Standards for Invasive Procedures (Natsips) and Local Safety Standards for Invasive Procedures (Locsips) highlighting a number of areas for improvement. An action plan has been developed and is being overseen by a Task and Finish group. An update on progress has been scheduled for a future meeting.
- The most frequently reported direct patient care incident highlighted by the Surgical Divisional Deep Dive was on the day patient cancellations. An update was provided on actions being taken to address this issue.
- The Harm Free Care report highlighted that there has been an overall Trust increase in patients acquiring skin damage from pressure ulcers in 2024/ 25 compared to 2023/2024. A more robust approach to manage the learning from HAPU has been undertaken with a Trust wide rapid action review which has seen an impact. At the request of the CNO the metrics for all harm free care have been reviewed, and will provide further assurance and will correlate harms to direct omissions in care moving forward.

ASSURE

- The Surgical Division Deep Dive highlighted:
  - Actions being piloted to address themes arising within the Lost to Follow Up Group
  - Improved compliance with key measures as part of the National Emergency Laporotomy Audit (NELA)
  - Improved compliance with Sepsis-6 Care Bundle
  - Alignment to Trust priorities

- The Perinatal Quality Surveillance Report highlighted :
  - Full compliance with the end of year 6 maternity incentive scheme measures
  - A reduction in term admissions to neonatal unit as a result of improvement work
  - Significant assurance received (87% compliance against a target of 70%) from the LMNS against the Saving Babies Lives 3 measures
- A comprehensive report was received in relation to a number of issues that had been highlighted using an insourcing company Medinet within gynaecology services. Despite a range of operational concerns the review concluded that no patient harm had ocurred.
- The Aspire Accreditation Quarter 4 Report provided assurance that significant progress has been made. The framework has recently been restructured to align with national standards and updated to incorporate CQC quality statements.
- Information within the Harm Free Care report highlighted a range of improvements made across the Trust including a number of wards where there had been zero pressure ulcers throughout the year. There is now the triangulation of the increase in PU harm and that of long waits within ED and a recent mechanical fault identified with the new mattress offer implemented into the Trust. The trust is working with NWAS to understand patients wait prior to conveyance and if this could have also had an impact of the patient's skin integrity. At the request of the CNO a new metric within the IPR will monitor the number of HAPU that have omissions in care v's those that do not.
- The Safe Medical Staffing report provided assurance in relation to appropriate levels for the majority of shifts across Acute Medicine and SDEC during the period October 2024 to February 2025. Locum usage was highlighted as well as potential actions to reduce reliance on temporary staffing.

ADVISE

- The Peer review to assess the Trust against the Improving Quality In Physiological Services (IQIPS) within paediatric audiology was deferred; therefore the committee was unable to receive an update. This will be rescheduled for a future meeting.
- A paper was received outlining progress against the 2024/25 corporate objective to improve diabetes care for our paediatric population. Improvement in some of the measures used to track progress was highlighted as well as some ongoing challenges. Work will continue to address the themes identified.
- A report highlighting progress against the Advancing Quality (AQ) metrics for sepsis was received. Improvements were noted in most of the measures tracked between April 2023 and January 2025. There are still some challenges to sustaining improvements against some of the measures, actions are ongoing to address the issues identified.
- The Committee's reflections on Equality Diversity and Inclusion included:
  - The external review of LD standards highlighted a number of recommendations which will be actioned over the next few months and we are expecting to see improvements
  - Maternity reports regularly track inequalities data and can evidence actions being taken to provide appropriate support

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the Board Assurance Framework were reviewed; no amendments were made.

Agenda item: 26.2

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	27 May 2025
Chair:	Julie Gill

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

ALERT

- The committee considered a workforce reduction strategy which will look at reducing the number of WTE staff and decreasing the Trust's pay bill. It was noted that the strategy is aligned to WWL's financial sustainability plan and fully involves the divisional management. Workforce figures remain part of ongoing financial monitoring, and the plan delivery will continue to be overseen at the People Committee.
- The performance against the 4-hour standards has remained static and there are still significant challenges with the performance of patients waiting 12-hours of more in the A&E department,
- Ambulance handover time is improving but there are still some challenges, which are impacted by the number of 'no criteria to reside' patients within the Trust which affects flow around the hospital.
- The Better Lives funding has been approved for phase 2b which is non-recurrent until November 2025. Therefore, it is unlikely to be affected by the current spending review's impact upon council (partner) funding as the programme as defined, is due to conclude in the 2025/26 financial year. However, it was noted that this does provide a risk for future social care funding and its' impact upon health.
- The Trust has been placed into tier two of the elective recovery programme, and this is linked to challenges ins Gastro, ENT, General surgery, dermatology and plastics. It was recognised that mutual aid that has been offered by WWL, has also impacted upon the backlog for WWL's delivery.

ASSURE

- The 2025/26 final transformational plan was received, and it was noted that the divisions have been involved in its design and delivery.
- The workforce reduction plan is robust, and the committee noted that this will be monitored through the People Committee, and the Board of Directors meeting.

- Areas of the financial governance processes have been updated meaning that CIP updates will now be incorporated into the Finance reports as this is closely linked to the Trust's delivery of the financial position.

ADVISE

- In relation to the workforce reduction plan the committee noted that the reduction in staffing could impact health inequalities within the borough and the populations that WWL serves due to increased demand.
- The committee were advised that the Trust has delivered £1.6 million CIP against a plan of £2.2 million with £0.4 million being delivered recurrently against a plan of £1 million, during Month 1.
- The opening balance of the Trust's cash position was £18.1m, which was favourable to the plan. The cash support process will be more challenging in 2025/26 with management plans in place to support the Trust's cash position. The committee noted the associated risks to the cash balance given the challenging delivery targets, and that this would be monitored through the committee.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- No new risks were identified, and no risk scores were increased at this meeting.

Committee report

Report from:	People Committee
Date of meeting:	8 April 2025
Chair:	Mark Wilkinson

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

ALERT

- Divisional plans to underpin workforce reduction targets will be submitted by 30 April 2025.
- The importance of approaching workforce reductions sensitivity was emphasised at several points during the meeting (bearing in mind reputational risks) and likewise, of engagement with staff, including enabling leaders to engage with their staff in the right way and working in partnership with trade unions.
- The National Staff Survey scores show that 30% of staff do not feel secure raising concerns about unsafe clinical practice – the Committee has requested further information/assurance around this.

ASSURE

- In discussions on the workforce plan, the Committee noted WWL's commitment to an integrated approach to understanding the quality impacts of all plans and decisions, ensuring no siloed decision-making.
- The Committee heard from a participant of the 'SWAP' (sector work based academy programme) which WWL is taking part in with the local job centre and how positively this has been received.
- The quality impact assessment process is utilised appropriately to ensure WWL maintain quality and safety in patient care while addressing workforce reduction, with engagement and involvement of staff in discussions.

ADVISE

- The Committee noted the focus on addressing the National Staff Survey findings through specific actions and executive led engagement sessions which have been planned. The Committee felt this was positive action to get underneath what motivates our staff in work and will receive a feedback report at our next meeting.
- Collaborative efforts by all Executives and Trade Union partners are already beginning to give confidence around increasing the response rate for the next National Staff Survey
- The People dashboard is now more detailed and aligned to the work of the Finance and Performance Committee, as the Committee had requested at its last meeting.

• Discussions were had around ensuring that the Committee are kept up to date on the whole time equivalent reductions (as requested by the ICB) • The subject of the divisional deep dive this time was the surgery division – they are considering booking team resource and some digitalisation opportunities to reshape the workforce.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• No new risks identified.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Audit Committee
Date of meeting:	8 May 2025
Chair:	Simon Holden

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

ALERT

- The Head of Mersey Internal Audit Agency (MIAA) has issued a "substantial assurance" for 2024/25, meaning that there is a good system of internal control.
- Amendments were approved to the "overpayments & advances of salary policy", in line with national NHS guidance (which seeks to be both fair & pragmatic).
- The draft annual accounts for 2024/25 were received and noted. They include a significant technical impairment of £27m, in line with accounting guidance, which was also discussed. These accounts are now subject to external audit by KPMG.

ASSURE

- A Private Audit Committee was held, in line with good practice, although there was nothing significant to report.
- The draft accounts for 2024/25 were submitted to NHS England on the 25 April 2025, in line with the published timetable, showing a deficit for the year of £0.8m in line with the agreed Plan.
- The Committee reviewed, and approved, the annual internal audit plan for 2025/26 (noting the risk based approach).
- A deep dive was undertaken into a number of procurement waivers, and in particular the rationale for a number from estates (although assurance for the requirement was accepted).
- Losses & special payments for 2024/25 were reviewed, and all approved in line with standing financial instructions (SFIs). Noting the expenditure of £228,000 & 158 Cases (compared to £315,000 & 169 Cases in 2023/24).

ADVISE

- It was suggested that it might be beneficial for the Board to undertake cyber training, given the connected world & increased risks.
- From the draft annual accounts for 2024/25 the total operating income was £581m, and staff costs were £376m (up £43m).

- A review of the single tender actions, and governance processes followed, related to reinforced autoclaved aerated concrete (RAAC) was carried out.
- A review of the self-assessment action plan for local safety invasive procedures (LOCSIPs) & national safety invasive procedures (NATSIPs) was received, & will also be reviewed by the Quality & safety Committee. This action plan needs to be kept under review in line with suggested next steps.
- The International Internal Audit Charter, was approved, as part of an annual review process.
- The Trust's standing financial instructions (SFIs) were updated mainly for legislative changes relating to procurement.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Risks were considered as part of the 'risk deep dive' in the context of considering the robustness of this process.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Directors' fit and proper person checks
Presented to:	Board of Directors
On:	4th June, 2025
Presented by:	N/A – Consent agenda
Prepared by:	Director of Corporate Governance
Contact details:	E: Steven.Parsons@wwl.nhs.uk

Executive summary

Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires the Trust to ensure that all of its Directors meet the 'Fit and Proper Person' test, related to their good character, qualifications and experience, physical and mental health, and prior conduct in the provision of health and social care services.

NHS England has published detailed guidance to support Trusts in complying with this requirement, including a range of annual checks and an annual report to the Board in public confirming the position, and any investigation or action taken during the year into potential non-compliance. This paper is the annual report to the Board.

In summary, there are no matters of concern to be drawn to the attention of the Board; and no investigations during the course of the year to be reported. The appended table formally reports the outcome of the checks undertaken in accordance with NHS England guidance on those currently in office as Directors.

Link to strategy

There is no direct link to the organisational strategy.

Risks associated with this report and proposed mitigations

The content of this report is intended to mitigate the risk of breaching the Regulation or the terms of the foundation trust's provider licence.

Financial implications

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

Legal implications

The content of this report is intended to mitigate the risk of breaching the Regulation shown above.

People implications

There are no people implications to highlight.

Wider implications

There are no wider implications to highlight.

Recommendation(s)

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

Name	Role	Search of register of disqualified directors	Search of bankruptcy and insolvency register	Search of register of disqualified and removed charity trustees	General search of public information via internet search engine	Professional registration checks[(i)]
NON-EXECUTIVE DIRECTORS						
AUSTIN, Clare	Non-Executive Director	No match	One entry with matching name. Case reviewed and different person. No match	No match	No issues identified	N/A
BRADLEY, Rhona	Non-Executive Director	No match	No match	No match	No issues identified	N/A
GILL, Julie	Non-Executive Director	No match	One entry with matching names (Julie Gill). Both reviewed and different person. No match (Julie Rehm)	No match	No issues identified	N/A
HOLDEN, Simon	Non-Executive Director	No match	No match	No match	No issues identified	N/A
MOORE, Mary	Non-Executive Director	No match	No match	No match	No issues identified	N/A
JONES, Mark	Chair	No match	60 entries with matching names. All reviewed and different people. No match	No match	No issues identified	N/A
THORPE, Francine	Non-Executive Director	No match	No match	No match	No issues identified	N/A
WILKINSON, Mark	Non-Executive Director	No match	13 entries with matching names. All reviewed and different people. No match	No match	No issues identified	N/A

Name	Role	Search of register of disqualified directors	Search of bankruptcy and insolvency register	Search of register of disqualified and removed charity trustees	General search of public information via internet search engine	Professional registration checks[ii]
EXECUTIVE DIRECTORS						
ARYA, Sanjay	Medical Director	No match	No match	No match	No issues identified	GMC registration confirmed. No fitness to practise issues identified.
BRENNAN, Sarah	Chief Operating Officer	No match	3 entries with matching names. All reviewed and different people. No match	No match	No issues identified	GPHC registration verified.
FLEMING, Mary	Chief Executive	No match	4 entries with matching names. All reviewed and different people. No match	No match	No issues identified	N/A
GARDNER, Tabitha	Chief Finance Officer	No match	No match	No match	No issues identified	CIPFA registration verified
MILLER, Anne-Marie	Director of Communications and Stakeholder Engagement	No match	1 entry with matching names. All reviewed and different people. No match	No match	No issues identified	N/A
MUNDON, Richard	Deputy Chief Executive/ Director of Strategy and Planning	No match	No match	No match	No issues identified	N/A
PARKER-EVANS, Kevin	Chief Nursing Officer	No match	No match	No match	No issues identified	NMC registration confirmed. No fitness to practise issues identified.
TAIT, Juliette	Chief People Officer	No match	No match	No match	No issues identified	CIPD registration verified.

[i] Professional registration checks are undertaken for posts where such registration was included in the person specification as an essential requirement of the role. Fitness to practice checks are also undertaken for those who require clinical registration.

[ii] Professional registration checks are undertaken for posts where such registration was included in the person specification as an essential requirement of the role. Fitness to practice checks are also undertaken for those who require clinical registration.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard and Optimisation Report
Presented to:	Trust Board
On:	4 June 2025
Item purpose:	Information
Presented by:	n/a consent agenda
Prepared by:	Gemma Weinberg (Digital Midwife)
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations.

The April dashboard has highlighted that there are some areas for increased observation. Delay in category 2 CS, stillbirths and Apgars. The governance team is looking closely into the Apgars. A deep dive into the CS timings is being completed to look for themes and trends. There is also a deep dive underway to look at possible themes for the stillbirths as these have seen a significant spike in April. 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 April 2025 dashboard and overview of indicators as outlined below.

Report

April 2025 Exception report - Maternity
Summary

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

- There were twenty validated midwifery red flags reported in April, 18 for delay in IOL, 1 for delay in care and one for a full clinical examination not being performed when presenting in labour. It should be noted here that the method of collecting red flag reports has changed. We are now pulling these figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. There is a separate red flag report which investigates the red flags in more detail.
- The shift coordinator was able to remain supernumerary for all shifts in April.
- 1:1 care is validated at 100% in April.
- There were 3 Maternity complaints received in April, but the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

PSII Commissioned Incidents

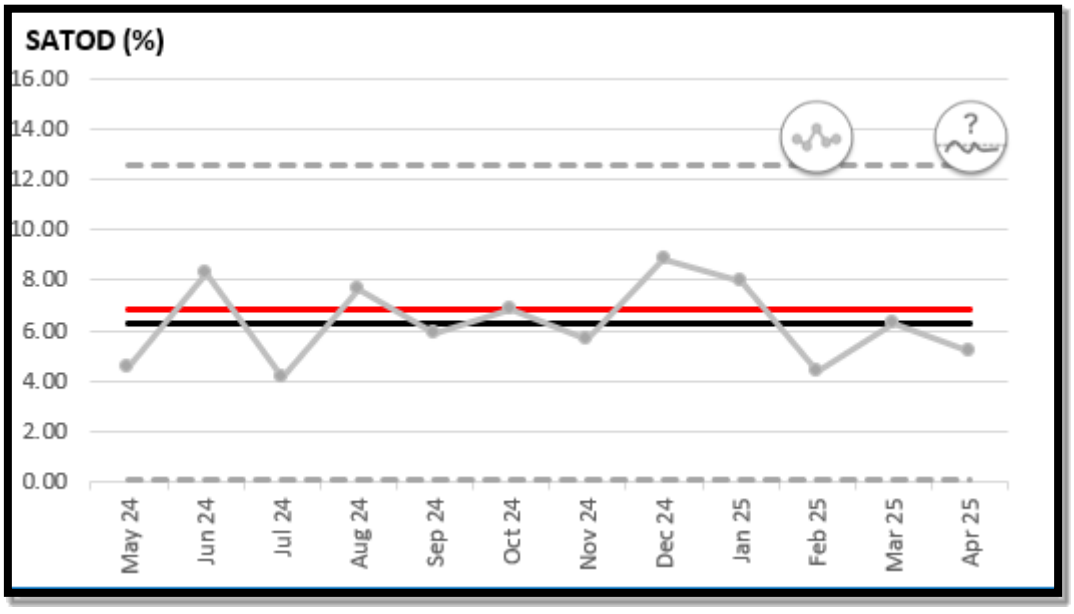
There were no PSII Commissioned incidents reported in April.

StEIS reported incidents

There were no StEIS reported incidents reported in April.

Green

Smoking at the time of Delivery (SATOD) (%). This figure has saw a slight increase in December into amber levels but returned to green levels in January. February saw the lowest figure for this metric since recording of it on the dashboard began. Work continues to promote and encourage smoking cessation throughout pregnancy. The below SPC chart shows our % SATOD rates in comparison to GM (red line).



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

Women readmitted within 28 days of Delivery (rate per 1000). There were 2 maternal readmissions to the obstetric unit in April. No omissions in care were noted. The admissions were both for headaches.

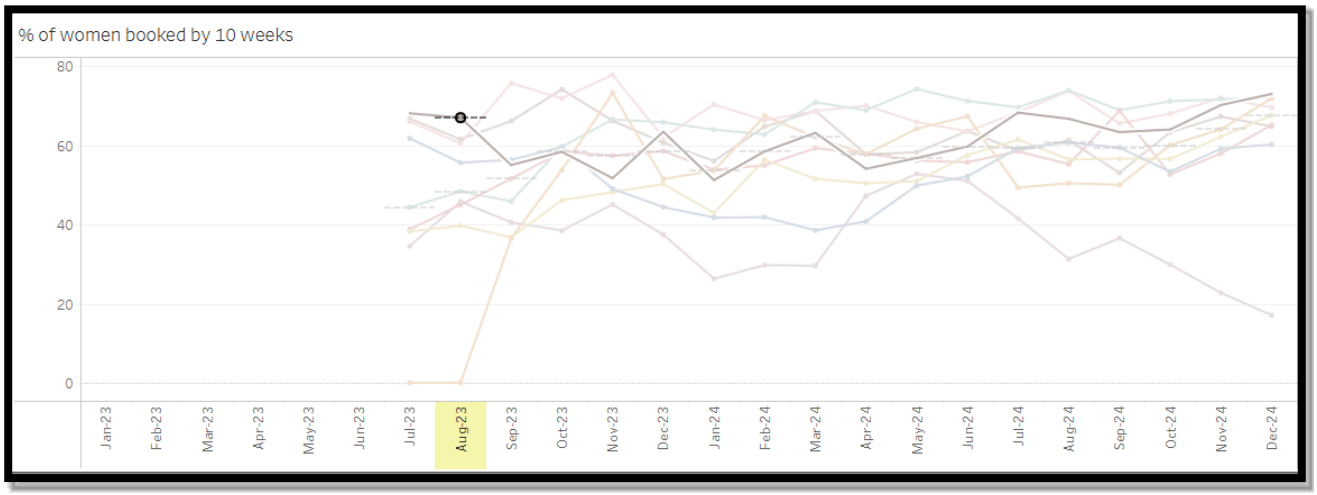
Skin to skin contact (%) This metric sees a significant increase in April after a slight drop into amber levels in March. Work continues to improve this metric.

The number of mothers who have opted to breastfeed (%) – This metric has seen a slight drop from March but remains green. Work continues to improve this metric.

Women booked by 12+6 weeks (%) These have been at green levels since they dropped into amber levels in January 2024. Wigan remains one of the highest performers in GM for this metric.

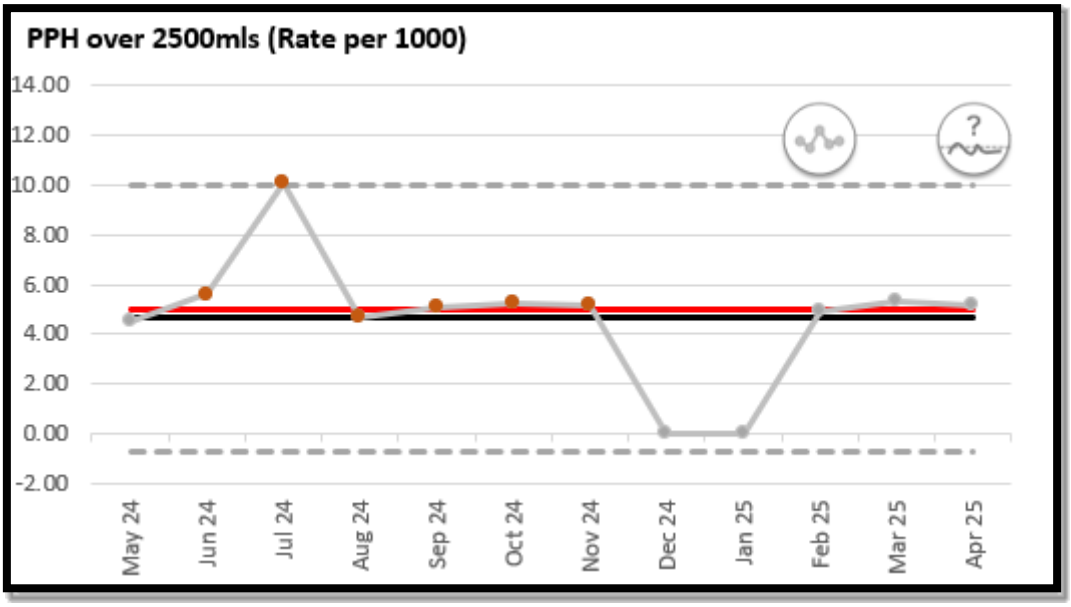
Amber

Booked by 9+6 – This parameter is a relatively new addition to the GM data. The aim is to work towards booking all women before 10 weeks of pregnancy. Whilst our figures are in amber levels, they have seen significant improvement since the start of 2024. The chart below shows how WWL is performing in relation to GM. As this is not currently one of the key parameters assessed by GM there is no GM average to be able to provide an SPC chart.

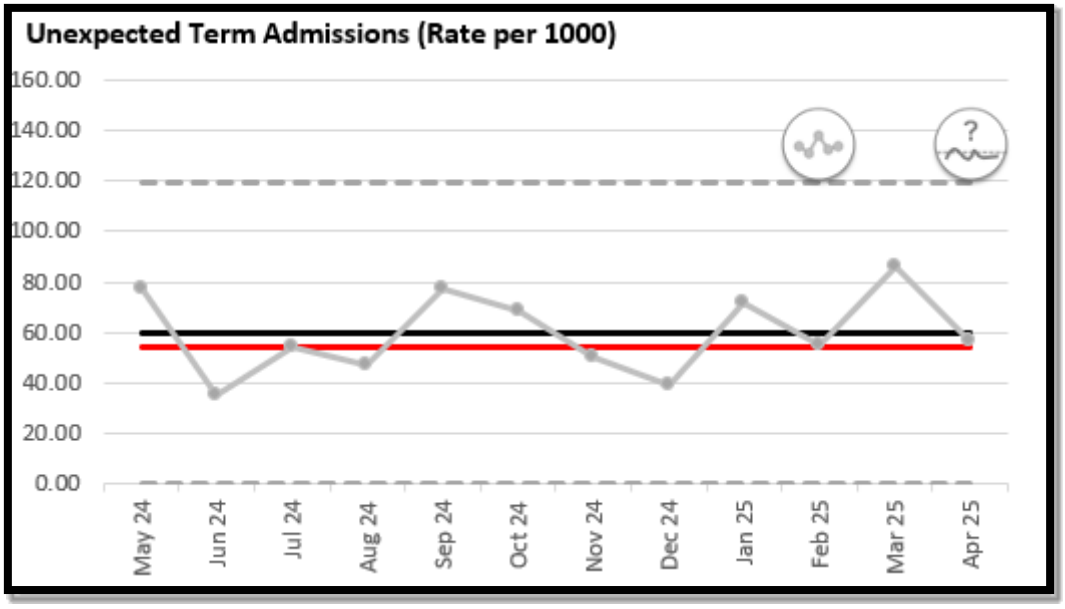


Category 1 Caesarean Sections with no Delay in Decision to Delivery interval (%). Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and knife to skin. April figures show slight improvement. 3 women out of 18 had an interval of more than 30 minutes. The times where there was a delay ranged from 31 to 62 minutes.

PPH over 2500mls (rate per 1000). There was one woman who had a PPH of over 2500mls in April (2520mls). The below SPC chart shows how WWL compare with GM (red line). The figures for this metric are recorded as rate per 1000.

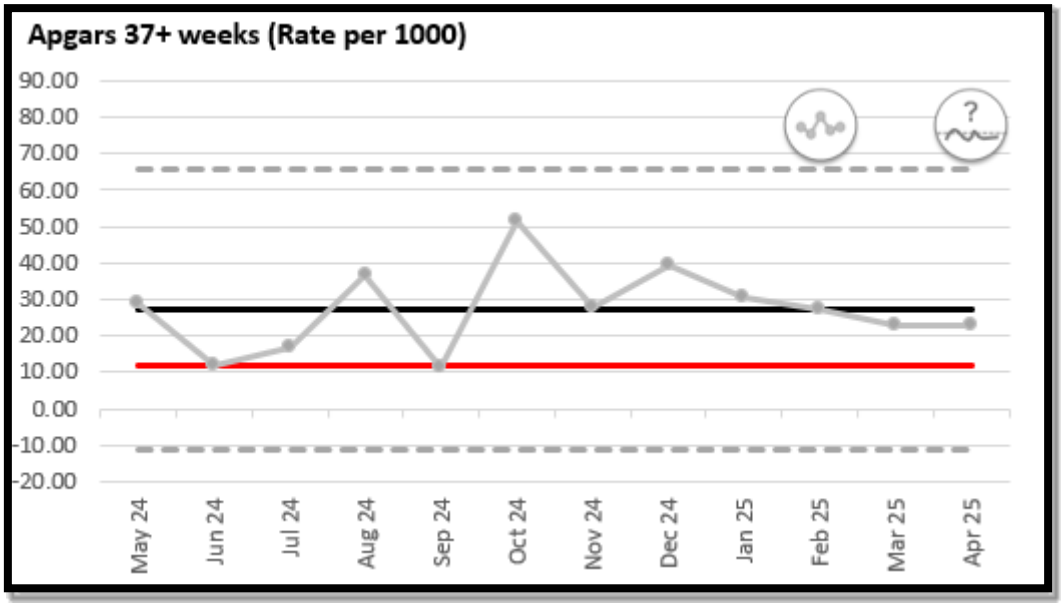


Term admissions to NNU (rate per 1000). This metric had seen a downward trend, but January and March show a spike in this metric. This figure is recorded as rate per 1000 and equates to 10 babies in April. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate and to try to improve the figures in this metric. The below is an SPC chart showing our rates in comparison to the GM average (red line).

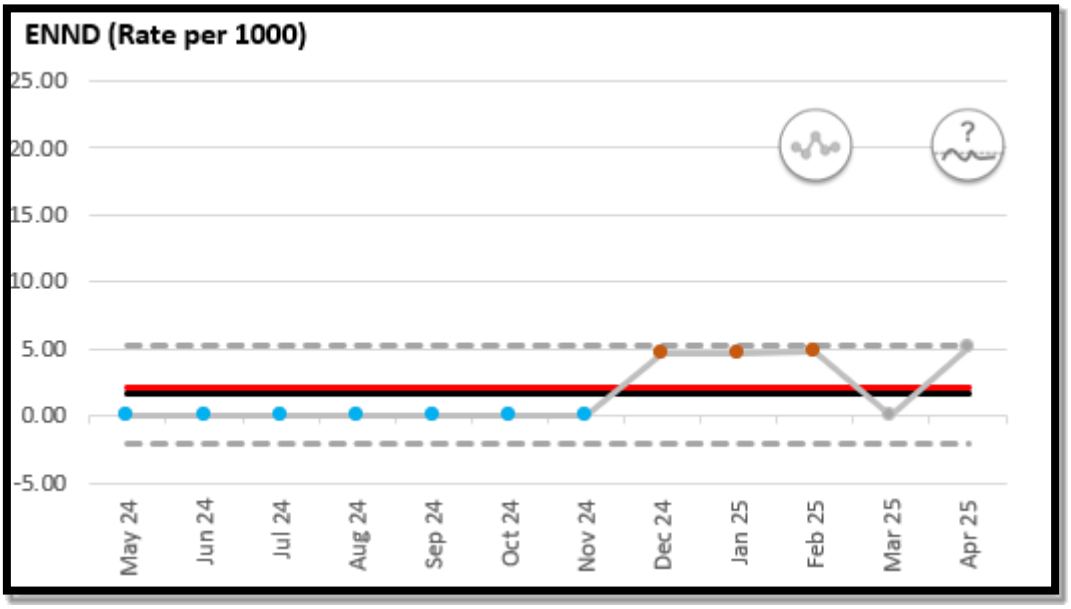


Red

All infants with Apgar's less than 7 (rate per 1000). This metric remains red and has been for 7 months. We are, however, starting to see downward trend in the rates for this metric. The rate per 1000 in April equates to 4 babies. All cases are being fully investigated by the governance team. The below SPC chart shows how our figures compare to the GM average (red line).



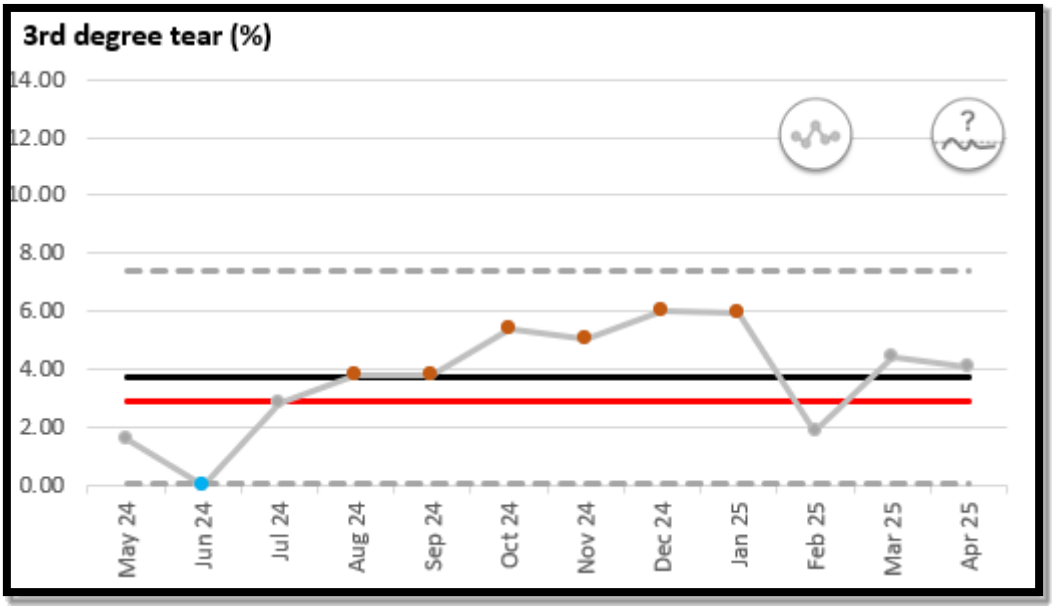
Number of Neonatal Deaths (rate per 1000). The figure is recorded as a rate per 1000. There was one ENND in March. This was a lady who had a late miscarriage at 19+ weeks and the baby showed signs of life. The below SPC chart shows how WWL compare with GM (red line).



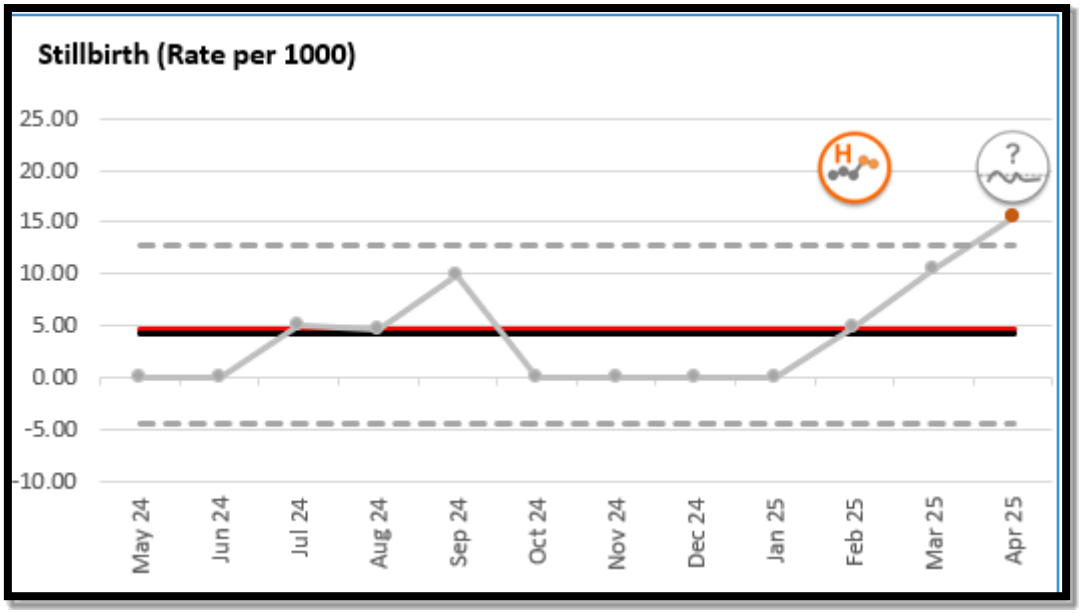
Induction of Labour (IOL) – (%) These levels have been very up and down over the past few months. February and April have seen a significant spike in cases. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes.

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 knife to skin. In April there were 8 women out of 26 who had an interval time of more than 75 mins. The times where there was a delay ranged from 76 minutes to 4 hours 14 minutes.

3rd / 4th degree tear (%). The figure is recorded as a rate per 1000. There were 5 women who had a 3rd degree tear April. The below SPC chart shows how we compare to the rest of GM for this metric. An OASI working group is continuing to look at this metric and at ways to improve it.

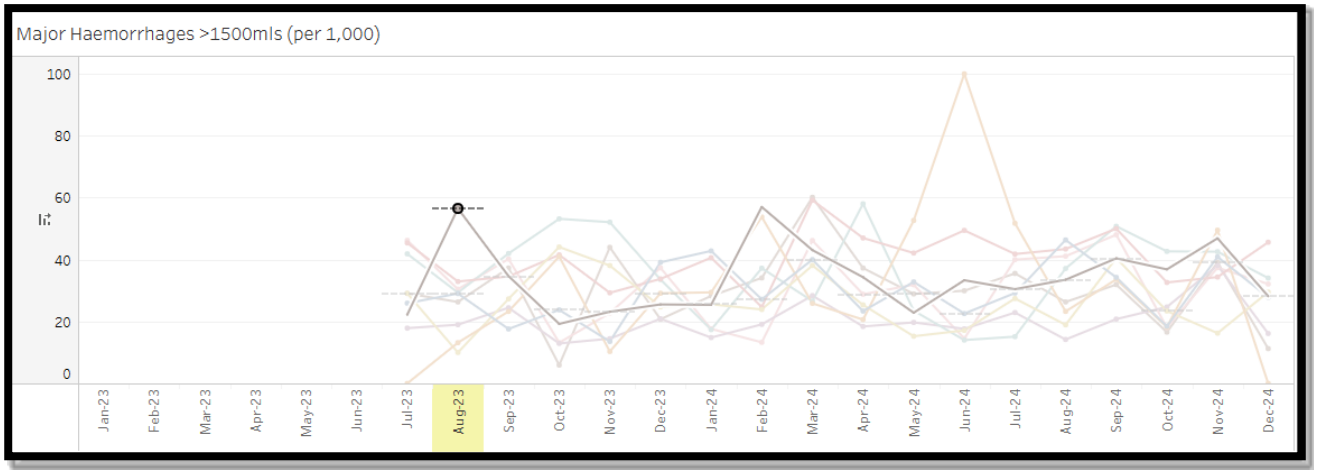


Number of stillbirths (rate per 1000). This figure is recorded as a rate per 1000. There were 3 stillbirths in March. One was a twin who has demised at 26 weeks due to TTTS and was delivered alongside a live baby at 31 weeks. The others were 25 and 31 weeks. A deep dive into these births are in progress. The below SPC chart shows how WWL compare with GM (red line).



Other areas not RAG rated

PPH 1500mls – 2500mls – The figure shown on the dashboard is shown as a rate. The rate in March equates to 12 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.



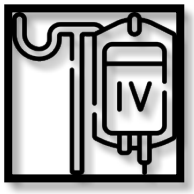
Conclusion

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 - April

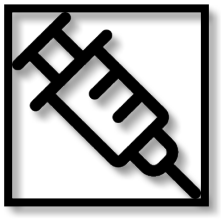
The below relates to 4 mothers who delivered 4 babies.

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



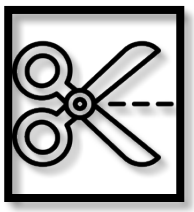
There were no babies born under 30 weeks so MgS04 24 hours prior to delivery is N/A.

All mothers were over 30 weeks but did still receive MgS04



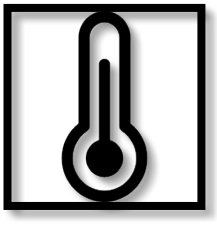
50% of babies received steroids within 7 days of delivery (< 34 weeks).

- 2 mothers received a full course.
- 1 mother received a full does but too far before delivery
- 1 mother received a partial dose.



50% received optimal cord management (< 34 weeks).

- 2 babies received delayed cord clamping at delivery.
- 1 did not receive as placenta praevia
- 1 did not receive and the reason why was not documented.



100% of babies had a Normothermic Temperature (36.5-37.5C) on admission to NNU, measured within one hour of birth (< 34 weeks).

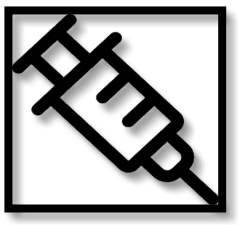
- 4 babies had a normothermic temperature taken within an hour of birth.

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

- 3 babies received EBM after 24 hours following birth.
- 1 tried to give EBM but was unable.

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

- 1 mother received IVAB's.
- 3 babies N/A as CS prior to labour.



Safety Dashboard 2025

Maternity

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

		Goal	Red Flag	Measure	2025 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 Q1	Q2	Q3	Q4	YTD	Trend
Activity	Bookings (Total bookings)				245	231																\
	Booked by 10 weeks (as % of total bookings – Exclude transfer to area)	Above 80%	Below 50%																			\
																						\
	Registerable births				214	205																\
	Planned home births (as % of all births)				0.93%	0.00%																\
	Unplanned home births (as % all births) – BBA				0.93%	0.49%																\
	NVD (as % of total births)				40.65%	46.34%																/
	Instrumental deliveries (as % of total births)				6.54%	7.32%																/
	Total number of Caesarean Sections (all categories – as % of total births)				53.74%	46.34%																\
	Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour				3	6																/
	Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour				19	21																/
	Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS				9	11																/
	Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour				4	1																\
	Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour				11	5																\
	Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS				15	8																\
	Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy				32	26																\
	Robson Group 6: Nulliparas; single breech pregnancy				5	2																\
	Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus)				5	2																\
	Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus)				6	5																\
	Robson Group 9: All women with a single oblique or transverse pregnancy (including women with a scarred uterus)				0	0																-
	Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus)				6	8																/
	Number successful VBAC				6	4																\
	% of Category 1 Caesarean Sections with no Delay in decision to delivery (over 30 minutes) – as % total cat 1 CS				72.73%	71.43%																\
	% of Category 2 Caesarean Sections with no Delay in decision to delivery (over 75 minutes) – as % total cat 2 CS				80.65%																	/
	Number of Caesarean Section at Full Dilatation				8	2																\
		Under 35.9%	Above 40%																			/

	Number of women induced when RFM is the only indication <39 weeks				0	3																	
	Number of women induced for Suspected SGA				7	9																	
	Number of In-utero transfers in from other units				4	7																	
	Number of In-utero transfers out to other units				2	2																	
	Average Postnatal Length of Stay				1.7	1.7																	
Maternal Morbidity	3rd and 4th degree tears (as % vaginal births)	Under 2.5%	Above 3.5%		5.94%	1.82%																	
	Of which 4th degree tears (number)				0	0																	
	PPH 1500 – 2500 mls (Rate per 1000)				46.73	19.51																	
	PPH > 2500mls (Rate per 1000)	Under 4	Above 6		0.00	5.00																	
	Number of Women Requiring Level 2 Critical Care				2	.																	
	Number of Women Requiring Level 3 Critical Care				0	.																	
	Number of Blood Transfusions > 4 Units				0.00%	.																	
	Number of Maternal deaths				0	0																	
	Number of women re-admitted within 28 days of delivery (Rate per 1000)	Under 25	Above 35		23.36	24.39																	
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis (Number)				0	2																	
Neonatal Morbidity and Mortality	Total stillbirths (as rate per 1000)	Under 3.5	Above 4		0.00	4.88																	
	Stillbirths (excluding MTOP as rate per 1000)				0.00	4.88																	
	Number of stillbirths (excluding MTOP)				0	1																	
	Early neonatal deaths (as rate per 1000)	Under 1	Above 1.77		9.35	4.88																	
	Early neonatal deaths (excluding MTOP as rate per 1000)				4.67	4.88																	
	Number of Early Neonatal Deaths (excluding MTOP)				2	1																	
	Number of babies born below 37 weeks				18	21																	
	Shoulder Dystocia (as % of total births)				1.87%	0.98%																	
	Number of singleton babies born under 27 weeks				0	0																	
	Number of multiple babies born under 28 weeks gestation				0	0																	
	Number of above babies where transfers out not facilitated				N/A	N/A																	
	% of Mothers who delivered under 34 weeks who received AN steroids				25%	73.00%																	
	% of Mothers who delivered under 34 weeks who received AN Magnesium Sulphate				25%	85.70%																	
	% of Mothers who delivered under 30 weeks who received AN Magnesium Sulphate				N/A	100%																	
	Number of mothers who delivered under 34 weeks who received a partial dose of steroids				1	1																	
	Number of mothers delivered under 34 weeks who did not receive any course of steroids and omissions in care noted				N/A	N/A																	
	% of babies who had delayed cord clamping (% of total births)				88.79%	88.29%																	

	% of babies born <37 weeks whose mother received intrapartum IV Antibiotics (% of births under 37 weeks)				56.25%	92.31%																	
	Neonates with Apgars <7 at 5 minutes (>_37 weeks gestation) - Rate per 1000	Under 15	Above 21		30.61	27.32																	
	Term Admissions to NNU (births >_ 37 weeks gestation) - Rate per 1000	Under 54	Above 65		71.43																		
	Number of babies re-admitted with 28 days of birth				16	18																	
	Number of babies born < 3rd centile				13	5																	
	Number of babies born < 3rd centile >_ 38 weeks				6	1																	
Public Health	% women smoking at time of booking (as % of total bookings)				7.76%	3.95%																	
		Under 8.5%	Above 10%																				
		Above 75%	Under 65%		75.23%	74.15%																	
		Above 58%	Under 50%																				
					0	1																	
Workforce	1:1 Care in Labour (as % all births - excluding El CS and BBA)		Under 100%		98.96%																		
	Percentage of shifts where shift Co-ordinator able to remain supernumerary		Under 100%																				
					0	0																	
	Sickness (as % of overall staffing) – report quarterly																						
					1.82	2.22																	
	Prospective Consultant hours on Delivery Suite				60	60																	
	Number of Midwifery Red Flags Reported				8	9																	
Incidents					87	77																	
	Number of MNSI Investigations				0	0																	
	Number of StEIS Reported Incidents				2	1																	
					3	5																	
	Number of Letters of Claim Received in the month				0	0																	
				GM average 2023 0.555/1000	0	0																	

Safety Dashboard 2025

Neonatal

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	
Safety	% of Shifts Staffed to BAPM	100.00%	< 90%	Badger	100%	90.74%	84.21%	94.64%									
	% of Shifts with Supernumeary Shift Leader	100.00%	< 50%	Badger	98.36%	94.44%	94.74%	98.21%									
	Unit Closed Due to Capacity	0	≥ 1	Datix	0	1											
	Unit Closed Due to BAPM/Staffing	0	≥ 1	Datix	0	0											
Admissions	Number of Births from Maternity			Maternity Data	214	205	191	195									
	Admissions Under 27 Weeks to NNU	< 1	≥ 1	Badger	0	0	0	0									
	Admissions 27+1 – 34 Weeks to NNU			Badger	2	8	2	4									
	Total Admissions to Neonatal Unit			Badger	25	28	30	20									
	Transitional Care Admissions: 34 – 36+6			Badger	2	4	1	2.00									
	Transitional Care Admissions: 37+			Badger	11	9	17	8.00									
	Total TC Admissions			Badger	13	13	18	10.00									
	Postnatal Ward IVAB admissions 34-36+6 weeks			Badger	2	1	1										
	Postnatal Ward IVAB admissions over 37 weeks			Badger	10	8											
	Number of unexpected Term Admissions to NNU				14	10	15	10									
	Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)	5.4%	≥ 6.5%	Maternity/Badger	7.14%	5.46%	8.60%	5.60%									
	Unexpected Term Admissions to NNU (*as % of Total Admissions*)			Badger/ NWNODN	56.00%	35.70%	50%	50.00%									
	Mothers Eligible for AN Steroids (*< 34 Weeks*)			NNAP/ NWNODN	2	7	2	4									
	% of Mothers Who Received Full Course of Antenatal Steroids	≥ 93%	< 89%	NNAP/ NWNODN	50.00%	57.10%	50.00%	50.00%									
	Mothers Eligible for AN $MgSO_4$ (*< 30 Weeks*)			NNAP/ NWNODN	0	1	0	0									
	% of Mothers Receiving Antenatal $MgSO_4$	≥ 85%	< 73%	NNAP/ NWNODN	N/A	100.00%	N/A	N/A									
	Babies Eligible for Delayed Cord Clamping			NNAP/ NWNODN	2	11	2.00	4.00									
	% of Babies Receiving Delayed Cord Clamping	≥ 85%	< 73%	NNAP/ NWNODN	100.00%	72.72%	100%	50%									
	Babies Eligible for Temperature on Admission (*< 32 Weeks*)			NNAP/ NWNODN	2	11	2	4									
	% of Babies With Temperature Within First Hour of Admission (*< 32 Weeks*)			NNAP/ NWNODN	100%	100%	50%	100%									

NNAP	% of Babies With Temperature on Admission of 36.5°C – 37.5°C (*< 32 Weeks*)			NNAP/ NWNODN	100%	100%	50%	75%															
	Babies Eligible for Senior Review			NNAP/ NWNODN	24	27	24	18															
	Number of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	23	25	24	17															
	% of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	95.80%	92.59%	100.00%	94.40%															
	Total Ward Rounds Where Parents Present			NNAP/ NWNODN	28	33	130	184															
	% of Ward Rounds Where Parents Present			NNAP/ NWNODN	64.20%	62.30%	60.50%	74.20%															
	% of Eligible Babies Reciving Retinopathy Screening (*ROP*)			NNAP/ NWNODN	75.00%	N/A	N/A	50.00%															
	% of Babies With Central Line Blood Infections			NNAP/ NWNODN	0.00%	0.00%	0.00%	0.00%															
	Babies Eligible for Follow-Up At 2 Years			NNAP/ NWNODN	2	N/A	N/A	2															
	% of Babies Receiving Follow-Up At 2 Years			NNAP/ NWNODN	100%	N/A	N/A	0%															
Incidents	Number of Incidents Reported			Datix	15	21	25																
	Number of Network Exception Reports			NWNODN	2	-																	
	Number of Concise Investigations	0	≥ 1	Datix	0	0	0	0															
	Number of StEIS Reported Incidents	0	≥ 1	Datix	0	0	0	0															
	Number of Complaints	< 2	≥ 2	Datix	0	0	0	0															
	Number of Letters of Claim Received	0	≥ 1	Datix	0	0	0	0															
Breastfeeding	% of Mothers Expressing Breast Milk in First 24 Hours Following Baby's Admission to NNU			Unicef/ NWNODN	16.00%	67.90%	53.30%	50.00%															
	% of Babies Receiving Human Milk in First 24 Hours Following Admission to Neonatal Unit			Unicef/ NWNODN	16.00%	67.90%	43.30%	45.00%															
	% of Babies Receiving Human Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	37.50%	57.90%	69.70%	57.90%															
	% of Mothers Expressing Breast Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	12.50%	21.10%	54.50%	15.80%															
	% of Mothers Breastfeeding on Discharge from Neonatal Unit			Unicef/ NWNODN	25.00%	47.40%	54.50%	42.10%															
	Number of Babies Eligible to Receive Breast Milk in the First Two Days of Life (*< 34 Weeks*)			NNAP/ NWNODN	2	11	2	4															
	% of Babies < 34 Weeks Receiving Breast Milk in First Two Days of Life			NNAP/ NWNODN	50.00%	100.00%	50.00%	75.00%															
	Number of Babies < 34 Weeks Eligible for Breast Milk at Day 14			NNAP/ NWNODN	4	1	8	4															
	% of Babies < 34 Weeks Receiving Breast Milk at Day 14			NNAP/ NWNODN	100.00%	100.00%	100.00%	75.00%															
	Number of Babies < 34 Weeks Eligible for Breast Milk at Discharge			NNAP/ NWNODN	6	1	7	5															
	% of Babies < 34 Weeks Receiving Breast Milk at Discharge			NNAP/ NWNODN	66.70%	0.00%	100.00%	80.00%															
	Care Days ICU (*HRG1*)			Badger	3	19	16	1															
	Care Days HDU (*HRG2*)			Badger	39	20	83	57															

Activity	Care Days SC (*HRG3, HRG4, HRG5, and code9*)			Badger	155	158	148	239															
	Cot Capacity ICU %			Badger	9.67%	68.85%	51.61%	3.33%															
	Cot Capacity HDU %			Badger	41.93%	23.80%	89.20%	63.33%															
	Cot Capacity SC %			Badger	50.00%	56.42%	47.70%	79.66%															
	Overall Cot Capacity %			Badger	45.39%	50.25%	56.91%	70.71%															
	Care Days TC (*HRG3*)			Badger	0	0	0	0															
	Care Days TC (*HRG4*)			Badger	56	35	50	30															
	Care Days TC (*HRG5*)			Badger	0	0	0	0															
	Care Days TC (*code 9*)			Badger	12	6	1	2															
	Total TC Care Days			Badger	68	41	51	32															
	Care Days PN (HRG3)			Badger	7	3	0																
	Care Days PN (HRG4)			Badger	32	32	30																
	Care Days PN (HRG5)			Badger	0	0	0																
	Care Days PN (code 9)			Badger	1	1	0																
	Total PN Care Days (IVAB) Days			Badger	40	36	30																
	Total TC & PN Care Days			Badger	108	77	81																
	Overall TC Cot Capacity %			Badger	54.84%	36.61%																	
Training	NLS Accrediated	≥ 70%	< 70%	WWL	97.60%	97.60%																	
	NLS In-House	≥ 90%	< 90%	WWL	97.70%	100.00%																	
	Qualified In Speciality of Intensive Neonates	≥ 70%	< 70%	WWL	87.00%	89.10%																	
	Foundation In Neonates	≥ 70%	< 70%	WWL	95.70%	96.20%																	
	Family Intergrated Care	≥ 85%	< 85%	WWL	100.00%	100.00%																	
	Unicef BFI	100%	< 80%	WWL	96.00%	100.00%																	
	Perinatal Mental Health	≥ 80%	< 80%	HEE	100.00%	100.00%																	

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Perinatal Quality Surveillance Full Report (Q4 2024-2025, Jan-March 25)
Presented to:	Board of Directors
On:	4th June 2025
Purpose	Information
Presented by:	n/a – Consent agenda
Prepared by:	Eve Broadhurst Head of Governance Maternity and Child Health for Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	T: 01942 822993 E: eve.broadhurst@wwl.nhs.uk

Executive summary

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

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations.

Individual risks are discussed within the report for each metric and area.

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)

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

Key Findings

Incidents

Maternity/Obstetrics

There were 6 moderate or above harm incidents in maternity/obstetrics in Q4 which is higher than in previous quarters.
1 of the moderate harm incidents involved harm to staff in the course of their duties. RIDDOR reported.
2 of the moderate harm incidents have been managed in Division – bladder injury at LSCS and injury to baby following forceps birth.
3 of the moderate or above harm incidents have been escalated to LfPSE and will require further investigation within the PSIRF - Intrauterine death with care or service delivery issues, fractured skull following baby drop, and delay in diagnosis of pre-eclampsia (scheduled for LfPSE in April 25).
Duty of Candour – 100% compliant.

Neonates

There were 0 moderate or above harm incidents in neonatology in Q4 and 0 incidents requiring escalation via the PSIRF.

Exceptions

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

Reminder to be sent to all staff that the incident location is the area the baby was transferred to the neonatal unit from and NOT the neonatal unit. This is falsely inflating the number of neonatal incidents.

Investigations

The report details all learning from approved investigations and actions will be monitored via Trust LfEG. There have been no completed investigations presented at LfPSE in Q4.
There have been no eligible MNSI cases for referral to NHS Resolution since 15.8.2023.
5 incidents were logged on 'StEIS' for monitoring purposes in Q4 and will be investigated in line with PSIRF (3 of these incidents occurred before Q4).
WEB167940 – SIAF – now closed by NHSE
WEB169230 – SIAF - now closed by NHSE
WEB173059 – For PMRT – 22+4 twin death.
WEB175888 – PSII – Dropped baby
WEB176473 – For PMRT – Antenatal stillbirth

No exceptions

Feedback and complaints

In Q4 24/25, 13 formal complaints have been received for maternity services, which is higher than previous quarters. Of these 13 complaints, 3 were resolved informally as concerns due to the quick action of staff members.
0 complaints were received for neonatal services.
There is an upward trend in the number of formal complaints received over the rolling 12-month period in maternity services, with neonatal service complaints remaining very low.
A wealth of positive feedback has been collated from service users via the MNVP and the P&PE midwife and has been fed back to staff.
FFT response rates slightly increased in Q4 with a 97.2.% positive response rate. Themes from negative comments were related to staff being noisy and appointment waiting times in the antenatal clinic.

There has been a marked increase in the number of women accessing the Birth Thoughts service with no clear rationale or theme identified.
The Picker action plan was presented at PEEG in March 25.
No Exceptions.

SCORE survey
WWL Maternity and Neonatal services participated the SCORE staff survey to get a better understanding of team culture and engagement. 169 members of staff responded to the survey, giving a response rate of 54%. Analysis of the SCORE survey was undertaken in Q2.
Boo Consultancy have been working with the Maternity Services in Q4. Drop in session dates have been circulated with a bespoke day for 7s and above, with a focus on wellbeing.

Risks
The Risk Register has been included for maternity and neonatal services.
At the end of Q4 24/25,
0 risks under review.
1 risks awaiting approval - NEO 4189 No immediate availability of video laryngoscope on the neonatal unit 12
0 risk approved
0 risks closed
Exceptions
Work continues with low scoring risks. There are 6 risks scoring 6 or less which are under review to establish if can be tolerated or require further action. The Trust tolerance risk score has just increased so risks scoring 8-10 will need to be reviewed.

Ockenden 2
Q4 24/25 has seen progress against the actions.
The MIAA Ockenden 2 audit has been completed, and the result was substantial assurance given.
Exceptions - 2 actions remain outstanding; both are in progress. All action leads have been asked to provide regular updates on their actions.

Maternity Incentive scheme
CNST MIS Year 6 was published on the 2nd April 2024, and we work closely with the LMNS for shared oversight and quality assurance. Final submission was on 3 March 2025 and WWL Maternity and Neonatal Services have received confirmation of full compliance. CNST MIS Year 7 is due for release on the 2nd April 2025.
No exceptions

ATAIN
In Q3, the total number of term admissions to the NNU was 5.31% of total term live births. This is a decrease from Q2 6.34%
Unexpected term admissions to the NNU accounted for 5.14% of total term live births. This is a decrease from Q2 5.97%
There is still work to be done with 7 (22.5%) of total admissions being potentially avoidable.
The findings and recommendations from audit are shared in the body of the report.
Recommendations include;
Continue to audit all Apgars less than 7 at 5, to identify and correlate themes.
Continue to use the new neonatal resuscitation scribe sheet
Embed the use of the new resuscitation scribe sheet into neonatal resuscitation skills drills

Discuss regional guidance for clinical escalation and consider adopting at WWL
Continue to embed RCOG escalation toolkit in all midwifery training.
The thermoregulation sticker has been moved in the notes, to ensure it prompts midwives to think about temperature and warm care bundle as part of resuscitation and effective documentation.
Present the findings to the clinical teams to support dissemination of the learning.
No exceptions

Mortality and PMRT
There were 3 stillbirths in Q4 2024. 1 required escalation to LfPSE as potentially avoidable.
There were 2 reportable early neonatal deaths (within 1st week of life) in Q4 24/25. 1 was following MTOP for fetal anomaly. 1 was following a spontaneous birth, not under care of WWL.
There was a further 17 week loss that was documented as a neonatal death however this does not meet MBRRACE reporting criteria as less than 20 weeks.
Themes
Maternal age ≥30 years
Maternal BMI ≥ 30.
4 of the 5 losses were from the lowest 2 deciles.

In Q4 24/25, 1 case was finalised at PMRT. No FH at 25 weeks at routine antenatal appointment. No learning identified. Grade A & A.
No exceptions

Saving Babies Lives 3
The report provides a full gap analysis of our progress against SBL 3 targets. The LMNS has reported significant assurance with 87% compliance (target 70%) in Q2. Work continues and the midwifery sonography service was commenced in Q3 to further support the SBL agenda.
No exceptions

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

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

Mandatory training
Training compliance for individual staff groups is in the body of the report.
Exceptions
Prompt training has fallen below 90% compliance for Consultant Obstetricians and MSWs in Q4.
3 Consultant obstetricians have booked onto training for PROMPT on 4/4/25, 3 MSWs have also booked on which will take us out of amber and into green status.

Workforce/ Safe staffing

At the end of Q4, there are 6.67 WTE midwifery vacancies, and 2.74 WTE MSW vacancies.
At the end of Q4, there are 0.06 WTE neonatal nurse vacancies, and 0.64 Band 3 HCA vacancies.

Staffing Red Flags
In Q4 2024/2025 there were 21 validated staffing red flag events which is a decrease from Q3.
The significant majority of staffing red flags in Q4 were due to a delay between admission and commencing the induction of labour process (15 cases) largely due to staffing shortages caused by short term sickness. Escalation was in line with Trust guidance and there was no harm reported.

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

GM benchmarking data
Between Jan 24 and Dec 24, WWL performed better than GMEC average for rates of major obstetric haemorrhage >2500mls, pre-term births, stillbirths, early neonatal deaths and neonates with confirmed diagnosis of HIE 2 & 3 at term.

SPC charts (until end Q4 24/25)
The SPC charts below are a more up to date and useful tool to review our own progress and position against GMEC average over time. The charts below give assurance of continued improvement and QI work continues in all areas and themes and trends monitored.

In the last rolling 12 months the parameters outside the GMEC mean are for term admissions to the NNU, 3rd degree tears and Apgars <7 at 5 minutes.

In line with the PSIRF, data and learning from incidents is reviewed to inform QI work and workstreams have been set up for PPH >1500mls, OASI (3rd and 4th degree tears) and LocSSIP. ATAIN reviews are undertaken weekly with an overarching QI action plan to drive improvement work and an overall downward trend in the number of admissions is noted. Themed analysis is underway to identify areas for improvement in relation to Apgars <7 at 5 minutes. Rates of Apgars <7 at 5 have improved in Q4 but the gap between GMEC and WWL remains marked. An emerging theme relating to low Apgar scores was following induction of labour; WWL have reached out to the Royal Bolton Hospital as they have undertaken a piece of work in relation to induction of labour. An improvement initiative on neonatal resuscitation is underway supported by the Governance Team. 3rd degree tear rates stabilised in January 2025 and there has been an overall decrease in Q4 2025.
No exceptions

LMNS Outlier Assurance
No requests from the LMNS for data assurance were made in Q4.
No exceptions

Maternity Perinatal Quality Surveillance Full Report

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

1. Obstetrics/Maternity Incidents occurring in Q4 – Severity (data pull 23/04/2025 - DATIX)

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
No Harm	64	71	45	57	67	48	49	55	66	58	57	61
Low	10	7	15	14	5	18	6	7	7	9	6	5
Moderate	0	1	0	0	0	0	0	1	2	1	3	1
Severe	0	0	0	0	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	1	0
Total	**74**	**79**	**60**	**71**	**72**	**66**	**55**	**63**	**75**	**68**	**66**	**67**

There were 6 moderate or above harm incidents in maternity/obstetrics in Q4 which is higher than in previous quarters.

1 of the moderate harm incidents involved harm to staff in the course of their duties. RIDDOR reported.

2 of the moderate harm incidents have been managed in Division – bladder injury at LSCS and injury to baby following forceps birth.

3 of the moderate or above harm incidents have been escalated to LfPSE and will require further investigation within the PSIRF - Intrauterine death with care or service delivery issues, fractured skull following baby drop, and delay in diagnosis of pre-eclampsia (scheduled for LfPSE in April 25).

Duty of Candour – 100% compliant.

1.1 Neonatal Incidents occurring in Q4 – Severity (data pull 23/04/2025 – DATIX)

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
No Harm	42	26	8	3	4	12	7	14	12	10	21	24
Low	1	3	1	0	0	2	0	0	0	2	1	0
Moderate	0	0	0	0	0	0	0	0	0	0	0	0
Severe	0	0	0	0	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total	**43**	**29**	**9**	**3**	**4**	**14**	**7**	**14**	**12**	**12**	**22**	**24**

There were 0 moderate or above harm incidents in neonatology in Q4 and 0 incidents requiring escalation in the PSIRF.

Exceptions

162 incidents are under investigation in obstetrics/maternity.

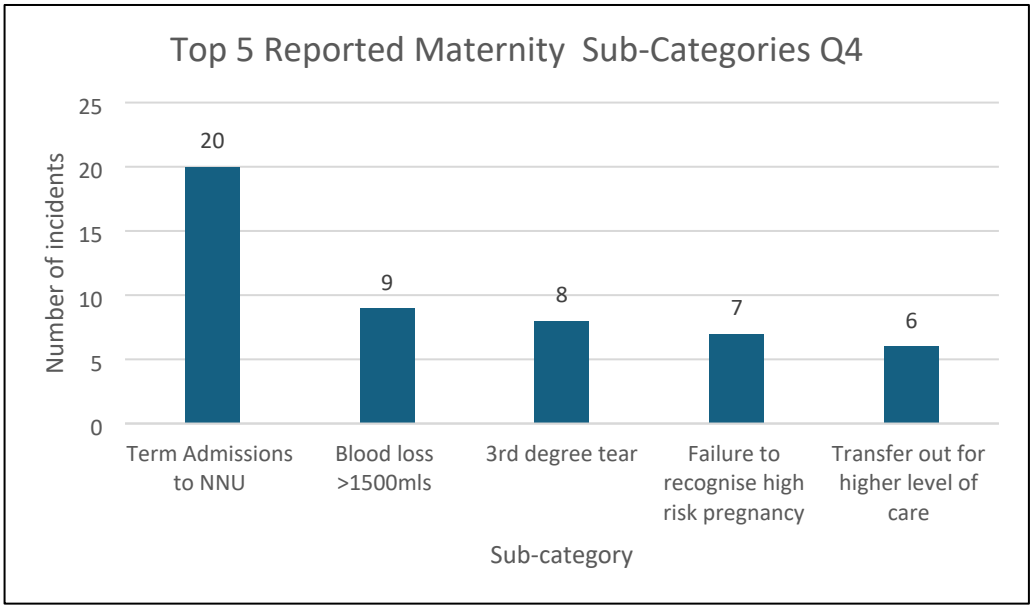
26 incidents are under investigation in neonatology.

All incidents are triaged in Division daily.

Ongoing support given to staff to complete within 10 days of incident.

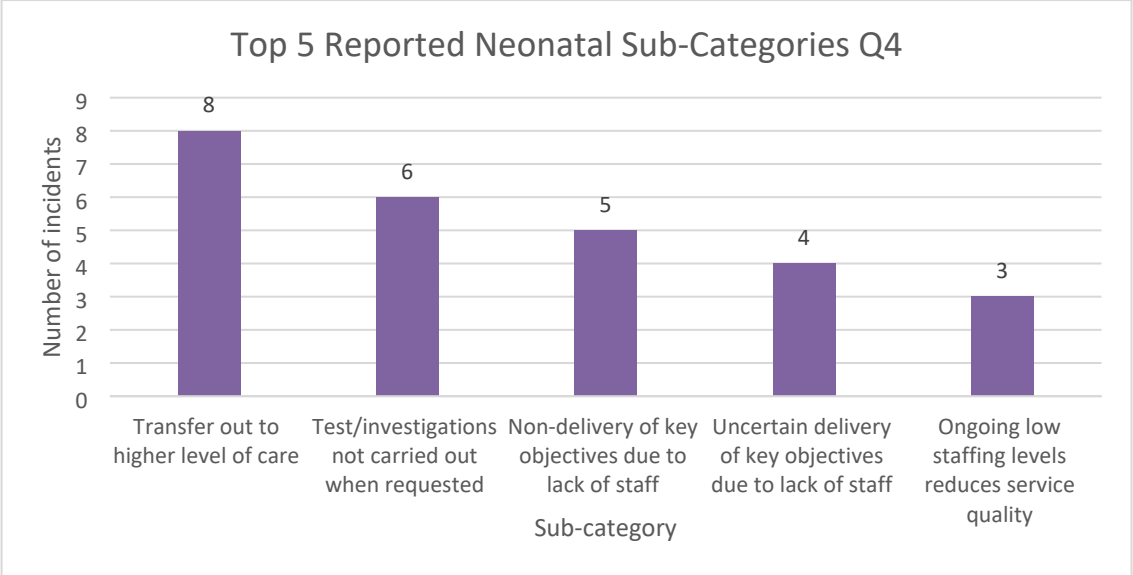
Reminder to be sent to all staff that the incident location is the area the baby was transferred to the neonatal unit from and NOT the neonatal unit. This is falsely inflating the number of neonatal incidents.

1.12 Top 5 Reported Incident Sub-Categories Maternity– Q4 24/25 (data pull 23/04/2025 - DATIX)



Workstreams are in place for the review of term admissions to the NNU, Blood loss >1500mls, undiagnosed SGA and in Q3 a new workstream to look at the rising trajectory for 3rd degree tears was set-up which is ongoing.

1.13 Top 5 Reported Incident sub-categories Neonatology – Q4 24/25 (data pull 23/04/2025 DATIX)



Staffing continues to be the main reporting sub-category of incidents reported. All incidents reported were no/low harm.

1.14 Incidents reported to 'StEIS' and external agencies Q4 24/25

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Incidents reported to 'StEIS' via LfPSE	2	0	1	1	0	0	0	0	0	3	0	2
MNSI referrals	0	0	0	1	0	0	0	0	0	0	0	0
Accepted MNSI referrals	0	0	0	0	0	0	0	0	0	0	0	0
Cases referred to NHSR	0	0	0	0	0	0	0	0	0	0	0	0
SIAFs (Antenatal and newborn screening)	-	-	-	0	0	0	1	0	1	0	0	0

5 incidents were logged on 'StEIS' for monitoring purposes in Q4 and will be investigated in line with PSIRF (3 of these incidents occurred before Q4).

WEB167940 – SIAF – now closed by NHSE

WEB169230 – SIAF - now closed by NHSE

WEB173059 – For PMRT – 22+4 twin death.

WEB175888 – PSII – Dropped baby

WEB176473 – For PMRT – Antenatal stillbirth

No incidents met the MNSI referral criteria

No exceptions

1.15 MNSI overview

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

No cases were referred to MNSI in Q4 24/25.

There are no open MNSI cases at the end of Q4 24/25.

The next MNSI QRM will be held in June 2025 with the just Governance Team and DDOM due to lack of cases.

1.16 MNSI /NHSR assurance Maternity Incentive Scheme Year 6 reporting period

There have been no eligible cases for referral to MNSI/NHS Resolution since 15/08/2023. MIS Year 7 will be published on the 02/04/2025 and assurance data will continue to be provided. on the table below as cases occur.

Advise, Resolve, Learn – MNSI / NHSR

MIS Year 7 reporting period 1.12.2024 - 30.11.2025

MNSI REF	Criteria	Date of incident	MNSI /NHSR Duty of Candour complete	Accepted / Rejected by MNSI	Details to legal for NHSR referral	NHSR REF

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

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

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

No Exceptions

1.17 Learning from completed investigations

In Q4 24/25, 0 completed investigations were approved at LfPSE. Action plans will be monitored via LfEG.

1.18 Investigation progress – overview of open investigations

At the end of Q4, 4 PSIIs are open and 1 review is awaiting presentation at LfPSE.

WEB number	Date	Incident	Progress	Stage	Plan
PSIRF					
WEB156568 StEIS 2024/3444	Feb 24	Suspected co-sleeping death at home	RR presented at LfPSE	Inquest complete Jan 25	To complete joint PMRT with Bolton
WEB173059 LfPSE 2025/653	Dec 24	Death of twin 22 +4 born in DGH	RR presented at LfPSE	Preliminary PMRT completed	To complete joint PMRT with St Mary's hospital
WEB175888 LfPSE 2025/1400	Feb 25	Dropped baby	RR presented at LfPSE	Interviews	Due in Division 4/5/2025. PSII due for presentation at LfPSE 22/05/2025
WEB176473	Feb 25	Antenatal stillbirth	RR presented at LfPSE	Preliminary PMRT completed	For full PMRT

WEB177375	Mar 25	Delay in diagnosis of pre-eclampsia	RR completed	Take through Divisional processes	Present at LfPSE in April to confirm further review method.

Exceptions

No exceptions.

1.19 Regulation 28

There were no Regulation 28s issued in Q4

1.2 New claims

0 new claims in Q4

1.21 Triangulating data – Claims, Incidents, Complaints

On a quarterly basis, the Trust's Scorecard is reviewed alongside incident and complaint data and themes triangulated. In Q4 the themes identified were Fail/delay treatment and Unnecessary pain. Actions are instigated based on the findings.

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

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

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust
Advise, Resolve, Learn

Triangulation Q4 2024-25

Fail/delay treatment – delays in IOL, delay following up UPCR – severe pre-eclampsia, UtAD result not reviewed – 28-week scan not arranged - antenatal stillbirth
Unnecessary pain – dropped baby, inadequate pain relief after LSCS x 2, during LSCS X 1.

Learning Q4 2024-25

Treat all people with dignity and respect
Ensure clear processes in ANC for review following UtAD
Work with laboratory to see if urgent urine results can be phoned through
Need to ensure that results are followed up daily in ANC

Complaints Q4 2024-25 (10 formal complaints, 3 handled as concerns)

Communication - Process at appointment re routine enquiry, frustration in the process for admission for IOL and delays, informed of incorrect cervical dilatation, lack of update with management of labour, communication regarding care in labour, unfair referral to social services, misrepresentation of the NIPE screen as a mandatory requirement.
Values and behaviours – Dismissive and unhelpful attitude when making an appointment, discriminatory treatment due to perceived age gap in parents' relationship, potential breach of GDPR.
Patient care – Not acknowledging individual with autism.
Clinical treatment – Decision for an instrumental delivery, delay in IOL, delays in providing analgesia after an emergency caesarean X2, management of intravenous access .

Actions Q3 2024-5

ADHD/ASD Mandatory Training	By 31/4/2026 KO	
Liaise with lab re urgent urine results and any improvement work possible	By 31/06/2025 LH (SS)	
Review clinic processes and ensure daily test follow-up	By 31/06/2025 SD	
Liaise with sonography to ensure robust process following UtAD scan for follow up.	By 31/06/2025 SD	

Incidents Q4 2024-25 6 moderate or above harm incidents

1 involved harm to staff in the course of their duties (RIDDOR). 1 X bladder injury at LSCS. 1X injury to baby at forceps. 1X dropped baby, 1X stillbirth –UtAD result not reviewed missed opportunity for scan from 28 weeks, 1X delay following up UPCR – severe pre-eclampsia.

2. Patient and staff experience Q4 24-25.

2.1 Patient and Public Engagement

A wealth of positive feedback has been collated from service users from ward visits, in-patient survey and the MNVP Thank you Thursday, and has been fed back to **27** individual midwifery and medical team members.

The P&PE midwife has visited **30** women in Q4 on the Maternity Ward who have had emergency procedures during their birth and a further **10** women whilst completing the WWL in-patient survey.

In Q4 24/25 there has been 100% positive feedback given about the care that had been received. Themes of positive feedback were values and behaviour, clinical treatment and good communication and support.

22.5% identified areas for improvement for the Maternity service, themes were communication, continuity of carer during antenatal care, clinical treatment, record keeping and availability of contact numbers. Feedback is given to individual leaders of the service/ department involved to manage, including the sonography department.

The P&PE midwife manages an overarching action plan based on service improvement feedback.

The **Birth Thoughts** service has seen an increase of referrals in Q4 by 46% compared to the average of 2024 referrals. The P&P engagement midwife is unable to identify any one reason why this may be. It has also been noted that 24% of the appointments so far this year have generated further actions for the midwives, there have not been any themes identified. These actions have included arranging discussions with individual staff members, actions for the Delivery suite, Maternity ward and Theatre team via the area leaders, incident reporting via Datix, referral for mental health care and anaesthetic appointment and facilitating individual queries to be answered by a consultant.

2.1.1 Examples of positive feedback received by the P&PE midwife from ward visits

Fantastic, phenomenal care. Cannot praise staff enough. Good explanation of care/ reassuring.
Absolutely brilliant, above and beyond. Everyone so good and calming.
Fabulous care I cannot fault it.
Cannot fault care. Staff helpful, continuity from midwives on the ward which was great. Staff in labour were helpful and supportive.
Last baby during Covid, so amazing experience.
Would like to increase wages. Supportive staff all outstanding including NNU.
Everyone helpful, supportive, informative, took time to explain information. Had a negative hospital experience in the past but this has more than made up for that.

Borderline personality disorder, upset at time of visit feeling over stimulated had a GA section, had been in pain and very frightened. When I called back the next day, this lady was feeling much better and appreciative of the support and care she has been given by staff

Care second to none, has felt supported.

Felt welcome, like staff wanted to help. Did not feel alone when partner went home able to ask for help. Flexibility given with partner

Overall - fantastic.

All staff friendly and approachable, felt comfortable. Good support from staff. I cannot fault the care.

Good quality care, happy with it. Midwives kind, supportive, on it, and not judged.

Made me feel comfortable and explained everything. Been brilliant.

Explained everything - brilliant care. Chaos but everything ran so smooth - reassured and supported. Cannot fault anyone.

All positive, incredible and amazing care. Everyone has been so good.

Everything perfect, feel well cared for. Feel like 7 stars compared to their own country.

Very, very lovely, wasn't expecting this as a healthcare worker myself.

2.2 MNVP engagement

Walk the Patch visit was completed on 17th January and 28th February 2025 by the MNVP Lead. On the 17th of January 12 service users were spoken with during the visit (of these, 25% were non-white ethnic origin, 25% receiving transitional care). On the 28th of February 25, 10 service users were spoken to during this visit (of these, 20% were of a non-white ethnic origin)

Q4 - Positive Feedback from MNVP Walk the Patch (Maternity Ward and Neonatal Unit)
Very friendly staff, good CoC. Midwives remember from previous pregnancy which 'made me feel looked after'.
Explanations/ communications have been good, information at the right time.
Quick to answer buzzers
Partners have felt included in decision making and information sharing
Triage was a good experience – were accommodating
Felt that Drs explained what was happening throughout birth experience
IFT have been excellent
'Nothing could have been better' 'Nothing has been too much trouble' 'Staff have been really helpful'
Consultant led care – prepared for a long wait for section (low risk) but it was explained fully so felt ok
Chose RAEI over neighbouring units due to past trauma
NNU care has been a good experience – 'really put the care and effort in'.
Whole hospital feels very clean
Smoking cessation service is great
When service users were able to build relationships with midwives antenatally, feedback is much more positive
Q4 - Areas for improvement from the MNVP Walk the Patch (Maternity Ward and Neonatal Unit)
Parking has continued to be highlighted as an issue, (one service user described as 'hell on earth')

Long waits at TLC x 5 (especially between scan and Consultant). Waiting rooms reported to be uncomfortable when heavily pregnant
Communication with community midwives has been difficult, appointments seem limited, some reported seeing multiple midwives antenatally
Partner unable to stay overnight. Impacted anxiety and could have helped care for the baby.
Dilation checks limited; triage was not a good experience – felt midwife on the phone was not reassuring enough; felt overwhelming.
Partner reported a long wait to be let into the ward.
Felt BF support at night was not as good as during the day. Felt pressured to keep a feeding schedule; conflicting advice from HCP.
Some confusion about who would provide formula for first feeds, was not prepared in advance for this or would have bought in.
Was on the ward for antenatal monitoring. Had been admitted previously due to Hg. First time was a good experience. This time not as good – did not feel listened to and felt that she was a nuisance.
Long wait for induction
Reports of delays to discharge – various reasons including screening not completed.
Some staff were not empathetic overnight x2

2.3 Elective Section Patient Survey – February 2025

As Elective section numbers are increasing, the Inpatient and Antenatal Clinic Matron had requested the survey. This was to understand the reasons why, and to improve the overall experience for service users, the survey was co-produced between the MNVP and the P&P engagement midwife. It was launched in January for a total of 4 weeks. Surveys were completed in- person or online and 52 responses were received.

The main aim of the survey was to understand if there are any service improvements that we can put in place to reduce the number of sections e.g. earlier and improved communication regarding VBAC clinics, improved debrief following sections.

Findings will be shared in the next report.

2.4 Friends and Family Test source Envoy 24.04.2025

	Responses	Positive
Antenatal	7	6
Birth	54	54
Postnatal Community	19	19
Postnatal Ward	68	65
Total	**148**	**144**

There has been a slight increase in responses in Q4 as compared to Q3

Positive FFT comments

144 out of 148 comments were positive, giving an overall positive response rate of **97.2%** which again is a slight improvement on Q3.

Negative FFT comments

- Waiting times are excessive.
- Consider changing opening hours so consultants start work no later than 15 minutes after 1st scan of the day (not an hour). Everyone is only ever going to be late going into their follow on appointment. respect peoples time. it is not fair to give an appointment time knowing it is never going to be then and also double booking timeslots.
- Be Quiet. Staff were shouting and joking so couldn't sleep. All talking in the office loudly and swearing at night.
- Staff in the back office were laughing and screeching whilst we waited and waited to go home. Asked twice and I was told they were very busy.

Work is underway to gather patient feedback specific to the Antenatal and Newborn Screening Service to inform service improvement on the back of NHS England recommendations.

Work is underway to access neonatal unit patient feedback which is not collected via Envoy.

2.5 National Picker Maternity Survey (Patient Survey)

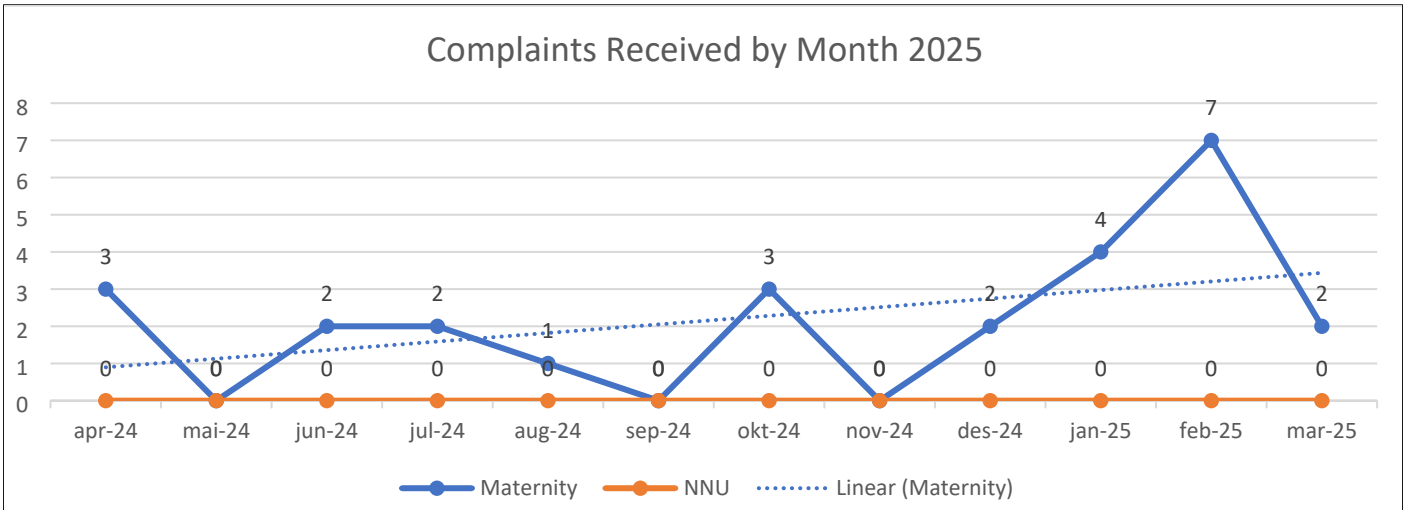
The results of the 2024 National Picker Maternity survey were received in Q2.
The CQC have released the national survey results officially in December 24.
The results are incredibly positive for WWL.

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

The action plan was presented at the PEEG meeting in March 25.

2.6 Complaints

Formal Complaints	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Maternity	3	0	2	2	1	0	3	0	2	4	7	2
NNU	0	0	0	0	0	0	0	0	0	0	0	0



In Q4 24/25, 13 complaints have been received for maternity services, which is higher than previous quarters. Of these 13 complaints, 3 were resolved informally as concerns due to the prompt action of staff.

0 complaints were received for neonatal services.

Themes from complaints

Q4	Jan	Feb	Mar	Total
Appointments	1	1		**2**
Communication	3	4		**7**
Clinical Treatment	1	3	3	**7**
Values and Behaviours	1	2		**3**
Patient Care			1	**1**
Privacy and Dignity			1	**1**
Trust Admin Policies			1	**1**

Appointments (2)

- Complaint raised concerns at not receiving an Anti D appointment
- Concerns that there was no ultrasound appointment postnatally to check for retained placenta

Communication (7)

- Concern raised around process at appointment re the opportunity to make a routine enquiry regarding domestic abuse.
- Complaint raised frustration in the process for admission for IOL
- Concern with being informed of incorrect cervical dilatation
- Concerns about lack of update with management of labour
- Concerns expressed regarding communication regarding care in labour
- Concerns about unfair referral to social services

- Extensive concerns regarding the misrepresentation of the newborn physical examination as a mandatory requirement.

Clinical Treatment (7)

- Complaint raised around decision for an instrumental delivery
- Complaint received over delay in IOL
- Complaint raised around delays in providing analgesia after an emergency caesarean
- Concern re appropriateness to break waters during the induction process
- Extensive concerns regarding anaesthesia and analgesia during and after caesarean
- Complaint around treatment post caesarean resulting in extensive bruising and infection
- Extensive concerns regarding management of intravenous access

Values and Behaviours (3)

- Complaint raised around dismissive and unhelpful attitude when making an appointment
- Concerns raised around discriminatory treatment by the perceived age gap in parents' relationship
- Concerns raised regarding a potential breach of GDPR

Patient Care (1)

- Concern raised around not acknowledging an individual with autism.

Privacy and Dignity (1)

- Complaint at the little privacy and dignity between bed areas, sometimes having to pass next to people through the curtain

Trust Admin Policies (1)

- A concern has been raised that the Trust does not have a minute taker with shorthand experience to notate meetings

No Exceptions

2.6 SCORE staff survey

The SCORE survey is a measure of culture and engagement in the workplace. 169 members of staff across maternity and neonatal services responded to the survey, giving a response rate of 54%.

Analysis of the SCORE survey was undertaken in Q2.

Boo Consultancy have been working with the Maternity Services in Q4. Drop in session dates have been circulated with a bespoke day for 7s and above, with a focus on wellbeing.

3. Risk register – Maternity and neonatal services

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

Under review	-	-	-	-

Awaiting approval	NEO	4189	No immediate availability of video laryngoscope on the neonatal unit	12
Approved	MAT	3772	Euroking System Error	20
	MAT		Lack of End-to-End Maternity Patient Record	12
	MAT	3802	Obstetrics/Gynaecology Tier 2 Staffing Shortages	12
	MAT	3605	Obstetricians and Gynaecologists on call rotas not allocating compensatory rest	12
	NEO	1977	Specialist AHP services should be available in all units for neurodevelopment and family integrated care	12
	MAT	4003	Inability to provide ultrasound scanning within 24 hours (SBL 3)	10
	MAT	3780	Maternity Ligature Risk	5
	MAT	3732	Entonox Risk	9
	MAT	1469	The risk of abduction from the maternity unit	8
	MAT	3756	Medical Devices Training	8
	MAT	3727	Euroking To PAS Error Risk	6
	MAT	3400	Screening for GBS at 36 weeks gestation in women with a history of GBS (group B beta-haemolytic streptococcus) infection	6
	NEO	1975	BAPM staffing guidelines - Staff shortages on the Neonatal unit	6
	MAT	140	Backflow of raw sewage due to blocked drains	6
	MAT	2459	Transportation and supply of Entonox (Nitrous oxide 50% and oxygen 50%) by Community Midwives for use at Homebirths	4
	MAT	3362	Midwifery Staffing Shortages	4

At the end of Q4 24/25,

0 risks **under review.**
1 risks **awaiting approval** NEO 4189 No immediate availability of video laryngoscope on the neonatal unit 12
0 risk **approved**
0 risks **closed**

Exceptions

Work continues with low scoring risks. There are 6 risks scoring 6 or less which are under review to establish if can be tolerated or require further action. The Trust tolerance score has just increased so risks scoring 8-10 will need to be reviewed.

4. Ockenden 2 progress update

Q4 Update		Local Actions			N/A	Trust Corp Action	National/ regional Action
		Red	Amber	Green			
EA1	Workforce planning and sustainability	0	2	6			3
EA2	Safe staffing	0	0	9			1
EA3	Escalation and accountability	0	0	5			
EA4	Clinical governance-leadership	0	0	6		1	
EA5	Clinical governance – incident investigation and complaints	0	0	7			
EA6	Learning from maternal deaths	0	0	2			1
EA7	Multidisciplinary training	0	0	7			
EA8	Complex antenatal care	0	0	4			1
EA9	Preterm birth	0	0	4			
EA10	Labour and birth	0	0	4	2		
EA11	Obstetric anaesthesia	0	0	7			1
EA12	Postnatal care	0	0	4			
EA13	Bereavement care	0	0	4			
EA14	Neonatal care	0	0	5			3
EA15	Supporting families	0	0	3			
	Total	0	2	77	2	1	10

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

Q4 24/25 has seen progress against the actions and 2 remain outstanding.

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

Exceptions - 2 actions remain, all are in progress. All action leads have been asked to provide regular updates on their actions.

5. CNST - Maternity Incentive Scheme Year 6

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

MIS Year 6 was published on the 2nd of April 2024, and WWL works closely with the LMNS for shared oversight and quality assurance. The final submission date was 3rd March 2025 and WWL Maternity and Neonatal services have now had confirmation of **full compliance** with all Safety Actions. The next report will focus on progress against CNST year 7, which is due for publication on the 2nd of April 2025.

Safety Action Requirements:

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

Key:

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

No exceptions

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q3 24/25

	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU	TARGET
Sept – Dec 2024	602	32 (5.31%)	31 (5.14%)	7 (22.5%)	**<4.6%**

In Q3, the total number of term admissions to the NNU was 5.31% of total term live births. This is a decrease from Q2 6.34%

Unexpected term admissions to the NNU accounted for 5.14% of total term live births. This is a decrease from Q2 5.97%

There is still work to be done with 7 (22.5%) of total admissions being potentially avoidable.

Findings from Q3 audit

- Rates of term admissions to the NNU are on an overall downward trajectory
- The highest cause of admission in Q3 was respiratory distress (57.6%)
- 9 of the unexpected term admissions had Apgars less than 7 at 5 (29%). In 4 of these cases there was evidence of delay in escalation and support during resuscitation and in 2 cases inadequate documentation to evidence if the NLS algorithm was followed.
- There were 4 instances where the new neonatal resuscitation was completed ineffectively, lack of information, incorrect terminology or lack of evidence to support the NLS algorithm.
- 51.61% of unexpected term admissions were born by ELCS.
- 50% of the unexpected term admissions born by ELCS were born less than 39 weeks.
- There was no correlation between birth centile and NNU admission
- The Warm Care Bundle sticker was not used consistently, and 4 (12%) of babies were hypothermic and 5 (16%) did not have a temperature taken at birth.

Recommendations

Continue to audit all Apgars less than 7 at 5, to identify and correlate themes.
Continue to use the new neonatal resuscitation scribe
Embed the use of the new resuscitation scribe sheet into neonatal resuscitation skills drills
Discuss regional guidance for clinical escalation and consider adopting at WWL
Continue to embed RCOG escalation toolkit in all midwifery training.
The thermoregulation sticker has been moved in the notes, to ensure it prompts midwives to think about temperature and warm care bundle as part of resuscitation and effective documentation.
Present the findings to the clinical teams to support dissemination of the learning.

No exceptions

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

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Total births	**204**	**223**	**181**	**202**	**211**	**203**	**192**	**194**	**216**	**214**	**205**	**191**
Total Stillbirths	**1**	**0**	**0**	**1**	**1**	**2**	**0**	**0**	**0**	**0**	**1**	**2**

Stillbirths adjusted for MTOP	1	0	0	0	0	1	0	0	0	0	1	1
Total late fetal loss 22 – 23+6	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Total Neonatal Deaths (≥ 20 weeks)	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**0**
Early neonatal deaths (0-7 days)	0	1	0	0	0	0	0	0	1	1	1	0
Neonatal deaths adjusted for MTOP	0	0	0	0	0	0	0	0	1	1	1	0
Total Maternal Deaths	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

7.1 Stillbirths

There were 3 stillbirths in Q4 2024.

2025	Type Stillbirth	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
Feb	Antenatal	30+5	White British	2	25	43	No	No	0	The patient did not have a midwife review after her positive UtAD scan. No consultant review after a positive UtAD at FAS, the UtAD pathway states growth scans from 28wks. There was a missed opportunity to determine	Escalated to LfPSE. For PMRT

										fetal wellbeing at 28 weeks gestation.	
Mar	MTOP	27	White/Any other Asian	1	36	32	No	No	0.8	No learning	Not eligible for PMRT
Mar	Antenatal	33	White British	1	23	23	Smoker – did not engage with Stop Smoking Services Reports - uses E-cig.	No	91	Incidental learning - There was frequent attendance at Triage (11 times-sporadic) with abdominal pain – this patient would have benefited from a consultant review for an overview of care as complex patient	For PMRT

It has been identified that in Q4 there have been 10 medical terminations of pregnancy ranging from 13 weeks to 27 weeks gestation which is an increase from previous years. Of the 6 occurring in March there were 3 confirmed T21, 1 confirmed Edwards', 1 Congenital Diaphragmatic Hernia and 1 Triploid. There are no themes identified in terms of time of year, ethnicity or age in these women.

7.2 Neonatal Deaths

There were 2 reportable early neonatal deaths (within 1st week of life) in Q4 24/25. 1 was following MTOP for fetal anomaly. 1 was following a spontaneous birth, not under care of WWL.

There was a further 17 week loss that was documented as a neonatal death however this does not meet MBRRACE reporting criteria as less than 20 weeks.

All losses were below 22 weeks and are therefore not eligible for PMRT.

2025	Type of NND	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
Jan	Early (MTOP)	20+3	White Any other Background	7	30	25	No	No	Not recorded	None. MTOP due to fetal anomaly	Not eligible for PMRT <22 weeks
Feb	Early	21+3	Black African	1	26	-	No	-	Not recorded	None. Did not book at WWL. Antenatal care at Bolton. Attended with PV bleed and spontaneous labour	Not eligible for PMRT <22 weeks

Themes

Maternal age ≥30 years

Maternal BMI ≥ 30.

4 of the 5 losses were from the lowest 2 deciles.

7.3 PMRT and MIS Year 7 compliance data source MBRRACE

In Q4 24/25, 1 cases were finalised at PMRT. No FH at 25 weeks at routine antenatal appointment. No learning identified. Grade A & A.

Case (date of death)	Standard 1 Notify all deaths within 7 working days	Standard 2 Seek parents' views of care: For at least 95% of all the deaths of babies	Standard 3a 95% of reviews to be started in 2 months of death	Standard 3b Minimum of 60% MDT reviews to be completed/published within 6 months
29/03/25	Met (4 day)	Not yet met	Not yet met	Due 29/09/25
10/03/25	Notification only			
28/02/25	Met (1 day)	Met	Met	Due 28/08/25
13/02/25	Met (1 day)	Not suitable for review		
15/01/25	Notification only			
09/12/24	Met (1 day)	Met	Met	Due 09/06/25

No exceptions

8. Saving Babies Lives (SBL) audit Q4

Element	RAG	Compliancy/ Improvement Plan
Element 1- reducing smoking in pregnancy		CO at booking (97%), CO at 36 weeks (99%) and CO at every antenatal contact (82%). Pregnant smokers were referred to an inhouse smoking cessation service appropriately (94%). The service was below target for pregnant smokers setting a quit date (39%) and non-smokers at 36 week appointment (39%). Out of the 32 smokers still smoking at 36 weeks- 16 never had a face-to-face appointment, with the opportunity for intervention at dating scan missed. Since December, the smokefree team have endeavoured to provide an intervention at dating scan if required and are currently developing this service. 88% of smokers at delivery were White British and 12% of Eastern European heritage. 47% of smokers at delivery were from the most deprived areas (dep 1) and 69% from dep 1 and dep 2. 88% had at least 1 complex social factor (dep 1, mental health, substance use, social services involvement, non-English speaking, domestic violence), and 50% had more than one.
Element 2- risk assessment and surveillance for fetal growth restriction		Audit completed monthly. All SFH and scan plotted correctly, Digital grow is now in full use. Scan accuracy no longer investigated as part of SGA Babies. Face to face training for SFH measurement and plotting, grow 2.0 digital plotting. Trends, equality, ethnicity all used in audits.
Element 3- Raising awareness of reduced fetal movements.		Audit shows Dawes Redman above SBL parameter of 80%. Next working day scan is 78.7% which is below minimum of 90% but demonstrating an upward trajectory. Sonographer aide was now available within the service. IOL figures for RFM alone currently not available due to sickness in SBL team
Element 4- Effective fetal monitoring during labour		Number of staff with up-to-date training for CTG is 95%. SBL parameter is 80% Number of audited records that had a risk assessment completed at onset of labour is 98%- SBL parameter is 90%. Maternal and fetal wellbeing hourly review is 98% - SBL parameter is 90. Fresh eye review within the time frame and CTG categorisation with escalation is 99%. SBL parameter is 90%.
Element 5- Preterm Births.		All optimisation interventions are 86% - SBL parameter is >60% which is a significant improvement. Data is small sample of women in category, if some women don't receive a metric, factors affect percentages and can fluctuate results massively. Preterm birth clinic has been running for 12 months, and a12-month audit of the preterm birth clinic is currently being done. Work on the use of Actim Partus and correct assessment of threatened preterm labour in triage remains on going
Element 6 – Diabetes in Pregnancy.		Clinic template for one stop clinic. All women with type 1 and type 2 diabetes are offered CGM, 100% of women with type 1 are using (stretch target 95%). All women (100%) with type 1 and type 2 diabetes in the third trimester have had their HbA1c measured (stretch target 95%).
SBL training Elements 1-6.		96% midwives compliant with element eLearning modules and 85% of obstetricians. Face to face training 80% compliance for midwives and obstetricians to attend from April 2025. Non-compliant staff contacted via e mail and face to face to address any ongoing issues with access, time allocation or learning challenges. GROW 2.0 training continues.

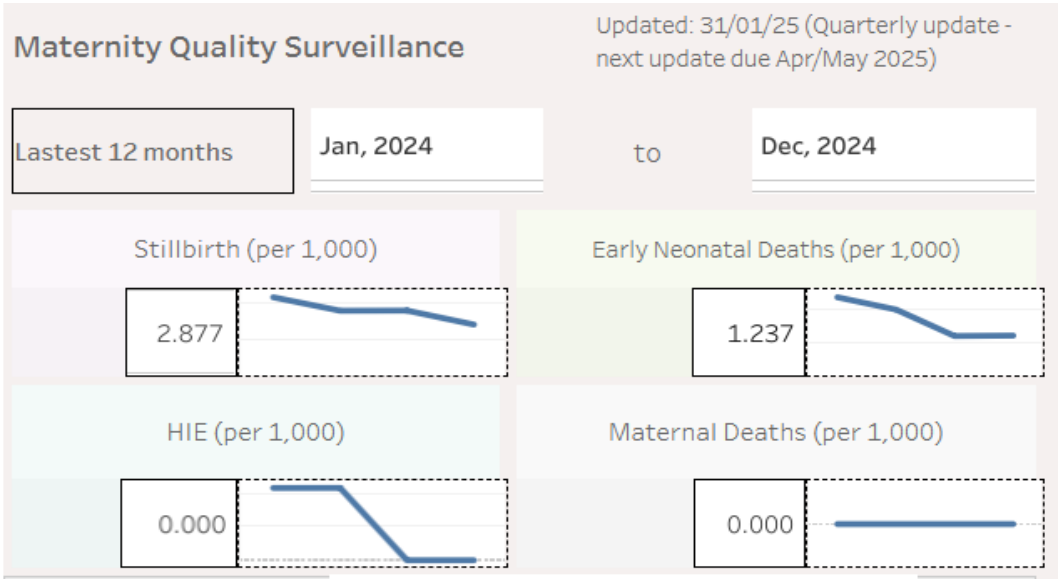
9 GMEC LMNS Ambition

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

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

9.1 WWL rates against GMEC ambition – October 2024 - September 2024

WWL measures its progress against the National and GMEC LMNS ambition. Over this rolling 12 period, stillbirth and early neonatal death data has continued a steady decline. Data for the rate of maternal deaths & HIE is positive and within national targets. It is vital that we continue to monitor, learn and improve to sustain this figure.



10. Mandatory Training Compliance Midwifery

	Number attended	Percentage of staff	Rolling percent
BLS	36	22.08%	94%
NLS	36	22.085	94%
PROMPT	33	20.49%	91%
Fetal Physiology	41	25.46%	98%

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

No exceptions

10.1 Mandatory Training Compliance Other Specialities

	PROMPT		Fetal Physiology	
	Number attended	Rolling percentage	Number attended	Rolling percentage
Consultant Obstetrician	1	83%	4	92%
Obstetric registrar	4	93%	2	100%
Anaesthetist	2	94%		
MSW	7	89%		

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

Exceptions

3 Consultant obstetricians have booked onto training for PROMPT on 4/4/25, 3 MSWs have also booked on which will take us out of amber and into green status.

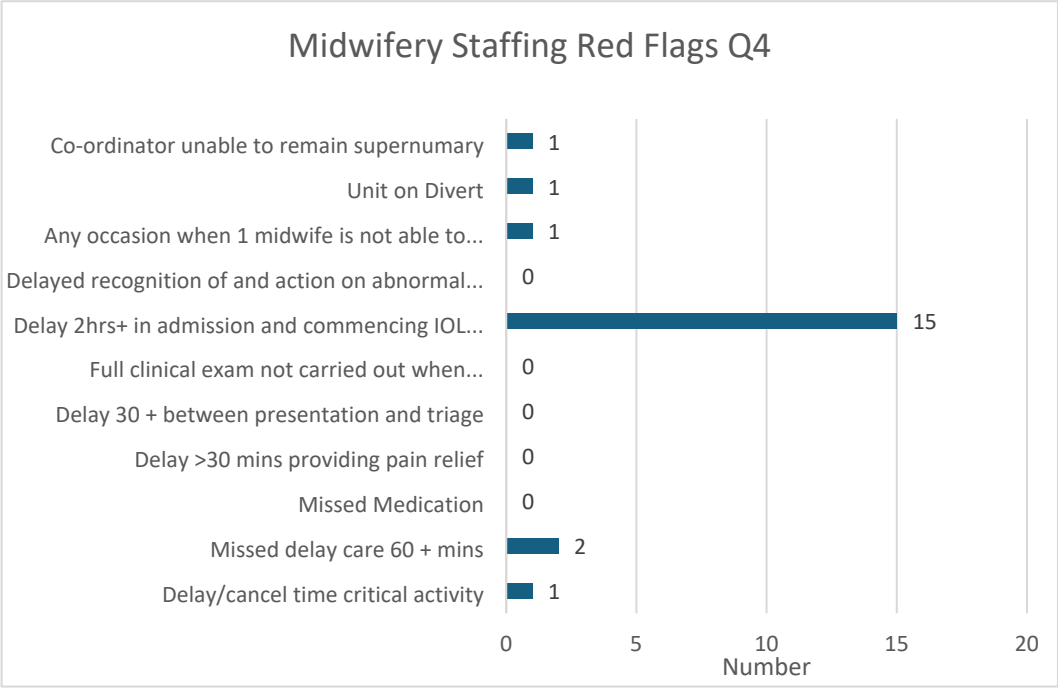
11. Workforce / Safe staffing

At the end of Q4, there are 6.67 WTE midwifery vacancies, and 2.74 WTE MSW vacancies.

At the end of Q4, there are 0.06 WTE neonatal nurse vacancies, and 0.64 Band 3 HCA vacancies.

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

In Q4 2024/2025 there were 21 validated staffing red flag events which is a decrease from Q3.
The significant majority of staffing red flags in Q4 were due to a delay between admission and commencing the induction of labour process (15 cases) largely due to staffing shortages caused by short term sickness. Escalation was in line with Trust guidance and there was no harm reported.



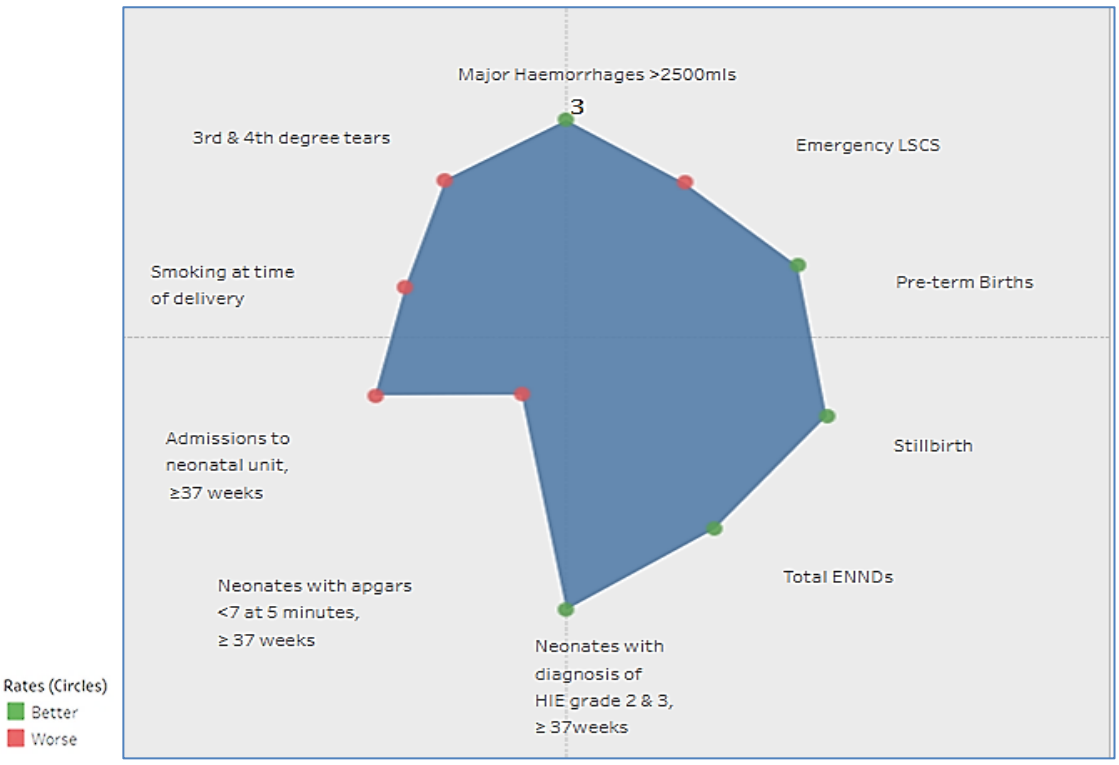
11.2 Maternity Unit Diverts

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

Letters of apology were sent to all 3 women.

Graded as low harm.

12. WWL data as compared to GMEC using spidergraph - rolling 12 months (Jan 24 – Dec 24)



Between Jan 24 and Dec 24, WWL performed better than GMEC average for rates of major obstetric haemorrhage >2500mls, pre-term births, stillbirths, early neonatal deaths and neonates with confirmed diagnosis of HIE 2 & 3 at term.

12.2 Statistical Process Control charts Q4 24/25

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

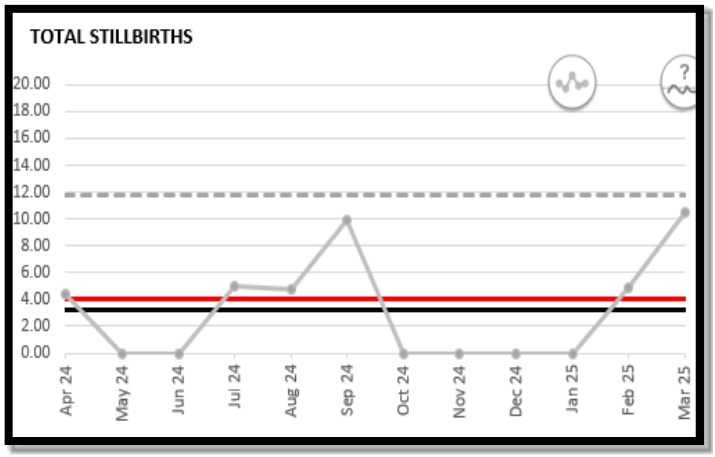
In the last rolling 12 months the parameters outside the GMEC mean are for term admissions to the NNU, 3rd degree tears and Apgars <7 at 5 minutes.

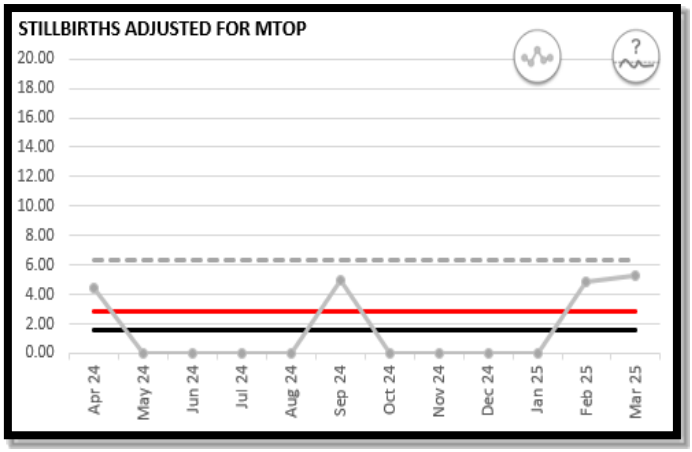
In line with the PSIRF, data and learning from incidents is reviewed to inform QI work and workstreams have been set up for PPH >1500mls, OASI (3rd and 4th degree tears) and LocSSIP. ATAIN reviews are undertaken weekly with an overarching QI action plan to drive improvement work and an overall downward trend in the number of admissions is noted. Themed analysis is underway to identify areas for improvement in relation to Apgars <7 at 5 minutes. Rates of Apgars <7 at 5 have improved in Q4 but the gap between GMEC and WWL remains marked. An emerging theme relating to low Apgar scores was following induction of labour; WWL have reached out to the Royal Bolton Hospital as they have undertaken a piece of work in relation to induction of labour. An improvement initiative on neonatal

resuscitation is underway supported by the Governance Team. 3rd degree tear rates stabilised in January 2025 and there has been an overall decrease in Q4 2025.

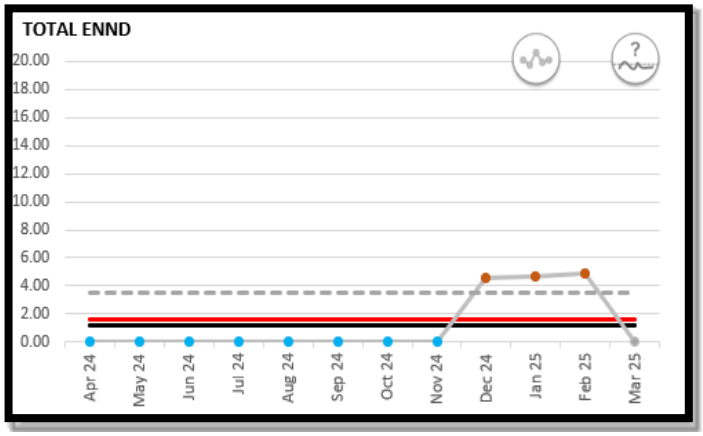
The black line shows WWL mean.

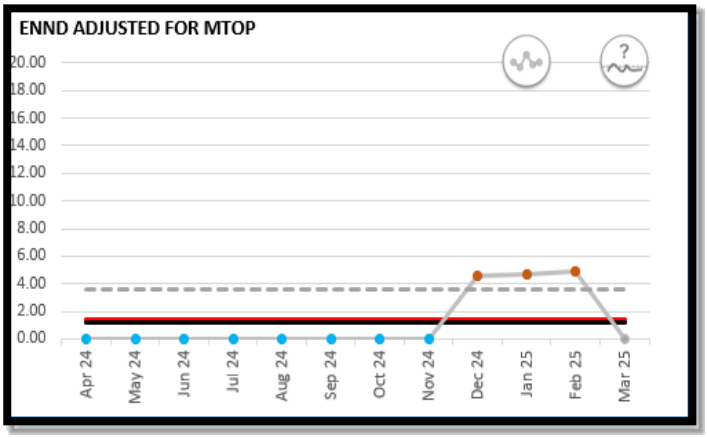
The red line shows GM mean.



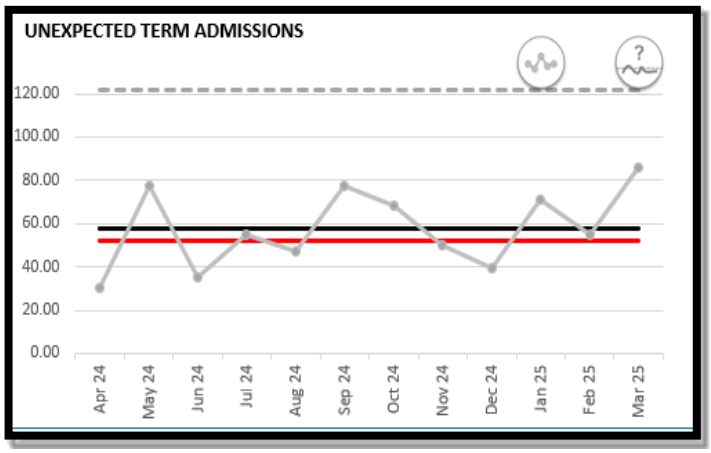


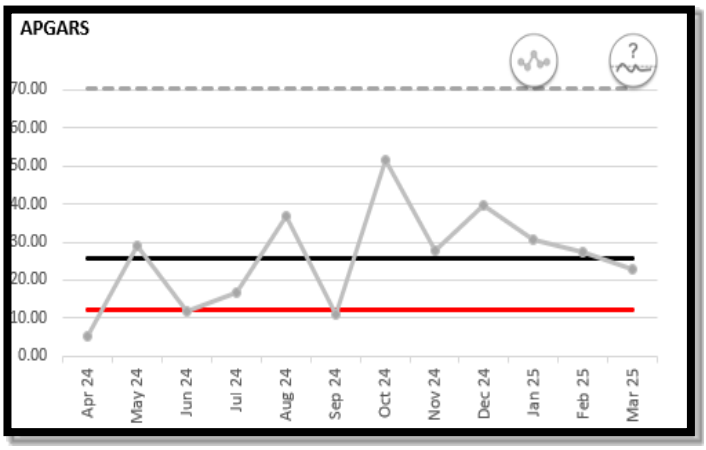
The first of the above two charts shows the total number of stillbirths. The second shows revised figures where medical termination of pregnancy (MTOP) is not included. All figures are shown as a rate per 1000.
There were 3 stillbirths in Q4, 1 of which was an MTOP.



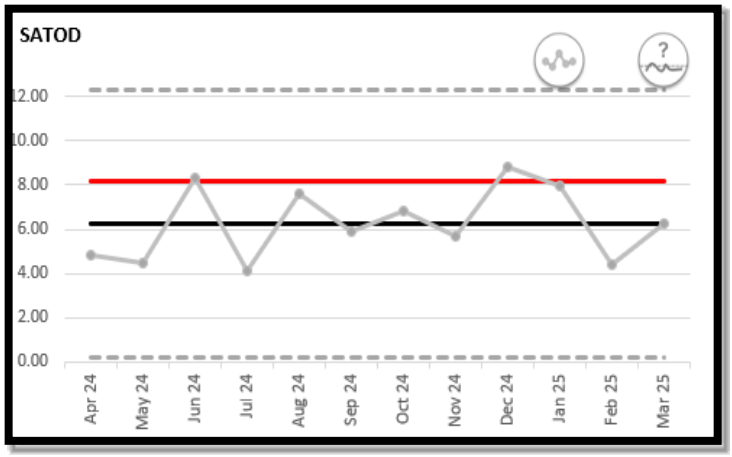


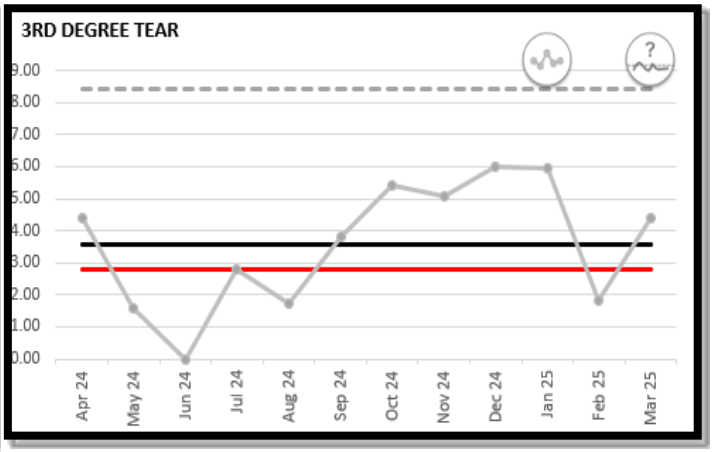
The first of the above two charts shows the total number of early neonatal deaths (ENND). ENND refers to deaths in the first week of life from 20 weeks. The second shows revised figures where MTOP is not included. The figures are shown as rate per 1000.
There were 2 ENND in Q4, 0 of which were following MTOP.





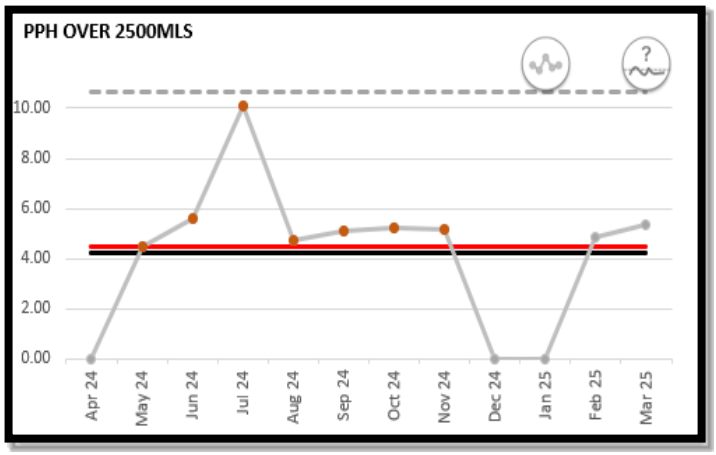
There has been an overall downward trend and significant progress to reduce the gap between WWL Term Admission to NNNU performance and the GMEC mean.
The Apgar score data is shown as a rate per 1000. Themed analysis is underway with a view to identifying learning to support improvement. Emerging themes are the correlation between induction of labour and Apgar scores <7 @5. This metric will continue to be monitored. We remain an outlier against the GMEC mean.

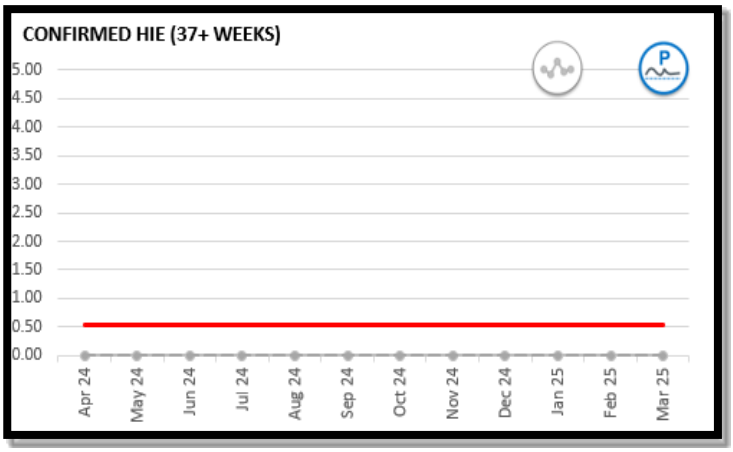




There has been a steady downward trajectory over this rolling 12-month period. All SBL 3 initiatives are on track. Smoking At Time of Delivery figures are shown as a %.

The OASI bundle was rolled out on 2 April 24 to improve outcomes. Initial findings saw a decrease in the number of tears however this has not been sustained. An OASI working group was set up in Jan 25 to explore progress with OASI & to embed QI work. Recent improvements in data (shown as a %age of vaginal births) noted. There were 12 3rd degree tears in Q4.





The WWL mean is better than the GMEC mean in this rolling 12-month period. In Q4 WWL joined Obs UK PPH research trial. In Q4 2 women had a PPH >2500 mls.

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

12.3 Outlier assurance data Q4 24/25

No data escalation assurance has been requested in Q4 24/25.

Summary

WWL has received confirmation of full compliance against all 10 Safety Actions for MIS Year 6. MIS Year 7 is due for publication on the 2nd April 2025 and progress will be reported via the PSQM.

A rise in moderate or above harm incidents was noted in Q4. Escalation has been in line with the PSIRF.
WWL has received a vast amount of positive feedback. However, a rise in maternity complaints was also noted in Q4 with main themes of communication and clinical treatment. The demand for the Birth Thoughts service is increasing and this needs to be monitored to inform how the service responds to this increased demand.

3rd degree tear rates stabilised in January 2025 and there has been an overall decrease in Q4 2025. Rates of Apgars <7 at 5 have improved in Q4 but the gap between GMEC and WWL remains marked. An emerging theme relating to low Apgar scores was following induction of labour; WWL have reached out to the Royal Bolton Hospital as they have undertaken a piece of work in relation to induction of labour. Another link was neonatal resuscitation and QI work is underway supported by the ATAIN lead. ATAIN QI work has resulted in a sustained downward trend in term admissions overall with the gap significantly closed between WWL rates of admission and the GMEC mean.

There were no data outlier responses requested by the LMNS in Q4.

Boo Consultancy have been working with WWL MatCH in Q4 and a variety of supportive drop in sessions, bespoke days and wellbeing packages are being offered to staff.

No new areas for concern identified.

01 May 2025

Dear Kathryn,

Baby Friendly Initiative Gold Progress monitoring review– Maternity
Wrightington, Leigh and Wigan NHS Foundation Trust

Many thanks to you and the service for participating in the Gold Progress Monitoring process. We have completed the written report, and this has been reviewed by the Designation Committee.

We were pleased to see that most of the standards have been maintained and it is to be commended that there is an increase in breastfeeding initiation. Given the overall findings, we are pleased to confirm the service is able to maintain the Gold award. We pass on our congratulations to you and the staff.

Additional evidence

Please send an action plan and further internal audit results to demonstrate an improvement regarding the unmet criteria. Please send the action plan to bfi@unicef.org.uk, as well as written response to the report's recommendations as soon as possible, followed by your audit results using the attached form by November 2025.

Your next Gold revalidation is due in June 2026 and you'll receive a reminder about this nearer the time.

If you have any queries as you work towards this please do get in touch.

With best wishes,

Anne Woods.

Anne Woods
Deputy Programme Director

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www.babyfriendly.org.uk

The UK Committee for UNICEF (UNICEF UK)
Baby Friendly Initiative

Progress monitoring review report
Maternity Service

Wrightington, Leigh and Wigan
NHS Foundation Trust

on 2 April 2025

UNICEF UK Baby Friendly Initiative
1 Westfield Avenue, Stratford, London, E20 1HZ
Tel: 0207 375 6144 bfi@unicef.org.uk
unicef.org.uk/babyfriendly/

Contents

Introduction

Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Services implement the standards in stages over a number of years and are externally assessed by UNICEF UK at each stage. When all the stages are passed they are accredited as Baby Friendly. The initial accreditation lasts for two years; after this, re-assessments take place on a regular basis to ensure that the standards are being maintained and to explore how the service is building on the good work it has already done. Moving forward, successful services can be assessed and accredited with a Gold award demonstrating sustainability. This award is made to services who maintain core standards as well as implementing effective processes in four key areas: Leadership, Culture, Monitoring and Progression.

Gold services no longer require to be reassessed on a regular basis. A random selection of services will be chosen to receive a short notice progress monitoring review as part of our routine external monitoring programme to ensure standards are maintained. These can be instigated by Baby Friendly at any time. In addition to the routine visits, these may also be instigated as a result of the following issues:

- Significant changes in the structure of the organisation, or in key personnel
- Concern about the standard of care provided based on annual audit submissions
- Complaints from parents or staff about care provided by the service
- Negative press coverage
- Poor results in other national monitoring programmes such as the Care Quality Commission (CQC).

The review will usually consist of observations, review of documents, interviews with key members of the Baby Friendly and Leadership teams, interviews with other staff and interviews with mothers which may be carried out face-to-face or by telephone. The aim of the review is to inform the Designation Committee about the current situation and to help with decision making regarding any further support needed or actions to be taken.

Rationale

Wrightington, Leigh and Wigan NHS Foundation Trust has been accredited as a Baby Friendly service since 2012 and was last re-accredited in 2018. The Gold award was made in 2019 and the service has successfully been re-validated on 2 occasions.

This progress monitoring review was carried out as part of the standard monitoring process applied by the UNICEF UK Baby Friendly Initiative to all services which have achieved Gold accreditation. The service was chosen randomly, and the review was not made in response to any particular concern.

The review

The review was carried out by a senior Baby Friendly assessor supported by two assessors who interviewed mothers by telephone. The following was carried out to inform this report:

- Interviews with the Director of Midwifery and Deputy Chief Nurse (Guardian)
- Interview with the Baby Friendly Lead
- Interviews with mothers by telephone
- Review of training records
- Review of breastfeeding data, internal audit results and action plans
- Review of senior management team meeting notes
- Review of examples of feedback from mothers

Findings

The interviews with the leadership team demonstrated strong commitment to maintaining Baby Friendly accreditation. The Infant Feeding team consists of an overall Lead supported by two Infant Feeding Midwives. All posts are substantive. The team has been through a change period in the last 12 months awaiting the recruitment of a replacement Infant Feeding Midwife. The post has now been filled and the training needs of the post-holder met. We received much positive feedback from the mothers we spoke to about the support received from the team. It is clear that infant feeding and Baby Friendly is valued across all levels of staff with representation at key meetings such as Safety Champions, Governance and MNVP. A new Guardian is recently in post, she is an excellent choice, having a background in Health Visiting and a clear interest in and knowledge of the work and how this is impacted and can impact care across the wider Trust footprint. It is notable that the NNU is working towards re-instatement of its Baby Friendly accreditation, that the children's ward is a pilot service for the Baby Friendly Hospital Based Children's Standards (HBCS) and that the Health Visiting and Family Hubs services are also Gold accredited and work closely with Maternity.

The culture within an organisation can have a significant impact on the ability to provide compassionate care and as such has been included as a standard in the Baby Friendly Achieving Sustainability award. This includes both how staff work with each other and whether the families feel that they have been treated with kindness. We received many very positive comments about the staff from the mothers we interviewed. There has been a recent programme of work to support the staff culture including leadership training for staff and management support. It was reported that staff sickness levels had improved as a result. We carried out a staff culture audit, all bar one of the criteria were met, many at a high level (see page 15).

Ongoing monitoring of Baby Friendly core standards is crucial in maintaining high standards of care. Internal audits and action plans were submitted. We carried out a sample of mother interviews with most standards met and a couple of weaker areas. See results below. An audit programme is in place and it was reported that plans being developed to include this in the standard routine Trust audit programme which will result in support with scheduling, analysing and reporting of outcomes. Infant feeding data is robustly monitored and reported via a

dashboard. Initiation rates have increased steadily with a 3% increase from 2023-4. 6-8 week rates are also increasing locally.

There are a number of positive initiatives related to the Baby Friendly standards:

- Introduction of antenatal group education and Pregnancy Circles
- Antenatal hand expression with plans to roll out to mother prior to induction of labour
- Early expressing optimisation
- Ongoing ATAIN work to reduce postnatal admissions to NNU
- NNU implementing the full Neonatal standards
- Early contact from the Infant Feeding team post discharge following feeding challenges
- Pilot of HBCS, early indications that children's ward staff are managing feeding issues more proactively.

The findings in detail

What mothers told us

All mothers interviewed were asked to rate their overall satisfaction with the service and given an opportunity to feedback further comments. The results are presented below:

Overall care from maternity service	% of mothers
Very happy with care – no complaints or comments	82%
Fairly happy or neutral	18%
Unhappy with care overall	

"Lovely people they helped me straight after the caesarean in the recovery room as soon as I said I wanted to breastfeed."

"During the night there was a big gap in care - if you asked for something like painkillers it takes hours to come."

"The support was excellent, despite very busy staff."

"I liked getting the texts."

"Excellent support, I was seen by the team every week."

The following standards were not met, and action is required to ensure improvement:

1. Evidence of an increase in the percentage of:
    a. Mothers who reported a conversation/information about feeding and forming a relationship with their baby in pregnancy.
    b. Mothers who recall information about responsive breastfeeding.
    c. Mothers who are formula feeding who recall information about how to make up feeds as safely as possible.
2. An increase in the percentage of staff who report that if they voiced ideas, that these would be listened to.

We recommend the following to enable you to achieve and maintain the standards:

1. Standard 1 – Antenatal information

   - The antenatal standards were not met at a borderline level. Two new initiatives have just commenced - a four week antenatal programme carried out in collaboration with community colleagues and Pregnancy Circles within the maternity service and it is anticipated that these will have a positive impact. We recommend that uptake and outcomes are monitored. We also recommend that midwives are encouraged to engage mothers during pregnancy with this information.

2. **Standard 2 – Care at birth (breastfeeding mothers)**
   - Care at birth was noted to be of a very high standard. 100% of mothers reported skin contact after the birth and that this continued for as long as they wanted/had fed their baby. This was particularly notable for mothers post caesarean section with skin contact recommended after transfer. This is commendable given the increasing section rates.

3. **Standard 3 – Support with breastfeeding**

   - Mothers fed back on the high standard of care overall with breastfeeding, with many commenting on the excellent support from the midwives and particularly the Infant Feeding team. This continued once home, with strong evidence of effective breastfeeding assessments, support to overcome challenges and to move back to full breastfeeding if formula feeds had been given. The staff are highly commended for this.

   - In one area- responsive breastfeeding, the outcome was poor, with mothers not recalling the many other reasons than feeding that offering the breast would be helpful for them or their baby. We noted this particularly amongst multigravid women and therefore recommend that staff are encouraged to check current knowledge or offer information regardless of parity.

4. **Standard 3 – Initiating expressing for mothers with baby on the neonatal unit**
   - We spoke to only 3 mothers with a baby who had been cared for in NNU, all had excellent support to initiate and maintain lactation.

5. **Standard 4 – Maximising breastmilk**
   - It was reported that mixed feeding was increasing, with mothers introducing infant formula after difficult births and to expediate transfer home. As mentioned above, some excellent support to return to full breastfeeding was noted. We recommend that this area would benefit from a piece of work to further understand this trend and to develop strategies to support exclusive breastfeeding, should this be the mother's goal.

6. **Standard 4 – Support for mothers who are using infant formula**
   - Most of our sample of bottle feeding mothers started breastfeeding with only one mother initiating formula feeding post birth (1/11). Mothers reported excellent support with responsive breastfeeding, however a significant number did not recall an offer of information about how to make up feeds as safely as possible. Many commented that they felt staff thought they knew as they had previously bottle fed, or that they were using

ready made feeds. We strongly recommend that staff are encouraged to explore this with mothers at the relevant time.

Achieving Sustainability

Themes	Standard/Criteria
Leadership	• Baby Friendly lead/team with sufficient knowledge, skills and capacity. • Effective updating for Baby Friendly team • Baby Friendly Guardian in post • Leadership structures support proportionate responsibility and accountability • Managers are educated to support the maintenance of the standards
Culture	• Support for ongoing staff learning • Mechanisms to support a positive culture • Positive feedback from staff, managers and mothers
Monitoring	• Robust, consistent monitoring and reporting mechanisms in place • Evidence of analysis and action planning
Progression	• Demonstrates innovation and progress • Improvement in outcomes • Evidence of integrated working

The following requirements and recommendations are made in relation to the Achieving Sustainability standards.

1. **Leadership**
   - Strong leadership of the programme is evident, the newly in post Guardian brings excellent experience and a passion to further strengthen the programme across maternity and neonatal and to work to develop a local borough wide Infant Feeding Strategy. Baby Friendly and infant feeding is represented at all appropriate fora.
   - The gap in the Infant Feeding Team has now been filled and it is excellent to note that relevant training and development opportunities have been provided for the new postholder, supporting future succession planning.
2. **Culture**
   - Staff training has been maintained with high levels of attendance demonstrable through an effective training database. Evidence of positive feedback from parents was shared
3. **Monitoring**
   - The audit programme has been diminished due to staffing constraints in the Infant Feeding Team during the last 12 months, with capacity restored we recommend that this is revitalised.
   - The increase in breastfeeding initiation is commendable. We note the improved support for data analytics which could help with ongoing work to support exclusive and ongoing breastfeeding.
4. **Progression**

- The service works closely with community colleagues with both health visiting and children's centre services having achieved and maintained Gold status. The NNU is working towards regaining accreditation. We recommend collaboratively reviewing the challenges which have contributed to the current outcome, including capacity within the Infant Feeding Lead hours dedicated to the unit.

The results in detail

The sample

All mothers were randomly selected for interview:

Number of mothers interviewed:	
Breastfeeding	21
Formula feeding	11
With a baby on the neonatal unit	3

Standard 1 Antenatal care

Criterion	**Result**	**Standard required**
Mothers who confirmed that they had the opportunity for a discussion about feeding their baby	77%	80%
Mothers who confirmed that they had the opportunity for a discussion about the importance of developing a relationship with their unborn baby and that the conversation met their needs	72%	80%

Standard 2 Care at birth

Criterion		**Result**	**Standard required**
Care at birth (breastfeeding mothers)	Mothers who confirmed that they were able to have skin contact for at least one hour and support to offer the first feed in skin contact	100%	80%
Care at birth (formula feeding mothers)	Mothers who confirmed that they were able to have skin contact for at least one hour and support to offer the first feed in skin contact	1/1	80%
Skin contact on the neonatal unit	Mothers who confirmed that they had been able to hold their baby in skin-to-skin contact	3/3	80%

Standard 3 Getting breastfeeding off to a good start

Criterion		Result	Standard required
Positioning and attachment	Mothers who confirmed that they were supported with learning how to position and attach their baby	95%	80%
Hand expression	Mothers who confirmed that staff offered to show them how to hand express	80%	80%
Responsive feeding	Mothers who confirmed that they understood baby led feeding and how to recognise feeding cues	95%	80%
	Mothers who confirmed that they understood responsive feeding	45%	80%
Recognise effective feeding	Mothers who confirmed that they were aware of how to recognise effective feeding	86%	80%
Ongoing support information	Mothers who confirmed that they were aware of support available and how to access this	100%	80%
Breastfeeding assessments	Breastfeeding assessments were carried out	100%	80%
Initiating expressing for mothers with a baby on the neonatal unit	Mothers who confirmed that they had been encouraged to express as soon as possible after the birth	100%	80%
	Mothers who confirmed that they received effective support to express	100%	80%

Standard 4 Informed decisions regarding the introduction of food or fluids other than breastmilk

Criterion	Result	Standard required

Maximising breastmilk	Mothers who confirmed that their baby had received a supplement Informed maternal decision or clinical indication	5	N/A
	Mothers who confirmed that their baby had received a supplement **Not** informed maternal decision or clinical indication, or care could have been improved	4	0
Formula feeding mothers	Mothers who confirmed that they had been supported with learning about making up feeds	45%	80%
	Mothers who confirmed that they had been supported with responsive bottle feeding	90%	80%

Standard 5 Close and loving relationships

Criterion	Result	Standard required
Mothers who confirmed that they had received information about the importance of close and loving relationships	81%	80%
Mothers confirmed that they were not separated from their baby	90%	80%

Culture

Criterion	Result	Standard required
Mothers reported that staff were kind and considerate	All of the time 86% Mostly 14% Sometimes Not at all	Achieving Sustainability standard

Supporting information

Criteria	Result	Standard required
Observations within the facility	N/A	No advertising
Staff training records	100%	80%
Documentation reviewed • Antenatal records • Breastfeeding assessments	N/A	Meet standards
Policies and guidelines	N/A	Meets standards
Written and other information	N/A	Meets standards
Mechanisms	Meets standards	Meets standards

Staff culture audit

41% of staff (62/150) completed the Baby Friendly staff culture audit.

The results overall are very positive with 7/8 criteria met, most at very high levels. Some very positive feedback was documented:

"I am very proud of our Baby Friendly status and the team that lead on it".

"On the whole very good. Managerial team working hard to improve staff recognition and wellbeing."

"We have differing priorities. The golden hour creates a bed blocking situation on labour ward".

"Culture would improve if all managers were located in the areas they manage so they are visible and have a deeper understanding of the work in that area."

"When morale appears low there is always someone available to bring up the culture, offer advice & give support to increase the morale when it comes to Baby Friendly".

Question	Response (N 62)		Standard
1. How valued is Baby Friendly within your service?	Very valued	89%	80% Very valued
	Somewhat valued	11%	
	Not very valued	-	
	Not at all valued	-	
2. How motivated do you feel to implement the Baby Friendly standards?	Most of the time	95%	80% Most of the time
	Some of the time	3%	
	Occasionally	-	

	Not at all	2%	
3. Do you feel there is an opportunity for you to raise concerns about how the service provides Baby Friendly care?	Yes	94%	80% Yes
	No	4%	
4. If you raised concerns, do you think that positive action would be taken?	Probably (high chance of happening)	92%	80% Probably
	Maybe (equal chance of happening/not happening)	6%	
	Unlikely (low chance of happening)	2%	
5. If you had ideas about how to further improve care for parents and babies, is there a way in which you can voice your ideas?	Yes	98%	80% Yes
	No	2%	
6. If you voiced ideas, do you think you would be listened to?	Probably (high chance of happening)	73%	80% Probably
	Maybe (equal chance of happening/not happening)	27%	
	Unlikely (low chance of happening)	-	
7. Do you feel that there is a culture of kindness between staff of all grades?	Nearly all the time	47%	80% Nearly/Most
	Most of the time	50%	
	Some of the time	3%	
	Occasionally or not at all	-	
8. Do you feel that there is a culture of kindness towards women and families?	Nearly all the time	81%	80% Nearly/Most
	Most of the time	19%	
	Some of the time	-	
	Occasionally or not at all	-	

What happens next

We thank the service for facilitating the review at short notice. The report will be reviewed by the Designation Committee at the next meeting you will be informed about the outcome.

Anne Woods
23 April 2025

Appendix: The Achieving Sustainability Standards

THEME 1: LEADERSHIP

DEVELOP A LEADERSHIP TEAM THAT PROMOTES THE BABY FRIENDLY STANDARDS

- There is a named Baby Friendly lead/team with sufficient knowledge, skills and hours to meet their objectives
- There is a mechanism for the Baby Friendly lead/team to remain up-to-date with their education and skills
- A Baby Friendly Guardian with sufficient seniority and engagement is in post
- The leadership structures support proportionate responsibility and accountability
- All relevant managers are educated to support the maintenance of the standards.

THEME 2: CULTURE

FOSTER AN ORGANISATIONAL CULTURE THAT PROTECTS THE BABY FRIENDLY STANDARDS

- There is support for ongoing staff learning
- There are mechanisms in place to support a positive culture, such as staff recognition schemes, mechanisms for staff to feedback concerns and systems to enable parents' and families' feedback to be heard and acted upon.

THEME 3: MONITORING

CONSTRUCT ROBUST MONITORING PROCESSES TO SUPPORT THE BABY FRIENDLY STANDARDS

Mechanisms exist to ensure that:

- Baby Friendly audits are carried out regularly according to service needs
- All relevant data is available and is accessed
- Data is analysed effectively and collectively to give an overall picture
- Action plans are developed in response to findings
- Relevant data is routinely reported to the leadership team
- Relevant data is routinely reported to UNICEF UK.

THEME 4: PROGRESSION

CONTINUE TO DEVELOP THE SERVICE IN ORDER TO SUSTAIN THE BABY FRIENDLY STANDARDS

- The service demonstrates innovation and progress
- There is evidence to demonstrate that outcomes have improved
- The needs of babies, their mothers and families are met through effective integrated working.