Board of Directors - Public Meeting

Wed 04 February 2026, 10:30 - 13:45

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

10:30 - 10:31 (1 min)

1. Chair and quorum

Information *Robina Shah*

10:31 - 10:32 (1 min)

2. Apologies for absence

Information *Robina Shah*

Richard Mundon

Sanjay Arya

10:32 - 10:34 (2 min)

3. Declarations of Interest

Information *Robina Shah*

3.1. Register of directors' interests

Information *Robina Shah*

03.1. Public - Directors DoIs - Feb 2026 - CROSS CHECK DECLARE.pdf (3 pages)

10:34 - 10:35 (1 min)

4. Minutes of the previous meeting

Approval *Robina Shah*

04. Minutes_Board of Directors - Public meeting _031225.pdf (9 pages)

10:35 - 10:37 (2 min)

5. Action Log

Assurance *Robina Shah*

05. Public Board Action Log 2026.pdf (2 pages)

10:37 - 10:42 (5 min)

6. Chair's report and stakeholder update

Information *Robina Shah*

10:42 - 10:57 (15 min)

7. Chief Executive's report

Information *Mary Fleming*

07. CEO Board Report_Feb26_PUBLIC_FINAL.pdf (5 pages)

10:57 - 10:57 (0 min)

8. Agenda item not used

10:57 - 11:02 (5 min)

9. Annual Sustainability report

Information *Chris Clark*

09. Annual Sustainabilty Report 25 26.pdf (7 pages)

11:02 - 11:22
20 min

10. Committee chairs' reports

Information *Non Executive Directors*

10.1. Quality and Safety

Information *Francine Thorpe*

Verbal due to the close proximity of the meeting

10.2. Finance and Performance

Information *Julie Gill*

To follow due to the close proximity of the meeting

10.3. People Committee

Information *Mark Wilkinson*

10.4. Research Committee

Information *Clare Austin*

11:22 - 11:32
10 min

Break

11:32 - 12:07
35 min

11. Maternity updates

11.1. CNST update assurance presentation

Decision *Cathy Stanford*

11.1. CNST YEAR 7 Quadrumvirate Presentation Feb 2025 (updated).pdf (18 pages)

11.2. Maternity dashboards

Information *Cathy Stanford*

11.2. Maternity Dashboard Report - Dec 25.pdf (10 pages)
11.2a. Maternity Dashboard - Dec 25.pdf (3 pages)
11.2b. Neonatal Dashboard - Dec 25.pdf (3 pages)
11.2c. Perinatal Dashboard - Dec 25 (1).pdf (1 pages)

11.3. Perinatal quality oversight report

Information *Cathy Stanford*

11.3. Perinatal Quality Oversight Report Q3 25-26 Oct-Dec 2025 (For Board) (003).pdf (50 pages)

12:07 - 12:22
15 min

12. Freedom to Speak Up guardians report

Information *Selina Morgan*

12. FTSU Quarterly Report Q3 2025 for Board v2.pdf (12 pages)

12:22 - 12:32
10 min

13. Finance Report

Assurance *Tabitha Gardner*

13. Board Cover Sheet - Finance Report M9.pdf (3 pages)

13a. Trust Finance Report 25-26 December Month 9 Board.pdf (17 pages)

12:32 - 12:57
25 min

14. Integrated Performance Report

Approval *Chris Clark*

14. Board of Directors IPR M9 2526.pdf (3 pages)
14a. IPR_M9_2526.pdf (24 pages)
14b. Benchmark Access Standards - Jan 2026.pdf (5 pages)

12:57 - 13:07
10 min

15. Board Assurance Framework

Approval *Steve Parsons*

15. BAF Report Board February 2026 FINAL.pdf (28 pages)

13:07 - 13:12
5 min

16. Reflections on equality, diversity and inclusion

Discussion *Robina Shah*

Verbal item

Consent Agenda

13:12 - 13:12
0 min

17. EDI annual report

Approval

17. EDI Annual Report 2024-2025 Executive Summary for Board approval.pdf (3 pages)
17a. EDI Annual Report 2024-2025 Final.pdf (45 pages)

13:12 - 13:12
0 min

18. Safeguarding annual report

Information

18. Safeguarding Annual Report 202425 Front Cover Board of Directors Feb 2026.pdf (2 pages)
18a. WWLTH Safeguarding Annual Report 2024 2025.pdf (28 pages)

13:12 - 13:12
0 min

19. Guardian of Safe Working Hours report

Information

Workshop, 21 January 2026, 9.45 to 11.45am, Boardroom, Trust Headquarters

19. GOSWH Quarter 1 Apr to Jun 2025.pdf (11 pages)

13:12 - 13:42
30 min

Break

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Directors' declarations of interest
Presented to:	Board of Directors
On:	04 February 2026
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	Retired from Edge Hill University as Pro-Vice-Chancellor and Dean of the Faculty of Health and Social Care and medicine, now holding the title of Emeritus Professor
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 Deputy Lieutenant of Greater Manchester
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)
MOORE, Mary	Nil declaration
SHAH, Robina	Professor of Medical Education and Psycho-Social Medicine, University of Manchester Board member, Health Data Research UK Deputy Lieutenant of Greater Manchester
WILKINSON, Mark	Non-Executive Director and Vice Chair, Bolton At Home Ltd Non-Executive Director, Mastercall Healthcare Governor, Edge Hill University Director and shareholder, Fairway Consulting Services Ltd (CRN: 13767002)

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

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

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

Board of Directors - Public meeting

Wednesday 3 December 2025, 14:15 - 16:15

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Board members

Robina Shah (Chair (in the 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), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Mary Moore (Non-Executive Director), Richard Mundon (Deputy Chief Executive), Kevin Parker-Evans (Chief Nurse), Francine Thorpe (Non-Executive Director), Juliette Tait (Chief People Officer), Mark Wilkinson (Non-Executive Director)

Absent: Simon Holden (Non-Executive Director)

In attenadance

Nina Guymer (Head of Corporate Gov & Deputy Company Secretary), Steve Parsons (Director of Corporate Governance), Harriet White (Graduate Trainee), Member of the public, Member of the public (2), Member of the public (3), Member of the public (4), Member of the public (5)

Meeting minutes

154. Declarations of Interest

Information

Robina Shah

No declaration of interest were raised.

154.1. Register of directors' interests

Information

Robina Shah

The register of interests was noted.

14.1. Public - Directors DoIs - Dec 2025.pdf

155. Minutes of the previous meeting

Approval

Robina Shah

The Board **AGREED** the minutes of the two previous public meetings held in November 2025.

15. Minutes_Board of Directors - Public meeting _011025.pdf
15a. Minutes_Board of Directors - Public meeting _051125.pdf

156. Action Log

Discussion

Robina Shah

In respect of actions 76/25 and 121.1/25, updates in the log were noted.

121/25 - Research Committee AAA

Profs S Arya and C Austin affirmed that the Research Committee had received an update on the position the previous day and that this would be taken forwards by the executive team through their meeting.

126/25 - University Hospital Status

Prof S Arya noted the updated included in the action log and that this would come back to the February 2026 board meeting.

16. Public Board Action Log 2025.pdf

157. Staff Story

Information

Juliette Tait

Ms J Tait introduced the staff story video, which centred on the SWAP (Sector Work-based Academy Scheme) developed in partnership with the local college.

Board members were pleased to see how the scheme supports the reduction of inequalities across the borough and strengthens the Trust's position in the borough as an anchor institution. It was further noted that moving forwards, the Trust would require a large proportion of its workforce to come from the local community and therefore, schemes like SWAP will be key to supporting the future proofing of the workforce.

17. Board _SWAP_April 2025.pdf

158. Chair's report and stakeholder update

Information

Robina Shah

Dame R Shah noted that this would be her first public board meeting as the new Chair of WWL and thanked fellow board members for such a warm welcome in to the role. She begun by thanking Mrs F Thorpe for stepping in to the role of the Chair at short notice for the last 6 months. She invited Mrs F Thorpe to share what activities she has been involved in recently.

Mrs F Thorpe noted that she had:

- Attended the community research improvement events with Prof C Austin.
- Chaired the annual members' meeting in November, which had seen fair challenge put forward by attendees around the current pressures on services and was a good opportunity for executive colleagues to share plans, rationale and associated goals with the public.
- Chaired the Long Service Award ceremony, which she praised for its contribution to staff well being
- Attended the volunteers Christmas event with the Chief Executive, where she had been pleased to recognise the service of volunteers, who support many day to day activities across hospital sites.

The Board received and noted the update.

159. Chief Executive's report

Information

Mary Fleming

Ms M Fleming summarised the report which had been shared prior to the meeting, in particular, she highlighted that flu had hit the region three weeks earlier than expected and that, in tandem, A&E attendances are at their highest for three years. In more positive news, she was pleased to share that WWL's Associate Chief Nurse, Mrs E Addie was awarded 'Leader of the year at the Nursing Times Workforce Awards for, amongst other achievements, her projects which aim to address inequalities and support intentionally trained nurses.

Dame R Shah wished to convey to Mrs E Addie, on behalf of the Board, thanks for all of the hard work that she has done and how well deserved her achievement of the Nursing Time Award has been.

The Board received and noted the report.

19. CEO Board Report December 2025 Public_FINAL.pdf

160. Planning outline

Information

Richard Mundon

Mr R Mundon presented the report, which had been shared prior to the meeting.

Mrs F Thorpe questioned the alignment of operational targets with the three aims of the 10-year plan, emphasising the need to focus on digital innovation, community care, and health inequalities, not just the nine measures.

Dame R Shah agreed that at this stage, that may be the case but that moving forwards, there will be an opportunity to reframe the targets set out to ensure that they have an innovative focus and are aligned with the 10-year plan.

Mr R Mundon felt that this is implicit and although the numbers are not explicitly linked to the three shifts, they are what will support the realisation of the goals set out - achieving the targets will require embracing prevention, community, and digital solutions. He described a twin-track approach: meeting the numbers and transforming practice. Him and Ms M Fleming agreed that the risk is in submitting a plan that is both honest and achievable, and that the board must be confident in its robustness.

Dame R Shah agreed that these would be a key driver and that working with stakeholders would help to further shape and also to deliver goals set out, including governors and those who have a reach out in to the community. Further, there will be a need to both incorporate staff and patients feedback in any work moving forwards.
The Board of Directors noted:

- The requirements of the NHSE medium-term plan, and
- The timetable for developing the operational plan

20. 2025 12 03 26-27 planning update for Board - public.pdf

161. Committee chairs' reports

Information

Non Executive Directors

Non-Executive Directors presented their respective reports.

161.1. Quality and Safety

Information

Mary Moore

Ms M Moore summarised the report. She reiterated that the Committee had noted lack of compliance with the 'right patient, right ward' requirements and had asked that this be followed through the next annual revision of the board assurance framework, which would be informed by the next set of corporate objectives.

Mrs F Thorpe was pleased to see that mortality metrics had not been negatively affected due to patients not begin on the right ward but asked whether other metrics are also tracked to ensure that they are also not being affected.

The Medical Director confirmed that this is the case, with Ms S Brennan adding that discharge times can become longer and that these are being tracked through the 'all roads lead to home' scheme.

Ms M Fleming acknowledged how uncomfortable it is to have to hold a bed empty for a long period of time, particularly given the current pressures but reiterated that this is absolutely necessary, in order to ensure that overall, all patients are seen by the most appropriate specialist, with minimal movement around the hospital, so that they can be treated quickly, with less risk of infection and therefore discharged at a faster rate.

It was noted that this has been scheduled to be reported to the Quality and Safety Committee on a regular basis.

21.1. AAA Q&S Nov 2025.pdf

161.2. Finance and Performance

Information

Julie Gill

Noting that the F&P Committee had agreed to increase the risk score for elective performance, specifically the risk of not achieving elective waiting time targets (PR7), Ms S Brennan wished to ensure that the Board were cognoscente of how urgent and emergency care pressures affect decisions on spending additional funding, specifically to reduce 65-week patient waits by the end of December.

The discussion highlighted that, although mitigation plans and additional funding are in place, the risk has increased due to time pressures and challenges in certain specialities (notably gastroenterology), with limited improvement seen so far.

The Committee felt that as the year-end approaches, the likelihood of not delivering the plan increases, justifying a higher risk score (from 9 to 12).

21.2. AAA - FP - Nov 2025.pdf

161.3. People Committee

Information

Mark Wilkinson

Mr M Wilkinson drew attention to the General Medical Council's survey of doctors in training as well as the continuity of the Freedom to Speak up Service (FTSU) and that the Committee had asked for further assurance around how the service would be continued.

Ms J Tait advised that the FTSU service is currently being provided by NHS GM, which has been in contact with WWL with a view to extending that contract.

Mr M Wilkinson advised that the Committee had identified concerns which remain outstanding but that the Committee members feel assured that there are plans in place to address each concern.

The Board heard that sickness absence rates have increased but agreed that this is not surprising, given the current levels of pressures and time of year.

Ms J Tait reported a 48% response rate to the staff survey, being an increase of 13% against a national trend of a decrease in response rates. She was congratulated on her efforts to increase the score here.

21.3. People Committee- TripleA report, October 2025 R.pdf

161.4. Research Committee

Information

Clare Austin

Prof C Austin reported upon:

- Low numbers in terms of the research capability funding
- Positive work on research related audits and discussions on how audits can be converted in to pieces of research
- Actions being put in place to address documenting of publications
- The need for more focus on research in the corporate objectives for 2025/26

161.5. Audit Committee

Information

Simon Holden

Following a summary of the report, queries were raised as to why some potentially high scoring risks had not yet been reviewed by the Risk Management Group.

The Deputy Chief Executive and Director of Governance explained that some high risks are shared with the Audit Committee, in accordance with the risk management policy, however, these risks had been shared prior to being properly scrutinised by the Risk Management Group (RMG) and therefore were not at that time accepted by it as risks.

The Chair asked for clarification on the timeline for the risks coming back to RMG for review.

ACTION: R Mundon

21.5. AAA - Audit Committee - 20 Nov 2025 NG.pdf

162. Finance

162.1. Monthly finance report

Information

Tabitha Gardner

Ms T Gardner summarised the report which had been shared prior to the meeting.

Mr M Wilkinson sought clarity on the reported workforce numbers, specifically questioning whether the figure of 186 whole time equivalent (WTE) above plan accurately reflected the current position, given changes made during the year (such as decisions on community and district nursing).

Ms T Gardner comment that the pay bill is considered as one whole, she explained that when bank spend is converted to substantive posts, it does not change the overall WTE figure, and that overtime is also included, so the pay bill is looked at in totality across the organisation.

Mrs J Tait added that, in addition, the organisation is in the process of working with divisions to reprofile the WTEs based on realistic prospects of what will be achieved, considering ongoing changes such as the mutually agreed resignation scheme exercise, organisational redesign, and corporate restructure. She emphasised that these updates will be reflected in future People Committee meetings.

Mrs F Thorpe was pleased to see that deficit funding had been provided for month 8 and asked when WWL would know about deficit support funding for the remainder of the year, and whether it would continue to be provided on a month-by-month basis.

Ms T Gardner responded that deficit support funding for November and December had been secured, and explained that the process involves external provider assurance meetings where the deliverability of both the organisation's and the system's plans are assessed. She noted that even if the organisation delivers its plan, deficit support may still be withheld if the system does not provide a comprehensive narrative. At the request of Ms M Fleming, she explained that the organisation broadly started with a £30 million deficit, exited the previous year at a £25 million deficit, and in the current year is at a £20 million deficit—showing a £10 million reduction in the underlying deficit. She emphasised the importance of exiting the year in the right way to move towards a break-even position next year.

The Board received and noted the paper.

22.1. Board Cover Sheet - Finance Report M7.pdf
22.1a. Trust Finance Report 25-26 October Month 7 Board.pdf

162.2. Cash update

Approval

Tabitha Gardner

Ms T Gardner summarised the report which had been shared prior to the meeting. She explained that the request for the agreement to cash support is begin made as a precaution and similarly approved but then not required.

Mr M Wilkinson asked whether beyond system support, there were any other local partners or organisations (such as local authorities) that could be approached for cash support, referencing previous arrangements.

Ms T Gardner explained that system support is mainly threefold: the ICB now pays on the 1st of the month (giving two extra weeks of cash), the local authority is very supportive in moving invoices quickly, and they are proactively discussing with other providers and ICBs to expedite outstanding debt payments. She clarified that it's difficult to ask another organisation with a cash surplus to provide funds directly, but WWL can request prompt payment of invoices.
The Board of Directors:

- Noted the current cash position, forecast risks, and the measures being taken to preserve cash balances and manage financial risk.
- **APPROVED** the submission of a cash support application to NHSE in the event this is required.

22.2. Board Cash Paper 03.12.25.pdf

163. Integrated performance report

Information

Richard Mundon

Executive directors summarised their respective quadrants.

Mr R Mundon introduced the report, which provides a monthly overview using key metrics across quality, safety, people, operational, and financial performance, following the Making Data Count methodology.

Mrs F Thorpe was surprised to see lack of themes through the complaints report and queried this.

Mr K Parker-Evans noted that there is a theme of complaints being reported about the emergency department (including waits, staff attitudes and how the overcrowding is being managed), however, due to reporting time frames, this is less visible through the report provided for the meeting and will be better illustrated at through the next one.

Mrs F Thorpe and Prof S Arya discussed "right patient, right ward" compliance. Prof S Arya wished to highlight that despite suboptimal compliance, mortality rates remain good (the hospital-standardised mortality rate (HSMR) is at 94, which is exceedingly low, particularly in comparison to the target of 100) but there are increases in length of stay, complaints, and incident reports for patients not on the correct ward.

The Board noted the importance of triangulating patient feedback, staff feedback, and performance data to drive improvements.

23. Board of Directors IPR M7 2526.pdf
23a.IPR_M7_2526.pdf

164. Workforce Race Equality Standard and Workforce Disability Equality Standard (WRES and WDES)

Ratification

Juliette Tait

Ms J Tait summarised the report, which had been shared in advance of the meeting.

Prof S Arya was pleased to note that on the day of the meeting, WWL's 'Wall of FAME' had been unveiled, in the hospital at the Wigan site, which was led by the trust-wide 'Focus on All Minority Ethnic' Group. It was noted that there are 67 different nationalities of staff working at WWL.

In response to a query from Prof C Austin, Ms J Tait noted that since the work on the global majority 90 day challenge begun, there has been much traction in this area. She highlighted a recent step-up in focus on

WWL as an anti-racist organisation and the recent anti-racism statement issued by the board, which embraced the North West BAME Assembly's Anti-Racist Framework.

Dame R Shah reminded the Board that this mandated reporting had been introduced many years ago in response to evidence that the NHS was losing staff from ethnic minority backgrounds and staff with disabilities, who felt they did not have the same opportunities to progress and who also reported concerns about how they were treated by patients and colleagues. She invited the Board to reflect on what this might suggest about the way in which patients from similar backgrounds are treated.

Ms M Fleming added that around 70% of WWL staff also live in the local borough and so, an indication that staff are acting in a racist manner also indicates that patients may be likely to act in a racist manner. She told an anecdote about a recent complaint which had identified patients racially abusing staff. She noted that the organisation has taken a firm stance against this kind of racism and that patients who act inappropriately will be refused treatment.
The Board **RATIFIED** the WRES and WDES report and proposed action plans to improve staff's experience at WWL.
24. WRES and WDES Report 2025.pdf

165. Maternity

Mr K Parker-Evans reported that the Quality and Safety Committee had scrutinised the reports provided already. He wished to highlight in particular:

- An increase in complaints;
- The need to ensure that expectations of women given c-section dates are managed where these need to be changed;
- 24 hour visiting now introduced for new dads who have previously been asked to leave sometimes after only having spent an hour with their new baby;
- A focus on reaching out in to undeserved communities to gather feedback on service provision;
- Overall, no immediate areas of concern.

Mrs F Thorpe observed that the culture between midwives and obstetricians/gynaecologists does not stand out within the report, with Mr K Parker-Evans agreeing and noting an issue in that none of the national inspections or reviews focus on this, despite the proven examples of poor dynamics here affecting clinical outcomes. He advised that WWL will be starting a piece of work to help to improve this.

Dame R Shah asked about the disparity in the number of caesarean sections performed by different colleagues in obstetrics and gynaecology, and whether this might be related to late presentation, case mix or other factors. She also asked whether this variation had any implications for training requirements and competency development for obstetricians and gynaecologists. She further suggested widening the lens to include prevention and health inequalities, by examining the whole maternity pathway (antenatal, delivery and postnatal care) to understand whether particular groups in the population are disproportionately affected.

The response was that the specific level of detail about individual performance was not known at the time, but Mr K Parker-Evans agreed to bring back more information on this. It was also noted that there is a national trend of women requesting specific dates for cesarean sections, and that education and early engagement are needed to address this.

ACTION: K Parker-Evans

165.1. Perinatal quality oversight report

Information

Kevin Parker-Evans

The Board of Directors noted the contents of this paper to discharge their responsibilities for oversight and assurance of clinical governance and safety monitoring within maternity and neonatal services.

25.1. Perinatal Quality Oversight Report Q2 25-26 Jul-Sep 2025 (For Board).pdf

165.2. Maternity dashboards

Kevin Parker-Evans

The Board received and noted the dashboards.

25.2. Maternity Dashboard Report -October 25.pdf
25.2a. Maternity Dashboard - October 25.pdf
25.2b. Neonatal Dashboard - October 25.pdf

165.3. Briefing report - actions to improve care for women, babies and families

Information

Kevin Parker-Evans

The Board noted the recommendations set out in the report.

25.3. Board of Directors Briefing Paper - Actions to improve care for women, babies and families - next steps.pdf

166. Board Assurance Framework

Information

Steve Parsons

Dame S Shah noted the report and asked if there were any comments.

Ms J Tait noted that a risk would be added after the next People Committee meeting around the 10-point plan for resident doctors, per the requirement.

Mr S Parson reminded the Board of the F&P Committee's recommendation to raise the risk score for PR7 and review it again at the next F&P Committee, with the understanding that if mitigation actions show results, the score could be reduced. He asked if this was agreed.

Ms M Fleming asked why the risk score was reccomended to increase, noting that mitigation had also increased and asking if this was not enough to assure the committee that the objective would deliver.

Ms J Gill and Ms S Brennan advised that the Committee felt that since the Trust are off track on the plan, the risk to delivery has increased, although it is not necessarily the case that the Committee consider that the objective will not be met.

The Board **APPROVED** the F&P Committee's recommendation to increase the risk score for PR7 from 9 to 12, with a note to revisit the process for risk scoring, as a learning point, at one of its future workshops. This increase was already reflected in the paper.

ACTION: S Parsons

The Board therefore **APPROVED** the risks as set out and confirmed that they were an accurate representation of the current significant risk to the delivery of the Trust's strategic objectives.

26. BAF Report Board December 2025 Final.pdf

167. Reflections on equality, diversity and inclusion

Discussion

Robina Shah

The Board confirmed that equality, diversity, and inclusion (EDI) had been thoroughly covered in their discussions and comments throughout the day.

The Board turned to consider the consent agenda, the content of which it had been **AGREED** did not require discussion.

Consent Agenda

168. Green plan

Information

The final version was noted, having being approved in draft form previously.

28. 2025-2030 Green Plan Board Paper RM edit.pdf
28a. WWL_Green_Plan_2025_30_v6.pdf

Business as the Directors of the Charity Trustee

169. Charity annual report and accounts

Approval

The Directors of the Charity Trustee **APPROVED** its annual report and accounts for submission to the Charity Commission as well as the signing of the letter of management representation.

29. Three Wishes Charity Accounts 2024-25 Report.pdf
29a. Final Trustee s Annual Report and Accounts 24-25 Audited 07.11.25.pdf
29b. Letter of Comment 2025 - Three Wishes.pdf
29c.. Three Wishes Charity Letter of Representation 2025.pdf

170. Date, time and venue of the next meeting

Information

Workshop - 21 January 2026, 9.45 to 11.45am, Boardroom, Trust Headquarters

Action log: December 2025

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
1 Oct 2025	126/25	Update - University Teaching Hospital status	Provide assurance for the Board around WWL's ability to achieve University Teaching Hospital status in March 2026	S Arya	5 Feb 2026	The University Hospital Association's criteria is been revised, with revisions likely to be implemented in January 2026 and WWL's application to be made in March 2026.
3 Dec 2025	161/25	Committee Chairs' reports: Audit Committee	Clarify the timeline for the identified potentially high scoring risks being reviewed by RMG.	R Mundon	5 Feb 2026	
3 Dec 2025	165/25	Maternity reports	Bring information to address queries on: whether disparity in the number of caesarean sections performed by different colleagues is related to late presentation, case mix or other factors; whether this variation had any implications for training requirements and competency development for obstetricians and gynaecologists.	K Parker-Evans	5 Feb 2026	

3 Dec 2025	166/25	Board Assurance Framework	Support scheduling to discuss process for risk scoring at future Board workshop	S Parsons	5 Feb 2026	

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	04 February 2026
Item purpose:	Information
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy and corporate objectives

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial risks associated with this report.

Legal implications

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

People implications

There are no people risks associated with this report.

Equality, diversity, and inclusion (EDI) implications

There are no EDI implications in this report.

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.

The winter period has presented several challenges, and I would like to begin by thanking our staff and our community for their support and dedication throughout what has been a challenging pre-Christmas and New Year period. Although 2026 has started with challenges, much of which we have planned for, I am deeply optimistic about the progress being made and our ongoing efforts to ensure that 2026 becomes a year of positive change. Together with our partners, we are committed to making a meaningful contribution to improve the lives of Wigan Borough residents and the wider NHS.

National Oversight Framework
Since the Board met last December, the NHS National Oversight Framework (NOF) 2025/26 published the second round of results, placing WWL in Segment 4. The NOF is the national system for monitoring organisational performance, and here at WWL we know exactly the key areas that require our attention. Significant transformation programmes are already underway to improve our performance, focusing on what matters most to patients, staff, and Wigan Borough residents.

Our system-wide Better Lives Programme is a major initiative driving these improvements. This system approach not only supports necessary improvements in urgent and emergency care but also enhances residents' ability to live independently, thereby contributing to a higher quality of life. It's important to recognise that lasting change doesn't happen overnight and currently, the Emergency Department at the Royal Albert Edward Infirmary is facing a much higher patient volume than it was ever designed for, as we've seen throughout December and January. As a result, wait times for our patients have increased, especially for those who require admission to hospital. During heightened demand, patient safety remains our top priority which means our teams clinically prioritise care for individuals with the most critical needs and because of this prioritisation, some patients have experienced extended wait times than we would want.

Service Preparedness and Winter Resilience
During December, the Trust successfully managed a five-day period of Industrial Action by Resident Doctors. Despite the timing coinciding with one of our busiest periods, robust operational planning ensured safe and effective services across all WWL sites. Elective activity continued, and all protected services – including Emergency Department care, cancer pathways and maternity – remained fully operational. This was achieved thanks to the dedication and professionalism of colleagues across the organisation.

Our preparations earlier in the year for winter resilience also played a significant role in supporting urgent and emergency care. The 'Home for Christmas' campaign enabled early identification of patients requiring support upon discharge, and collaborative working between clinical teams, operational teams and system partners helped facilitate safe and timely discharges ahead of the Christmas and New Year Bank Holiday. This not only strengthened operational safety during the anticipated period of increased demand but also enabled many patients to return to the place they call home, further supporting their recovery during the festive season.

Our winter plan was further tested in January, when the Trust responded to two Business Continuity Incidents and one Critical Incident. High occupancy levels at the Royal Albert Edward Infirmary, combined with increased emergency demand and limited discharges, resulted in significant pressures across wards and the Emergency Department. In line with other Trusts across Greater Manchester, we reached OPEL Level 4 and escalated the incidents to ensure patient and staff safety. Through joint working with Wigan Borough system partners, safe discharge pathways were strengthened, allowing incidents to be stepped down promptly. Throughout this challenging period, WWL colleagues again demonstrated exceptional commitment, compassion and teamwork - embodying the very best of our organisational values.

Finally, maintaining a safe and resilient workforce over winter has also been a priority. I am pleased to report that our staff vaccination programme delivered almost 2,000 vaccinations. When combined with vaccinations received by staff in the community, this means we exceeded last year's uptake (34%) achieving 40.3% overall to date.

Care Quality Commission Visit
Our Thomas Linacre Centre facilitated a planned unannounced inspection in early January from the Care Quality Commission (CQC) and whilst we are awaiting the final report following our data submission, the CQC wanted to pass on their thanks to the team at TLC for the way in which they facilitated the visit and the care they are providing. The visit took place because of the length of time since the last inspection, rather than due to any care concerns or risk triggers within the CQC framework.

Internal Organisational Redesign
One of our key Trust-wide Transformation Programmes remains the Organisational Redesign Programme, intended to strengthen our ability to meet future challenges and to continue delivering high-quality, safe and integrated care for our patients and communities. The redesign of our clinical divisions provides a critical opportunity to better support whole-pathway working, improve accountability, and enable more joined-up clinical and operational decision-making as we progress on our journey to outstanding care and improved patient experience. Since the update provided to the Trust Board in December 2025, the programme has progressed well. Senior leadership teams for each of the two new divisions – Start Well & Planned Care and Live Well & Urgent Care – have now been appointed, establishing clear clinical and managerial leadership and enabling momentum to be built within the new structure. Alongside this, detailed work has been undertaken to refine and confirm the service portfolios within each division, ensuring that services are grouped in a way that best facilitates integrated working across patient pathways, strengthens collaboration between acute and community services, and supports our prevention and population health ambitions. The new divisional structure is still working within a formal transitional period, which runs until 31st March 2026. During the remainder of this period, the focus will be on completing the full restructuring, confirming and implementing final structures, and ensuring that all corporate and support functions are fully aligned and geared up to support the new divisional arrangements from the start of the 2026/27 financial year.

Capital Developments
Throughout December and January, the Trust completed several significant capital developments at the Royal Albert Edward Infirmary that will enhance patient and staff experience. The new 356-space multi-storey car park at Freckleton Street was formally handed over in January, providing an additional 64 surface spaces for staff, 21 disabled bays and 20 EV charging points. This long-awaited facility addresses a longstanding need for improved parking provision, and I would like to thank local residents and our wider community for their engagement and support throughout the development period.

In addition, a new Emergency Department (ED) diagnostics area is now operational and receiving patients. This purpose-built facility houses a state-of-the-art CT scanner and two new x-ray rooms, supporting both ED attendances and inpatient diagnostics. The new layout will reduce transfer times from ED to imaging, improve compliance with national imaging standards, and support faster diagnostic turnaround. Collectively, these improvements will strengthen patient flow, reduce waiting times and enable more timely discharge where appropriate.

Finally, RAEI's Discharge Lounge has been fully refurbished to support speedier and more comfortable discharges. Loved ones are now able to drive up to the facility to collect their family members once discharges are complete and patients can wait in a more comfortable and updated environment.

National Staff Survey
For the 2025 National Staff Survey, the Trust strengthened its approach to staff engagement to ensure broader and more representative participation. Increasing response rates remained a priority for the Executive Team, and early indications (ahead of the national embargo being lifted in March) suggest improved uptake. This reflects growing confidence among colleagues that their feedback leads to meaningful action. Our refreshed, staff-focused campaign helped to improve visibility and accessibility of the survey and was supported by a new incentive scheme. Executive-led listening events and targeted site visits further encouraged participation and created opportunities for

colleagues to share their experiences directly with senior leaders. Regular communications and leadership guidance helped to empower staff to have protected time and support to complete the survey. The continued use of “You Said, We Did” updates reinforced how staff insight informs organisational improvement and, as a result, responses from a significantly larger proportion of colleagues were secured, strengthening the evidence base for future improvement planning. Staff feedback from last year’s survey directly shaped major improvements across WWL, leading to clearer care standards through the Fundamentals of Care Strategy, strengthened leadership via the We Lead programme, and a new Nursing Career Pathway Map to enhance fairness and development. We also improved support for workplace adjustments with the Wellness at Work process and empowered staff involvement in change through the Innovate Together Campaign, which generated 191 ideas to enhance experience and efficiency. Once the embargo is lifted, findings will be shared through a structured cascade process beginning with the appropriate assurance committees.

Planning for the Future

Finally, in-depth work has continued across the Trust to develop robust activity, performance, finance, workforce and capital plans in line with the Medium-Term Planning Framework, published jointly by NHS England (NHSE) and the Department of Health and Social Care, building on the initial submission made on 17th December 2025. Planning activities have helped refine our assumptions, while ensuring alignment across planning components. The final submission is still scheduled for 12th February 2026 to NHSE. We plan to communicate our intentions with staff and the community, keeping stakeholders informed about how this important work will support the NHS 10 Year Plan and contribute to WWL’s refreshed Our Strategy 2030.

Title of report:	Annual Sustainability Report
Presented to:	Board of Directors
On:	03 February 2026
Item purpose:	Information
Presented by:	Deputy Chief Executive
Prepared by:	Sustainability Manager
Contact details:	07884902020

Executive summary

WWL's 2024/25 sustainability performance highlights both progress and growing challenges in meeting the NHS Net Zero agenda. The Trust has seen a slight 0.5% increase in its NHS Carbon Footprint emissions compared to the 2019/20 baseline, driven largely by estate expansion without aligned sustainability investment. Clinical sites account for 93% of emissions, with the Royal Albert Edward Infirmary contributing the highest proportion. Scope 3 emissions within the NHS Carbon Footprint Plus also increased, reflecting supply chain impacts and limitations in current methodologies. Despite these pressures, several key clinical, digital, and estates-related initiatives have delivered meaningful carbon savings, including reductions achieved through improved deprescribing practices, switching off non-essential ventilation systems, reusable diathermy mats, and community imaging hubs that cut both patient travel emissions and waste.

Across the Trust, teams have delivered innovative projects aligned to the Green Plan, producing measurable environmental and financial benefits. Digital transformation—most notably through the adoption of intra-oral scanning—and procurement changes in wound care management have reduced waste and emissions. Estates initiatives such as replacing single-use cups with reusable options promise further significant carbon reductions. Biodiversity assessments conducted with Groundwork have identified opportunities to enhance green spaces, particularly at Wrightington Hospital. Workforce engagement continues to strengthen through the Greener WWL Ambassador network and the Green Teams SusQI competition projects annual savings of £141,622 and 41,342 kgCO2e. Governance arrangements, including TFCD-aligned disclosures and regular board oversight, demonstrate continued commitment to embedding sustainability within the Trust's strategic decision-making.

Link to strategy and corporate objectives

- Site strategies for all owned sites. Net zero is a requirement of these strategies
- Estates strategy – Achieving net zero is a requirement of this strategy.
- Net Zero Strategy – The net zero strategy is a detailed plan of how the Trust will achieve its mandated net zero targets. Decarbonisation of the estate is a key part of the strategy.
- Heat Decarbonisation Plan (HDP) – The HDP details how we will decarbonise our generated heat and is a key part of the net zero strategy.
- Green Plan – Achieving a net zero estate is a requirement of the Green Plan.

Risks associated with this report and proposed mitigations

Risks are unclear and aren't detailed in any legislation, but meeting net zero targets is mandatory under the Climate Change Act 2008.

Financial implications

Opportunities to reduce energy expenditure and backlog maintenance significantly. Potential fines/penalties if we do not meet net zero targets

Legal implications

Achieving Net Zero is a legal requirement for the organisation.

People implications

N/A

Equality, diversity and inclusion implications

N/A

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

F&P

Recommendation(s)

For information.

Report

Summary of progress on delivery of the Green Plan

As part of the NHS standard contract, all NHS organisations are required to monitor and report on compliance with the various requirements of the 'Green NHS and sustainability' clause.

NHS Carbon Footprint

Figure 1 shows we are behind progress when compared to our net zero trajectories. We should focus on implementing emission reduction measures to ensure progress to net zero is restored. Emissions in this category are heavily linked to the built estate and rely on capital investment in items such as lighting, plant and building fabric. Given our capital restraints we are limited in what we can do in this area.

There has been a 0.5% increase in total emissions compared to the 2019/20 baseline. This is a concerning trend that highlights the focus and funding that is required in order to reduce these emissions. As the Trust expands its estate but fails to invest in sustainability measures, our carbon footprint will continue to increase.

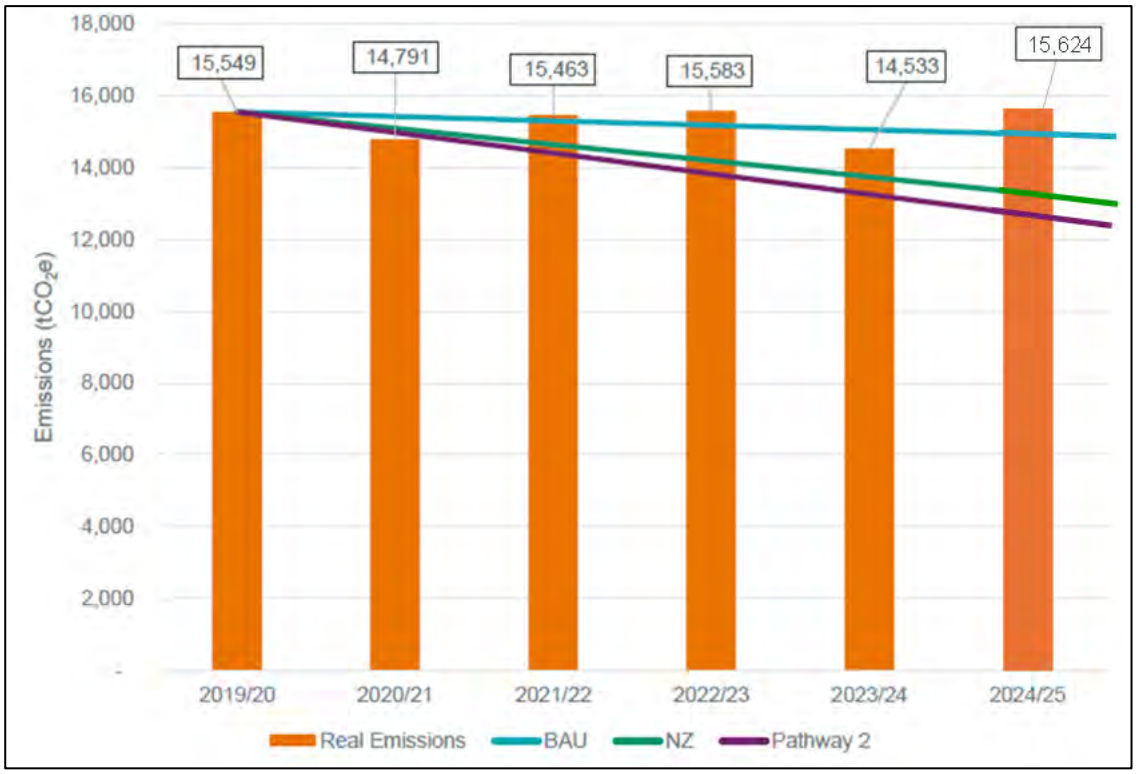


Figure 1 - Real Emissions Performance comparison with Business as Usual, Net Zero and Pathway 2

Carbon footprint by site type (including transport) is presented in Figure 2. The emissions associated with Clinical site types accounted for 93% of the overall 24/25 NHS Carbon Footprint.

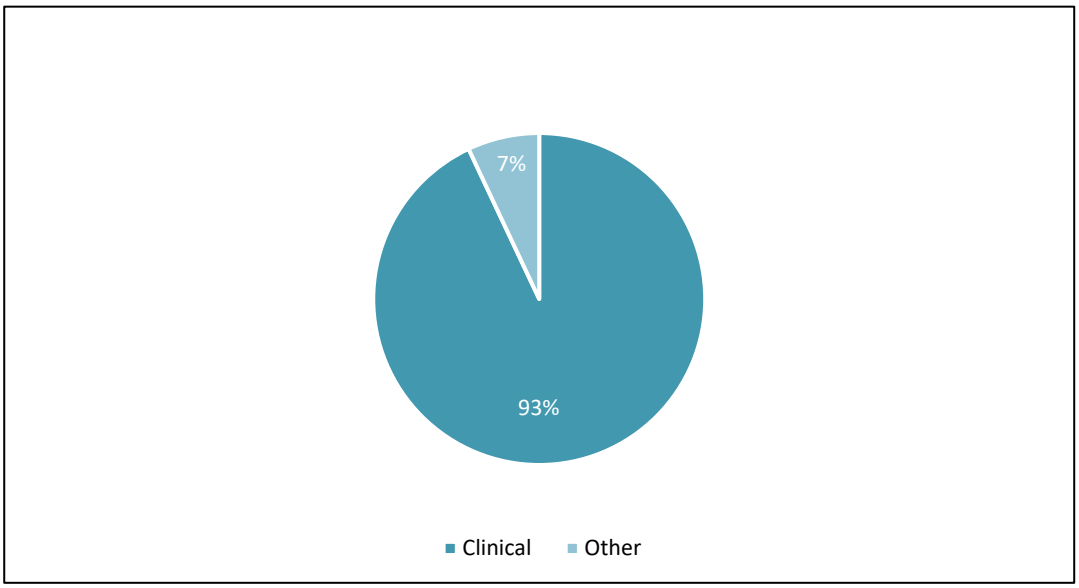


Figure 2 - 2024/25 Carbon Footprint Emissions by Site Type (tCO2e)

The NHS Carbon Footprint for key clinical sites is shown in Figure 3. Royal Albert Edward Infirmary has the greatest proportion of emissions associated with it, at 6,469 tCO_2e.

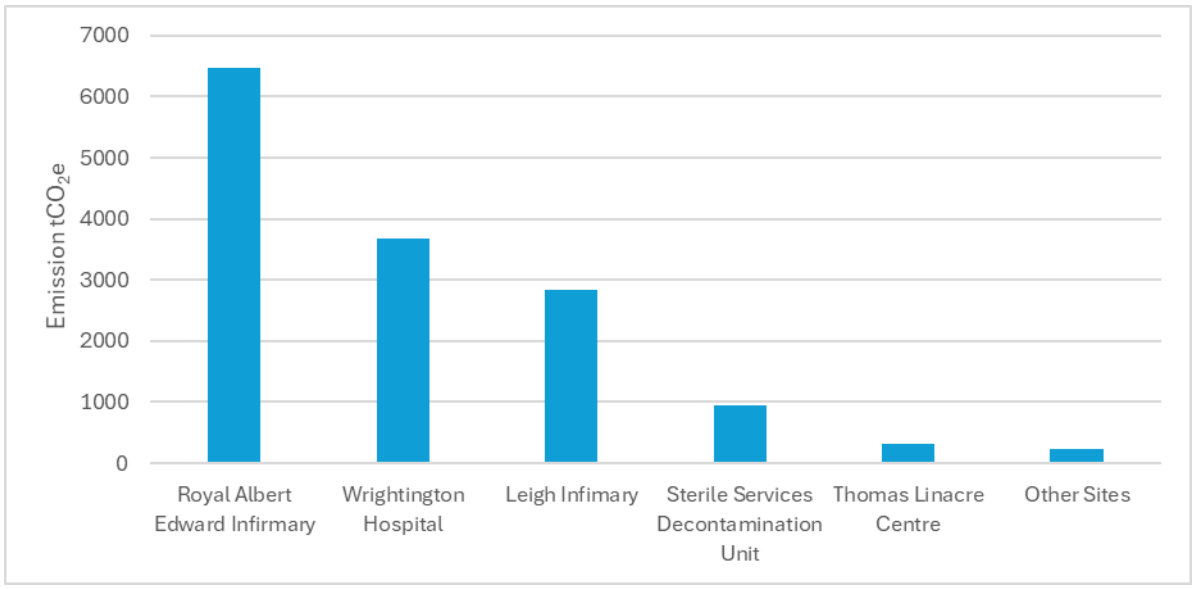


Figure 3 – 2024/25 Carbon Footprint Emissions by Key Clinical Site (tCO2e)

NHS Carbon Footprint Plus

Figure 4 shows an increase in carbon footprint linked to Scope 3 emissions from our supply chain. Work to determine a specific net zero pathway for NHS Carbon Footprint Plus is ongoing, therefore it is difficult to say how we are performing against a trajectory. The methodology used also has a significant error margin however it is the best methodology available to us at present.

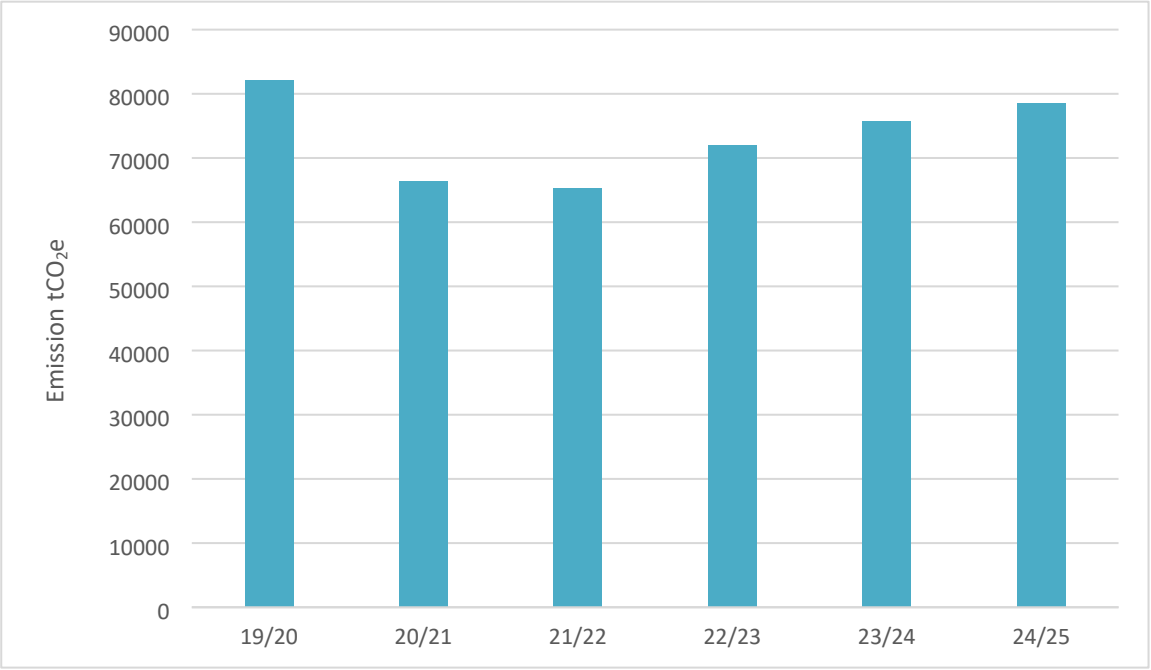


Figure 4 - NHS Carbon Footprint Plus

Progress in year

Medicines and Sustainable Models of Care:

WWL aims to reduce the environmental impact of medications in frail patients on a medical ward, and address the issue of medicine wastage for any treatments which are no longer needed. The ageing and complex medicine team have worked to reduce their carbon footprint by improving deprescribing through effective polypharmacy reviews, whilst ensuring medication is optimised to reduce the risk of harm.

The Trust is looking to reduce its footprint associated with the use of Anaesthetic Gass Scavenging Systems and Ventilation Systems by developing a strategy to switch off both AGSS and ventilation systems whilst the theatre is non-operational. It was identified that this would reduce the running time of these systems from 168 hours per week to 60 hours, and a 64% reduction in energy use per week. This work could also be implemented in other areas which use active ventilation systems such as Endoscopy or the Cardiac Catheter Lab.

The anaesthetic team also aim to replace single use diathermy pads with a reusable alternative across all theatres at WWL, reducing the Trust's reliance on single use products and the associated carbon footprint in line with its aims to make surgery more environmentally sustainable. Changing from single use diathermy pads to reusable diathermy mats will result in a significant carbon saving of 1,505.4 kgCO2e if implemented across the three main hospital sites.

The dermatology team have increased the accessibility of their Tele-Dermatology service by setting up "imaging hubs" in the community as the first point of contact in the Urgent Suspected Skin Cancer pathway. Prior to the project, all patients assessed via this pathway were required to travel to Leigh Infirmary to attend clinic; most of these patients travelling via car. Following its implementation, patients who attended the Imaging Hubs saved an average of 1.20225 KgCo2e per return journey, representing a 41% reduction in comparison to patients who attended Leigh Infirmary. There was also an increase of 53% in the number of patients choosing to walk to their appointment, resulting in further carbon savings. Staff are now often able to car-share, reducing the number of vehicles and associated carbon emissions by 50%.

Digital Transformation

WWL aims to create a more sustainable orthodontic practice by replacing traditional dental impressions with digital intra-oral scanners, resulting in a reduction in clinical waste, financial savings and optimised resource use. By switching to digital scanning, there would be around a 50% reduction in gypsum models, with these impressions being stored digitally instead, leading to an estimated saving of 1,037 kgCO2e/year for the Trust. Whilst traditionally used in orthodontics, intra-oral scanning also has significant potential to be used in other departments such as Maxillofacial surgery, ENT and Oncology.

Supply Chain and Procurement

The Community Transformation Team have transferred the process for managing procurement and distribution of wound care products too WWL community division, providing wound care dressings to patients at the point of care instead of via prescription services. Following this work, wound care formulary items for community patients will be ordered using NHS Supply Chain, and patients will be able to receive the correct number of dressings based on individual need. The total savings from this change are estimated to be 1,991 kgCO2e per year. District Nursing Services are phase 2 of the initiative and account for 70% of wound care provision in the Trust. Expanding the project to this area is anticipated to potentially quadruple these savings.

Estates & Facilities

The catering team aimed to replace single-use cups for drinks and soup with reusable alternatives for inpatients. Reusable soup cups have been successfully introduced to replace the single-use bowls that were being used previously, and the team are now introducing reusable cups across the inpatient wards. Prior to this change, WWL procured an average of 71,000 single-use cups per 28 bed ward. Once reusable cups are implemented across all wards, there is potential to save 8332 kgCO2e. This initiative also has potential to be expanded to other areas such as A&E which serves around 240 drinks per day, accounting for a substantial volume of single-use cup consumption.

Climate Change Adaptation

The Trust understands its commitments to climate change adaptation and the risk that climate change poses. Risk assessments and business continuity plans have been updated to account for the effects of climate change, but more work needs to be done to detail how the Trust will adapt to the unavoidable climate change impacts.

Green Spaces and Biodiversity

Our charity partner Groundwork have completed assessments of green space on all our owned sites. The assessments will be used to develop a biodiversity plan which will be utilised within capital schemes to increase their biodiversity in line with Local Nature Recovery Schemes. They will also be used to influence the grounds maintenance programme with a view to better managing biodiversity. Reports have now been received and there is a promising outlook for biodiversity, particularly at Wrightington Hospital where valuable green space could be potentially put to use in improving boroughwide biodiversity whilst also improving staff wellbeing, patient outcomes and generating a revenue.

Workforce, Networks & System Leadership

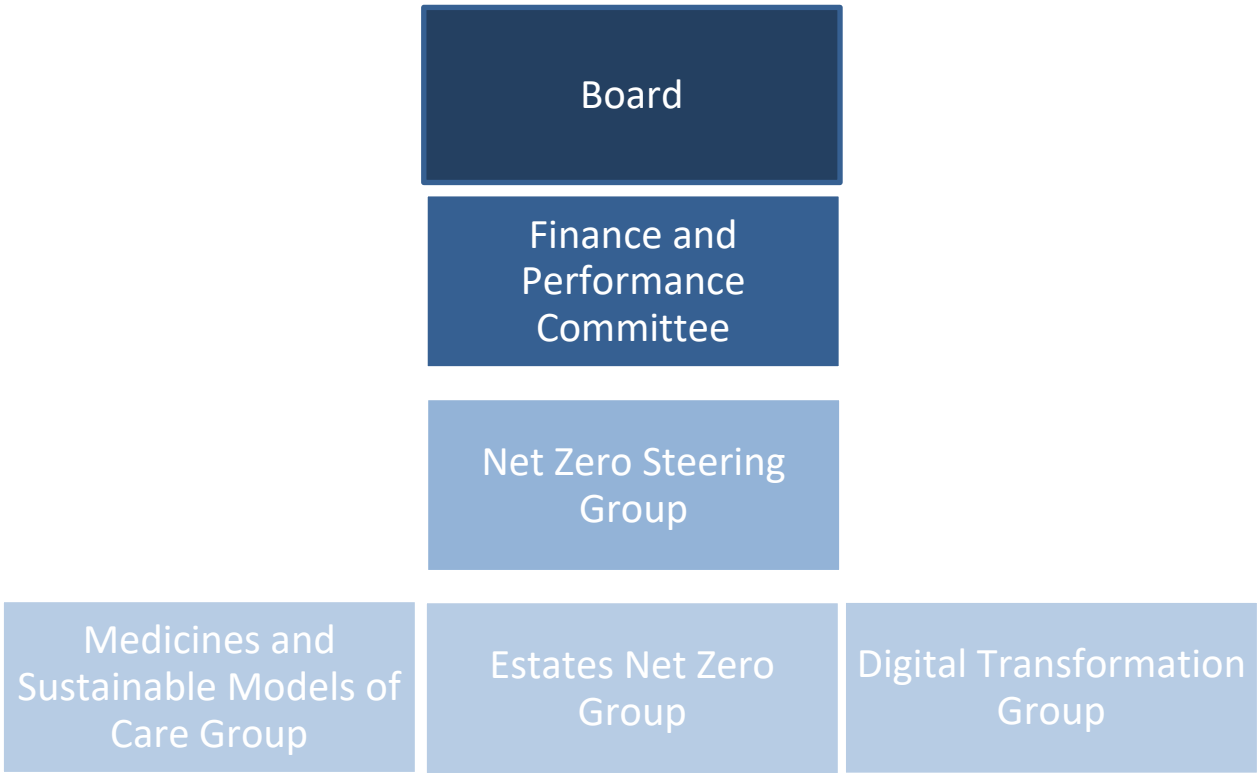
The Sustainability team run a network of “Greener WWL Ambassadors” to provide a key role in the success of the Trust’s Green Plan. Ambassadors can collaborate on projects, share experiences and best practice, and promote sustainability across the trust. Ambassadors, and all other staff, will

have access to various training and development opportunities (generic and role-specific) to further support the Green Plan.

This year the Trust held a Green Team competition in collaboration with the Centre for Sustainable Healthcare. 6 teams of staff from various departments worked on Sustainable Quality Improvement (SusQI) projects which all have the potential to provide significant sustainability savings for the Trust, as well as financial savings and benefits to patients and staff. The combined projects have projected annual savings of £141,622 and 41,342kgCO2e. These savings will continue to increase as the projects progress and expand further following the competition.

Climate Related Financial Disclosures

In line with all NHS bodies, TFCD disclosures will be included in WWL sustainability annual reporting in a phased approach from 2023/24, which will include disclosure requirements of the governance pillar. The board has oversight of climate-related issues through several avenues. The senior leadership team at WWL endorsed the Green Plan ahead of its release in 2022. The Trust Deputy Chief Executive, Richard Mundon, is the Board Net Zero Lead and maintains oversight on progress against the Green Plan in regular updates from the Sustainability Team. The Board of Directors receive an annual paper reviewing the year-to-date carbon emissions and quantitative performance, qualitative performance in line with national Greener NHS mandatory reporting, and highlights from the current programme. Recommendations to the board in 2023/24 have included endorsing the inclusion of sustainability considerations in local priorities and hospital-level strategies, and ensuring sustainability messaging is strengthened within leadership communications to support the agenda.



NHS Resolution

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Year 6 Maternity Incentive Scheme Compliance.

Wrightington Wigan. And Leigh Teaching Hospital NHS Foundation Trust

Name of Person completing :		Cathy Stanford - Divisional Director of Midwifery and Child Health
Date completed:		January 2025
Date due to Board of Directors for final Sign off of declaration form:		Board of Directors sign off 4th February 2025
Do you submit your CNST progress to the Board of Directors as per the Perinatal Quality Surveillance Model?:		Yes

Year 6 Maternity Incentive Scheme Compliance.

Executive Summary

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

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

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

The LMNS has had oversight and assurance by reviewing the evidence that WWL are meeting the ten safety actions leading up to the Board Declaration form submission on or before the 3rd March 2026.

In line with section 4.7 of the Three-Year Plan for Maternity and Neonatal Services ICBs are requested to oversee and be assured of trust's declarations to NHS Resolution for the maternity incentive scheme (CNST).

The process for oversight and assurance allows for overall compliance of the ten safety actions. The CNST document outlines that the LMNS, or in some instances the ICB require sight of or 'sign off' of certain pieces of evidence. The process includes three elements:

A. The submission of evidence to the LMNS/ ICB stated in the CNST document.(submitted by WWL January 6th 2025)
B. The development of an assurance process to have oversight and gain assurance of the ten safety actions.
C. The process of sign off by NHS GMEC ICB CEO

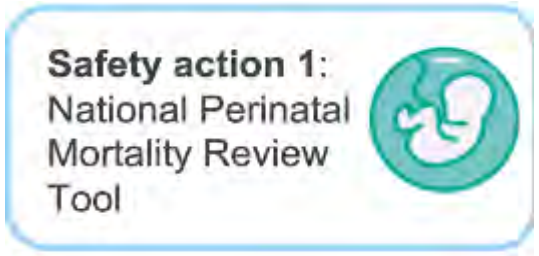
CNST requirements for signing off the Board declaration form must be presented to the Board by the Quadrumvirate prior to the Board Declaration of compliance being signed by the Chief Executive Officer which will be February 2025.

A list of the evidence required, and dates of submission to the Board and LMNS, are presented in the tables within the next slides for Safety Actions 1-10.

The Quadrumvirate request that the board note the evidence that has been submitted over the course of the year within the Maternity Board papers and review any subsequent and final documents within the February Board papers , predominantly evidence is within the Quarterly Perinatal Quality Surveillance Reports which have all been been presented as evidenced within the slides to the Board and Sub Committee's.

The oversight of the actual evidence of compliance has been undertaken by the LMNS within a detailed evidence spreadsheet that is housed within The FutureNHS Collaboration Platform, and this has been declared as compliant and meeting all of the Safety Standards requirements.

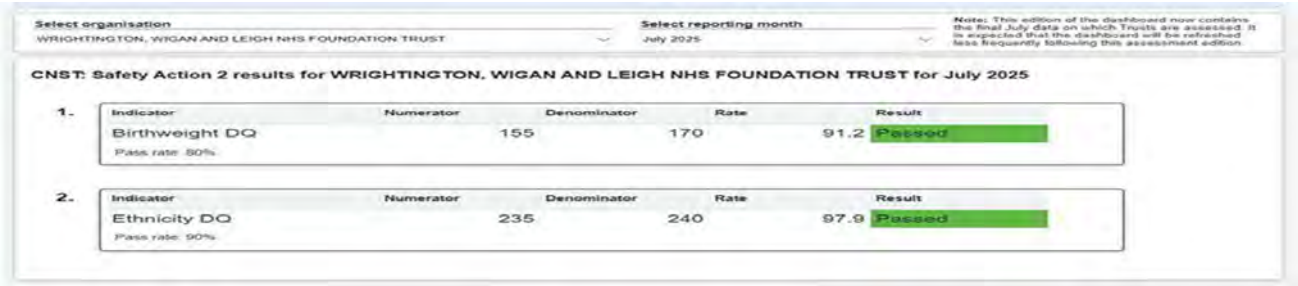
Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?



	Safety action requirements	Likely to be compliant for submission date? (Yes/ No /Not applicable)	Actions for compliance
A	**Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.	Yes / 100%	**Notifications and Reporting Requirements** • All notifications must be submitted, and surveillance forms completed via the **MBRRACE-UK reporting website**. Refer to the technical guidance on the introduction of the **NHS Submit a Perinatal Event Notification (SPEN) system** for further details.
B	**Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	Yes / 100%	• The **Perinatal Mortality Review Tool (PMRT)** must be used to review care, and individual death reports should be generated through the PMRT. • A **quarterly report** must be presented to the **Trust Executive Board**, detailing: The deaths reviewed. Any themes identified. Associated action plans. The report should demonstrate that: The PMRT has been used to review all eligible perinatal deaths. Required standards **a), b), and c)** have been met. For **Standard b)**, if parents have not been informed about the review, the reasons must be documented within the PMRT review.
C	**Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	Yes /100%	• **Self-certification** by the Trust Board must be completed and submitted to **NHS Resolution** using the Board declaration form **by 3 March 2026**. **Risks / Assurance / Support needed** • Monitored through CNST Oversight meeting with LMNS
D	**Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	Yes / 100%	• PMRT tracker in place with external members listed and monitored by Maternity Governance Team. • Included within Quarterly Perinatal Quality Surveillance reports submitted to: Board of Directors Quality and Safety Committee Safety Champions

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

Safety action 2: Data and the Maternity Services Data Set

	Safety action requirements	Confident/ Requirement met? (Yes/ No /Not applicable)	Actions for compliance
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.			
1	Trust Boards to assure themselves that at least 10 out of 11 MSDS-only (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. Final data for July 2024 will be published during October 2024.	Yes/ 91.2 Passed	
2	July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).	Yes/ 97.9 Passed	

Select organisation: WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

Select reporting month: July 2025

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST for July 2025

	Indicator	Numerator	Denominator	Rate	Result
1.	Birthweight DQ Pass rate: 80%	155	170	91.2	Passed
2.	Ethnicity DQ Pass rate: 90%	235	240	97.9	Passed

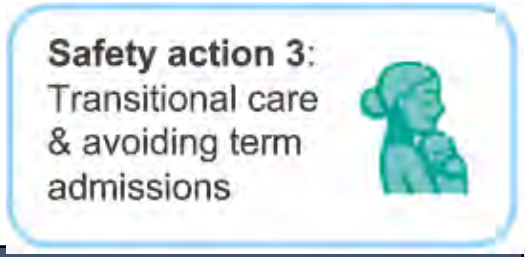
Notifications and Reporting Requirements

- The time period for the required standards is from 2 April 2025- 30 November 2025 and there is anticipated compliance for the July 2025 submission for 1) and 2).

Risks / Assurance / Support needed

- Monitored through CNST Oversight meeting with LMNS
- Included within Quarterly Perinatal Quality Surveillance reports submitted to:
  - Board of Directors
  - Quality and Safety Committee
  - Safety Champions

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



	Safety action requirements	Requirement likely to be met by Submission date? (completed /Yes/ No /Not applicable)	Actions for compliance
A	Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice.	Yes.	**Notifications and Reporting Requirements** A)The pathway of care into Transitional Care is embedded in alignment with BAPM as per previous years submission. B) 2 quality improvement initiatives have been commenced and registered with the Trust Improvement team. Updates are scheduled within the Safety Champion annual planner and have been presented to the LMNS via the monthly LMNS Quality & Safety forum. **Risks / Assurance / Support needed** • Assurance via perinatal governance and CNST Oversight meetings. • Presented at LMNS Oversight panel • Included within Quarterly Perinatal Quality Surveillance reports submitted to: Board of Directors Quality and Safety Committee Safety Champions
	<u>Or</u> Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.	n/a	
B	Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.	Yes.	

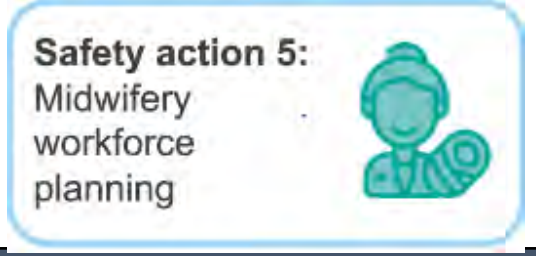
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

	Safety action requirements	Likely to be compliant by submission date? (Yes/ No /Not applicable)	Actions for compliance
a) Obstetric medical workforce			
1	NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums.	Yes	**Obstetric workforce:** Local policies and standard operating procedures are in place to manage the induction of locum staff, compensatory rest and consultant attendance. Mechanisms are in place to capture noncompliance. Following a change in requirements, 100% compliance is required against the standard for short term locum usage.
2	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.	Yes	A policy is in place and an ongoing monthly audit from January- November 2025 has demonstrated 100% WWL compliance. Oversight is monitored by the rota coordinator in the first instance and any Issues of non-compliance will be reported within the Perinatal Quality Surveillance Report and escalated through directorate governance meetings and Divisional meetings.
3	Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**	Ongoing	Compensatory rest is not measured within Year 7 however the Trust continue to work towards full compliance with several measure in place to support as on call are based around individual Consultants job plans and clinical commitments to allow rest following on call wherever possible by undertaking non-scheduled clinical work to minimise disruptions to clinical activity and planned elective care.

4	Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations: : 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes	For the time period 1st August 2025 to 31st October 2025 there were 10 instances where the Consultant should have been contacted to attend. The consultant was in attendance in all 10 of these cases (100%). This is an improvement on last year's figures and meets compliance with the MIS requirements for year 7. **Senior doctors and Consultants have achieved 100% attendance in the specified time period**

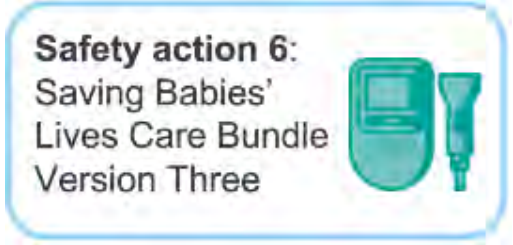
b) Anaesthetic medical workforce			
	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes	The funded establishments for anaesthetics are compliant with the required standards. Rota evidence submitted and compliant.
c) Neonatal medical workforce			
	The neonatal unit meets the relevant BAPM national standards of medical staffing. or the standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	Ongoing	Significant improvements are now in place with the introduction of a new rota which includes GP Trainees onto the night rota allowing for a designated Trainee to cover NNU for the 24-hour period. Also included is the Advanced Neonatal Nurse Practitioners (ANNP'S) who will contribute to the rota to provide additional support. The existing 2 Paediatric Advanced Nurse practitioners will also contribute to the paediatric rota which additionally free's up trainee's cover for dedicated NNU cover. This was formalised in August 2025 to allow for the change over of paediatric trainees in order to not change the rota schedule part way through their placements. Additionally, the 2 newly qualified ANNP 's needed time to consolidate their knowledge and skills. This has significantly improved compliance, and shortfalls should then only occur due to sickness and unavoidable absences. These changes support BAPM requirements on NNU and will reduce risks that were identified in recent reviews of only having one tier1 and one tier2 doctor overnight covering multiple areas. **This action now meets the Maternity Incentive Scheme Year 7 Safety Action 4 for Neonatal staffing.**
d) Neonatal nursing workforce			
	The neonatal unit meets the BAPM neonatal nursing standards. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal ODN.	Yes	**Leadership Staffing:** The neonatal unit at WWL has the appropriate level of leadership staffing in place, as per budgeted establishment. The annual staffing and skill mix report incorporating the further requirements for Neonatal services to work towards the integration of Allied Health Professionals into the Multi-disciplinary team to enhance care and provide a holistic approach to neonatal care was submitted to the Board of Directors in August 20205 Gaps remain within the **Allied Health Professional (AHP)** and **Nurse Quality roles**, as highlighted in the Neonatal Critical Care Review. Collaboration with the Community Division is ongoing to identify sustainable support for these roles. In the meantime, AHP services are provided on a reduced, ad hoc basis to ensure babies receive some level of input, supporting improved care and outcomes. **Neonatal Nursing Workforce meets BAPM standard requirements**

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



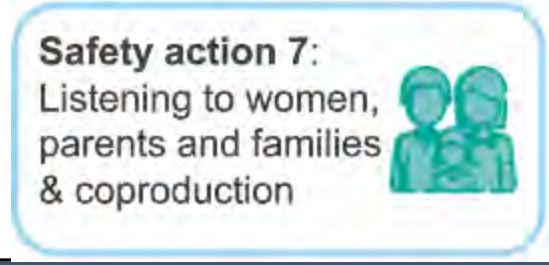
	Safety action requirements	Requirement met or likely to be met for the submission date? (Yes/ No /Not applicable)	Actions for compliance
A	A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.	Yes	**Minimum Evidence** The Biannual midwifery staffing reports submitted include evidence to support a, b, c and d achievement. It also included the required detail to provide: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. • The midwife to birth ratio. • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. •The staffing reports also include evidence from The Birthrate+ acuity tool, and local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one care in active labour long side details of plan for mitigation/escalation to cover any shortfalls. A Midwifery staffing review and paper was completed and submitted to Board in August 2025.(in line with previous years reporting these are submitted every 6 months) There were no concerns identified, and the paper demonstrated that the midwifery staffing budget reflects the recommendations as calculated by BirthRate Plus® 2022 and the Trust Board can take assurance from the report that there has been an effective system of Midwifery workforce planning and monitoring of safe staffing levels for Q1 and Q2 of 2025 . A second bi-annual Midwifery workforce paper for Q1 & Q2 will be submitted in November 2025 to Trust Board to demonstrate full compliance with the standard.. A second bi-annual Midwifery workforce paper for Q3 & Q4 will be submitted in January/ February 2026 to Trust Board to demonstrate full compliance with the standard. The service is currently undertaking a commissioned new BirthRate Plus® assessment which may provide preliminary data to support the staffing review. **Risks / Assurance / Support needed** Assurance through LMNS CNST Oversight Panel and through daily review of staffing across the unit and following the Maternity Escalation Policy.
B	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	Yes	
C	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes	
D	All women in active labour receive one-to-one midwifery care.	Yes	
E	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Yes	

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



	Safety action requirements	Requirement met or likely to be met for the submission date? (Yes/ No /Not applicable)	Actions for compliance
A	Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.	Yes	**Minimum Evidence** Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) SBLv3 through quarterly quality improvement discussions and the Trust. These discussions should include the following: with the ICB/ LMNS . • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Saving Babies Lives Version Three by March 2024. Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies Lives Version 3 is fully / will be in place as agreed with the ICB's Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2026. **Risks / Assurance / Support needed** Assurance is gained through regular oversight of audit & performance through monthly meetings with element leads, governance meetings and quarterly LMNS Assurance visits. **LMNS Assurance:** June 2025: **96% compliance** against SBL 3 intervention parameters Q2: **SBL team reports 99% assurance** (awaiting LMNS confirmation)
B	Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes	
C	*The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.	Yes	
D	Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in	N/A	

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



Panel	Safety action requirements	Likely to meet requirement by submission date? (Yes/ No /Not applicable)	Actions for compliance
1	Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Engagement and listening to families. b) Strategic influence and decision-making. c) Infrastructure.	Yes.	**Minimum Evidence** 1 a) Evidence of MNVP infrastructure being in place from your LMNS/ICB including all of the following: • Job descriptions for MNVP team • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare) There is a new requirement that Terms of reference for quality meetings are to include the MNVP Lead as part of quoracy in multiple meetings. This is a risk to compliance due to having funding for a part-time post and no deputy lead in place or funded. This is a challenge nationally. However, we are currently compliant with this recommendation. b)Terms of Reference and evidence of attendance including minutes/action logs that show the MNVP Lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: • Safety Champion meetings • Maternity quality and safety meetings • Neonatal quality and safety meetings • PMRT review meeting • Patient safety meeting • Guideline committees c) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan. 2) Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan. An action plan against the 2024 Maternity CQC survey has been co-produced with the MNVP and progress has been presented to Safety Champions quarterly throughout 2025. **Risks / Assurance / Support needed** Monitored via CNST Oversight panel and governance meetings. Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2026.
2	Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	Yes	

Safety Action 7 update and mitigations as agreed by the LMNS/ ICB

- **Safety Action 7** was discussed following a MNVP webinar with all Maternity Leads and, it was decided that a scoping exercise was required to understand what governance/ quality and safety meetings the MNVP's were expected to attend in each individual service. This will assist the MNVP lead and LMNS in understanding any gaps in MNVP provision and understanding individual Trusts position for CNST year 7.

- To be fully compliant for Safety Action 7 MNVP leads must attend Perinatal Mortality Review meetings. However, training had not been rolled out across the region for MNVP leads, therefore they are unable to attend. **This is now in place and WWL MNVP Chair has completed her training**

- If non-compliance is declared for SA7 escalation is required through the trust board, LMNS, ICB and Regional team. To facilitate this in the timeline

outlined in CNST, it was suggested in the meeting that non-compliance is escalated to Trust Boards in good time to allow onward escalation. This was escalated as recommended and submitted to the LMNS/ ICB as recommended . **Therefore, WWL is fully compliant**

- MNVP's are required to be commissioned and function in line with the MNVP guidance by the end of the Three-Year Delivery Plan (March 2026) and it is an expectation that Trusts will be compliant by this time. **The mitigations as described above makes WWL compliant and compliance can still be declared on the Trust Board declaration form.**

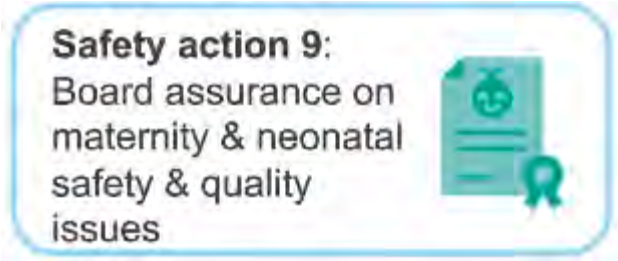
- ICB's are expected to develop an action plan with the Trust in response to the escalation and monitor progress through agreed governance processes and via a risk register.

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

Requirements		Safety action requirements	Requirement likely to be met by submission date? (Yes/ No /Not applicable)	Actions for compliance
90% of attendance in each relevant staff group at:	**1**	Fetal monitoring training	Yes	Training plans should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework. All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. **Trusts must be able to evidence the four key principles:** 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. 4. Promote shared learning across a Local Maternity and Neonatal System. 12 consecutive months should be considered from 1st December 2024 until 30th November 2025 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. At least one emergency scenario needs to be conducted in the clinical area or at point of care. 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area. **Risks / Assurance / Support needed** • Oversight through perinatal Safety Champions and Included within Quarterly Perinatal Quality Surveillance reports submitted to: Board of Directors Quality and Safety Committee Safety Champions **Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2026**.
	2	Multi-professional maternity emergencies training	Yes	
	3	Neonatal Life Support Training	Yes	

Nov 2023 – Nov 2024	PROMPT	FETAL PHYSIOLOGY	NLS
Midwives	90%	91% Assessment – 91%	90%
Maternity Support Workers	94%	N/A	91%
Obstetric Consultants	93%	93%	N/A
Obstetric Registrars	92%	92%	N/A
Consultant Anaesthetists (Obstetric Rota)	100%	N/A	N/A
All other Obstetric Anaesthetic Doctors (Obstetric Rota)	100%	N/A	N/A
Anaesthetists (General Rota)	92%	N/A	N/A

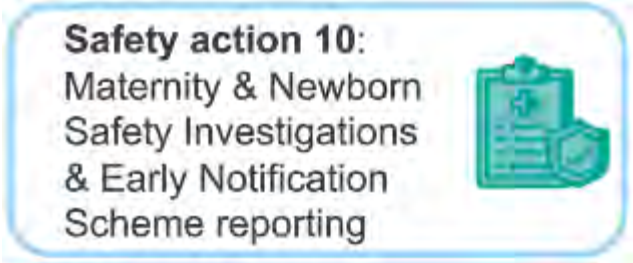
Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?



	Safety action requirements	Requirement likely to be met prior to submission date ? (Yes/ No /Not applicable)	Actions for compliance
A	**All Trust requirements of the PQSM must be fully embedded.** Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action	Yes	Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop collaborative relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Board of Directors to understand, communicate and champion learning, challenges, and best practice.
B	The expectation is that discussions regarding safety intelligence take place at the Board of Directors (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation.	Yes	Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Board of Directors to understand, communicate and champion learning, challenges, and best practice. Evidence that a review of maternity and neonatal quality and safety is undertaken by the Board of Directors (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback. Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to **These discussions must include** • ongoing monitoring of services and trends over a longer time frame; • concerns raised by staff and service users; • progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). • Evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

C	All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures. Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including • identifying and escalating safety and quality concerns and offering relevant support where required.	Yes	**Evidence includes:** • Board of Directors and Safety Champions minutes identifying that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Board of Directors has been identified and is being implemented. • Evidence in the Quality and Safety Committee and Board of Directors (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented. **Risks / Assurance / Support needed** **The service continues to hold discussions around safety intelligence at** **Quality and Safety Committee** **Perinatal Safety Champions** **Board of Directors** **Schedule of monthly Safety Champion meetings and engagement sessions with staff; feedback is shared via monthly Q&S newsletter.** **The Claims scorecard shared at Safety Champions & Q&S within the Quarterly Perinatal Quality Surveillance Report.** **There is continued sharing of learning and safety intelligence via LMNS Monthly Safety & Quality forums. PQS tool is embedded and used to support bi-monthly review of MatNeo safety at the Board of Directors meetings.**

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?



Requirement	Safety action requirements	(Yes/ No /Not applicable)	Actions for compliance
A	Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes	The current position is that all qualifying MNSI and EN cases have been reported within the reporting period. Cases are documented within the PQS tool and included within the MatNeo reports to Quality and Safety Committee and Trust Board. All information provided where required is shared in a format accessible to patients and families. Duty of candour (DoC) is currently at 100%. **Assurance through weekly updates of the incident tracker and oversight through the Maternity Governance team, who provide reports to Board of Directors and Quality and Safety Committee via the Quarterly Perinatal Quality Surveillance Reports which include all qualifying cases and DoC data.**
B	Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024.	Yes	
C	For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes	

Thank You.
Any Questions

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard and Optimisation Report
Presented to:	Board of Directors
On:	5th Feb 2026
Item purpose:	Information
Presented by:	Kevin Parker-Evans (Chief Nurse & DIPC)
Prepared by:	Gemma Weinberg (Digital Midwife)
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations.

The November dashboard has highlighted that there are some areas for increased observation. In particular, the supernumerary shift coordinator has been red for the past 4 months. Going forward, this figure may need to be triangulated with other data to provide some narrative for it.

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?

Quality & Safety Committee

Recommendation(s)

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

Report

December 2025 Exception report - Maternity
Summary

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

- There were 48 validated midwifery red flags reported in December.
- We are now validating red flag figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. However, they only relate to Delivery suite There is a separate red flag report which investigates the red flags in more detail.
- The shift coordinator was unable to remain supernumerary for one shift in December.
- 1:1 care is validated at 100% in December with all women recorded to have had 1:1 care.
- There were 4 Maternity complaints received in December, and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

PSII Commissioned Incidents

There were no PSII Commissioned incidents reported in December.

StEIS reported incidents

There were no StEIS reported incidents in December.

Green

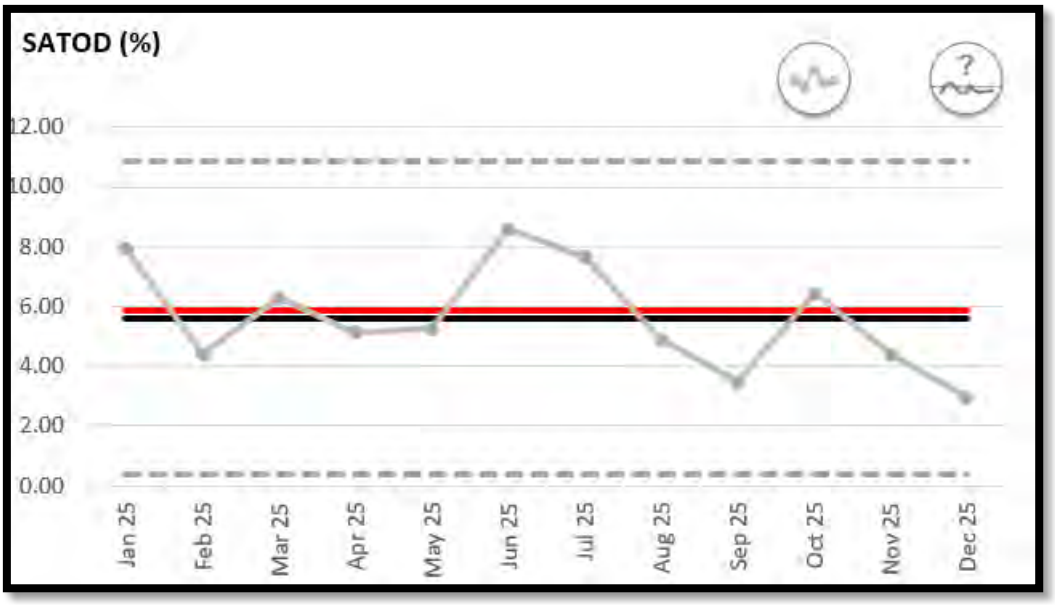
1:1 care in labour (%).
There were no women in December reported to have not had 1:1 care.

Women booked by 12+6 weeks (%)
These figures saw a slight dip into amber levels in May but have been at green and normal levels since. Work continues to ensure that women are booked early, the ideal being before 10 weeks.

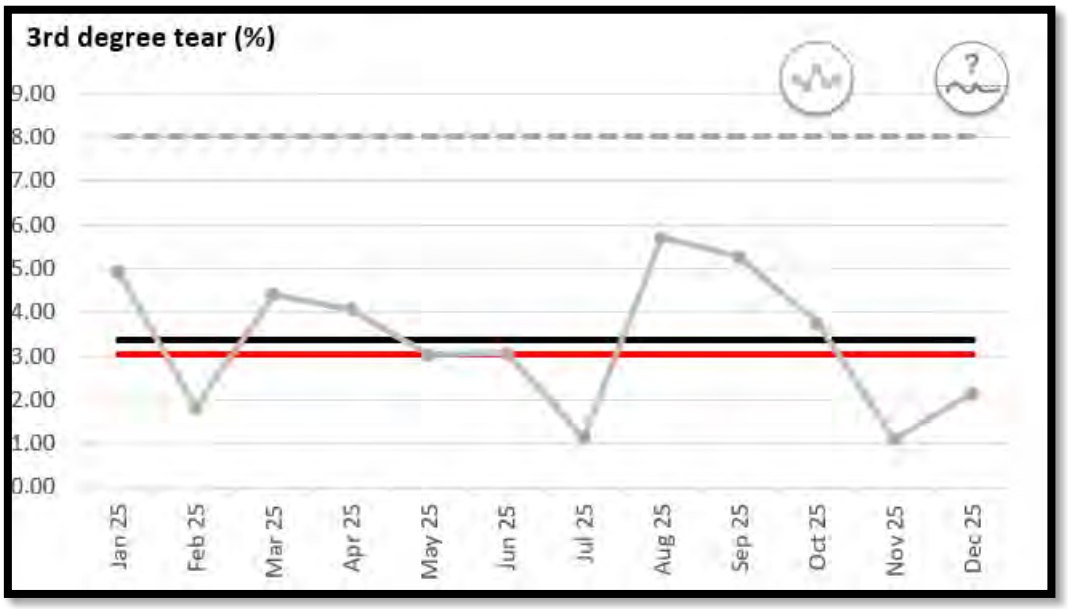
Skin to skin contact (%)
This has returned to green levels after September and October saw a drop into amber levels. Work continues to improve this metric with antenatal education and Midwifery training. The infant feeding team have been asked to attend the pregnancy circles which are commencing in Hindley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

The number of mothers who have opted to breastfeed (%) –
This metric has been green for several months. Work continues to improve this metric by the infant feeding team. The team have been asked to attend the pregnancy circles which have just started at Hindley and Tyldesley. The team are also promoting the ANYA app to pregnant and newly delivered people. The December metric shows the highest BF initiation rate of 2025.

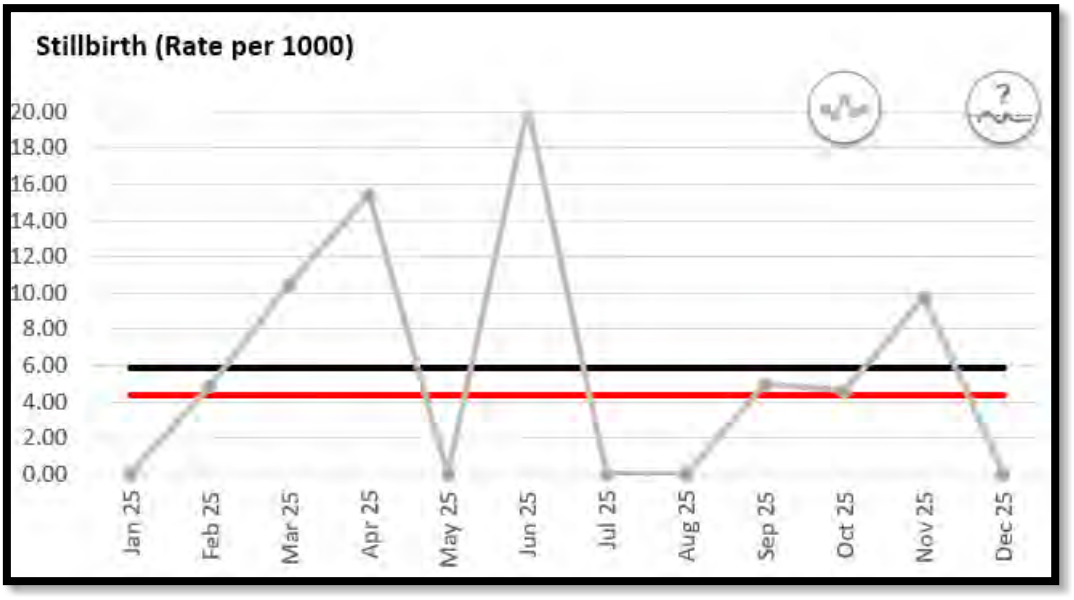
Smoking at the time of Delivery (SATOD) (%).
December sees the lowest SATOD figure ever at WWL. Work continues to promote and encourage smoking cessation throughout pregnancy. Changes have been made by the smokefree pregnancy team where contact is established earlier in pregnancy. The below SPC chart shows our % SATOD rates in comparison to the 2024 average from GM (red line).



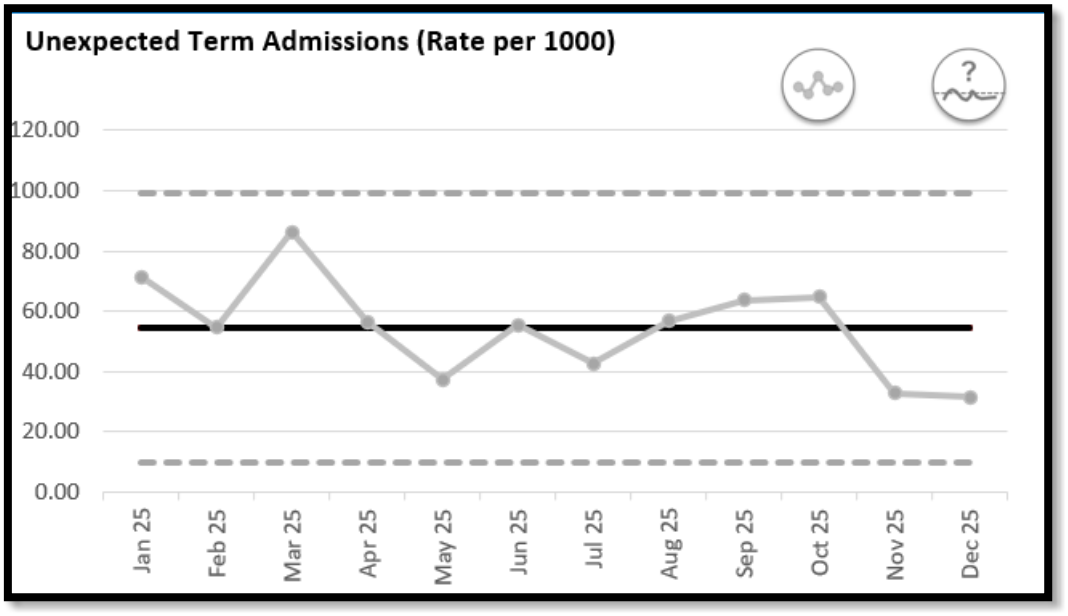
3rd / 4th degree tear (%).
The figure is recorded as a percentage of vaginal births. There were 2 women who had a 3rd degree tear in December. The below SPC chart shows how we compare to the 2024 GM average for this metric (red line). An OASI working group is continuing to look at this metric and at ways to improve it. Several QI projects are in place to support the ongoing work to reduce perineal injury. The PPHS specialist Midwife has just come into post.



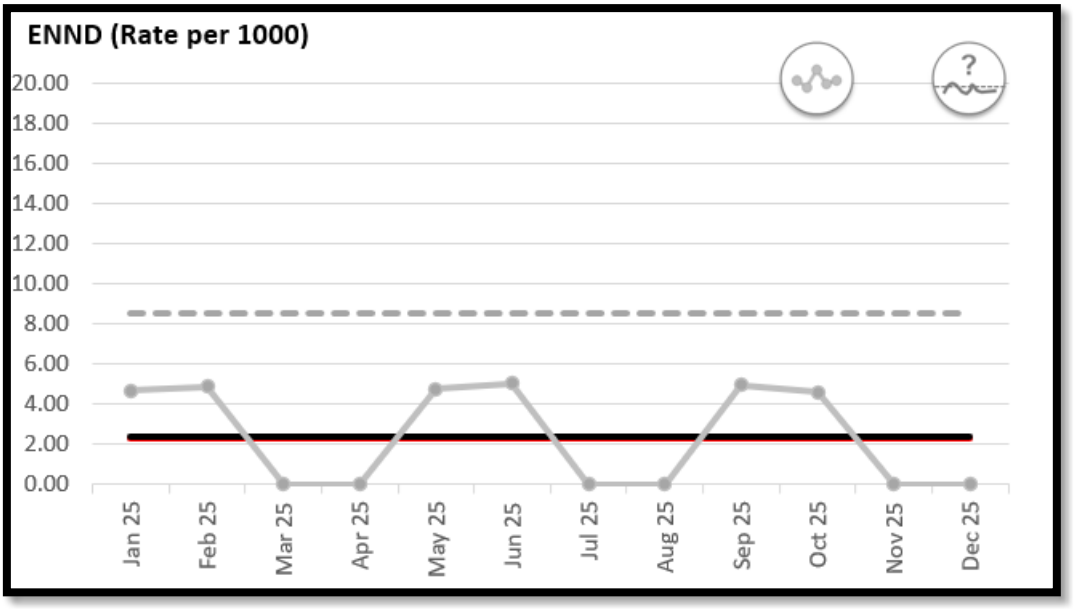
Number of stillbirths (rate per 1000).
This figure is recorded as a rate per 1000. There were no stillbirths in December. The below SPC chart shows how WWL compare with the 2024 average from GM (red line).



Term admissions to NNU (rate per 1000).
This figure is recorded as rate per 1000 and equates to 6 babies in December. This metric has been beginning to see a downward trend. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate and to try to improve the figures in this metric. The below is an SPC chart showing our rates in comparison to the 2024 GM average (red line).



Number of Neonatal Deaths (rate per 1000).
The figure is recorded as a rate per 1000. There were no recordable ENND in December. The below SPC chart shows how WWL compare with the 2024 GM average (red line).

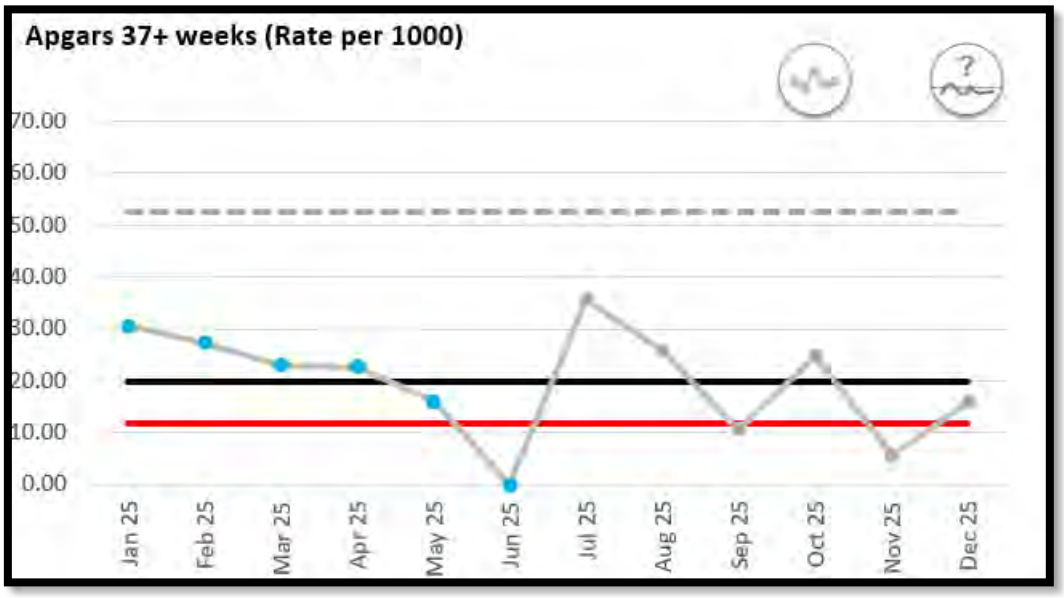


Amber

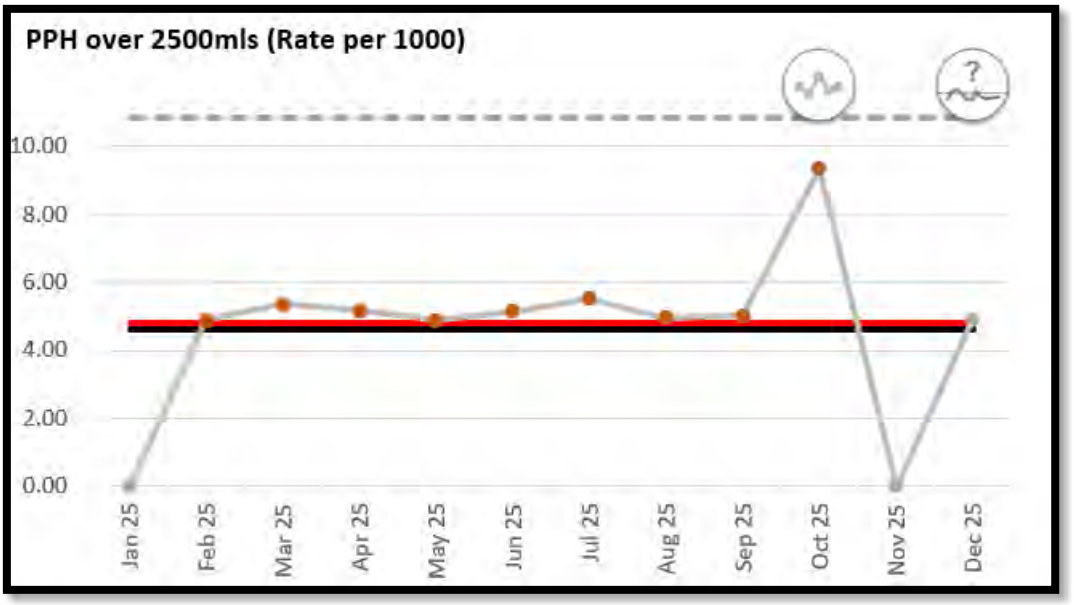
Induction of Labour (IOL) – (%).
These levels continue to fluctuate. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes, with no outlying themes and trends noted.

Women readmitted within 28 days of Delivery (rate per 1000).
There were 6 maternal readmissions to the obstetric unit in December. No omissions in care were noted.
These admissions were for possible wound infection, UTI x2, Haematoma, Chest pain, Headache

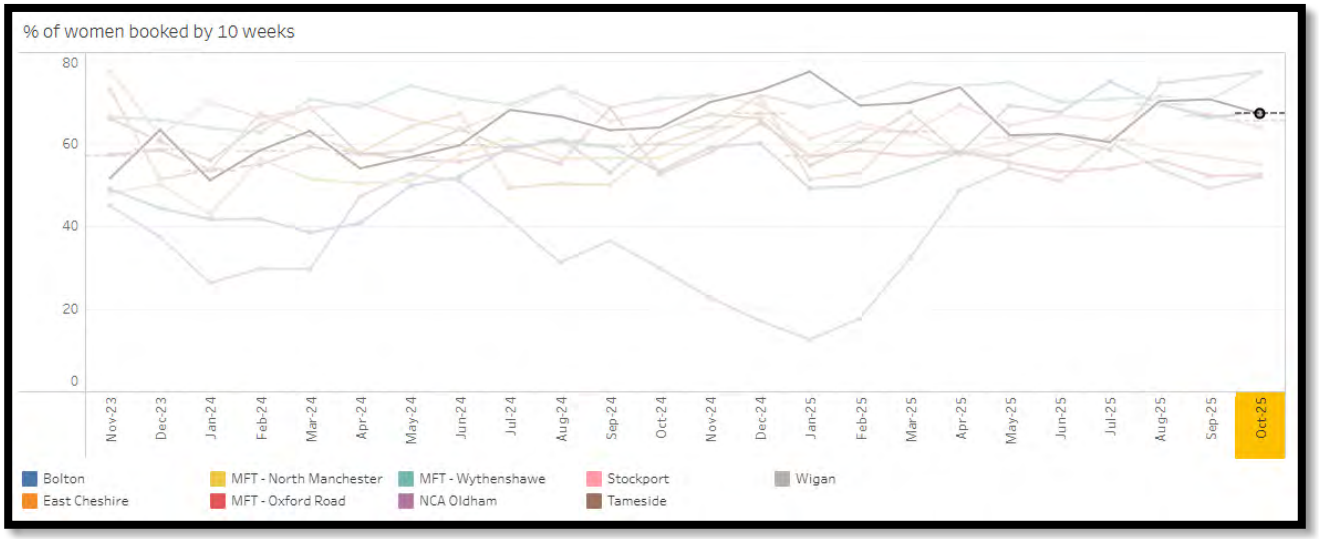
All infants with Apgar's less than 7 (rate per 1000).
This metric was beginning to see a downward trend, but October saw a spike in these figures. The rate per 1000 in December equates to 1 baby. A themed analysis of these babies will be carried out by the governance team and any findings fed back. The below SPC chart shows how our figures compare to the 2024 GM average (red line) and demonstrate the improvement following the focused work that has been undertaken around training and documentation.



PPH over 2500mls (rate per 1000).
There was 1 woman who had a PPH of over 2500mls in December (2633mls). The below SPC chart shows how WWL compare with the 2024 GM average (red line). The figures for this metric are recorded as rate per 1000.



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



Category 2 Caesarean Sections with no Delay in Decision to Delivery interval (%).
Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and delivery. In December (according to Euroking records) there were 5 women out of 35 who had an interval time of more than 75 mins. The times where there was a delay ranged from 83 minutes to 4 hours 56 minutes. This metric is continuing to be reviewed with a deep dive audit. The initial results of this audit indicated discrepancies between the written notes and what is recorded on Euroking. It was therefore agreed in Safety Champions that this audit should be ongoing for a while

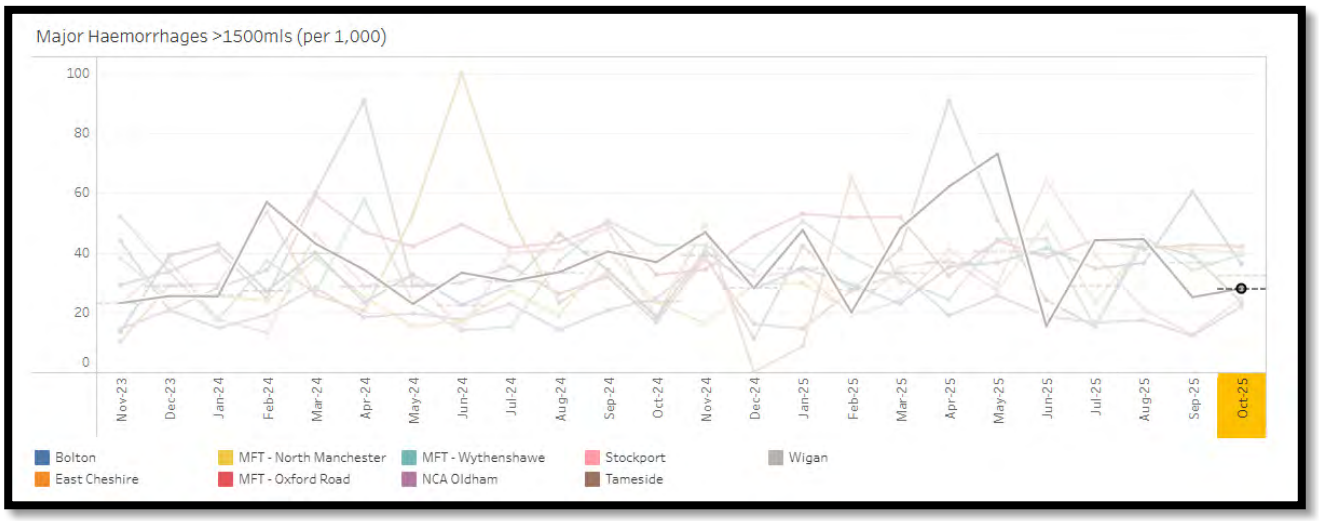
for increased assurance. It should be noted that there are 5 records in December where we have been unable to calculate the DDT interval. This is due to there being no information on Euroking and being unable to locate the hospital notes.

Red

Supernumerary Shift Coordinator
This has been red for five months now. In December there was 1 shift where the shift coordinator was unable to remain supernumerary. This was due to significantly increased activity and acuity on the unit. As requested on safety champions this will be triangulated with sickness data etc to look at possible issues.

Category 1 Caesarean Sections with no Delay in Decision to Delivery interval (%).
Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and delivery. The figures pulled from Euroking for December show that 5 out of 16 women had an interval of more than 30 minutes. The times where there was a delay ranged from 35 to 85 minutes. This metric is continuing to be reviewed with a deep dive audit. The initial results of this audit indicated discrepancies between the written notes and what is recorded on Euroking. It was therefore agreed in Safety Champions that this audit should be ongoing for a while for increased assurance. It should be noted that there are 5 records in December where we have been unable to calculate the DDT interval. This is due to there being no information on Euroking and being unable to locate the hospital notes.

Other areas not RAG rated
PPH 1500mls – 2500mls
The figure shown on the dashboard is shown as a rate. Our rate in December equates to 7 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.



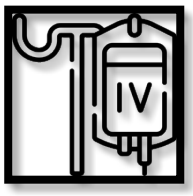
Conclusion

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 - December

The below relates to 4 mothers who delivered 4 babies.

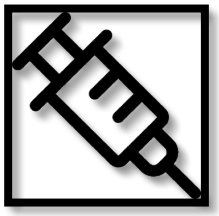
- All babies were born in an appropriate care setting.
- 4 baby born < 34 weeks gestation (0 under 30 weeks).

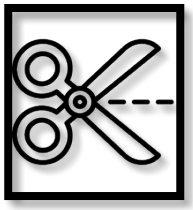


% of mothers under 30 weeks received MgS04 24hrs prior to delivery is N/A as all babies were over 30 weeks

25% of babies received a full dose of steroids within 7 days of delivery (< 34 weeks).

- 1 mother received a full course
- 3 mothers received partial doses as delivery needed to be expedited.



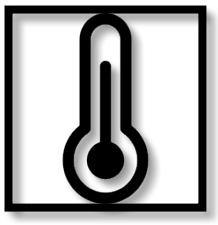


75% received optimal cord management (< 34 weeks).

- 1 baby did not receive delayed cord clamping due to condition at birth.

75% of babies had a Normothermic Temperature (36.5-37.5C) on admission to NNU, measured within one hour of birth (< 34 weeks).

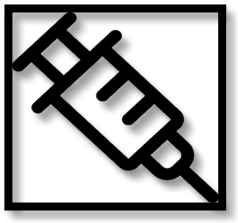
- 1 baby had a temperature <36.6.



50% of babies received maternal breast milk (EBM) within 24 hours of birth (< 34 weeks).

- 2 babies received EBM within 24 hrs of birth
- 2 babies did receive EBM but within 48 hours, not 24.

N/A% received Intrapartum Antibiotics >4 hrs prior to delivery (< 34 weeks)



- X4 N/A as not in labour

Safety Dashboard 2025
Maternity

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

		Goal	Red Flag	Measure	2025 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 Q1	Q2	Q3	Q4	YTD	Trend
Activity	Bookings (Total bookings)				245	228	233	198	248	242	250	189	233	230	216	236	706	688				
	Booked by 10 weeks (as % of total bookings – Exclude transfer to area)	Above 80%	Below 50%		77.55%	69.30%	69.96%	73.74%	62.10%	62.40%	60.40%	70.37%	70.82%	67.39%	63.43%	68.22%	72.27%	66.08%				
					92.65%	90.35%	95.28%	95.96%									92.76%	**92.95%**				
	Registerable births				214	205	191	195	209	198	183	205	201	217	205	204	610	602				
	Planned home births (as % of all births)				0.93%	0.00%	1.05%	1.03%	0.96%	2.02%	0.00%	1.95%	1.00%	2.30%	0.98%	0.98%	0.66%	**1.33%**				
	Unplanned home births (as % all births) – BBA				0.93%	0.49%	0.52%	0.51%	0.48%	1.01%	1.09%	0.49%	1.00%	1.38%	0.49%	0.00%	0.65%	**0.67%**				
	NVD (as % of total births)				40.65%	46.34%	41.88%	42.05%	38.76%	42.42%	37.70%	43.41%	38.81%	40.09%	37.07%	36.76%	42.96%	41.08%				
	Instrumental deliveries (as % of total births)				6.54%	7.32%	5.76%	8.21%	8.61%	7.07%	9.84%	7.80%	8.46%	8.76%	6.83%	8.82%	6.54%	**7.96%**				
	Total number of Caesarean Sections (all categories – as % of total births)				53.74%	46.34%	52.36%	64.62%	52.15%	50.00%	51.91%	47.80%	52.74%	51.15%	56.10%	54.41%	50.81%	**55.59%**				
	Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour				3	6	6	6	6	4	2	5	6	6	9	7	15	16				
	Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour				19	21	22	20	24	15	21	15	18	19	27	18	62	59				
	Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS				9	11	14	15	14	7	11	19	14	23	13	16	34	36				
	Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour				4	1	1	2	2	1	0	2	1	3	1	0	6	5				
	Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour				11	5	6	7	7	8	8	4	6	6	6	7	22	22				
	Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS				15	8	7	2	8	12	8	6	7	11	9	5	30	22				
	Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy				32	26	23	26	27	32	29	29	35	26	28	37	81	85				
	Robson Group 6: Nulliparas; single breech pregnancy				5	2	4	3	6	4	3	3	4	3	3	6	11	13				
	Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus)				5	2	2	3	0	3	5	1	6	3	2	4	9	6				
	Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus)				6	5	7	4	8	6	2	6	4	6	6	2	18	18				
	Robson Group 9: All women with a single oblique or transverse pregnancy (including women with a scarred uterus)				0	0	0	1	1	1	1	4	1	1	1	0	0	3				
	Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus)				6	8	8	7	7	6	5	4	4	4	4	9	22	20				
	Number successful VBAC				6	4	8	5	3	2	2	2	5	2	2	3	18	10				
	% of Category 1 Caesarean Sections with no Delay in decision to delivery (over 30 minutes) – as % total cat 1 CS				72.73%	71.43%	71.43%		63.64%	60.00%		76.40%	60.00%	73.33%	71.42%	68.75%	71.86%	**68.99%**				
	% of Category 2 Caesarean Sections with no Delay in decision to delivery (over 75 minutes) – as % total cat 2 CS				80.65%		66.67%	69.23%	63.89%	80.00%	79.17%		72.50%		80.40%		77.23%	**71.04%**				
	Number of Caesarean Section at Full Dilatation				8	2	8	6	10	2	6	3	3	4	5	8	18	18				
	IOL (as % of all women delivered – excluding pre labour SROM)	Under 35.9%	Above 40%			42.44%		42.56%		40.40%	37.16%	34.15%	36.32%	28.11%			36.37%	40.57%				
	Number of women induced when RFM is the only indication <39 weeks				0	3	0	0	2	0	0	1	0	0	0	1	3	2.00%				
	Number of women induced for Suspected SGA				7	9	2	10	5	4	9	4	9	4	5	6	18	19%				

	Number of In-utero transfers in from other units				4	7	2	2	2	4	3	5	3	4	6	4	13	8%				
	Number of In-utero transfers out to other units				2	2	6	4	0	0	2	4	7	5	3	7	10	4%				
	Average Postnatal Length of Stay				1.7	1.7	1.9	1.7	1.7	1.5	1.7	1.8	1.8	1.8	1.7	1.7	1.76	1.63				
Maternal Morbidity	3rd and 4th degree tears (as % vaginal births)	Under 2.5%	Above 3.5%		5.94%	1.82%	4.40%	5.10%	3.03%	3.06%	1.15%	5.71%	5.26%	3.77%	1.11%	2.15%	4.05%	3.73%				
	Of which 4th degree tears (number)				0	0	0	0	0	0	0	1	0	0	0	0	0	0				
	PPH 1500 – 2500 mls (Rate per 1000)				46.73	19.51	47.12	61.54	71.77	15.15	43.72	43.90	24.88	27.65	48.78	34.31	37.79	**49.49**				
	PPH > 2500mls (Rate per 1000)	Under 4	Above 6		0.00	5.00	5.35	5.18	4.88	5.15	5.52	4.95	5.03	9.35	0.00	4.93	3.45	5.07				
	Number of Women Requiring Level 2 Critical Care				2	2	2	0	1	2	0	0	0	1	1	1	6	**3**				
	Number of Women Requiring Level 3 Critical Care				0	0	0	0	0	0	0	0	0	0	0	0	0	**0**				
	Number of Blood Transfusions > 4 Units				0	0	0	0	0	0	0	0	0	0	0	0	0	0				
	Number of Maternal deaths				0	0	0	0	0	0	0	0	0	0	0	0	0	0				
	Number of women re-admitted within 28 days of delivery (Rate per 1000)	Under 25	Above 35		23.36	24.39	26.18	10.26	9.57	15.15	10.93	4.88	34.83	4.61	29.27	29.41	24.64	11.66				
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis (Number)				0	2	0	0	0	0	1	1	2	3	4	0	2	0				
Neonatal Morbidity and Mortality	Total stillbirths (as rate per 1000)	Under 3.5	Above 4		0.00	4.88	10.47	15.38	0.00	20.20	0.00	0.00	4.98	4.61	9.76	0.00	5.12	11.86				
	Stillbirths (excluding MTOP as rate per 1000)				0.00	4.88	5.24	15.38	0.00	15.15	0.00	0.00	4.98	4.61	9.76	0.00	3.37	10.18				
	Number of stillbirths (excluding MTOP)				0	1	1	3	0	3	0	0	1	1	2	0	2	6				
	Early neonatal deaths (as rate per 1000)	Under 1	Above 1.77		9.35	4.88	0.00	5.13	4.78	5.05	0.00	0.00	4.98	4.61	0.00	0.00	4.74	4.99				
	Early neonatal deaths (excluding MTOP as rate per 1000)				4.67	4.88	0.00	0.00	0.00	0.00	0.00	0.00	1.00	1.00	2.00	0.00	3.18	0				
	Number of Early Neonatal Deaths (excluding MTOP)				2	1	0	1	0	0	0	0	1	1	0	0	3	1				
	Number of babies born below 37 weeks				18	21	14	15	22	18	18	11	12	14	21	12	53	55%				
	Shoulder Dystocia (as % of total births)				1.87%	0.98%	1.57%	0.51%	0.96%	1.01%	0.55%	0.49%	1.00%	0.00%	1.46%	1.47%	1.47%	0.83%				
	Number of singleton babies born under 27 weeks				0	0	0	0	0	0	0	0	0	1	0	0	0	0				
	Number of multiple babies born under 28 weeks gestation				0	0	0	0	0	0	0	2	0	0	0	0	0	0				
	Number of above babies where transfers out not facilitated				N/A	N/A	N/A	N/A	N/A	0	N/A	2	N/A	N/A	N/A	N/A	0	0				
	% of Mothers who delivered under 34 weeks who received AN steroids				25%	50%	50%	40%	40%	43%	33%	33%	25%	100%	100%	50%	42%	41				
	% of Mothers who delivered under 34 weeks who received AN Magnesium Sulphate				25%	8%	0%	20%	40%	14%	100%	100%	100%	100%	100%	50%	11%	25				
	% of Mothers who delivered under 30 weeks who received AN Magnesium Sulphate				N/A	100%	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	N/A	100.00%	N/A				
	Number of mothers who delivered under 34 weeks who received a partial dose of steroids				1	1	0	1	2	1	1	1	1	0	0	0	2	4				
	Number of mothers delivered under 34 weeks who did not receive any course of steroids and omissions in care noted				0	0	0	0	0	0	0	0	0	0	0	0	0	0				
	% of babies who had delayed cord clamping (% of total births)				88.79%	88.29%	79.06%	85.64%	85.65%	85.86%	86.89%	89.27%	88.06%	80.65%	90.24%	92.65%	85.38%	85.72%				
	% of babies born <37 weeks whose mother received intrapartum IV Antibiotics (% of births under 37 weeks)				56.25%	92.31%	64.29%	35.71%	28.57%	50.00%	44.44%	45.45%	41.67%	46.15%	75.00%	66.66%	70.95%	38.10%				
	Neonates with Apgars <7 at 5 minutes (>_37 weeks gestation) - Rate per 1000	Under 15	Above 21		30.61	27.32	22.99	22.60	16.04	0.00	36.59	25.77	10.64	24.88	5.46	15.79	26.97	12.88				

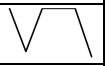
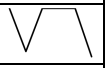
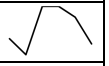
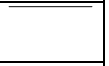
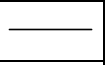
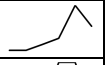
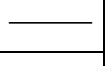
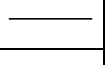
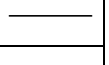
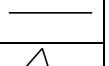
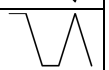
Section	Indicator																					
	Term Admissions to NNU (births >_ 37 weeks gestation) - Rate per 1000				71.43		86.21	37.40	37.43	55.56	42.68	56.70	63.83	64.68			70.76	51.61				
	Number of babies re-admitted with 28 days of birth				16	18	18	19	16	14	13	9	12	12	13	10	52	49				
	Number of babies born < 3rd centile				13	5	8	7	9	12	4	12	4	8	6	11	26	28.00%				
	Number of babies born < 3rd centile >_ 38 weeks				6	1	1	2	5	3	3	6	1	6	7	8	8	10				
Public Health	% women smoking at time of booking (as % of total bookings)				7.76%	3.95%	14.16%	7.58%	6.45%	6.20%	10.40%	4.76%	6.87%	7.39%	6.02%	3.81%	8.62%	6.74%				
	% women smoking at time of delivery (as % of total births)	Under 5.84	Above 10%		7.94%		6.28%	5.13%	5.26%	8.59%	7.65%	4.88%	3.48%	6.45%	4.39%	2.94%	6.21%	6.33%				
		Above 75%	Under 65%		75.23%			82.05%	78.95%	75.76%	77.05%	77.56%					74.05%	78.92%				
										57.60%	58.00%						62.97%	61.04%				
Workforce	1:1 Care in Labour (as % all births - excluding El CS and BBA)				98.96%		98.75%				98.83%		98.90%				99.24%	100.00%				
	Percentage of shifts where shift Co-ordinator able to remain supernumerary		Under 100%				98.39%					98.38%	95.00%	90.32%	98.33%	98.39%	99.00%	100.00%				
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	0	0	0	0	1	1	0	0	1	0	0				
	Number of times home birth service suspended													1	6	10						
	Number of vacancies				1.82	2.22	1.94	6.04	7.97	5.84	6.49	5.81	6.81	9.01	6.13	7.97	1.99	6.61				
	Midwife : Birth Ratio				1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28						
	Prospective Consultant hours on Delivery Suite				60	60	60	60	60	60	60	60	60	60	60	60	180	180				
	Number of Midwifery Red Flags Reported				8	5	7	20	17	6	24	43	68	49	57	60	21	43				
Incidents	Number of incidents reported				87	77	76	52	47	44	64	65	92	81	65	63	240	143				
	Number of MNSI Investigations				0	0	0	0	0	1	0	0	0	0	0	0	0	1				
	Number of StEIS Reported Incidents				2	1	1	0	1	0	1	0	1	0	0	0	4	1				
	Number of Complaints received in the month				3	5	2	3	2	0	3	2	2	4	4	4	10	5				
	Number of Letters of Claim Received in the month				0	0	0	0	0	1	0	1	0	0	0	0	0	1				
	HIE 2 &3 > 37 weeks (rate per 1000)			GM average 2023 0.555/1000	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
	PSII Commissioned Incidents								0	0	0	1	0	0	0	0		0				
	Routine enquiry asked at booking													87.70%	85.10%	88.90%						

Safety Dashboard 2025

Neonatal

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

		Goal	Red Flag	Measure	2025 Jul	Aug	Sep	Oct	Nov	Dec	2025 Q3	Q4	YTD	Trend
Safety	% of Shifts Staffed to BAPM	100.00%	< 90%	Badger					67%	92%	98.33%			
		100.00%	< 50%	Badger		98%	95%	97%	62%	95%	97.78%	84.48%		
		0	≥ 1	Datix					2	0	0.0	0.7		
						1	1		1					
Admissions	Number of Births from Maternity				183	205	201	217	205	204	196	209		
	Admissions Under 27 Weeks to NNU				0	0	0	0	0	0	0	0		
	Total Admissions to Neonatal Unit				20	19	23	24	21	18	21	21		
	Total TC Admissions			Badger	15	19	20	12	18	13	18	14		
	Number of unexpected Term Admissions to NNU			Badger	6	10	12	13	6	6	9	8		
	Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)	<6%	≥ 4.5%	Maternity/Badger	3.28%	4.88%	5.97%	5.99%			4.71%			
	Mothers Eligible for AN Steroids (< *34 Weeks*)				2	2	2	2	1	3	2	2		
	% of Mothers Who Received Full Course of Antenatal Steroids				50.00%	50.00%	50.00%			66.70%	50.00%	88.90%		
	Mothers Eligible for AN $MgSO_4$ (< *30 Weeks*)			NNAP/ NWNODN	1	1	2	1	0	0	1	0		
	% of Mothers Receiving Antenatal $MgSO_4$				100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
	Babies Eligible for Delayed Cord Clamping (< 34 Weeks)			NNAP/ NWNODN	3	3	3	2	1	4	3	2		
	Babies Received Delayed Cord Clamping >1min	≥ 85%	< 73%	NNAP/ NWNODN	33.30%	66.60%	66.60%	50%		50%	56%	67%		

NNAP					3	3	3	2	1	4	**3**	**2**		
					100.00%	33.30%	100.00%	100.00%	100.00%	25.00%	**77.77%**	**75.00%**		
					100.00%	33.30%	100.00%	100.00%	100.00%	25.00%	**77.77%**	**75.00%**		
					16	13	22	22	20	15	**17**	**19**		
					100.00%	100.00%	95.00%	86.36%	100.00%	80.00%	**98.33%**	**88.79%**		
					74.60%	76.70%	83.80%	66.40%	77.30%	71.30%	**78.37%**	**71.67%**		
					1	3	2	1	3	3	**2**	**2**		
					100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**		
					0	0	0	0	0	0	**0**	**0**		
					0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**		
					2	0	0	1	0	3	**1**	**1**		
	-				0.00%	100.00%	100.00%	0.00%	100.00%	75.00%	**66.67%**	**58.33%**		
Incidents					11	11	13	15	26	19	**12**	**20**		
											0.0	**1**		
											0.0	**0**		
											0.0	**0**		
											0.0	**0**		
											0.0	**0**		
ding					48.60%	60.90%	78.90%	29.20%	55.00%	44.40%	**62.80%**	**42.87%**		
					3	3	4	2	1	4	**3**	**2**		
					100.00%	100.00%	50.00%	50.00%	100.00%	50.00%	**83.33%**	**66.67%**		

Breastfee					3	0	3	0	2	2	**2**	**1**		
					100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**		
					2	4	4	3	6	5	**3**	**5**		
					100.00%	75.00%	75.00%	66.70%	100.00%	100.00%	**83.33%**	**88.90%**		
Activity					19	5	11	26	9	11	**12**	**15**		
					24	21	38	53	55	83	**28**	**64**		
					43		49	79	64		**39**	**79**		
					159	148	170	172	290	204	**159**	**222**		
					202	174	219	251	354	298	**198**	**301**		
					61.29%	16.13%	36.67%	83.87%	30.00%	35.48%	**38.03%**	**49.78%**		
					25.81%	22.58%	42.22%	56.99%	61.11%	89.25%	**30.20%**	**69.12%**		
					51.29%	47.74%	56.67%	55.48%	96.67%	65.81%	**51.90%**	**72.65%**		
					46.54%	40.09%	52.14%	57.83%	84.29%	68.66%	**46.26%**	**70.26%**		
					74	93	82	64	83	64	**83**	**70**		
					59.68%	75.00%	68.33%	51.61%	69.17%	51.61%	**67.67%**	**57.46%**		
Training										%		**100.00%**		
	-									%		**97.60%**		
										%		**93.00%**		
										%		**97.70%**		
										%		**100.00%**		
										%		**100.00%**		
										%		**100.00%**		

Maternity Perinatal Quality Surveillance Dashboard December 2025

CQC Maternity Rating – Last assessed 2023

OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
Good	Requires Improvement	Good	Good	Good	Good

December 2025 Exception report

Stillbirth	Neonatal Death	Red Flags
There was 0 Stillbirths in December 2025	There was 0 Neonatal Deaths in December 2025	There are 44 Red Flags 29 - Missed or delayed care (for example delay fo 60 minutes or more in washing and suturing) 1 Missed medication during admission to the hospital or midwifery-led unit 13 - Delay between admission for induction and beginning the process 1 - Coordinator unable to maintain supernumerary status - not providing 1:1 care
Supernumerary Shift coordinator	**1:1 care in labour**	**Divert**
The shift coordinator remained supernumary for 98% of shifts thoughout December 2025	1:1 care in December 2025 - 100%	There was 1 Diverts in December 2025. There was no Obstetric Registrar Cover and due to the short notice unable to cover. Therer were no women diverted to other units and no safety events occurred during the divert period.

Cardiotocograph (CTG) training	Practical Obstetric Multi-Professional Training (PROMPT)
Midwives = 91% rolling compliance Obstetric Consultants = 92% rolling compliance Obstetric Registrar = 93% rolling complaince **Over 90% compliance across all roles for Fetal Physiology Training**	Midwives 16 attended rolling figure (90%) MSW 4 attended rolling figure (94%) Obstetric Consultant 4 attended rolling figure (93%) Obsteteric Registrar 3 attended rolling figure (92%) Anaethetists 4 attended rolling figure (100%) **Over 90% compliance across all roles for PROMPT Training**

Feedback

Service User Voice Feedback	Staff Feedback from Frontline Champions & Walkabouts (Bi-Monthly)
Feedback from Service User FFT I was warmly received by the midwife. At the point of delivery, the midwife on duty, by name Alison was super amazing. I saw someone whose kind heart was demonstrated while on her job. After she closed her shift, she came back to the delivery suite to check on us (myself and baby) and to bid us a farewell *what we could have done better?* I was updated with information regarding life after baby. For example contraceptive options etc. But at some point no one came around to let us know when we were eventually going to be discharged home until very late at night when my husband went to ask	Next Formal Walkabout 12th January 2026

Title of report:	Perinatal Quality Oversight Report (Q3 2025-2026, Oct - Dec 25)
Presented to:	Board of Directors
On:	4 February 2026
Purpose	Information, Oversight and Assurance
Presented by:	Cathy Stanford Divisional Director of Maternity and Child Health
Prepared by:	Eve Broadhurst Head of Governance Maternity and Child Health
Contact details:	T: 01942 822993 E: eve.broadhurst@wwl.nhs.uk

Executive summary

Patient Safety Events

Maternity/Obstetrics

Incident reporting trends in Q3 are stable, despite ongoing staffing pressures on the clinical floor.
Moderate and Above Harm Incidents:
There were 2 incidents classified as moderate harm or above in maternity/obstetrics during Q3.
Duty of Candour 100% compliant

Neonatology

A focused drive on incident reporting has been in place throughout Q1 and Q2 of 2025/26. There has been increased reporting in Q3.
There was 1 patient safety event in neonatology reported as moderate or above harm in neonatology during Q3.
Duty of Candour 100% compliant

Exceptions

97 obstetric/maternity DATIX incidents remain under investigation beyond 30 days. The Governance team are supporting with incident closure.

PSIRF

The report details all learning from approved investigations. Two completed investigations were approved and closed following presentation at Learning from Patient Safety Events (LfPSE) group during Q3.
Associated action plans will be monitored via the Trust Learning from Experience Group (LfEG).
No safety incidents were logged on StEIS for monitoring purposes during Q3.
4 Screening incident assessment forms (SIAFs) were completed in Q3. These will be managed as per PSIRF, in liaison with NHSE.
5 Mortality reviews were undertaken; eligible cases will be taken through PMRT.
2 Screening Assessment Incident Forms (SIAFs) were closed by NHS England during this period.
No eligible MNSI cases.

The PSIRF Maternity Chapter outlining local maternity priorities 2026-2028 was added to the Trust PSIRP.
No exceptions

Legal

There were no Regulation 28s issued in Q3
There were no claims received in Q3.

Feedback and complaints

In Q3 25/26, 12 formal complaints have been received for maternity services, which is higher than previous quarters.
1 complaint was received for neonatal services.
12 complaints closed during the quarter, of which 3 were downgraded to a concern and did not require a full, formal response.
FFT response rates decreased, with a slight increase in positive responses (95.3%).
A wealth of positive feedback has been collated from service users via the FFT, MNVP and the P&PE midwife and has been fed back to staff. Emerging themes are detailed in the report. Triangulation and analysis of themes from the various sources of patient feedback is included in the report.
There has been a marked increase in the number of women accessing the Birth Thoughts service in 2025 compared to 2024. Prevalent theme is women not remembering what happened to them in labour.
Demographic data of service users who have engaged / fed back is detailed where possible.
Triangulation of claims, complaints and incidents is also evidenced in the report with actions.
No Exceptions.

SCORE survey

WWL Maternity and Neonatal services participated the SCORE staff survey in 2024 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. The survey results high-lighted
1. Burnout Climate – working too hard, exhaustion and work-life balance.
2. Safety - Values alignment, particularly in Maternity and on Antenatal Clinic.
3. Team Working - Communication breakdowns in and between teams.
4. Fairness - perception that staff were not treated fairly regarding deployment and recruitment
In Q3, maternity senior leaders raised concerns regarding the level of engagement from Boo Consulting and the limited system-level insight and support being provided. Current recommendations have largely focused on small, localised interventions rather than addressing broader strategic or organisational priorities to address workplace culture. This matter will be discussed at the Safety Champions meeting in January 2026 (Q4) to determine next steps and required assurance.

Risks

The Risk Register has been included for maternity and neonatal services.
At the end of Q3 25/26,
0 risks under review or awaiting approval.
1 risk approved: 4291 Obsolete Oxygen Saturation Equipment in Neonatology Outreach Services (6)
2 risks closed:
4236: Antenatal CTGs approaching end of service contract.

Fetal Surveillance Midwife confirmed that we now have access to new antenatal CTG machines. No additional training requirements required from the staff.
4189: No immediate availability of video laryngoscope on the neonatal unit.
Video Laryngoscope sourced via charitable funding and fully implemented. Training has been rolled out by the training team to all staff.

Exceptions

Work continues with low scoring risks and outstanding risk actions. Training to be arranged with Trust Risk Lead for Matrons and other risk holders.

Ockenden 2

Q3 25/26 has seen some progress against the actions and 1 action remains outstanding.
Exceptions - 1.10 *All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.*
In progress: Workforce review (s) with GAP analysis and Band specific development pathways.

Maternity Incentive scheme

Full compliance with MIS Year 6 was confirmed in Q4 24/25.
MIS Year 7 was published on the 2 April 2025. The relevant review period for the 10 Safety Actions is 1 December 2024 to 30 November 2025. The report tables progress with the 10 Safety Actions – on track.
No exceptions

3-Year Maternity Plan

In March 2023, NHSE published its three-year delivery plan for maternity and neonatal services with a focus on personalised care and equity and equality. On track for completion by end Q4.
No exceptions

ATAIN (Q2 audit)

In Q2, the total number of term admissions to the NNU was 5.10% of total term live births. This is a slight increase from Q1 (4.96%)
Unexpected term admissions to the NNU accounted for 4.92% of total term live births. This is a slight increase from Q1 (4.77%)
There is still work to be done with 4 (14%) of total admissions being potentially avoidable, this is a decrease from Q1 where 19.2% of total term admissions were potentially avoidable.
Findings from Q2 audit/MDT review group are detailed in the report.
No exceptions

Mortality and PMRT

There were 3 reported stillbirths in Q3 2025/26, representing an increase from Q2.
Ethnicity, deprivation, fetal growth restriction, raised BMI and increased age are noted themes.
The themes—particularly fetal growth restriction and socioeconomic deprivation—remain aligned with known national risk factors for stillbirth. **The Board should note that the ongoing lack of weight**

management support in pregnancy in the Borough (decommissioned in 2024) presents a system level risk, given the over representation of raised BMI in this cohort.
Internal guideline alignment work, together with strengthened oversight of hypertension management (as part of the WWL Maternity PSIRF Priority 2026–2028), demonstrates that learning is already being translated into practice improvement.
There were 2 reportable neonatal deaths in Q3 2025/26 which represents an increase from Q2. Due to low numbers, thematic analysis remains limited. However, all cases are logged to support longitudinal analysis and inform future learning and will inform the annual Mortality report.
5 PMRT cases were completed within the quarter, with learning outlined in the report.
Actions in place.
No exceptions

Saving Babies Lives 3

The report provides SBL3 Q3 audit findings.
LMNS Assurance:

- June 2025: 96% compliance against SBL 3 intervention parameters
- Q3: Awaiting LMNS confirmation for latest compliance check point.

No Exceptions

Mandatory training

The Perinatal Oversight model requires monitoring of training progress for MIS compliance (target 90%) across three key areas:

1. Fetal Monitoring Training
2. Multi-professional Maternity Emergencies Training
3. Neonatal Resuscitation Training

Progress against the six core modules of the Core Competency Framework is also tracked; however, this is not included in MIS Safety Action 8.
Current Position:

- Compliance monitoring is in place for all three mandatory training areas.
- Additional work is ongoing to ensure new starters and non-attendees are booked promptly to maintain compliance.
- Delivery method plan for Equity, Equality and Personalised Care training for medical staff will be via SBL day. Trajectory for Consultants and Registrars >90% by September 26.
-

Workforce/ Safe staffing

At the end of Q3, there were 0 WTE midwifery vacancies and 1.66 WTE MSW vacancies. Staffing rota gaps – 4.54 WTE midwives due to maternity leave.
At the end of Q3, there were 0.48 WTE neonatal nurse vacancies. Further staffing gap of 1 WTE nurse due to maternity leave
At the end of Q3 there were no vacancies in medical staffing in both Obstetrics and Neonatology. Tier 2 rota is reported to have shift gap of 1.6 WTE due to 1 WTE working supernumery and 1 extended phased return.
At the end of Q3 there are 6 anaesthetic vacancies across WWL. The maternity rota is covered as priority and there are no staffing gaps.
Exceptions
No anticipated change in Q4 for the Obstetric Tier 2 staffing gaps. Currently covered via Bank/Agency. On Risk Register.

Business Information (BI) Fill-Rate data is included in the report. Noted no data available from BI for Delivery Suite. Data does not reflect MAPS or staffing pressures. Action required.

Staffing Red Flags

There were 69 validated staffing red flag events recorded in Q3 2025/26, representing a significant decrease from Q2 likely due to efforts to analyse the reported Red Flags. These events are captured via the Birthrate Plus system. No known harm has been reported in relation to these events.
The majority of red flags were due to:
Delays of 60 minutes or more in care e.g. washing and suturing.
Delays in admission and commencement of induction within 2 hours.

Exceptions

Delivery Suite compliance for Q3 was 79.53 %, showing a decrease from Q2.

Maternity Ward compliance for Q3 was 77%, showing an increase from Q2.

Delivery Suite Manager is working closely with Band 7 shift coordinators and the Maternity Ward Manager to further improve compliance.

Maternity Unit Diverts

There was 1 maternity unit divert during Q3.
The unit diverted for 10 hours and 50 minutes on the evening of December 6th due to locum registrar not attending planned shift.
Unable to cover at short notice
No women required divert and none were received, however it necessitated delaying planned artificial rupture of membranes (ARMs).

RCOG Locum doctor compliance

WWL remains compliant with RCOG requirements from short-term locums in 2025. A full report will be provided to Board for assurance of adherence to MIS Year 7 Safety Action 4.

RCOG Consultant attendance

At the end of MIS Year 7 reporting period we were 100% compliant with consultant attendance in line with RCOG guidance. A separate report is provided to Board.

SPC charts (until end Q3 25/26)

In alignment with the Patient Safety Incident Response Framework (PSIRF), data outcomes and learning from incidents continue to inform targeted QI initiatives. Active workstreams include:

- Term Admissions to the Neonatal Unit (NNU)
- Postpartum Haemorrhage (PPH >1000mls)
- Obstetric Anal Sphincter Injury (OASI – 3rd and 4th degree tears)
- Local Safety Standards for Invasive Procedures (LocSSIP)

Weekly ATAIN reviews are undertaken, supported by an overarching QI action plan. A downward trend in term admissions and Apgar scores <7 at 5 minutes has been noted, indicating positive impact from improvement efforts.
The PPH multidisciplinary review group has now implemented an AMAT audit to formalise findings and strengthen assurance processes and preliminary data has been presented. A downward trend is noted in PPH>2500mls.
Quarterly themed analysis is now undertaken by the Perineal Pelvic Health Midwife and again an overall downward trend is noted in 3rd and 4th degree tear rates.

SATOD data is the best we have seen at WWL.
The number of stillbirths and neonatal deaths has increased in 2025 as compared to 2024. Robust governance processes are in place to ensure all findings are actioned. The annual mortality report will be completed in Q4 to provide detailed analysis.

Maternity Outcomes Signal System (MOSS)

WWL responded to their first Level 1 Safety Signal in December 2025 due to 3 term mortalities (1 in September; 1 in November; 1 in December). A detailed MOSS Safety Checklist was completed which identified NO safety issues.

Link to strategy and corporate objectives

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE Perinatal Quality Oversight Model (August 2025). The purpose of the report is to inform the ICB Board and Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. It is a CNST requirement.

Risks associated with this report and proposed mitigations

The risk associated with release of staff for training and education

Financial implications

Failure to meet all of the Maternity Incentive Scheme Safety actions will result in loss of 10% rebate of premium cost.

Legal implications

Supports compliance with National recommendations and standards for Perinatal care
.

People implications

Promotes staff development wellbeing, and retention as well as quality patient care.

Equality, diversity and inclusion implications

Supports inclusivity for women and families from diverse ethnic backgrounds, whilst identifying the population need in relation to improving health inequalities for marginalised groups.

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

None at present

Recommendations

The Board of Directors are asked to review the contents of this paper to discharge their responsibilities for oversight and assurance of clinical governance and safety monitoring within Maternity and Neonatal services.

Perinatal Quality Oversight Report

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

1.0 Obstetrics/Maternity Patient Safety Events reported in Q3 (data pull 16/01/2026 - DATIX)

Q3	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
No Harm	58	57	61	38	36	35	55	56	76	68	56	57
Low	9	6	5	12	8	7	6	9	9	8	4	6
Moderate	1	3	1	1	0	1	1	1	1	1	0	2
Severe	0	0	0	0	0	0	1	0	0	0	0	0
Death	0	1	0	0	0	0	0	1	0	0	2*	2*
Total	**68**	**66**	**67**	**51**	**44**	**43**	**63**	**67**	**86**	**77**	**62**	**67**

Reporting Trends:
Incident reporting trends in Q3 are stable, despite ongoing staffing pressures on the clinical floor.

Death reporting:

- Datix now offers 2 harm categories – death caused by incident and death not caused by incident.
- *The 4 reported deaths were categorised as death **not** caused by incident.
- A summary of mortality cases is found in section 7 of this report.

Moderate and Above Harm Incidents:
There were **3** incidents classified as moderate harm or above in maternity/obstetrics during Q3:

1. **WEB188453 (October)** – *Baby sustained broken arm at Caesarean Section*
   - Unknown cause/mechanism of injury. No manipulation required at Caesarean section.
   - DATIX review completed. Will form part of wider themed analysis on birth injury which is currently in progress.
   - Duty of Candour served.
2. **WEB191612 (December)** – *Baby sustained broken arm at Caesarean Section*
   - The procedure was technically challenging and required manipulation to achieve delivery.
   - Gaps in documentation and no handover of procedure to neonatal team.
   - The subsequent injury was not identified until two days after transfer to St Mary's. Imaging demonstrated callous formation, consistent with the timing of the difficult longline insertion carried out on the neonatal unit.
   - Two potential causes have been identified.
   - The non-mobile injury pathway was followed and has now been closed.
   - The case is under review and will contribute to the wider themed analysis on birth injuries, which is currently in progress.
   - Duty of Candour served.
3. **WEB191802 (December)** – *Re-admission of mother within 28 days.*

- 16 day readmission, now on ICU following emergency surgery to correct faeces and internal fluids being expelled from Caesarean wound. Patient has extensive abdominal surgery history including JP insertion and salpingectomy.
- Under review.
- Duty of candour served.

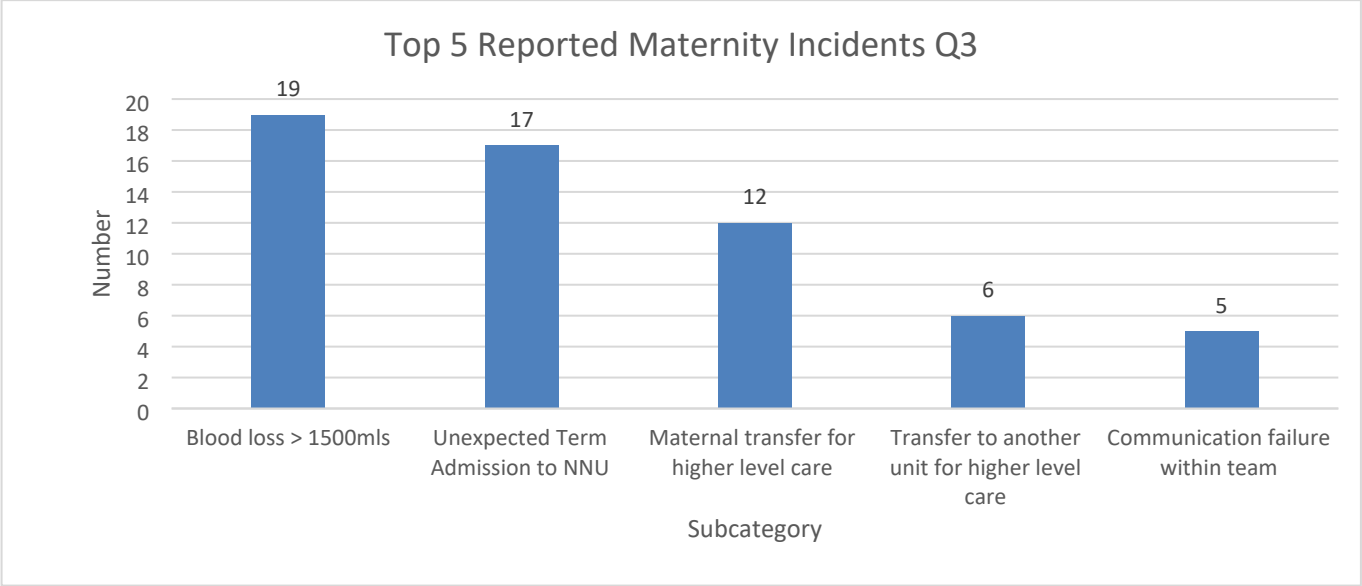
1.1 Neonatal Patient Safety Events reported in Q3 (data pull 16/01/2026 – DATIX)

Q3	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
No Harm	10	21	24	10	2	15	9	9	11	10	22	17
Low	2	1	0	0	3	1	2	2	0	0	0	1
Moderate	0	0	0	0	0	0	0	0	0	0	1	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	**12**	**22**	**24**	**10**	**5**	**16**	**11**	**11**	**11**	**10**	**23**	**18**

Harm Events and Escalations:
There was **1** patient safety event in neonatology reported as moderate or above harm in neonatology during Q3.

1. **WEB190070 (November) –** ***Transfer out to another unit for higher level of care.***
    - Rapid review with timeline completed.
    - Suboptimal care of the deteriorating patient identified with learning around the recognition and management of abnormal blood gases and the need for a more proactive approach to respiratory management in the septic baby.
    - Baby successfully repatriated to WWL following treatment at St Mary's Hospital.
    - Case presented at Trust LfPSE group– manage actions in Division.
    - Duty of Candour completed.

1.2 Top 5 Reported Incident Sub-Categories Maternity– Q3 25/26 (data pull 18/01/2026 - DATIX)

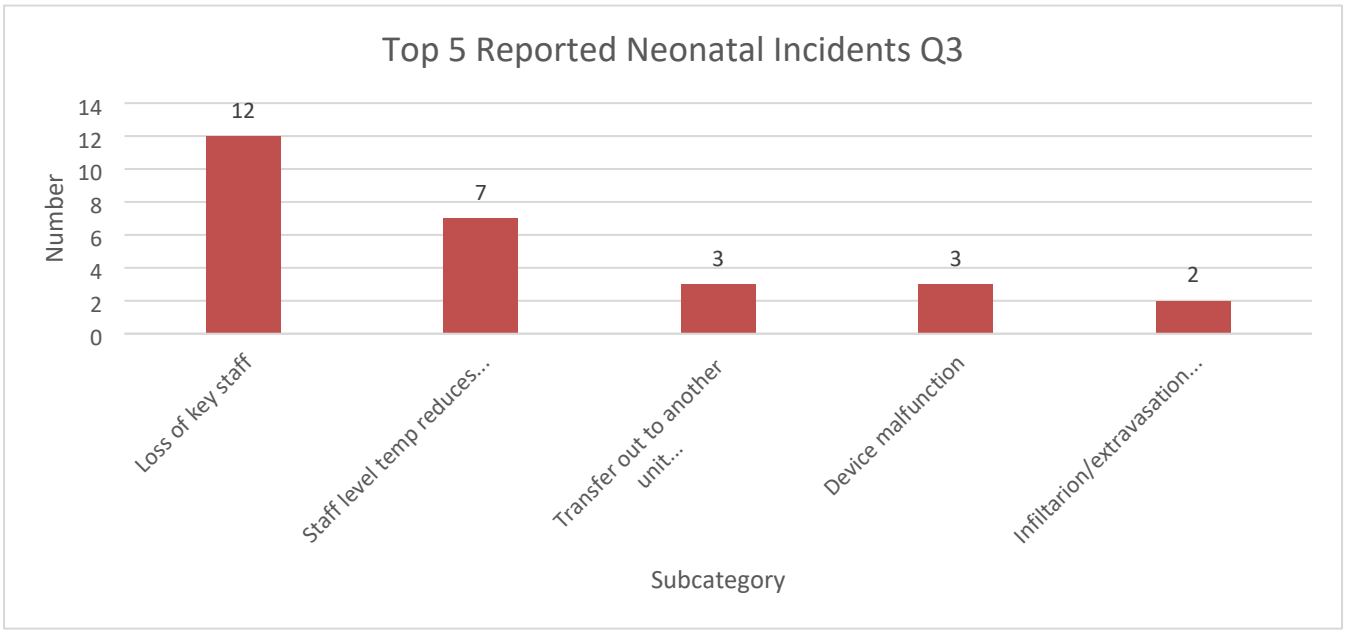


1.2.1 Quality Improvement (QI) Workstreams

In alignment with Patient Safety Incident Response Framework (PSIRF), data outcomes and learning from incidents continue to inform local priorities and targeted QI initiatives. Active workstreams include:

- Term Admissions to the Neonatal Unit (NNU)
- Postpartum Haemorrhage (PPH >1500mls)
- Obstetric Anal Sphincter Injury (OASI – 3rd and 4th degree tears)
- Local Safety Standards for Invasive Procedures (LocSSIP).

1.3 Top 5 Reported Incident sub-categories Neonatology – Q3 25/26 (data pull 18/01/2026 DATIX)



Staffing continues to be a theme in top 5 sub-category of incidents reported. All staffing incidents reported were no/low harm.

Exceptions – Q3 Maternity and Neonatology

- **Duty of Candour:**
  - *0* maternity or neonatal Duty of Candours remain outstanding.
- **Investigations >30 Days:**
  - *97* obstetric/maternity DATIX incidents remain under investigation beyond 30 days (↑ from Q2).
  - *0* neonatology DATIX incident remain under investigation beyond 30 days.
- **Oversight and Support:**
  - All incidents are triaged daily within the Division.
  - Ongoing support is provided to staff through the DATIX Review Group to promote completion of investigations within the 30-day timeframe.

1.4 Incidents reported to 'StEIS' and external agencies Q3 25/26

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Incidents reported to 'StEIS' via LfPSE	3	0	2	0	1	0	0	1	1	0	0	0
MNSI referrals	0	0	0	0	0	1	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	0	0	1	0	0	2	3	1	0

1.4.1 StEIS Reporting:
0 safety incidents were logged on **StEIS** for monitoring purposes during Q3.

1.4.2 Screening Assessment Incident Forms (SIAFs):
4 SIAFs were completed in Q3. These were not logged on StEIS, as they did not meet the StEIS threshold. A national meeting was scheduled for November to align screening incidents with PSIRF processes but was cancelled.

1. **WEB189509 – #018318 - *Missed haemoglobinopathy screen***
   - Picked up by failsafe officer. Contacted ward but not actioned.
   - Under review by NHSE.

2. **WEB188319 – #018344 – Missed *Fetal Anomaly scan***
   - Patient DNA anomaly scan
   - DNA not actioned
   - Failsafe strengthened
   - Baby born with no anomalies.

- Awaiting evidence of closure from NHSE.

3. **WEB189509 - #018344 -** ***Fetal anomaly completion scan appointment given outside screening window***
   - Picked up by failsafe officer when checking database
   - Scan appointment for completion given outside screening window.
   - Similar recent incident and new failsafe put in place (this incident happened prior to new system).
   - Awaiting evidence of closure from NHSE.

4. **WEB191867 #018625 –** ***Printed newborn blood spot labels amended by staff member***
   - Barcoded labels for twins amended by neonatal Outreach team
   - Laboratory rejected samples
   - Repeat samples - normal
   - Learning shared with staff involved
   - Closed by NHSE

No exceptions

1.5 MNSI overview

HSIB/MNSI cases to date	
Total Referrals	27
Referral / cases rejected	14
Total investigations to date	13
Total investigations completed	13
Current active cases	0
Exception reporting	0

There were no cases meeting MNSI referral criteria in Q3.

1.6 MNSI /NHSR assurance Maternity Incentive Scheme Year 7 reporting period

There have been no eligible cases for referral to MNSI/NHS Resolution since 15/08/2023.

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
MI-043442	Maternal Death	20.05.2025	NA	Rejected	NA	NA
MI-045154	Cooled	08.08.2025	NA	Rejected	NA	NA

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

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

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

Note: The Submit a Perinatal Event Notification (SPEN) system is a new national NHS England reporting portal designed to streamline and standardise the notification of perinatal and maternal safety events across England.

It replaces multiple separate reporting platforms (including MNSI, NHS Resolution's Early Notification Scheme, and MBRRACE-UK portals) with one single point of entry, reducing duplication and administrative burden. Information entered once is automatically shared with all relevant national bodies.

Key features and purpose:

- **Single unified portal** for reporting stillbirths, neonatal deaths, severe brain injuries, maternal deaths, and qualifying perinatal safety events.
- **Automatic routing of notifications** to the appropriate national organisation (MNSI, NHS Resolution EN Scheme, MBRRACE-UK, CDOP).
- **Improves data quality and timeliness**, supporting national learning and reducing duplicated workload for Trusts.
- **Phased national rollout (Sept–Nov 2025)** with Trusts onboarded regionally and supported by NHS England.

Overall aim:
To strengthen patient safety by ensuring **consistent, high-quality, and efficient reporting** of perinatal and maternal events, enabling faster learning and improved oversight at local, regional, and national levels

No Exceptions – compliant with Safety Action 10.

1.7 PSIRF activity

- Two **completed investigations** were approved and closed following presentation at **Learning from Patient Safety Events (LfPSE)** group during Q3.

  - Associated **action plans will be monitored via the Learning from Experience Group (LfEG)**.

- One **case** of a 4th degree tear was **de-escalated** following review by the **Patient Safety Group (PSG).**

- Two **Screening Assessment Incident Forms (SIAFs)** were **closed by NHS England** during this period.

WEB number	Date	Incident	Investigation tool/s	Learning
WEB176473 2025/1632	Feb 25	Antenatal stillbirth 30 weeks	Rapid Review PMRT	UtAD performed as per pathway but patient did not attend ANC following scan Abnormal result missed in subsequent appointments. Consequently, additional 28 week scan not arranged which likely affected the outcome. Appointment process strengthened and reflected in guidance. Preliminary audit findings positive. LfPSE group – no further investigation required.
WEB181982	January 2025 Reported: June 25	Antenatal and Newborn Screening Incident – Infectious diseases tests not selected on sticker	SIAF	No infectious diseases request marked on sticker in error. Blood sent to lab. Lab undertook testing for Syphilis and Hep B but omitted HIV which is not in line with usual process to test none, report omission and store sample until clear. Individual learning. Closed by NHSE.
WEB183762 2025/3456	July 25	Maternal cardiac arrest	Rapid Review PSII	The regional pathway has clear guidance around referral for cardiac and renal investigations for women who have chronic hypertension, though the Trust do not utilise this guidance as it is 3 years out of date. Align local

				protocols with regional / national standards. As per NICE guidance women require a urine dipstick check at every routine antenatal contact. This is particularly pertinent for women with raised blood pressure. There was no clear plan documented of how often the blood pressure was to be reviewed in the antenatal period. Regional guidance states between 1-4 weeks. Women with essential hypertension need a clear plan of care documented by a senior clinician. Escalation protocols for severe hypertension require reinforcement to ensure timely Consultant Obstetrician and Anaesthetist presence. Local protocol on combined antihypertensive use and magnesium sulphate administration to minimise risk of profound hypotension needs review and clarification. Disparity between invasive and non-invasive blood pressure readings requires clear documentation and rationale for which measurement is guiding practice. Learning event to be arranged to share learning across the region with regards to hypertension in pregnancy and the importance of taking an MDT approach. Theatre environment was overcrowded (23 staff), noisy, and lacked clear role allocation. The Maternity and Theatre team to jointly facilitate emergency skills drills to ensure there are clear

				roles and responsibilities and lines of communication in emergencies. Midwives are only required to complete Basic Life Support Training. Key Maternity Band 7 team to attend Immediate Life Support training.
WEB185468	Aug 25	4th degree tear	Detailed DATIX response	Forceps were applied and locked by the senior clinician, who then performed the first pull. During this stage, the senior requested that the midwife undertake the episiotomy. This request was a deviation from usual local practice, and the midwife was not prepared for this unexpected instruction. Before the episiotomy could be performed, the woman pushed, and a fourth-degree perineal tear occurred. Noted junior doctor present for training. Spoke Arabic (same language as mother). Need clear role allocation prior to procedure. Managed in Division
WEB187569	June 25 Reported date: September 25.	Antenatal and Newborn Screening Incident – Fetal anomaly scan booked outside window	SIAF	Sonographer human error Weak failsafe – strengthened. Closed by NHSE
WEB187342	Sep 25	Antenatal and newborn Screening - FAS	SIAF	Human error x 2. Sonography booked FAS outside screening window. Screening team entered wrong date into system. Failsafe in place. NHSE closed
	November 25	Transfer out to another unit for	Detailed Rapid Review	Septic baby (E-coli) transferred to St Mary's for higher level of care.

		higher level of care		Suboptimal care of the deteriorating patient identified with learning around the recognition and management of abnormal blood gases and the need for a more proactive approach to respiratory management in the septic baby. Baby successfully repatriated to WWL following treatment at St Mary's Hospital. Case presented at Trust LfPSE group– manage actions in Division. No further investigation required.

1.8 PSIRF – overview of open investigations

At the end of Q3, 8 investigations are open.

WEB number	Date	Incident	Progress	Stage	Plan
PSIRF					
WEB186268 2025/5281	Aug 25	Neonatal death – Twin 1	Awaiting final PMRT	RR complete External Review complete PMRT underway	Preliminary PMRT meeting to be scheduled by Bolton Hospital.
WEB183547	July 25	Fractured leg – difficult LSCS	RR complete	Addressing family's questions via PALS in investigation.	Complete and arrange meeting.
WEB189093	July 25 Reported Oct 25	Antenatal and newborn Screening – missed haemoglobinopathy screen	SIAF complete	Awaiting recommendations	Under review by NHSE
WEB188319	Sep 25 Reported Oct 25	Antenatal and newborn Screening – FAS	SIAF complete	Recommendations complete and with NHSE	Awaiting closure by NHSE.
WEB189509	Sep 25	Antenatal and newborn Screening – FAS	SIAF complete	Recommendations complete and with NHSE	Awaiting closure by NHSE

	Reported Oct 25				
WEB183547 WEB188453 WEB191612 WEB187480	Dec 25	Cluster of birth injuries	Themed analysis commissioned	Allocated	Governance team supporting investigator
WEB191802	Dec 25	Readmission within 28 days (surgical complication)	Rapid review with timeline underway	In progress	Await completion of Rapid review

No Exceptions – note: the new Trust PSIRP (2026-2028) now contains a separate maternity chapter detailing local maternity PSIRF priorities.

1.9 Regulation 28

There were **no** Regulation 28s issued in Q3 2025/26.

1.10 New claims

There were **no** new clinical negligence claim was received within the Division in **Q3 2025/26**:

2.0 Patient Experience

A wealth of feedback has been collated from multiple sources, including ward visits, MNVP 'Walk the Patch' visits, Friends and Family Test and Thank You Thursday initiatives. This feedback has been shared with 33 individual midwifery and medical team members, as well as the full Theatre team and Triage staff in Q3, reinforcing a culture of recognition and continuous improvement.

2.1 Patient and Public Engagement Midwife Activity Q3

The P&PE midwife has visited 30 women in Q3 on the Maternity Ward who have either had emergency procedures or the P&PE midwife has personally provided care to them. This included 2 spontaneous vaginal births and 6 women who had received an elective section.

Key Highlights

- **Patient Feedback**
  - **100% positive feedback** received in Q3 regarding care experiences.
  - Patient feedback continues to reflect a strong culture of compassionate, patient-centred care. The following themes emerged consistently in Q3:

- **Clear Communication and Explanations**
  Patients valued logical, transparent explanations of care and treatment, which helped them feel reassured and informed.
- **Feeling Supported and Involved**
  Women reported feeling involved in decisions and supported throughout their journey. Birth partners also felt included and well-informed.

- **Compassionate and Respectful Care**
  Feedback frequently described staff as “amazing,” “brilliant,” and “fantastic,” highlighting empathy, kindness, and professionalism.
- **Continuity and Consistency of Care**
  Positive experiences were linked to continuity, with patients appreciating care from the same midwife and consistent standards across teams.
- **Support for Complex Needs**
  Women with multiple admissions or medical conditions praised the proactive and attentive approach of staff.
- **Partner Inclusion and Family Support**
  Fathers and birth partners valued being kept updated and supported, with overnight stay opportunities seen as beneficial.
- **Positive Impact on Perceptions of Care**
  Some patients reported a transformation in their view of hospital care, describing their experience as “excellent” and “beyond expectations.”

- **Demographics**
  - **53%** of women were from areas below **Decile 3**, and **40%** below **Decile 2** (lowest areas of deprivation).
  - **23%** were from minority ethnic groups.

Areas for Improvement

- **20%** of respondents identified improvement opportunities, primarily around:
  - **Communication**
  - **Behaviours**
- Immediate actions taken:
  - Feedback to managers for **1:1 discussions** with staff.
  - Ward manager reminders to reinforce standards.
  - Consultant feedback on **consistent use of antenatal care plans** to avoid **conflicting advice.**

2.2 Birth Thoughts Service

- **Significant Growth**
  - Q3 referrals increased by **32%** compared to 2024 quarterly average.
  - Year-on-year comparison shows a **63% increase** in referrals from 2024 to 2025.
- **Activity**
  - **30 appointments offered**, **23 attended**, **6 DNA/cancellations**.
  - Engagement challenges noted among women referred directly by health professionals.
- **Demographics**
  - **36%** from Deciles <2, **59%** from Deciles <3.
  - **8%** from minority ethnic backgrounds.
  - **63%** were aged 30-39 years.
- **Follow-up Actions**
  - Positive feedback to staff.
  - Individual discussions arranged with line managers.
  - Mental health referrals and additional appointments where needed.
- **Major theme**
  - Birth events a blur / mothers not re-calling what had happened to them.

2.3 MNVP engagement

Engagement Sessions – demographics Q3 25/26

The WWL MNVP lead has collated data from Walk the Patch and Community Engagement sessions speaking with 40 service users in Q3.

Gender	%
Male	25%
Female	75%
Other	

Ethnicity	%
White British	74%
African	13%
Turkish	7%
White European	6%

Age	%
18-30	33.3%
31-60	66.6%

Service User Deciles	%
Deciles 1-2	24%
Deciles 3-4	24%
Deciles 5-6	7%
Deciles 7+	21%
Unrecorded	24%

2.3.1 Insights from service users and Maternity & Neonatal Voices Partnership co-production

Wigan Borough Maternity & Neonatal Voices

Voices for Choices COMMUNITY INTEREST COMPANY

Common Themes & Trends Across Feedback

1. High-Quality Personal Care — Especially from Midwives

In Q3, midwives are consistently described as:

- Caring, attentive, supportive, and informative
- Providing continuity and reassurance
- Delivering strong breastfeeding and infant-feeding support
- Creating positive experiences during labour and induction
- Student midwives also receive standout praise.

Trend: The human element of maternity care is a major strength. When families feel known, listened to, and supported, their overall experience is overwhelmingly positive.

2. Communication Challenges — The Most Persistent Theme

Communication issues appear in almost every section of feedback:

- Conflicting clinical advice (e.g., C-section plans)
- Poor explanation of services (family hubs, postnatal support)
- Missed or unclear follow-up calls
- Lack of birth plan discussions
- Confusion around appointment types (drop-in vs booked)
- Poor communication between hospital and community teams
- Overheard staff conversations causing anxiety
- Scan appointment rescheduling not communicated

Trend: Communication is the single biggest driver of negative experience — not clinical care. Families often feel uninformed, confused, or unsure what to expect.

3. Operational & Logistical Pressures

Several practical issues repeatedly affect experience:

- Parking difficulties (multiple sites, recurring theme)
- Long waits for consultants (and A&E)
- Delays in induction (sometimes several days)
- Theatre capacity concerns (often overheard)
- Travel costs creating financial strain

Trend: Operational inefficiencies create stress and uncertainty, even when clinical care is good.

4. Postnatal Gaps — Especially in Community Services

Postnatal care shows the widest variation:

- GP postnatal checks often inadequate (missed scar checks, reliance on photos)
- Health visitor support inconsistent
- Confusion about how to access services
- Lack of verbal guidance alongside leaflets

Trend: The postnatal period is the weakest part of the pathway, with fragmented care and inconsistent quality.

5. Emotional Impact: Anxiety, Stress, and Feeling Uncertain

Families frequently report:

- Anxiety due to unclear timelines (especially around C-sections)
- Stress from logistical issues (parking, waits)
- Worry triggered by overheard staff conversations
- Feeling dismissed or not believed in isolated cases

Trend: Uncertainty — more than clinical risk — is a major emotional burden for families.

6. Positive Impact of Continuity Models (in this instance, Pregnancy Circles)

Reported experience highlights:

- Strong continuity of care
- Peer support and community building
- Better breastfeeding outcomes
- More accessible information
- Greater empowerment and confidence
- Improved birth experience

Trend: Where continuity models are implemented well, they significantly enhance experience and outcomes.

7. Inclusion & Accessibility Considerations

Discussions at the quarterly meeting raised:

- How disabilities (hearing impairment, mental health conditions) affect communication
- Use of disability passports
- Need for more inclusive communication approaches

Trend: Accessibility is recognised but may not yet be fully embedded across services.

8. Service Awareness Gaps

Families often don’t know about:

- Family hubs
- Available support services
- What to expect at each stage

Trend: Information exists, but isn’t reaching families effectively.

9. Isolated Incidents of Poor Attitude or Dismissiveness

Though not widespread, some reports include:

- Dismissive comments during painful procedures
- Feeling pressured into decisions
- Lack of compassion during overnight postnatal care

Trend: These incidents are exceptions but have a disproportionate emotional impact.

Overall Summary

Across the MNVP dataset, a clear pattern emerges:

Strengths

- Midwifery care
- Breastfeeding/infant feeding support
- Induction processes (when timely)
- Continuity models like Pregnancy Circles
- Community-building and peer support

Challenges

- Communication breakdowns
- Inconsistent postnatal and community care
- Operational pressures (parking, waits, delays)
- Lack of service awareness
- Emotional strain caused by uncertainty

2.4 Friends and Family Test Q3 source Envoy 02.01.2026

	Responses	Positive
Antenatal	5	5
Birth	41	40
Postnatal Community	8	8
Postnatal Ward	10	8
Total	**64**	**61**

- **Overall positive response rate:** 95.3%
- **Change from Q2:** 33.33% reduction in response volume.

- **Slight increase** in the percentage of positive FFTs received

Positive Themes:

- High levels of satisfaction with care across all areas
- Staff described as kind, supportive, and informative

Negative Themes:

- Isolated report of the impact of Antenatal Clinics no longer running out of GP surgeries, necessitating an increase in travel time for patients.
- Isolated negative feedback on overnight visiting for partners.
- Isolated incident of feeling forgotten about after being placed in a side ward due to missing morning medication for blood pressure.

Ongoing Improvements to feedback collection:

- **Antenatal and Newborn Screening Feedback:**
  QR codes introduced to gather targeted feedback in line with NHS England recommendations. 0 responses received since advent. Screening team driving.
- **Neonatal Unit Feedback:**
  Work is underway to access and incorporate feedback not currently captured via Envoy.
- **Text service for FFT:** Work is underway by BI team

2.5 National Picker Maternity Survey

The **CQC** released the national maternity survey results in **December 2024**, with **exceptionally positive outcomes** for Wrightington, Wigan and Leigh (WWL):

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

These results reflect strong performance in key areas of patient experience.

Action Plan Progress:

The **MNVP Lead** and **PPE Midwife** continue to co-produce and deliver the associated action plan:

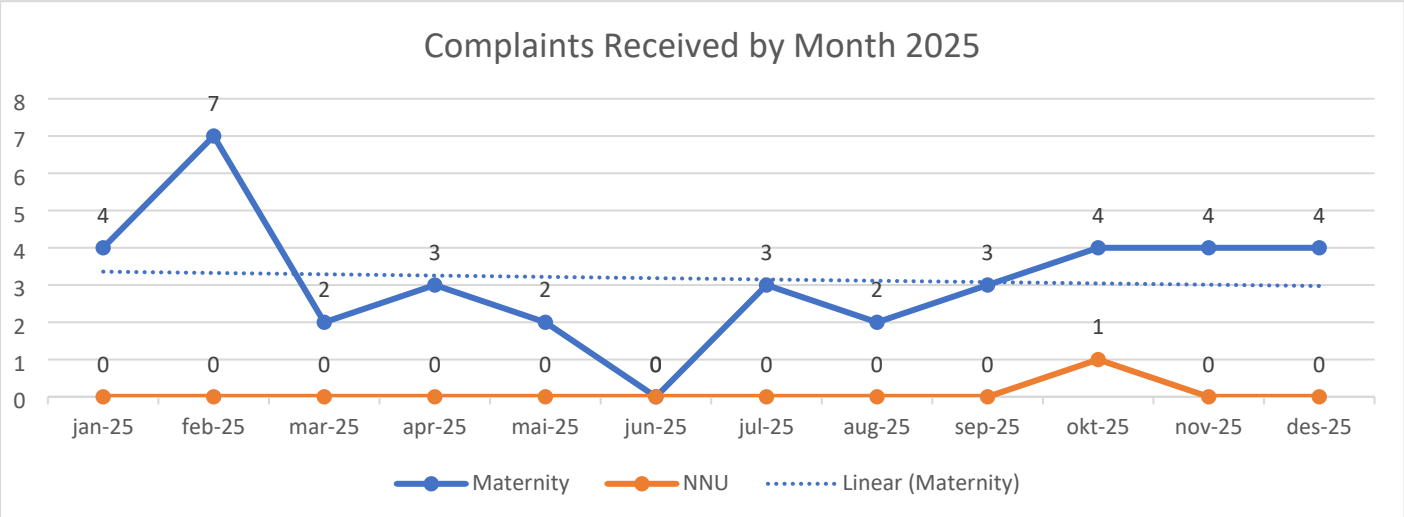
- **15 actions completed**
- **3 actions in progress**

Still working on actions in relation to appropriate advice and support at start of labour, partner involvement during labour and birth, and management of pain after birth, and partner overnight stay.

Note: Results for the **2025 survey** have been received but are under embargo awaiting the release from the CQQ, expected February 2026. The preliminary results are very positive.

2.6 Complaints

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



- **12 complaints** received for **maternity services,** and **1 complaint** received for **neonatal services** (↑ from Q2)
- **12 complaints** closed during the quarter, of which **3 complaints** were downgraded to a concern and did not require a full, formal response.

2.6.1 Themes from complaints

Q3	Oct	Nov	Dec
Clinical Treatment	1	3	4
Values and Behaviours	4	2	0
Communication	3	3	3
Consent	1	0	0
Patient Care	0	3	0
Medication	0	0	1

Clinical Treatment

- Concerns raised over the management of the latent phase of labour.

- Queries raised around the retaining of a fetus that had demised early in a twin pregnancy, which was delivered days after surviving baby and placenta.
- Concerns raised around decision to transfer into bath when patient reported she felt the baby was delivering, leading to an emergency transfer from the bath.
- A lack of postnatal care at Triage attendance with queries over c-section wound infection.
- Concerns raised around use of opioid painkillers in pregnant and breastfeeding women.
- Queries raised around delay in initiating a cervical suture.
- Perceived lack of exploration of symptoms (swollen ankles) during antenatal appointments when later diagnosed with pre-eclampsia.
- Concerns raised around being sent home from Triage in a pregnancy that resulted in pre-term delivery.
- Concerns over overheating newborn.

Values and Behaviours

- Patient concerns regarding unkind delivery of information during the active phase of labour, when she was experiencing a great deal of pain.
- Poor attitude of administrative staff at antenatal appointment.
- Reported lack of compassion provided by night staff.
- Reported threat of referring patient to social services due to request to be discharged prior to completion of NIPE.
- Lack of belief from the midwife caring for patient.
- Perceived lack of compassion shown in case of 19-week loss.

Communication

- Confusion over staff members leading patient to believe she had been left with a member of staff who had never delivered a baby.
- Lack of clarity over patient's personal requests and staff's ability to meet these.
- Lack of effective communication around inability to proceed with an induction of labour due to acuity and capacity.
- Perceived ineffective advice provided by medical staff at triage.
- Further contact made following loss of baby from midwives, congratulating on birth.
- Staff members not introducing themselves during antenatal appointments.
- Reports of a dismissive registrar.

Consent

- Reported lack of consent when being taken to theatre for emergency c-section.

Patient Care

- Reported lack of effective follow-up for mental health support after delivery.
- Lack of overall care given through labour and delivery.
- Congenital condition (it is coloboma) missed on newborn checks and NIPE.

Medication

- Deays in provided analgesia in patient with slipped discs and spinal injury in pregnancy and following delivery.

2.6.2 Complainants Demographics

Complaint	Age	Ethnicity	Gender	Decile
1	36	White British	Female	1
2	31	White British	Female	6
3	28	White British	Female	2
4*	Unknown	Unknown	Female	5
5	27	White British	Female	1
6	20	White British	Female	1
7	27	White British	Female	7
8	34	White British	Female	4
9	30	White British	Female	9
10	36	White British	Female	6
11	22	White British	Female	1
12	23	White British	Female	1
13	33	White British	Female	6

*Not all information held as the complainant was not the patient in this case.

- Q3 data indicates complainants are predominantly from White British population and data is skewed slightly toward higher decile areas. This will be monitored moving forward, to determine if there are any trends in the demographic data of our complainants over a 12-month period.

2.7 Triangulating data - Synthesis of patient experience feedback

Q3 - Triangulation of patient experience intel.

What is working well (high confidence):

- Compassionate, person centred midwifery care is a consistent strength (PPE, MNVP, FFT), with families describing staff as kind, supportive, and informative. Continuity models (e.g., Pregnancy Circles) and strong infant feeding support are repeatedly credited with improving confidence and experience.
- Partner inclusion is generally positive (PPE, MNVP, FFT), enhancing reassurance and shared decision making.

Where experience is most fragile

- Communication is the most persistent driver of negative experience (MNVP, Complaints, PPE), particularly:
  - Conflicting clinical advice and unclear plans (e.g., IOL timing, C section plans)
  - Poor expectation setting (what will happen, when, where, by whom)
  - Limited updates during delays/acuity related changes
  - Gaps between hospital and community teams, and missed/unclear follow ups
- Postnatal pathway variability (MNVP, Complaints): inconsistent GP/Health Visitor checks, access confusion, and limited verbal guidance alongside leaflets.
- Operational/logistical pressures (MNVP, FFT, Complaints): waits for consultants/theatre, delays in induction, parking/access issues.

Specific potential safety/quality concerns (from complaints, corroborated by PPE/MNVP themes):

- Triage and escalation decisions (sent home subsequently delivering preterm; no follow up after DNA)
- Hypertension/preeclampsia recognition and follow up (swollen ankles not explored; missed urinalysis/closer BP monitoring opportunities)
- Consent and communication in emergencies (perceived lack of consent to emergency CS)
- Clinical decision making episodes (latent phase management; timing of cerclage; movement to bath preceding emergency transfer)
- Medicines management (analgesia delays; opioid use queries in pregnancy/breastfeeding)
- Neonatal/newborn checks (missed NIPE finding; newborn overheating)
- After bereavement communication error (congratulatory contact after loss).

2.8 Triangulating data – Claims, Incidents, Complaints

On a quarterly basis, the Trust's Scorecard is reviewed alongside incident and complaint data and themes triangulated. In Q3 the themes identified were Fail/delay treatment, Psychological damage and Failure to Supervise. 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.

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

Triangulation Q3 2025-26

Fail/delay treatment – Missed anomaly scans; NBS samples (twins) required repeat due to altered blood forms; Manipulation of arm at delivery not documented or handed to neonatal team; Perception of delay in cervical suture.
Psychological damage – Congratulatory letter sent after loss; Dismissive behaviour; Felt unheard in advanced labour; Felt unheard when concerns re wound infection; Felt uncared for in labour.
Failure to supervise– Felt unheard when reports labour advancing, pushing in bath on ward; concerns re management and care in latent labour.

Complaints Q3 2025-26 (12 mat, 1 neo)

Clinical Treatment (7) Concern re management of latent labour; Concern re feeling pain ignored, started to deliver in bath; Perception of lack of care on Triage when concerned about CS wound; Concern re her and baby experiencing opioid withdrawal after standard pain relief; Concerns re delay in attempting cervical suture; Concern sent home from Triage too soon; Concern that swollen ankles ignored.
Communication (9) Confusion around midwife's skills set; Lack of communication around delays in induction; Congratulatory letter sent to family experiencing baby loss; Reports of a dismissive registrar.
Consent (1) Perception of lack of consent for emergency section.
Patient care (3) Missed condition on NIPE; Overall feeling of lack of care in labour; Lack of effective follow up for mental health support
Values and Behaviours (6) Unkind delivery of information within the delivery room; Attitudes; Lack of compassion.

Learning Q3 2025-26

Caesarean section notes should reflect any challenges at delivery including manipulation of baby to deliver.
Failsafe for FAS completion scan required.

Incidents Q3-2025-26

2 cases of broken arm at Caesarean – 1 with poor documentation of manipulation required at Section and no handover to neonatal staff. 1 readmission within 28 days with post Caesarean complications– faeces leaking through wound (previous extensive surgery). Multiple screening incidents missed ultrasound scans, missed screen, incorrect labelling of samples. 1 case of suboptimal care of deteriorating septic baby – recognition and management of abnormal cord gases and more proactive approach to respiratory support needed.

Actions Q3 2025-6

Share learning regarding the importance of CS records including any manipulation of baby required at delivery and ensuring that info handed over to neonatal team / postnatal team via e-mail to CD and Gov Gazette	31/01/2026 RR	
Failsafe to include completed FAS date (for when 2 scans are required)	By 01/02/2026 JC	

2.9 SCORE staff survey

The **SCORE survey** is a recognised tool for measuring **workplace culture and staff engagement**. In Q2 2024/25, **169 staff members** across maternity and neonatal services responded, representing a **54% response rate**, predominantly from **neonatal nurses and midwives**.

Key Themes Identified:

1. **Burnout Climate** – Staff reported feeling overworked, exhausted, and struggling with work-life balance.
2. **Safety Culture** – Concerns around values alignment, particularly within **Maternity** and **Antenatal Clinic** teams.
3. **Team Working** – Communication breakdowns within and between teams were highlighted.
4. **Fairness** – Perceptions of unfairness in **staff deployment** and **recruitment processes**.

Staff Engagement and Support:

- **Four Culture Coaches** were trained to facilitate feedback and support ongoing listening events.
- **Band-specific listening sessions** were held to allow staff to speak freely and raise concerns.

Actions:

- **Improved communication** channels, including feedback loops from **Senior Leadership Team meetings**.
- Increased **visibility of the Quad** and senior leaders as a unified leadership team.
- **Consistent approach to addressing poor behaviours** and promoting fairness in performance and management.

- A renewed focus on **celebrating successes** and **sharing learning**, with oversight from the **Trust Board**.

External Support:

- In Q3, maternity senior leaders raised concerns regarding the level of engagement from Boo Consulting and the limited system-level insight and support being provided. Current recommendations have largely focused on small, localised interventions rather than addressing broader strategic or organisational priorities. This matter will be discussed at the Safety Champions meeting in January 2026 (Q4) to determine next steps and required assurance**.**

3. Risk register – Maternity and neonatal services

Live Risk Register	Significant (15+)	High (8-12)	Moderate (4-6)	Low Risk (1-3)
	2	10	7	0

Approved	MAT	3772	Euroking System Error	16
	MAT	4267	Delay in Prescribing Antenatal Prescriptions	15
	MAT	4274	Theatre List Availability does not cover demand for Caesarean Sections	12
	MAT	4170	Lack of End-to-End Maternity Patient Record	12
	MAT	3802	Obstetrics/Gynaecology Tier 2 Staffing Shortages	12
	MAT	3732	Entonox Risk	12
	MAT	3362	Midwifery Staffing Shortages	12
	NEO	1977	Specialist AHP services should be available in all units for neurodevelopment and family integrated care	12
	MAT	4236	Antenatal CTGs approaching end of service contract	10
	MAT	4237	Newborn Blood Spot NHS number Barcode Label	10
	MAT	3669	Potential Inability to undertake more than 1 Emergency Delivery at a time due to number of theatres available	8
	MAT	1469	The risk of abduction from the maternity unit	8
	MAT	3782	Maintenance of Maternity Equipment	6
	MAT	3727	Euroking To PAS Error Risk	6
	MAT	3725	Resident Doctors Strike	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

	NEO	4291	Obsolete Oxygen Saturation Equipment in Neonatology Outreach Services	6
	MAT	2459	Transportation and supply of Entonox (Nitrous oxide 50% and oxygen 50%) by Community Midwives for use at Homebirths	4

At the end of Q3 25/26,

0 risks under review or awaiting approval.

1 risk **approved**: **4291** Obsolete Oxygen Saturation Equipment in Neonatology Outreach Services (6)

2 risks **closed:**

4236: Antenatal CTGs approaching end of service contract.

Fetal Surveillance Midwife confirmed that we now have access to new antenatal CTG machines. No additional training requirements required from the staff.

4189: No immediate availability of video laryngoscope on the neonatal unit.

Video Laryngoscope sourced via charitable funding and fully implemented. Training has been rolled out by the training team to all staff.

Exceptions

Work continues with low scoring risks and outstanding risk actions. Training to be arranged with John Harrop for Matrons and other risk holders.

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	1	7			3
EA2	Safe staffing	0	0	9			1
EA3	Escalation and accountability	0	0	5			
EA4	Clinical governance- leadership	0	0	6		1	
EA5	Clinical governance – incident investigation and complaints	0	0	7			
EA6	Learning from maternal deaths	0	0	2			1
EA	Multidisciplinary training		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	1	78	2	1	10

Q3 25/26 has seen some progress against the actions and 1 action remains outstanding.

Exceptions - 1.10 All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.

In progress: Workforce review (s) with GAP analysis and Band specific development pathways

5. Maternity Incentive Scheme Year 7 (CNST).

 Year **6:**
Full compliance confirmed in **Q4 2024/25**.

 Year **7:**
Published **2 April 2025**.
Review period for the **10 Safety Actions**:
1 December 2024 – 30 November 2025

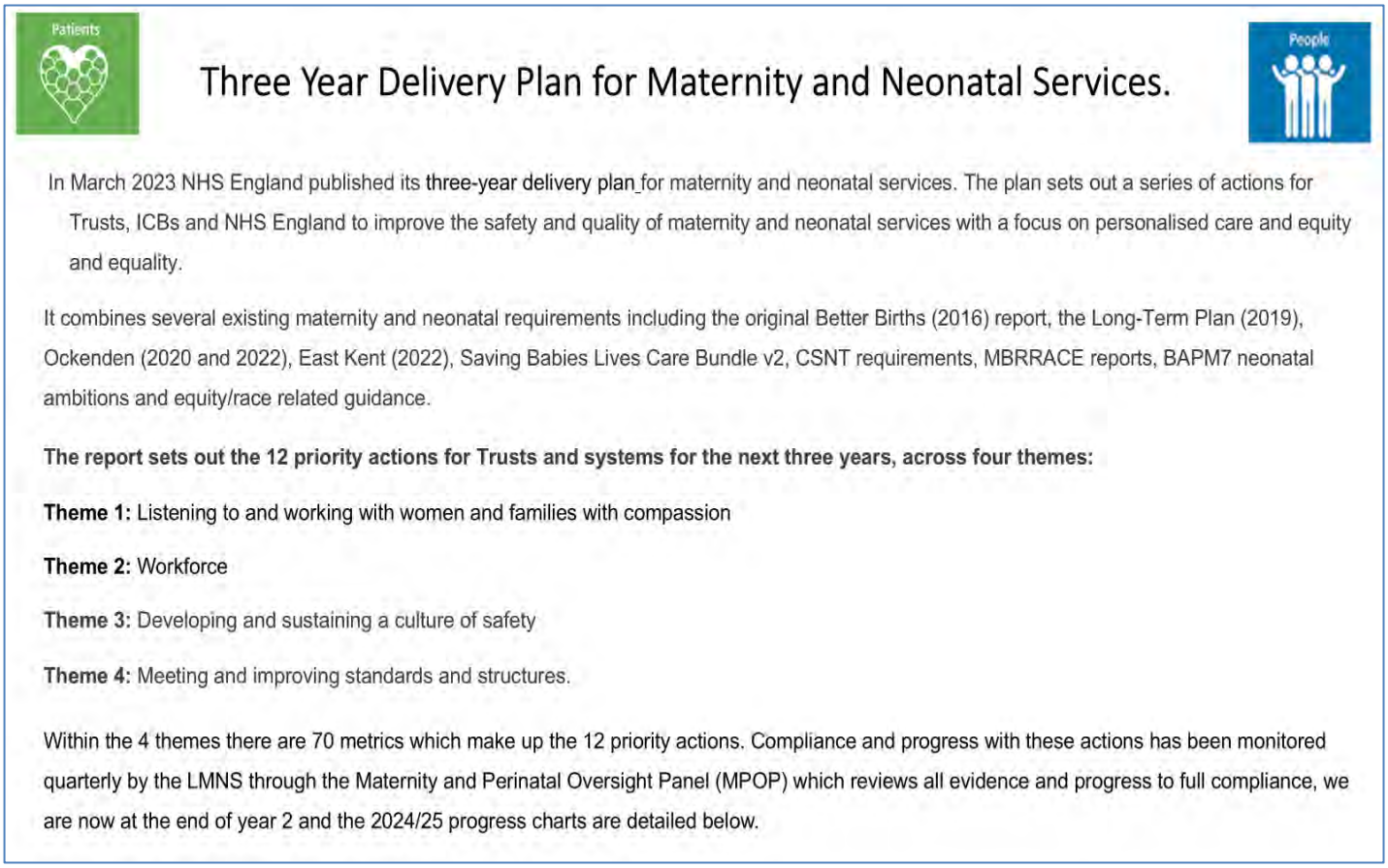
5.1 MIS Year 7 Progress

WWL maternity leaders met with the LMNS in Q3 for assessment of compliance with the 10 CNST MIS Year 7 Safety Actions.

MIS SA	LMNS Checkpoint Compliance Assessment	RAG Status
1	**Safety Action 1 –** evidence reviewed and panel agreed compliance has been achieved	
2	**Safety Action 2 –** evidence reviewed and panel agreed compliance has been achieved	
3	**Safety Action 3 –** evidence reviewed and panel agreed compliance has been achieved	
4	**Safety Action 4 –** evidence reviewed and panel agreed compliance has been achieved	
5	**Safety Action 5 –** evidence reviewed and panel agreed compliance has been achieved	
6	**Safety Action 6 –** evidence reviewed and panel agreed compliance has been achieved	
7	**Safety Action 7 –** evidence reviewed and panel agreed compliance has been achieved	
8	**Safety Action 8 –** evidence reviewed and panel agreed compliance has been achieved	
9	**Safety Action 9 –** Additional board report (Q3 PQOM) to be uploaded and then compliance will be met.	21/1/2026
10	**Safety Action 10 –** evidence reviewed and panel agreed compliance has been achieved	
11	**Next Steps** a. WWL to declare full compliance to Trust Board on 5 February 2026. b. Declaration Form to be completed & submitted to LMNS c. LMNS to forward Declaration Form for signature to ICB d. LMNS to return Declaration Form once signed by ICB Accountable Officer e. Provider to submit Declaration Form & any action plans no later than 12 noon on 3 March 2026 to nhsr.mis@nhs.net. Late submissions will not be accepted.	

No exceptions – on track

5.3 Delivery of the 3-Year Plan



Action is Complete	56
Action will complete by Q4	9
Action is mainly on track but may not complete by Q4 (mitigation in narrative)	0
Action will not complete by Q4	0

No exceptions - On track.

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q2 25/26

Q2	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU	TARGET
July - Sept 2025	548	28 (5.10%)	27 (4.92%)	4 (14%)	**<6% National <4.8% Regional**

In Q2, the total number of term admissions to the NNU was 5.10% of total term live births. This is a slight increase from Q1 (4.96%)

Unexpected term admissions to the NNU accounted for 4.92% of total term live births. This is a slight increase from Q1 (4.77%)

There is still work to be done with 4 (14%) of total admissions being potentially avoidable, this is a decrease from Q1 where 19.2% of total term admissions were potentially avoidable.

Findings from Q2 audit

- Rates of term admissions to the NNU are on an overall **downward trajectory**
- **Respiratory** continues to be the leading cause of term admission into the NNU (63%)
- **Lower gestation babies** ≥37 - <39 weeks are most at risk of unexpected term admission for respiratory issues
- Women with **BMI 30-40** are **over-represented** in the term admissions to NNU data when compared with the number of women with BMI 30-40 who have birthed in Q2
- Women from deciles 2, 8 and 9 are significantly over-represented in the term admissions to NNU data compared with the number of women who birthed in Q2 from these deciles
- There is no correlation between non-English-speaking women and term admissions to NNU, when compared with the number of non-English speaking women who have birthed in Q2
- Babies are **more likely** to be admitted to NNU if born to woman with **Gestational Diabetes**
- Woman from **Black African backgrounds are over-represented** in the term admission to NNU data when compared with the number of Black African women who have birthed in Q2
- Multiple maternal and fetal risk factors have been identified within the cohort of women and babies unexpectedly admitted to the NNU at term in Q2
- **Babies born via Term ELCS and EMCS are** overrepresented in the unexpected term admissions to NNU when compared with all ELCS and EMCS births in Q2
- **All** term unexpected **avoidable** admissions to NNU, were from babies born via **emergency caesarean section**
- There were **gaps** in utilising the resuscitation proforma, 80% of babies having received resuscitation had a resuscitation proforma completed. In the remaining (20%) of babies resuscitation was documented effectively in the paper notes.
- Thermoregulation of the newborn was **not** a theme in Q2
- No themes were identified from babies with Apgar scores less than 7 at 5 mins (5 babies, 18%)
- Small for Gestational Age and Fetal Growth Restriction was not a theme identified antenatally or at birth in Q2
- SBAR documentation between maternity and NNU is **not** embedded. Improvement work has now been introduced to improve completion.
- Documentation of Vitamin K on a drug Kardex is **not** a theme in Q2

Actions

- Continue to meet with the Maternity Specialist Teams to discuss health population data and how we can focus care and improvement work to support those most vulnerable
- Undertake a separate audit into Apgar score less than 7 at 5
- 1 case escalated for further review by the Fetal Surveillance Midwife (hyperstimulation and lack of escalation of pathological CTG). Use in training

No exceptions – Compliant with MIS Safety action 3

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

7.1 Overview

Monthly data	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
Total births	**214**	**205**	**191**	**195**	**209**	**198**	**183**	**205**	**201**	**217**	**205**	**204**
Total Stillbirths ≥ 24 weeks	**0**	**1**	**2**	**3**	**0**	**4**	**0**	**0**	**1**	**1**	**2**	**0**
Stillbirths (excluding MTOP)	0	1	1	3	0	3	0	0	1	1	2	0
Total late fetal loss 22 – 23+6	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Total Neonatal Deaths (≥ 20 weeks)	**1**	**1**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**1**	**0**	**1**
Early neonatal deaths (0-7 days)	1	1	0	0	1	1	0	0	1	1	0	0
Neonatal deaths (excluding MTOP)	1	1	0	0	0	0	0	0	1	1	0	1
Total Maternal Deaths	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

7.2 Stillbirths

There were **three reported stillbirths** in Q3 2025/26, representing an increase compared to Q2.

2025	Type Stillbirth	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/service delivery issues	PMRT grading
Oct	Antenatal	26+3	White British	10	32	26	No	No	0.0	Incorrect previous birth weight entered into GROW system	Under review

Nov	Antenatal	36+5	White British	1	33	27	No	No	11.2	Discrepancies in local guidance re: definitions of polyhydramnios	Under review
Nov	Antenatal	34+3	Any other mixed	1	27	30	No	No	0.0	Hypertension monitoring	Under review

1. Antenatal Stillbirth

A 26+3-week stillbirth occurred in a mother who had been booked for serial growth scans and uterine artery Doppler (UtAD) surveillance due to a history of delivering a small-for-gestational-age (SGA) baby. She attended all scheduled antenatal appointments. At a routine review, no fetal heart was heard, and an ultrasound scan confirmed an intrauterine fetal death.

The 72-hour review identified that the previous baby's birth weight had been incorrectly entered into the GROW system. As a result, the mother had been placed on a scan and UtAD surveillance pathway that, in retrospect, was not clinically indicated. However, this incorrect pathway allocation **did not contribute** to the stillbirth.

The case will undergo a full review through the **Perinatal Mortality Review Tool** (PMRT) process to ensure comprehensive analysis and identify any further learning.

2. Antenatal Stillbirth

A 36+5-week stillbirth occurred in a mother booked under Consultant-Led Care who had attended all scheduled antenatal appointments. At 33+4 weeks, reduced growth velocity was noted, and an ultrasound demonstrated normal fetal growth with mild polyhydramnios. A follow-up scan three weeks later showed that the liquor volume had normalised, with a maximum pool depth (MPD) of 8 cm.

At 36+5 weeks, the mother presented with over 24 hours of absent fetal movements. An urgent ultrasound confirmed an intrauterine fetal death.

The 72-hour review identified discrepancies within existing guidance regarding the definition of polyhydramnios. An MDT review of existing guidelines has since clarified that an MPD of 2–8 cm should be considered within normal range. This case will proceed through a full review under the **Perinatal Mortality Review Tool** (PMRT) to ensure comprehensive evaluation and to identify any further learning.

3. Antenatal Stillbirth – Twin 1

A 34+3-week delivery followed the confirmed intrauterine fetal death of Twin 2 in a DCDA twin pregnancy. The mother transferred her care at 16 weeks due to relocation and was booked under Consultant-Led Care on the DCDA twins pathway.

At 20+4 weeks, Twin 2 was identified as being below the 10th centile and was referred to Fetal Medicine. At 24+2 weeks, ultrasound findings demonstrated absent end-diastolic flow (EDF) and an elevated pulsatility index (PI). Given the poor prognosis, a referral to a tertiary Fetal Medicine Unit was arranged for ongoing management planning.

The mother underwent regular surveillance. At 30+4 weeks, Twin 2 was noted to have anhydramnios and reversed EDF. During this period, the mother also experienced episodes of hypertension and proteinuria; antihypertensive therapy was commenced. She was transferred to a tertiary unit for ongoing care, as the local neonatal unit was temporarily closed.

At 32+2 weeks, an ultrasound at the tertiary unit confirmed an intrauterine fetal death of Twin 2. The mother was subsequently discharged from tertiary care, with a planned caesarean section arranged at 34+4 weeks due to concerns regarding fetal growth restriction in Twin 1. Twin 1 was delivered alive.

The **72-hour review** identified learning related to the management of hypertension in pregnancy, specifically around urinalysis and medication adherence. A full review through the **Perinatal Mortality Review Tool** (PMRT) process will be undertaken.

7.3 Themes from stillbirth data

Ethnicity:

33% (1/3) of stillbirths occurred in mothers recorded as being from an "any other mixed background" ethnicity. This represents an over-representation compared with the overall proportion of births to mothers from non-White British backgrounds during the reporting period.

Deprivation:

66% (2/3) of stillbirths occurred in women living in areas within Decile 1. By comparison, 23.15% of all births in December were to women from Decile 1 areas.

Fetal growth:

66% (2/3) of stillbirths involved fetuses measuring below the 10th centile, consistent with fetal growth restriction.

BMI: 100% (3/3) of stillbirths involved mothers with BMI ≥25 (significant over-representation).

Age: 66% (2/3) of stillbirths involved mothers aged > 30 years of age (over-representation).

7.4 Review and Assurance:

The themes—particularly fetal growth restriction and socioeconomic deprivation—remain aligned with known national risk factors for stillbirth. The Board should note that the ongoing lack of weight management support in pregnancy in the Borough (decommissioned in 2024) presents a system level risk, given the over representation of raised BMI in this cohort.

Internal guideline alignment work, together with strengthened oversight of hypertension management (as part of the WWL Maternity PSIRF Priority 2026–2028), demonstrates that learning is already being translated into practice improvement.

The Board will receive further assurance following completion of PMRT reviews. Based on current evidence, the service is operating within expected safety and governance parameters, and areas of learning are being proactively addressed.

7.5 Neonatal Deaths

There were **two reportable neonatal deaths** in Q3 2025/26 which represents an increase from Q2.

2025	Type of NND	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
Oct	Early	20+2	White British	8	30	33	No	No	NA	Any PV blood loss should prompt advice for review in Triage	N/A
Dec	Late	39+1	White British	1	32	27	Yes	No	15.4	Lack of adherence to DNA policy	Awaiting grading of care

1. Early neonatal death

Mother attended Triage at 20+1 weeks with some vaginal bleeding from the previous day and experiencing abdominal pain. This was a spontaneous miscarriage where the baby was born with signs of life and lived for a short time. **Not** eligible for PMRT.

2. Late Neonatal Death

Baby died in day 19 of life in the community. Cause of death was influenza**. Case review by Safeguarding team. For PMRT review.**

7.6 Themes from Neonatal Deaths

Due to low numbers, thematic analysis remains limited. However, all cases are logged to support longitudinal analysis and inform future learning and will inform the annual Mortality report.

7.7 PMRT and MIS Year 7 compliance - data source MBRRACE 01/01/2026

Case (date of death)	Standard A Notify all deaths within 7 working days	Standard B Seek parents' views of care: For at least 95% of all the deaths of babies	Standard C 95% of reviews to be started in 2 months of death	Standard C Minimum of 75% MDT reviews to be completed/published within 6 months	Standard C For a minimum of 50% of deaths reviewed with an external member
25/11/25	Met (4 days)	Not yet met	Met	Due 25/05/2026	Not yet met
03/11/25	Met (3 days)	Met	Met	Due 03/05/2026	Not yet met
25/10/25	Met (1 days)	Not suitable for review			
11/10/25	Met (0 days)	Met	Met	Due 11/04/26	Not yet met
27/09/25	Met (0 days)	Met	Met	Due 27/03/26	Not yet met
18/09/25	Met (1 day)	Met	Met	Due 18/03/26	Not yet met
30/06/25	Met (3 days)	Met	Met	Met	Met

29/06/25	Notification only				
24/06/25	Met (2 days)	Met	Met	Met	Met
23/06/25	Met (3 days)	Met	Met	Met	Met
01/06/25	Notification only				
08/05/25	Notification only				
19/04/25	Met (2 days)	Met	Met	Met	Met
12/04/25	Met (1 days)	Met	Met	Met	Met
07/04/25	Met (4 days)	Met	Met	Met	Met
29/03/25	Met (4 days)	Met	Met	Not met	Not met
10/03/25	Notification only				
28/02/25	Met (1 days)	Met	Met	Met	Met
13/02/25	Not suitable for review				
15/01/25	Notification only				
09/12/24	Met (1 days)	Met	Met	Met 09/06/25	Met

7.8 PMRT Case Completion Overview

In Q3 25/26, 5 cases were **finalised** at PMRT.

Case 1: Stillbirth at 26+1

- **Cause of Death**: Placental Insufficiency
- **Care Grading**:
  - **Prior to Birth**: Grade **C** – care issues which may have made a difference to the outcome.
  - **After Birth**: Grade A – no issues identified.
- **Family Support**: Bereavement midwives involved; findings shared with the family.
- **Key Learning**:
  - Urinalysis was not performed at each contact, resulting in missed opportunities to detect potential pre-eclampsia, gestational diabetes, or urinary tract infections.
  - There was a missed opportunity to monitor blood pressure more closely. The existing hypertension-in-pregnancy guideline did not provide sufficient clarity around the diagnostic threshold—specifically that hypertension should be recognised when either the systolic or diastolic value exceeds 140/90 mmHg. This definition has now been clarified and the guidance strengthened accordingly.
  - Information provided at 24 weeks regarding fetal movements was inconsistent with the expected guidance. A targeted improvement programme, led by the SBL Lead, will be undertaken to ensure consistent messaging and enhance the quality of information shared with women.

- DNA Triage – there was no attendance at Triage after a call for advice. There is no process for contacting patients who DNA and there is an action for a pathway for women who DNA Triage appointments.

Case 2: Stillbirth at 35+0 Weeks

- **Cause of Death**: Trisomy 13 Patau Syndrome
- **Care Grading**:
  - **Prior to Birth**: Grade A – no issues identified.
  - **After Birth**: Grade A – no issues identified.
- **Family Support**: Bereavement midwives involved; meeting arranged with family.
- **Key Learning**:
  - Good practice identified at supporting and counselling family.

Case 3: Stillbirth at 34+0 Weeks

- **Cause of Death**: Unknown. The PMRT team were unable to establish cause of death without further investigations.
- **Care Grading**:
  - **Prior to Birth**: Grade B – care issues identified which would have made no difference to the outcome.
  - **After Birth**: Grade A – no issues identified.
- **Family Support**: Bereavement midwives involved; meeting arranged with family.
- **Key Learning**:
  - A maternal history of heart surgery was appropriately referred for cardiac review; however, this should also have been referred to the screening team for further investigation. This omission did not affect the outcome.
  - Uterine Artery Doppler (UtAD) was not performed at the fetal anomaly scan due to human error, as the request was written on a separate scan card. The omission was recognised, and a 28-week scan was arranged. The new process of consultant review following UtAD has since been implemented to prevent recurrence. The subsequent scan was normal and did not affect the outcome.
  - DNA Triage – there was no attendance at Triage after a call for advice. There is no process for contacting patients who do not attend and the Triage Manager undertook a scoping exercise to ascertain the pathways of maternity units within GM as immediate learning. Requires further work.

Case 4: Stillbirth at 31+3 Weeks joint review with GMMH

- **Cause of Death**: Placental Abruption
- **Care Grading**:
  - **Prior to Birth**: Grade **C** – care issues which may have made a difference to the outcome. (attributed to GMMH care)
  - **After Birth**: Grade A – no issues identified.
- **Family Support**: Perinatal Mental Health Midwives and Bereavement midwives involved; meeting with GMMH requested.
- **Key Learning**:
  - Learning identified for GMMH and an action plan has been devised.

- No learning identified for WWL.

Case 5: Stillbirth at 31+3 Weeks

- **Cause of Death**: Twin to Twin Transfusion (Grade 2)
- **Care Grading**:
  - **Prior to Birth**: Grade A – care issues identified but unlikely to have changed the outcome.
  - **After Birth**: Grade A – no issues identified.
- **Family Support**: Bereavement midwives involved; findings shared with the family.
- **Key Learning**:
  - No learning identified.

7.9 Summary of learning from completed PMRT reviews in Q3

Theme	Issue	Actions
Routine Antenatal Care	Missed Urinalysis at appointments	Share learning to importance of urinalysis and to plan for sample is unable to provide
Management of Hypertension	Management of mild hypertension	Update Guideline and flow charts to make clearer Update pathway for blood pressure profile
Communication	Reduced fetal movement	An improvement programme for consistent advice and to improve the quality of information shared will be undertaken by SBL lead.
Communication	Triage DNA pathway	To develop a robust pathway for women who DNA maternity Triage
Referral	Pathway to contact the Screening Team	To develop a criteria for referral to the Screening Team

No Exceptions

PMRT **compliant** with MIS Year 7.

8. Saving Babies Lives (SBL) audit – Q3

Element		Compliancy/ Improvement Plan
Element 1- Reducing smoking in pregnancy		Compliant for CO @ booking 99%, CO @ 36 weeks 98%. Number of pregnant smokers who had a referral to an inhouse service is 100%. Quit data is 45% for last quarter as data ID captured after period of weeks to allow for patient uptake. LMNS parameter is 60%. Regular teaching sessions of CO monitors are undertaken- staff training 94%. Audit regularly undertaken.
Element 2- risk assessment and surveillance for fetal growth restriction		Audit completed and compliant within SBL parameters. Babies at risk of FGR and SGA are detected within antenatal period is 66% - Target is >50%. Women who assessed for Risk, aspirin, Vitamin D and UTAD is 100% - target is 80%. Staff are in date with Serial Fundal Height training- 94%
Element 3- Raising awareness of reduced fetal movements.		Audit shows Dawes Redman CTG 100% within SBL parameters. Next working day scan is 77% which does not meet parameter of 80% minimum. Next working day

		scan figures were impacted by sonographers being on annual leave and further impacted by the reduction in scan capacity in TLC and RAEI scan departments.
Element 4- Effective fetal monitoring during labour		Q3 data for GMEC parameters are all above compliance of 90%. CTG interpretation is 92%, assessment is 93% and IIA competency assessment is 91%. There have been 15 CTG clubs held within the quarter and 42 attendees.
Element 5- Preterm Births.		Above target figure for number of women who give birth to singleton 16-23+6. Target 1%, WWL 1.64% (4 spontaneous losses, 4 missed miscarriages and 2 MTOPs). Antenatal corticosteroid guidance has changed for 12/24 hours apart to 24 hours apart. Likely to affect compliance with metric 5.19 until LMNS update stretch targets to reflect this.
Element 6 – Diabetes in Pregnancy.		One stop clinic template to be further improved upon, SBL parameters at present just below standard due to lack of dietician. All other parameters above GMEC required standards.
SBL training Elements 1-6.		99% doctors and midwives compliant with online element modules, non-compliant all contacted via e mail and face to face to address any ongoing issues with access, time allocation or learning challenges. 90% compliant with face-to-face SBL and SFH training.
Equity and Equality.		Wigan is a predominantly White British area. We do have a small number of other ethnic groups including migrants. Wigan has a mixture of socio-economic depravation score living areas. Wigan Maternity has an enhanced team which works closely with pregnant women who live in decile areas 1 & 2, many patients have complex needs across the borough. The smoking cessation team and the mental health team link in with enhanced team to provide a streamlined service to those who need a more personalised care plan. These teams are community based and liaise with the ward and delivery suite to complete specific care plans. New community model is under consultation.
OVERALL		Significantly Assured overall

8.1 Saving Babies' Lives (SBL) – Assurance Update

- **LMNS Assurance:**
  - June 2025: **96% compliance** against SBL 3 intervention parameters
  - Next LMNS compliance review 13 January 2026.

9. Mandatory Training Compliance

The Perinatal Oversight model requires monitoring of training progress for **MIS compliance** (target **90%**) across three key areas:

1. ***Fetal Monitoring Training**
2. ***Multi-professional Maternity Emergencies Training**
3. ***Neonatal Resuscitation Training**

Progress against the **six core modules of the Core Competency Framework** is also tracked; however, this is **not included in MIS Safety Action 8**.

Q3 25/26	Midwives	Obstetricians		MSWs	Anaesthetists	Neonatal medics		Neonatal nurses / ANNP
		Cons	Other			Cons	Other	
*Fetal monitoring and surveillance	93%	100%	92%					
*Maternity Emergencies and multi professional training	90%	100%	100%	92%	91%			
*Neonatal Life Support training	91%				89%	100%	100%	100%
Saving Babies Lives Care Bundle SBL Face to face	86.5%	25%	13%	78.5%	81% (Con 100%) (Reg 62%)			
SBL Online	99%	100%	15%					
Equality/ equity and personalised care (3-Year programme)	68%	0%	0%	60%	0%			
Care during labour and immediate post-natal period (3 Year programme)	85%	100%	100%	90%	87%			
Qualified in Speciality - QIS								93.3%

Exceptions

Fetal Monitoring training:

- Compliant

PROMPT training:

- Compliant

 NLS **(Newborn Life Support) training:**

- Anaesthetist compliance slightly <90%, sessions scheduled.

 Saving **Babies' Lives (SBL) training:**

- All outstanding midwives have been allocated a date to attend within next 2 months.
- All obstetricians have an allocated session to attend. Trajectory – Consultants >90% by July 26, Registrars >90% by September 26.
- Dip in compliance due to recent GMEC MDT pre-term birth training requirement.
- Anaesthetists (pre-term training) covered via PROMPT. Trajectory >90% by July.

 EE&PC (Equality, Equity & Personalised Care) training:

- Currently midwives/MSWs only; new GMEC cultural competency package requires MDT attendance.
- Delivery method for medical staff will be via SBL day. Trajectory for Consultants and Registrars >90% by September 26.

 Care During Labour training:

- Dip for midwives due to new starters (mid-way through 3-year program). GBS and epidural will be covered again on year 1 programme from September which will capture new starters.
- Dip in MSW compliance due to 1 x DNA. Will be rescheduled.

 NLS **(Newborn Life Support) training:**

- Anaesthetist compliance slightly <90%, sessions scheduled.

10.0 Safe Maternity Staffing

Q3 Fill rates – Source BI

Midwifery/Nursing staffing

Area	October		November		December	
	Daily Fill Rate	Nightly Fill Rate	Daily Fill Rate	Nightly Fill Rate	Daily Fill Rate	Nightly Fill Rate
Delivery Suite						
Maternity Ward	107%	92%	106%	101%	102%	98%
Neonatal Unit	117%	109%	122%	111%	118%	112%

Midwifery/Health Care Support Worker staffing

Area	October		November		December	
	Daily Fill Rate	Nightly Fill Rate	Daily Fill Rate	Nightly Fill Rate	Daily Fill Rate	Nightly Fill Rate
Delivery Suite						
Maternity Ward	92%	100%	87%	96%	91%	92%
Neonatal Unit	51%	-	52%	-	53%	-

Exceptions

No data available from BI for Delivery Suite. Data does not reflect MAPS or staffing pressures.

Recommendations

Matrons to work with BI to analyse the staffing data and data collection process.

To ensure process in place for monthly validation.

10.1 Maternity Staffing Vacancy Rates

Staff group	Vacancy rate
Midwifery	0.0 WTE (4.54 WTE staffing gaps due to Maternity Leave)
Midwife Support workers	1.66 WTE
Obstetric consultants Resident doctors	0 Consultant vacancies 0 Tier 1 vacancies 0.0 WTE Tier 2 vacancies (1.6 WTE shift gaps due to 1 WTE supernumerary and 1 extended phased return).
Neonatal Nurses	0.48 WTE (1 WTE staffing gap due to Maternity Leave)
Neonatal HCA	0.64 WTE
Neonatology consultants Resident doctors	0.0 Neonatal doctor staffing vacancies
Obstetric anaesthetists Resident doctors	6 anaesthetic vacancies across the Trust – maternity rota is covered as priority – no rota gaps.

Exceptions

No anticipated change in Q4 for the Obstetric Tier 2 staffing gaps. Currently covered via Bank/Agency. On Risk Register.

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

There were **69 validated staffing red flag events** recorded in Q3 2025/26, representing a **significant decrease** from Q2 likely due to efforts to analyse the reported Red Flags. These events are captured via the **Birthrate Plus system.** No known harm has been reported in relation to these events.

Key Themes from Red Flag Events:

- The **majority of red flags** were due to**:**
    - **Delays of 60 minutes** or more in care e.g. washing and suturing.
    - Delays in **admission and commencement of induction within 2 hours**.

Staffing Challenges:

- Midwifery staffing pressures continued in Q3, driven by **elevated levels of staff sickness (10%) and maternity leave**.
- On **8 occasions**, the **Delivery Suite Coordinator** was unable to remain **supernumerary**, but did need not need to provide 1:1 care.
- **Specialist and community midwives** were redeployed as required to maintain safe staffing levels.

Exceptions

- **Delivery Suite compliance** for Q3 was **79.53 %**, showing a decrease **from Q2**.
- **Maternity Ward compliance** for Q3 was **77%,** showing an increase **from Q2.**
- **Delivery Suite Manager** is working closely with **Band 7 shift coordinators** and the **Maternity Ward Manager** to further improve compliance.

10.2 RCOG Locum doctor compliance

WWL remains compliant with RCOG requirements from short-term locums in 2025. A full report will be provided to Board for assurance of adherence to MIS Year 7 Safety Action 4.

10.3 RCOG Consultant attendance

At the end of MIS Year 7 reporting period we were 100% compliant with consultant attendance in line with RCOG guidance. A separate report is provided to Board.

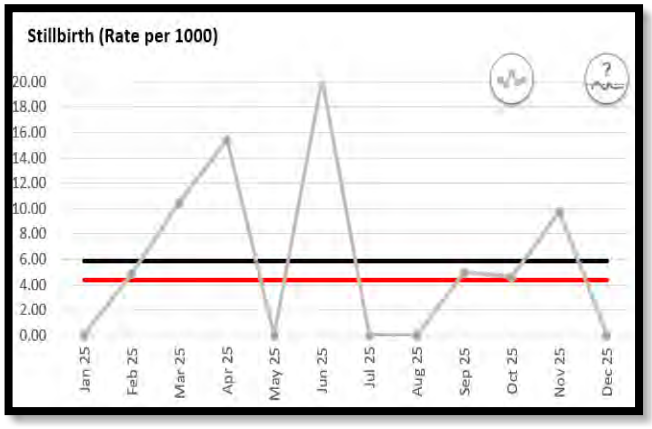
Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated

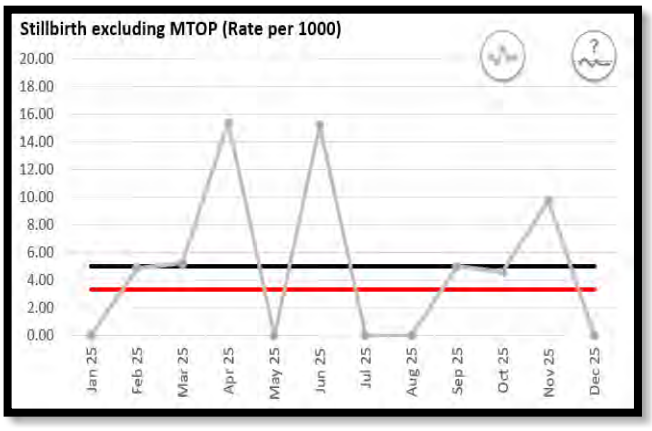
No exceptions: Compliant with Safety Action 4.

10.4 Maternity Unit Diverts

- There was 1 **maternity unit divert** during Q3.
- The unit diverted for 10 hours and 50 minutes on the evening of December 6th due to locum registrar not attending planned shift.
- Unable to cover at short notice
- No women required divert and none were received, however it necessitated delaying planned artificial rupture of membranes (ARMs)

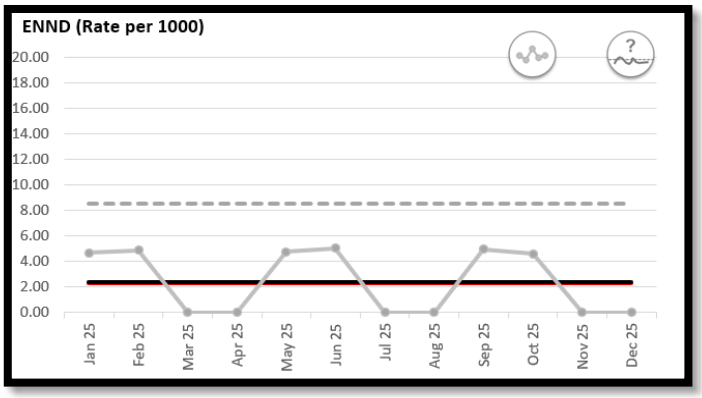
11.0 Statistical Process Control charts Q3 25/26Statistical Process Control (SPC) charts have been provided below. These offer a **reliable and current view** of performance over time, including comparison against the **GMEC 2024 mean**, and provide assurance of **ongoing improvement** across key metrics.

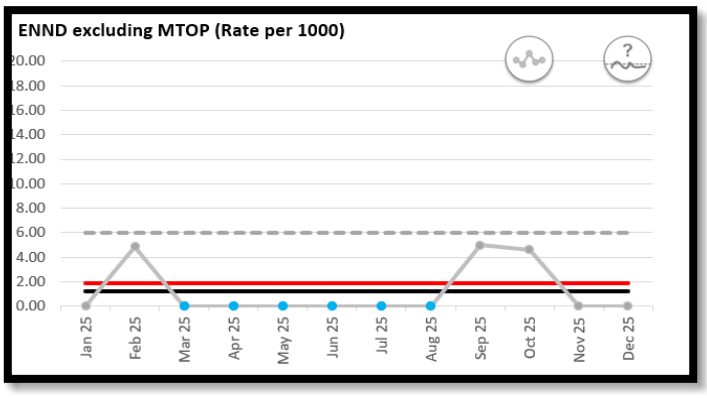




The first of the above two charts shows the total number of stillbirths as a rate per 1000 births (Red line is GM 2024 average). The second shows revised figures where MTOP is not included, as a rate per 1000 births.

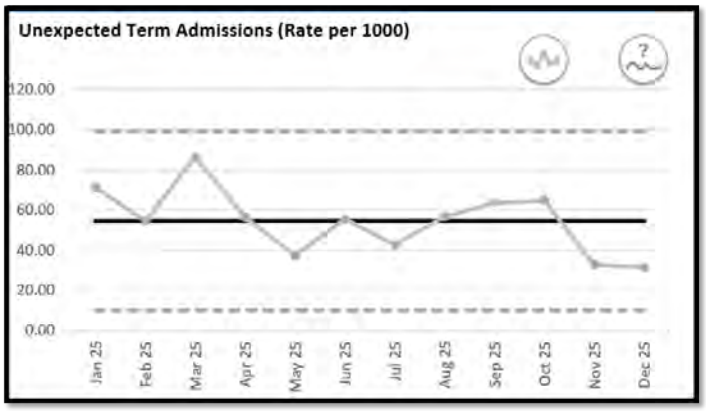
There were 3 antenatal stillbirths in Q3. 1 in October (26+ weeks) and 2 in November (37+ weeks, 1 twin who was known to have demised at 31 weeks, born at 34 weeks with their live sibling).

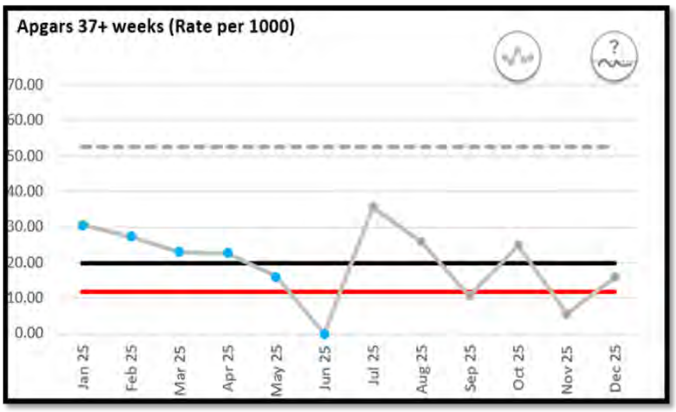




The first of the above two charts shows the total number of early neonatal deaths, as a rate per 1000 births. The second shows revised figures where MTOP is not included, as rate per 1000 births (Red line is 2023 GM average which is the latest available figure for this metric).

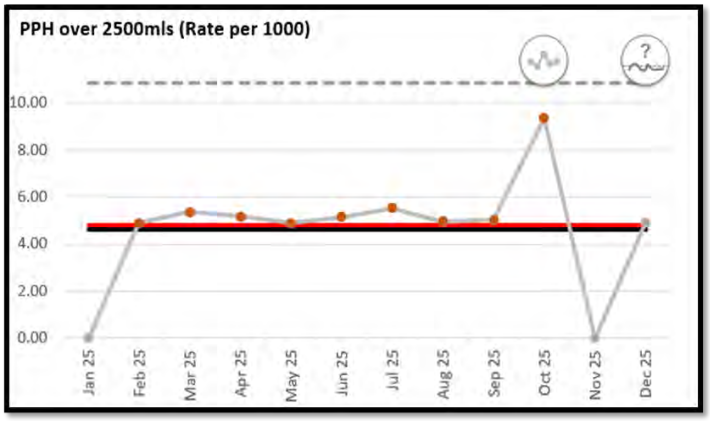
There was one early neonatal death (ENND) in October. This was a baby born spontaneously at 20+2 weeks who had a heart beat for 2 hours.

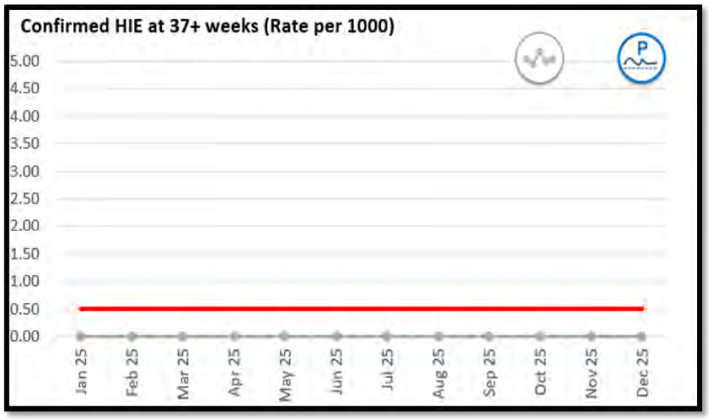




There has been an overall downward trend since April 2023, and significant progress made to reduce the gap between WWL Term Admission to NNU performance and the GMEC mean. The Avoiding Term Admission to Neonatal Units MDT review group and audit is embedded and QI work is ongoing.

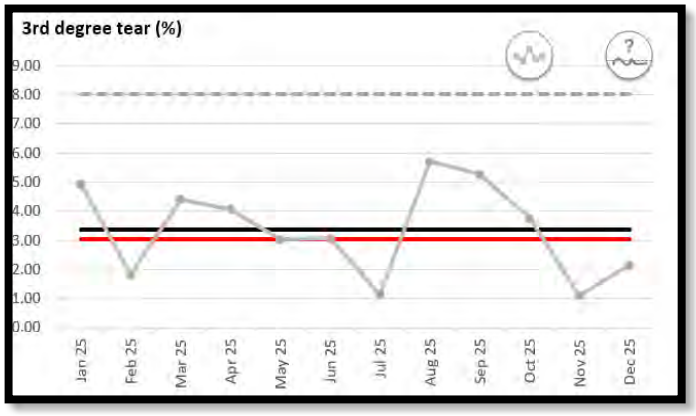
The Apgar score < 7 at 5 minutes data is shown as a rate per 1000. We remain an outlier against the GMEC 2024 mean. The downward trend is noted largely in response to ATAIN initiatives.

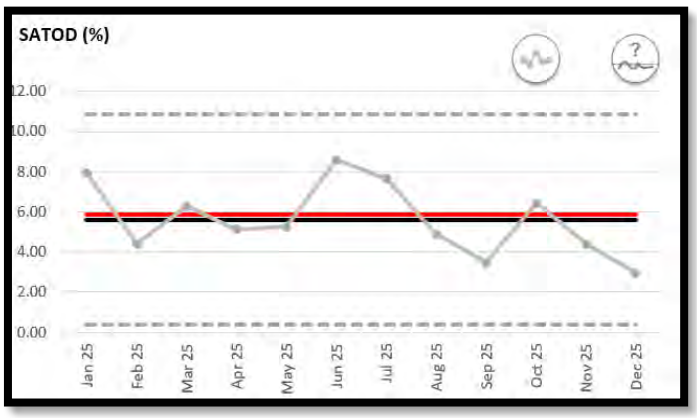




Data outcomes are steady for PPH >2500 mls. The PPH working group is starting to become embedded and learning collated via audit. Obs UK research trial continues. Learning outcomes now presented – associated QI including PPH grab bags and updated paperwork to support documentation gaps. There were 3 PPH >2500mls in Q3, 2 in October and 1 in December.

There have been no babies with confirmed HIE 2/3 (37 weeks +) or meeting the MNSI investigation criteria since August 2023. The red line is the GMEC 2024 average





The OASI working group continues its work to reduce this figure and the new PPHS Midwife is now in post. The red line is the 2024 GM average. A downward trend is showing for this metric.

Overall downward trend continues. All SATOD figures are shown as a %. The figure in December equates to 6 women SATOD. This is the lowest figure WWL have had for this metric. The red line is the 2024 GM average.

11.1 Maternity Outcomes Signal System (MOSS)

🔍 Purpose & Origins

- Developed by NHS England in response to the Reading the Signals report (stemming from the East Kent investigation), it aims to detect emerging safety concerns in maternity and neonatal care earlier and more reliably.
- Retrospective analysis shows that MOSS would have flagged issues at trusts like East Kent, Shrewsbury & Telford, Leeds, and Nottingham—prior to serious incidents
- Currently MOSS looking at data for all term stillbirths and term neonatal deaths, irrespective of cause, with a focus on identifying safety issues with intrapartum care.
- WWL responded to their first **Level 1** Safety Signal in December 2025 due to **3 term** mortalities (1 in September; 1 in November; 1 in December). A detailed MOSS Safety Checklist was completed which identified **NO** safety issues.

Summary

Staffing & Workforce Flexibility

- Q3 faced continued staffing challenges, with specialist and community teams stepping up to support inpatient services. BI fill rate data needs analysis as does not reflect current picture.
- Sickness rates across the service continue to be high.
- Acknowledgement is given to those who flexed roles under pressure.
- Emphasis on developing a flexible, rotational midwifery workforce is required to enhance adaptability across maternity services.

Culture & Leadership

- Boo Consultancy met the Quadrumvirate in Q3 for bespoke leadership session. Concern raised by staff regarding Boo Consultancy level of engagement and lack of system level insight in action planning. To discuss at Safety Champions meeting in Q4.

Health Equity & Data

- Strengthened efforts in capturing demographic and health equity data across services.
- MNVP lead and Patient & Public Engagement midwife collaborated effectively to improve patient experience and data inclusivity.
- Positive feedback from diverse birthing populations continues to be strong, with many staff commended.
- Audits now better reflect underrepresented patient voices.

Patient Experience

- Trial of overnight partner visiting is progressing positively.
- Analysis and triangulation of all patient-experience data shoes what’s working well and where experience is more fragile.

Complaints & Feedback

- Formal complaints skew toward white British and higher decile groups.

- Need to improve accessibility of complaints processes in prevalent languages to ensure inclusive learning.

Clinical Outcomes & Service Improvements

- Overall positive trends in KPIs.
- There has been an increase in stillbirths and neonatal deaths in 2025 when compared to the very low rates in 2024. There is a persistent theme of women who experience a pregnancy loss having a raised BMI. The lack of a weight management service in pregnancy is concerning. The annual Mortality Report will be completed in Q4 for further analysis.
- Stop Smoking Service achieved record-low smoking rates at delivery; focus now shifts to SATOD data for Eastern European users.
- ATAIN team's QI work shows reduced term admissions to NNU and improved data for Apgar scores <7 at 5 minutes.
- NNU team are leading the way nationally in airway management—recognised for their expertise and dedication.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Freedom to Speak Up Quarter 3 (Oct – Dec) Report 2025
Presented to:	Board of Directors
On:	4th February 2026
Item purpose:	Information
Presented by:	Selina Morgan, Freedom to Speak Up Guardian
Prepared by:	Selina Morgan, Freedom to Speak Up Guardian
Contact details:	T: 07826860276 E-mail: selina.morgan@wwl.nhs.uk

Executive summary

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

- Assurance on Freedom to Speak Up (FTSU) Guardian approach and activity throughout Quarter 3 (Oct to Dec) 2025.
- An update on FTSU Guardian's continuous developments, progress, and proactive work.
- An overview of FTSU casework including activity, themes, and trends.

Key points for noting include:

- **Volume of Concerns:** There were **37** cases in quarter 3, compared with 28 the previous quarter, demonstrating an increased flow of concerns raised across the quarter with a significant rise in December.
- **Themes Identified:** Common themes included Leadership/Management, staff wellbeing and process and procedures.
- **Staff Groups Involved:** Concerns were raised by a mix of clinical and non-clinical staff.
- **Outcomes & Impact:** Some concerns led to meetings with Chief officers, team talks, delivered by the FTSU Guardian and improved communication channels.
- **FTSU Champion network** After a Guardian team talk, Estates and Facilities staff have expressed an interest in becoming FTSU Champions.
- **Triangulation meetings** with Staff Side and Staff Experience Team and OD Team continue to take place.

Link to strategy and corporate objectives

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

- To improve the quality of care for our patients.

All staff, students and volunteers within the organisation should feel safe, comfortable, and confident to speak up and should not feel burden or face barriers for doing so. All staff including our leaders to adopt our organisational values to create the right environment, by doing this we improve health and care outcomes for the population we serve and staff experience.

Risks associated with this report and proposed mitigations.

There is a risk to the quality and safety of patient care, and to staff experience, engagement and productivity, if staff do not feel able to speak up regarding their concerns or are shut down when they do speak up.

Financial implications

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

Legal implications

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

People implications

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

Equality, diversity, and inclusion implications

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

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

NA

1. PURPOSE OF REPORT

1.1 This report provides the Board with an overview of concerns raised through the Freedom to Speak Up (FTSU) process during Q3 25/26 (October–December 2025). The data highlights emerging cultural, operational, and leadership themes that may warrant strategic attention. The Freedom to Speak Up Guardian continues to support individuals raising concerns and ensures that, where appropriate, senior leaders are informed and act upon the information provided.

2 BACKGROUND

2.1 The roles of FTSU Guardians and the NGO were established in 2016 following events at Mid Staffordshire NHS Foundation Trust and the subsequent public inquiry by Sir Robert Francis QC. One of the recommendations from the Sir Robert Frances report was the development of a FTSU Gurdian role.

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

3 CHAMPION DEVELOPMENT

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

3.2 FTSU Champion expansion

There has been ongoing expansion of the FTSU network of FTSU Champions across WWL. There are now **32** Champions accessible to support staff with ongoing awareness of the role. Champions are now delivering team talks to various teams.

3.3 There is no specific upper limit to the number of Freedom to Speak Up (FTSU) Champions an NHS trust can have. National guidance encourages trusts to develop a diverse network of champions to ensure all staff have access to support.

3.4 **Network Approach:** The FTSU Guardian created the Champion network on commencement in post, March 2024 via Expressions of interest. Champions represent different staff groups, services, and locations and now include staff from the Estates and Facilities division.

3.5 The role of the champion is to support the Freedom to Speak Up Guardian by signposting colleagues to appropriate services and acting as an alternative route for speaking up.

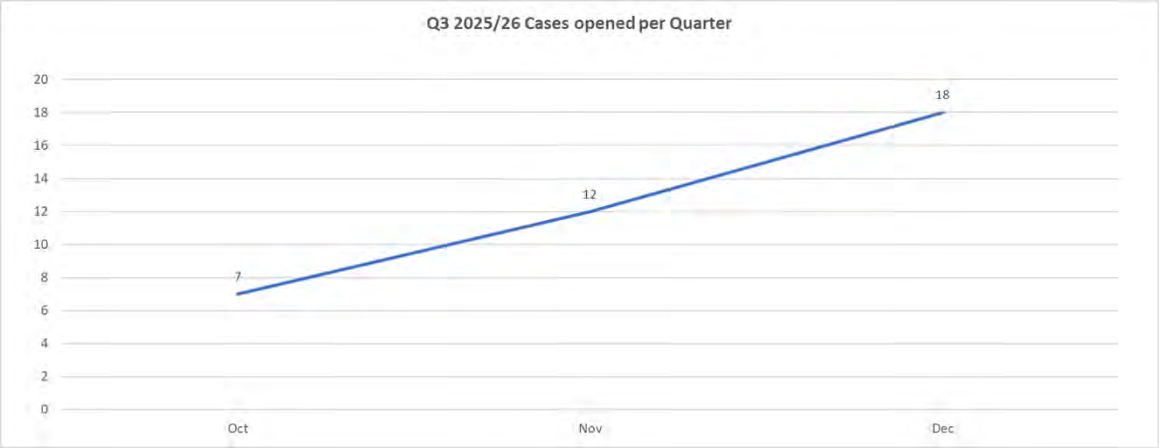
3.6 While there is no limit, the number of champions should be sufficient to ensure coverage across the organization, particularly for dispersed teams or those with high-risk areas.

3.7 While having many champions is encouraged, particularly for a larger organisation such as WWL with over 7,300 staff, they must maintain independence. The FTSU Guardian has ensured they are properly trained to avoid conflicts of interest, especially if they also hold other roles like union representatives.

Essentially, the number of champions is determined by the need for a comprehensive and accessible network, rather than a fixed maximum number.

4 ACTIVITY

4.1 Throughout quarter 3 the graph below shows that **37** concerns were reported to the FTSU Guardian during the period and illustrates the number of concerns reported each month.



4.2 Some reasons for fluctuation include:

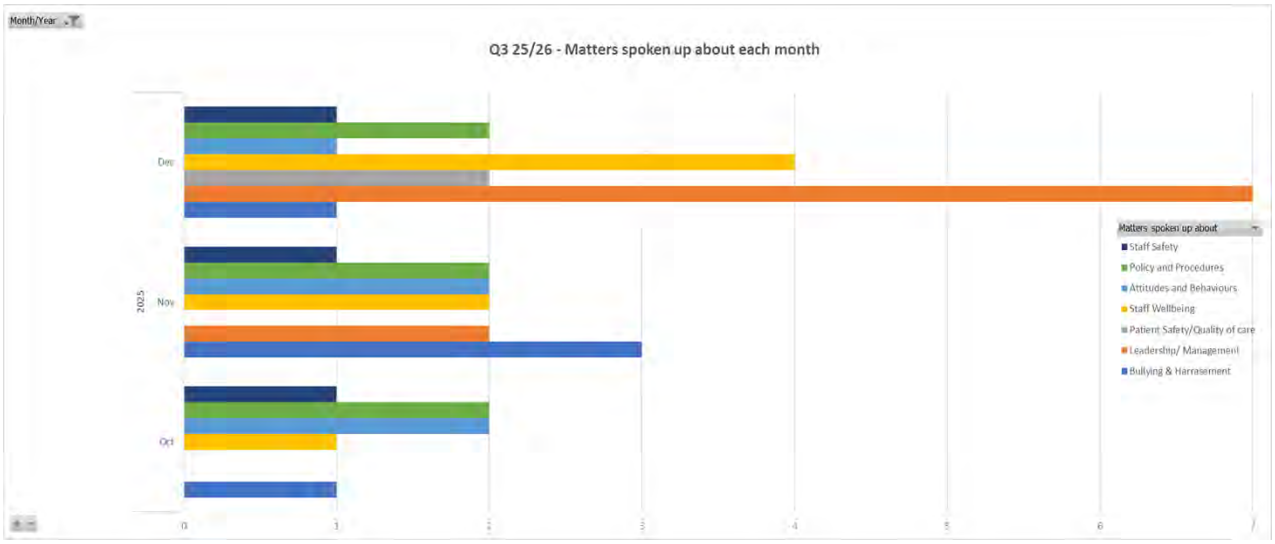
Organisational Change During periods of major restructuring, policy changes, or leadership transitions, staff may choose FTSU channels increasing the number of concerns, as seen in December.

#

5 THEMES AND TRENDS

5.1 Themes are recorded via a drop-down box on the FTSU Guardians tracker. Predominant themes of concern raised via FTSU over the 3-month period included:

- Leadership/Management
- Staff wellbeing and
- Process and procedures.



5.2 Data Analysis per Quarter

October Key Themes

- Policy and Procedures
- Attitudes and Behaviours

October presents a low volume of concerns, but the nature of issues raised suggests early signs of inconsistency in the application of policies and emerging behavioural tensions. While not indicative of systemic risk at this stage, these themes often precede wider cultural challenges if not addressed proactively.

November Key Themes

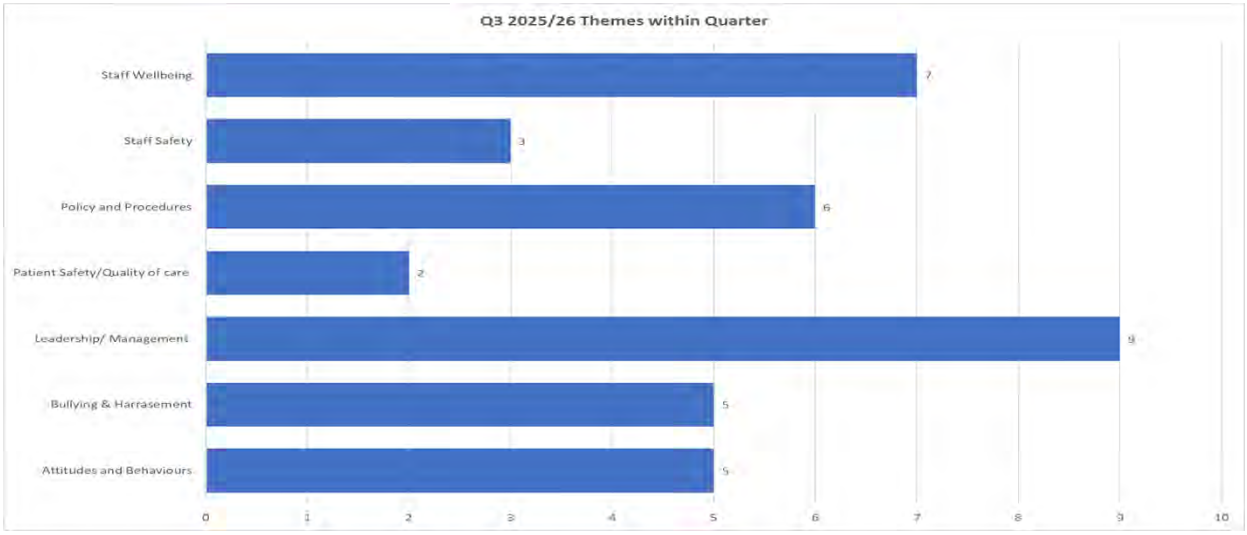
- Bullying & Harassment (highest category for the month)
- Policy and Procedures
- Attitudes and Behaviours

The significant rise in Bullying & Harassment concerns signals a potential deterioration in workplace culture or the presence of specific hotspots requiring targeted intervention. The persistence of procedural and behavioural issues suggests that more work is required to strengthen and prevent these themes re-emerging.

December Key Themes

- Leadership/Management (highest category across the quarter)
- Staff Wellbeing
- Patient Safety / Quality of Care

December shows a marked shift toward concerns relating to leadership capability, decision-making, and communication. The concurrent rise in patient safety and staff wellbeing concerns may reflect operational pressures impacting both service quality and workforce morale. This combination represents a potential organisational risk and warrants Board-level scrutiny of leadership behaviours, visibility, and responsiveness.



5.3 Quarterly Themes summary

Across the quarter, concerns evolve from procedural and behavioural issues to interpersonal conflict and, ultimately, to leadership and systemic challenges. This progression may indicate:

- Increasing staff confidence in raising concerns
- Potential gaps in leadership responsiveness or follow-through
- The cumulative impact of unresolved issues on staff and service quality

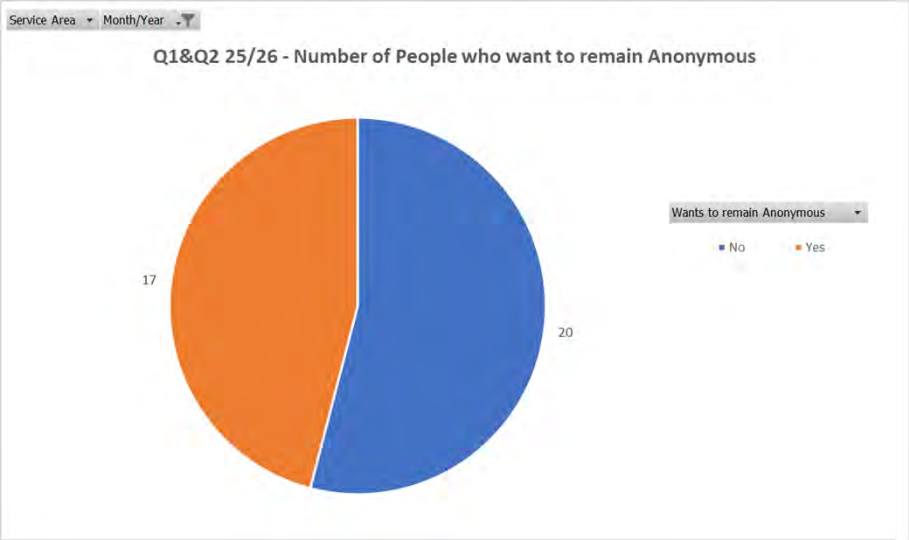
This trajectory suggests the need for sustained organisational focus on culture, leadership, and psychological safety.

6. INSIGHTS FROM ANONYMOUS CONCERNS (Oct – Dec 2025)

6.1 Volume & Distribution

In Q3, **45.95%** of all Speak Up cases were raised anonymously, highlighting that anonymity continues to be an important option for staff.

Anonymous reporting varied across the quarter, November being the highest, reflecting the continued need for staff to have a safe and confidential route when raising sensitive concerns. This pattern reinforces the importance of maintaining anonymous options such as the e-form, ensuring staff can choose the reporting method that feels safest for them.



17 individuals out of the 37 cases reported wanted to remain anonymous in quarter 3.

6.2 **Anonymous contact e-form amendment**

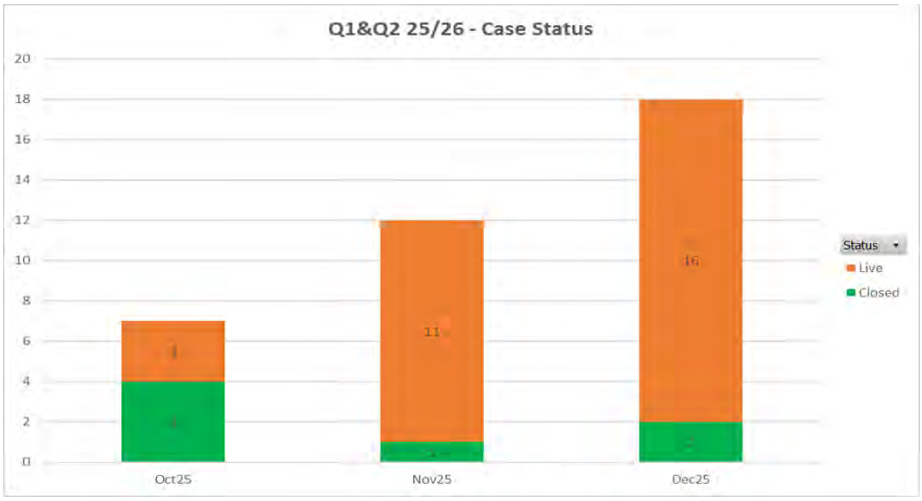
Please advise why you would like to remain anonymous was added in Q1 last year 2025 and after a discussion with the Medical Director the Guardian is now considering sub-categories that may help the Guardian and the person the concern is escalated to, to understand what the person *wants to happen next*, especially when they choose to stay anonymous and therefore can't receive feedback. The Guardian is considering this to improve clarity and manage expectations and proposes: ***"How would you like me to progress this issue?"***

The tick box options below will help the Guardian understand the reporter's expectations without needing to identify them or give feedback.

- Immediate action required
- Action required but not urgent
- No action required — for information only

7. CASES CLOSED

7.1 The closed-case data shows that while a significant number of concerns are being resolved, closure is not always straightforward, particularly when issues are multifaceted or involve several overlapping themes.



7.2 Key Observations

- A steady flow of cases *are* reaching closure each month, which demonstrates strong follow-through from the FTSU Guardian.
- However, the pace of closure varies depending on the complexity of the concern, the number of stakeholders involved, and whether the issue spans multiple domains (e.g., behaviour, leadership, wellbeing, patient safety).
- Cases involving multiple departments or cross-divisional escalation, tend to remain open longer.
- Some concerns require ongoing monitoring, external advice, or multi-step action plans, which naturally delays closure.
- This pattern reflects the FTSU Guardian's commitment to thoroughness, ensuring that issues are not closed prematurely.

7.3 Why Multifaceted Concerns are harder to close

- They often require input from several leaders or specialist teams (HR, OD, Medical Director, Chief Nurse, etc.).
- Staff may need ongoing support, meaning the case cannot be closed until the individual feels safe and satisfied with the outcome.
- Some concerns evolve over time, requiring repeated check-ins before closure is appropriate.

8. PROTECTED CHARACTERISTICS

- The Guardian is collecting and recording protected characteristics routinely, although there has been no national directive to do so.
- Staff are not declaring protected characteristics, and more work is required around this metric.

8.1 Some people don't declare because:

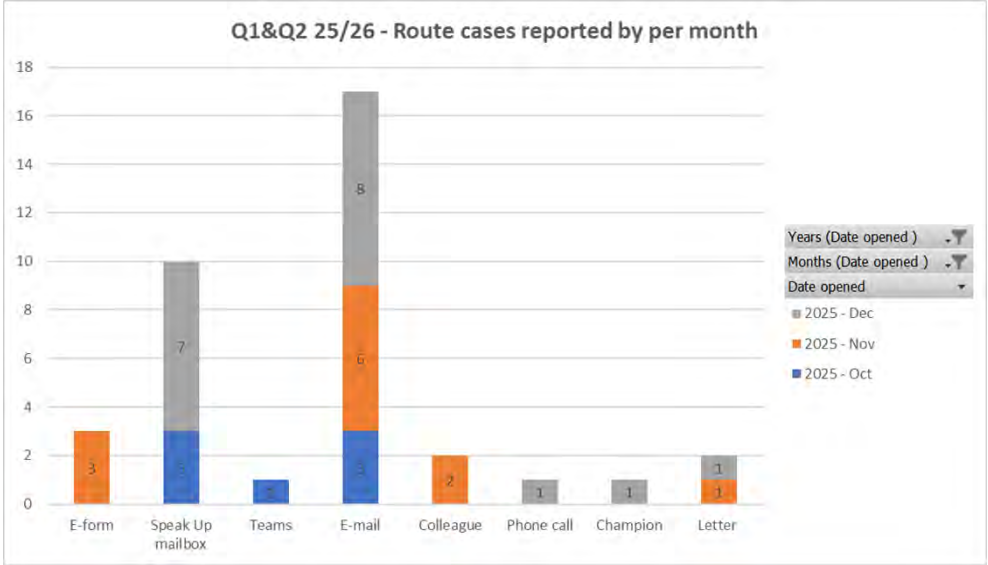
- Don't feel the categories reflect their identity
- Don't see the relevance
- Prefer not to label themselves or
- Some characteristics are personal.

8.2 The FTSU Guardian will continue to create the kind of environment where disclosure feels natural rather than risky, by:

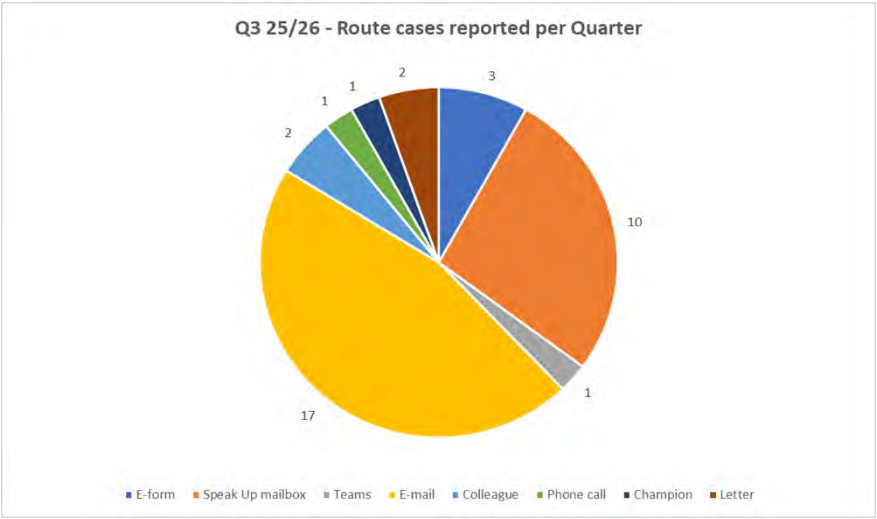
- Participate in or support staff networks
- Explain how data is stored, who sees it, and how anonymity is protected.
- Clarify that disclosure is voluntary

9. ROUTES

The graph below shows the routes staff used to raise concerns per month.



9.1 The data shows that staff are using a wide range of reporting routes, which is a strong indicator of accessibility and trust in the Freedom to Speak Up process. While email and the Speak Up mailbox remain the most frequently used channels, it is particularly encouraging to see FTSU Champions and colleagues emerging as meaningful pathways for staff to raise concerns.



9.2 **Email and the Speak Up mailbox** continue to be the most used routes, reflecting their convenience and familiarity.

- The **e-form**, which is the *anonymous* reporting route, is also being used. This is an important option because:
  - It provides a safe space for staff who may feel vulnerable or fear repercussions
  - It ensures concerns are still captured even when individuals are not ready to identify themselves

    - It demonstrates the organisation's commitment to offering psychologically safe alternatives.
- **Teams** is being used by staff who prefer remote or digital conversations, which is particularly valuable for those working across multiple sites or in community settings.
- **FTSU Champions** as a route, is increasing, which is a very positive sign. It shows:
    - Champions are visible and trusted
    - Staff value having a trained peer to approach
    - The Champion network is becoming embedded in the culture
- It is equally encouraging to see concerns raised via **colleagues**, suggesting:
    - Staff feel supported by one another
    - Speaking up is becoming more culturally normalised
    - Issues are being surfaced even when staff may not feel ready to approach formal channels directly.

9.3 Why this Mix of Routes Matters

- A healthy Speak Up culture relies on multiple access points, not a single route.
- Different staff groups have different comfort levels — some prefer anonymity, others prefer a known person, and some prefer remote or digital contact.
- The anonymous e-form helps capture concerns that might otherwise go unheard.
- Champions and colleagues reduce barriers for staff who prefer a more personal or informal route.
- Teams provides a flexible option for staff who may not be on-site or who feel more comfortable speaking up virtually.

It is important to have all options available, ensuring every member of staff can choose the route that feels safest and most accessible to them.

10. GUARDIAN REFLECTIONS, STAFF FEEDBACK AND NEXT STEPS

10.1 The Freedom to Speak Up Guardian continues to play a critical role in:

- Supporting individuals to raise concerns safely
- Ensuring concerns are escalated appropriately
- Providing senior leaders with timely intelligence
- Encouraging a culture of openness and accountability

The Guardian makes every effort to ensure that concerns are acted upon and that staff feel heard and supported throughout the process.

10.2 Staff Feedback

Once a case is closed the FTSU Guardian sends a feedback questionnaire to check how well the process worked. It helps the FTSU Guardian see if the service is functioning as it should, whether staff felt supported and what needs fixing. It is also part of national guidance and NHS England encourages Guardians to gather feedback as part of maintaining a healthy speaking-up culture.

Below is a snapshot of a recent feedback submission received 26th Dec 2025.

Is there anything that could have made your experience better? NO

Please explain your response:

I am extremely happy with the support I and my department received from the Freedom to Speak up service. Communication was always very quick and clear, and the issue at hand was resolved very quickly once escalated to the FTSU service. The FTSU service in my opinion is a much-needed service to help mediate problems that have been unable to be solved at a local/departmental level.

10.3 **Next Steps:**

- **Strengthen leadership visibility and engagement**, particularly in areas where concerns have escalated.
- **Ensure timely and transparent follow-up** on concerns raised, with clear feedback loops.
- **Monitor patient safety and staff wellbeing metrics** for any correlation with Speak Up themes.
- **Revisit the FTSU Reflection Tool** to assess the strength of safety culture, identify barriers and measure progress.

11. RECOMMENDATIONS

The Board of Directors are asked to note contents of the Report

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Financial reporting month 9 – Trust Finance Report
Presented to:	Board of Directors
On:	4th February 2026
Item purpose:	Information
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Senior finance team
Contact details:	heather.shelton@wwl.nhs.uk

Executive summary

December was a challenging month, ending with a £0.8m deficit – £1.0m worse than plan – and the YTD deficit has grown to £2.1m, £2.3m below target. We are tracking at our mid-case scenario and have yet to see the improvement needed to deliver our plan. Quarter 4 is critical: full delivery of the elective programme, achieving CIP targets, and rapid mobilisation of our internal recovery plan are essential to get back on track. Immediate focus and decisive action are non-negotiable.

Deficit Support Funding (DSF) for GM ICS has been secured for Quarter 4; however, this is subject to clawback in the event the system fails to deliver the 2025/26 financial plan (alongside further adverse consequences under the NHS business rules).

CIP performance deteriorated in December. Recurrent CIP slippage remains a contributing factor of our adverse variance, with the month 9 position now £5.4m behind the recurrent plan of £16.7m. The total CIP delivered in month 9 is £2.8m which is £0.6m behind the total plan, the total YTD slippage is £3.6m as non-recurrent CIP has partially mitigated the recurrent under-performance.

Divisional elective API income is £0.4m adverse to plan in month and did not deliver the recovery forecast by divisions. Unbundled drugs and devices is £0.7m favourable and this includes gainshare and limb salvage prosthesis; the latter is a risk whilst discussions continue with Specialist Commissioners.

The cash balance as at 31st December 2025 is £7.6m, which is equivalent to 5 operating cash days. Our cash remains on a downward trajectory linked to the slippage on CIP delivery and increasing run rate, with cash becoming a critical constraint for operational decision making.
Workforce in December is 6,970 WTE, which is an increase of 19 WTE on last month. The gap to the workforce plan is growing with the in-month position being 209 WTE above the plan of 6,761 WTE. Pay expenditure is £1.9m adverse to plan in month which is associated with recurrent CIP underperformance £0.7m, MARS £0.5m and industrial action £0.4m. National funding to cover industrial action for November and December has been assumed following advice from NHSE.

The full year forecast scenarios are updated each month. The mid-case shows a deficit of £1.2m, which includes 50% of the recovery plan for Q4 (£1.2m). Delivery of the remaining 50% (£1.2m)

associated with the recovery plan is required to close the gap to best case and to ensure delivery of breakeven position in line with plan and our forecast to NHSE. A monthly run rate improvement of £1.0m is required to deliver our revenue plan.

The key risks to delivery of the financial position in year are:

- **Recovery plan**: Fast mobilisation of the recovery plan is essential to deliver our revenue plan.
- **Recurrent CIP delivery**: CIP performance deteriorated in December. Recurrent CIP slippage remains a contributing factor of our adverse variance, with the month 9 position now £5.4m behind the recurrent plan of £16.7m.
- **API activity**: Divisional elective API income was below plan in month 9 and therefore the YTD underperformance has grown to £1.0m. There is a risk that the ICB will seek to use the current position to agree a year end settlement. Active discussion is taking place with the ICB.
- **Prosthesis recharge**: Discussions are ongoing with NHSE Specialist Commissioning regarding the recharge for bespoke prosthesis and limb salvage expenditure. A project has identified additional expenditure in scope for pass through; however, this is above the activity plan agreed for the financial year.

The underlying position is assessed quarterly. At Quarter 3, the underlying deficit was £17.2m, demonstrating continuing improvement but behind the planned trajectory. The 2025/26 exit run rate will form the starting point for the medium-term financial plan, with a planning assuming of an £11.9m forecast exit run rate deficit. Achieving the revenue plan through recurrent CIP delivery is essential to ensure the forecast exit run rate does not deteriorate.

Link to strategy

There are no direct links to strategy.

Risks associated with this report and proposed mitigations

There are no additional direct risks.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Equality, diversity and inclusion implications

There are no direct EDI implications in this report.

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

ETM reviewed the finance flash metrics on 8 January 2026. The full finance report was reviewed at the Financial Improvement Group on 15 January 2026 and the Finance and Performance Committee on 28 January 2026.

Wider implications

There are no wider implications of this report.

Recommendation(s)

The Board of Directors is asked to note the month 9 financial position.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Trust Finance Report

Month 9 – December 2025

Contents

Main report

Statistical Process Chart (SPC) Key

Key Financial Messages

December was a challenging month, ending with a £0.8m deficit – £1.0m worse than plan – and the YTD deficit has grown to £2.1m, £2.3m below target. We are tracking at our mid-case scenario and have yet to see the improvement needed to deliver our plan. Quarter 4 is critical: full delivery of the elective programme, achieving CIP targets, and rapid mobilisation of our internal recovery plan are essential to get back on track. Immediate focus and decisive action are non-negotiable.

Deficit Support Funding (DSF) for GM ICS has been secured for Quarter 4, however this is subject to clawback in the event the system fails to deliver the 2025/26 financial plan (alongside further adverse consequences under the NHS business rules).

CIP performance deteriorated in December. Recurrent CIP slippage remains a contributing factor of our adverse variance, with the month 9 position now £5.4m behind the recurrent plan of £16.7m. The total CIP delivered in month 9 is £2.8m which is £0.6m behind the total plan, the total YTD slippage is £3.6m as non-recurrent CIP has partially mitigated the recurrent under-performance.

Divisional elective API income is £0.4m adverse to plan in month and did not deliver the recovery forecast by divisions. Unbundled drugs and devices is £0.7m favourable and this includes gainshare and limb salvage prosthesis; the latter is a risk whilst discussions continue with Specialist Commissioners.

The cash balance as at 31st December 2025 is £7.6m, which is equivalent to 5 operating cash days. Our cash remains on a downward trajectory linked to the slippage on CIP delivery and increasing run rate, with cash becoming a critical constraint for operational decision making.

Workforce in December is 6,970 WTE, which is an increase of 19 WTE on last month. The gap to the workforce plan is growing with the in-month position being 209 WTE above the plan of 6,761 WTE. Pay expenditure is £1.9m adverse to plan in month which is associated with recurrent CIP underperformance £0.7m, MARS £0.5m and industrial action £0.4m. National funding to cover industrial action for November and December has been assumed following advice from NHSE.

Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Red		December was a challenging month, ending with a £0.8m deficit – £1.0m worse than plan – and the YTD deficit has grown to £2.1m, £2.3m below target. This includes a material upside from industrial action funding received to cover November and December (income £1.7m; expenditure £0.8m). We are tracking at our mid-case scenario and have yet to see the improvement needed to deliver our plan. Quarter 4 is critical: full delivery of the elective programme, achieving CIP targets, and rapid mobilisation of our internal recovery plan are essential to get back on track.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Red		The cash balance as at 31st December 2025 is £7.6m, a new low point, which is equivalent to 5 operating cash days. Our cash remains on a downward trajectory linked to the slippage on CIP delivery and static run rate, with cash becoming a critical constraint for operational decision making. A temporary reprieve is expected in Q4 due to timing of capital projects.
API Income	Achieve the elective activity plan for 2025/26.	Red		Divisional elective API income is £0.4m adverse to plan in month and did not deliver the recovery forecast by divisions. Unbundled drugs and devices is £0.7m favourable and this includes gainshare and limb salvage prosthesis; the latter is a risk whilst discussions continue with Specialist Commissioners.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Red		CIP performance deteriorated in December. Recurrent CIP slippage remains a contributing factor of our adverse variance, with the month 9 position now £5.4m behind the recurrent plan of £16.7m. The total CIP delivered in month 9 is £2.8m which is £0.6m behind the total plan, the total YTD slippage is £3.6m as non-recurrent CIP has partially mitigated the recurrent under-performance.
	Deliver Recurrent CIP of £23.0m	Red		
Agency expenditure	30% reduction in agency spend.	Red		Agency spend is showing a cumulative 6% reduction to the NHSE baseline (adjusted for industrial action costs) (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.
Bank expenditure	10% reduction in bank spend	Green		Bank spend is showing a cumulative 15% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE.
Capital expenditure	Achieve capital plan for 2025/26.	Amber		Total capital expenditure in month 9 is £1.2m which is £0.8m less than plan. We are forecasting capital expenditure in line with plan with close monitoring in Q4. We have been successful in securing additional national funding for Q4.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Green		BPPC performance in-month was 95.1% by volume and 97.5% by value. YTD performance was 92.5% by volume and 96.7% by value.

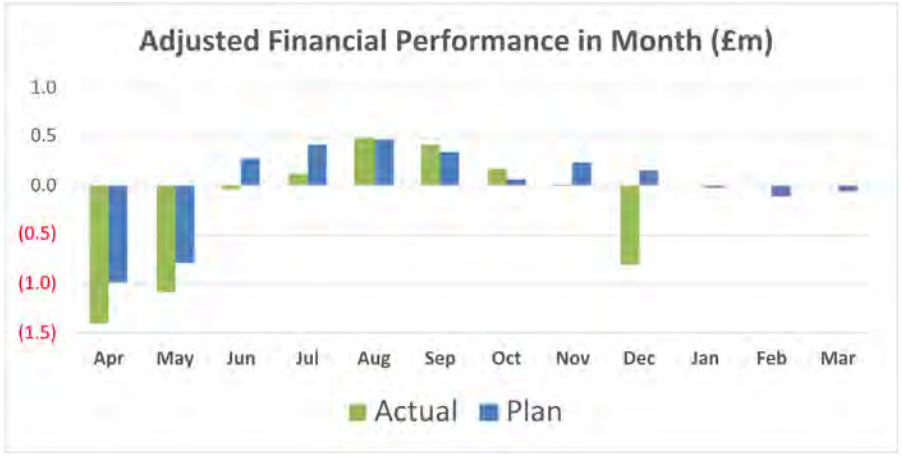
Financial Performance

Headlines

- In month, our actual position is a deficit of 0.8m, which is **£1.0m adverse to plan**. Our YTD position is a deficit of £2.1m, which is **£2.3m adverse to plan**.
- This is in line with our mid-case forecast but £0.6m worse than our best-case forecast required to deliver our revenue plan.
- The recovery plan is not yet delivering any material improvement to run rate.
- Income is £50m, **£2.2m above plan** in month. Elective API income is £0.5m behind plan, offset by industrial action funding of £1.7m for November and December and over performance on unbundled drugs and devices £0.7m.
- Pay is £34.7m, **£1.9m adverse to plan**, CIP underperformance £0.8m, industrial action £0.4m (offset by income), and MARS £0.5m (within forecast).
- Non pay is £15.1m, **£0.8m adverse to plan**, CIP on plan, overspends on clinical supplies £0.3m, drugs £0.3m, premises £0.3m.
- Actual CIP delivery in month is £2.7m, which is **£0.6m adverse to plan**.
- The National Oversight Framework (NOF) metric for variance YTD to financial plan has slipped to a score of 3 (Q1 metric score 3, Q2 metric score 2).

Improvement Trajectory to Deliver Revenue Plan

Based on the current run rate there needs to be a **£1.0m improvement each month** to March 2026 to deliver the 2025/26 plan**. The improvement trajectory is getting steeper.**



Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	50,025	47,842	2,184	437,426	429,402	8,023	572,943
Pay	(34,735)	(32,834)	(1,901)	(308,180)	(296,742)	(11,438)	(395,279)
Non Pay	(15,110)	(14,325)	(785)	(126,969)	(127,663)	693	(171,256)
Financing / Technical	(451)	(552)	100	(3,989)	(4,966)	977	(6,621)
Surplus / Deficit	(822)	131	(953)	(2,263)	32	(2,295)	(213)
Adjusted Financial Performance (AFP)	(803)	149	(953)	(2,143)	192	(2,336)	0
Memo							
Deficit support funding	(741)	(741)	0	(6,670)	(6,670)	0	(8,893)
AFP excluding deficit support funding	(1,544)	149	(1,694)	(8,813)	192	(9,005)	(8,893)

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

Underlying Position

Quarter 3 Update

2024/25	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Plan	2026/27 Planning assumption
•Underlying run rate £25.8m deficit •£7.4m improvement on prior year	•Extrapolated underlying run rate £21.3m deficit •Improvement £4.5m on 2024/25 •Assumes all income other than DSF is recurrent	•Extrapolated underlying run rate £20.6m deficit •Improvement £0.7m on Q1 •Behind improvement trajectory by £3.7m	•Extrapolated underlying run rate £17.2m deficit •Improvement £3.4m on Q2 and £8.6m on 2024/25 •Behind improvement trajectory by £4.7m	•2025/26 Planned exit run rate was £8.1m deficit •Further improvement required of £9.1m in Q4 to deliver original plan	•2026/27 Draft Plan assumes exit run rate of £11.9m deficit; our current forecast •Further improvement required of £5.3m in Q4 to deliver

Key messages

- **Current 2025/26 Forecast**: The underlying exit run rate is £11.9m deficit.
- **Methodology**: The regional NW NHSE team have standardised the methodology for the calculation of the underlying position as part of the oversight and assurance for the 2026/27 planning round. Our methodology has been aligned to this and verified by the NHSE team.
- **Medium-Term Planning**: The 2025/26 exit run rate will form the starting point for the medium-term financial plan.
- **Year-on-Year Improvement**: The 2024/25 exit run rate was a £25.8m deficit, demonstrating material improvement required in the underlying position during 2025/26.
- **Progress Tracking**: We assess the underlying position quarterly against the forecast trajectory. At Q3, the deficit was £17.2m—demonstrating continuing improvement, but behind the planned trajectory and the trajectory for the medium-term plan.
- **Critical Delivery Requirement**: Achieving the revenue plan through recurrent CIP delivery is essential to ensure the forecast exit run rate does not deteriorate.

Income

Division	In Month (£000)			Year to Date (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	685	415	270	4,482	3,726	756
Surgery	171	217	(46)	2,314	1,946	368
Specialist Services	1,345	1,600	(255)	14,260	14,374	(114)
Community Services	620	676	(56)	5,749	6,069	(320)
Non Divisional Income	46,035	43,932	2,103	399,999	394,296	5,703
Finance	16	17	(1)	133	142	(8)
Digital Services	3	7	(4)	36	66	(31)
Dir of Strat & Planning	179	136	43	1,591	1,222	368
Chief Operating Officer	0	0	0	0	0	0
Human Resources	82	71	11	766	640	126
Medical Director	97	74	23	820	663	157
Estates & Facilities	460	399	61	3,939	3,594	345
Nurse Director	87	83	4	1,026	844	182
Trust Executive	0	(19)	19	0	(267)	267
GTEC	174	168	7	1,506	1,487	19
Corporate	71	67	5	806	601	205
Total	**50,025**	**47,842**	**2,184**	**437,426**	**429,402**	**8,023**

Headline

- Income is **£2.2m favourable** in month and £8m favourable YTD.

Clinical divisions

- **Medicine**: Income is **£0.3m favourable** in month. Elective API income is £0.1m favourable in month and unbundled drugs and devices income is £0.1m favourable in month including drugs gainshare.
- **Surgery**: Income is **£46k adverse** in month. This is predominantly due to Elective API income which is £0.2m adverse in month, which is offset with over performance on Education income £40k and ENT tier 2 funding from the ICB £0.1m.
- **Specialist Services**: Income is **£0.3m adverse** in month. This is predominantly due to Elective API income which is £0.1m adverse in month including a £0.2m benefit relating to Physio coding from the prior month. Private patient income is £0.2m adverse in month.

Other

- **Non-Divisional income**: **£2.1m favourable** in month. £1.7m relates to Industrial Action funding from the ICB to cover the November and December costs. The Bespoke Limb Salvage recharge accounts for £0.4m of the over performance. The YTD Bespoke Limb salvage income attributed to NHSE totals £2.5m and this recharge was not included in the Trusts Indicative Activity Plan (IAP) and discussions with commissioners are ongoing.
- **Community Services: £0.1m adverse** in month primarily because the SOS feeding service has not yet commenced.
- **Estates & Facilities**: Income is **£0.1m favourable** in month due to over performance on catering and car parking.

Divisional Elective API Activity and Income v Internal Plan

Division	POD	In Month Activity			In Month (£000)			Year to Date Activity			Year to Date (£000)		
		Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,571	1,605	(34)	987	1,063	(76)	13,320	14,519	(1,199)	8,849	9,620	(770)
Medicine	Electives	245	41	204	272	56	216	702	372	330	940	507	433
Medicine	OP Proc New	117	149	(32)	33	55	(22)	794	1,348	(554)	241	497	(256)
Medicine	OP Proc FUP	635	620	15	125	117	8	6,455	5,612	843	1,349	1,055	294
Medicine	OPA New	2,293	2,681	(388)	593	702	(109)	22,045	24,259	(2,214)	5,699	6,355	(656)
Medicine	A&G	495	276	220	107	59	48	4,456	2,480	1,976	965	533	431
Medicine Total		**5,356**	**5,372**	**(16)**	**2,117**	**2,053**	**65**	**47,772**	**48,590**	**(818)**	**18,043**	**18,568**	**(524)**
Specialist Services	Day Cases	801	770	31	1,329	1,368	(39)	7,179	7,015	164	11,876	12,464	(588)
Specialist Services	Electives	341	372	(31)	2,550	2,780	(229)	3,278	3,400	(122)	25,127	25,442	(315)
Specialist Services	OP Proc New	851	914	(64)	137	154	(17)	8,951	8,273	678	1,503	1,392	111
Specialist Services	OP Proc FUP	1,664	1,347	317	240	190	49	14,233	12,188	2,044	2,017	1,722	295
Specialist Services	OPA New	2,920	3,266	(346)	606	691	(85)	30,081	29,549	532	6,360	6,252	108
Specialist Services	A&G	330	171	159	71	37	34	2,972	1,541	1,431	643	334	310
Specialist Services Total		**6,907**	**6,840**	**67**	**4,934**	**5,220**	**(287)**	**66,694**	**61,967**	**4,727**	**47,526**	**47,606**	**(80)**
Surgery	Day Cases	1,044	1,095	(51)	1,484	1,525	(41)	9,209	9,308	(99)	11,990	12,724	(734)
Surgery	Electives	138	183	(45)	529	520	9	1,321	1,660	(339)	4,772	4,707	65
Surgery	OP Proc New	1,587	2,016	(429)	365	441	(76)	15,754	18,175	(2,421)	3,524	3,964	(441)
Surgery	OP Proc FUP	3,458	3,154	304	741	647	93	33,059	28,538	4,521	6,941	5,856	1,084
Surgery	OPA New	3,396	4,331	(935)	704	882	(178)	34,886	38,139	(3,253)	7,194	7,808	(614)
Surgery	A&G	200	107	93	43	23	20	1,802	965	836	390	209	181
Surgery Total		**9,823**	**10,888**	**(1,065)**	**3,866**	**4,039**	**(173)**	**96,031**	**96,786**	**(755)**	**34,811**	**35,268**	**(458)**
Divisional ERF Totals		**22,086**	**23,100**	**(1,014)**	**10,916**	**11,311**	**(395)**	**210,496**	**207,342**	**3,155**	**100,380**	**101,442**	**(1,062)**

Elective API Performance

- In month 9, we have under performed against the elective API plan by £0.4m.
- Year to date, we are £1.1m below plan.
- **Medicine** are £65k favourable to plan in month predominantly due to General Medicine.
- **Specialist Services** are £0.3m adverse in month, predominantly within T&O.
- **Surgery** are £0.2m adverse to plan in month, mainly relating to Oral Surgery and ENT.
- Advice and guidance income of £0.2m has been included in month.

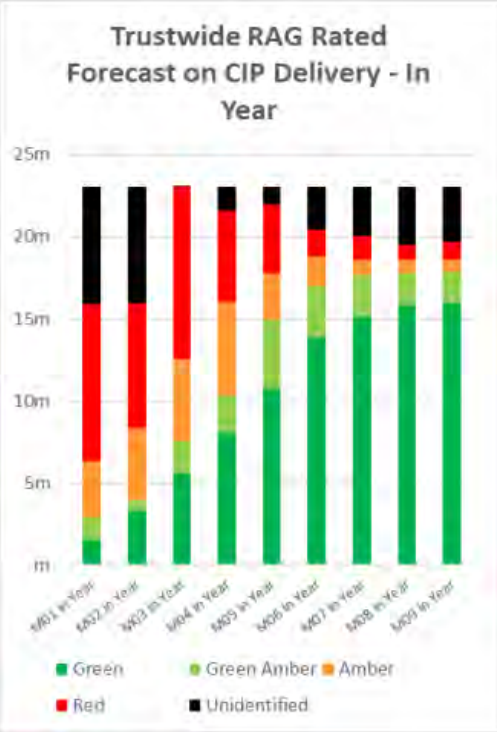
- Specialist Services £0.3m
- Surgery £0.2m

- Medicine £65k

Trust Wide CIP Delivery 2025/26

2025/26 CIP Delivery

- Total CIP delivered in Month 9 is £2.8m, which is £0.6m below plan: £1.48m is recurrent (53%) and £1.32m is non-recurrent (47%).
- The full value of recurrent CIP transacted or categorised as low risk has increased by £0.15m to £17.85m, however the recurrent delivery in the year to date position is £5.4m behind plan.
- At Month 9, £3.4m of the recurrent plan has slipped in year due to the delay in scheme start dates, which will have an impact on what can be delivered in year. This is mitigated non recurrently to ensure the trust meets the full CIP target of £38.4m.



Dec 2025 Reported Position (Rec)

RAG	Value £'000
	3,350
	1,047
	778
	17,846
CIP Total	23,020

Nov 2025 Reported Position (Rec)

RAG	Value £'000
	3,547
	849
	874
	17,750
CIP Total	23,020

CIP assumptions in the Scenarios

To ensure that we meet our mid case scenario, an assumption of delivering £17.18m of cash releasing CIP in year has been made. We have currently delivered and transacted £12.75.

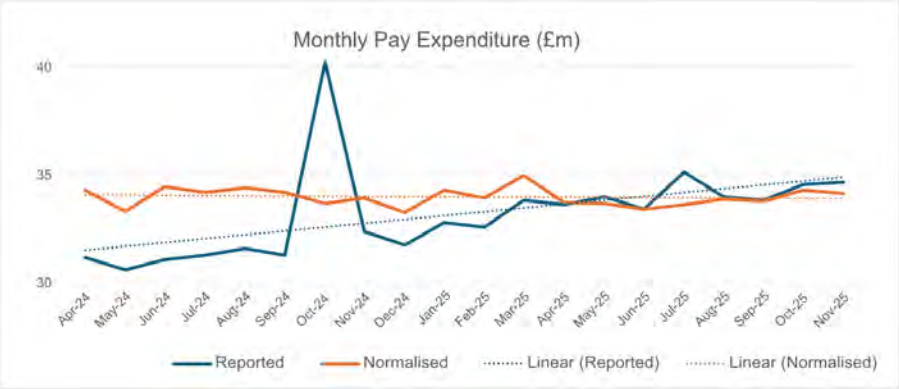
In total we have transacted £15.85m recurrent CIP in year with a full year impact of £19.28m

	In Year		Full Year Impact	
Recurrent CIP	Included in scenarios (£m)	Reported at M9 Actual (£m)	Target (£m)	Actual Transacted at M9 (£m)
All Recurrent	18.00	15.85	23.00	19.28
Cash Releasing	17.18	12.75	20.00	16.11

Workforce

Pay expenditure

- The in-month pay expenditure is £34.7m which is £1.9m above plan in month. This is due to CIP underperformance £0.8m, industrial action cost £0.4m (funded) and MARS severance payments £0.5m (expected within forecast).
- The normalised pay expenditure has been rebased in line with 2025/26 rates and remains within the range seen since from Q4. Q3 normalised pay is £34.1m which is an increase on Q2 but below the same quarter last year.



Pay £1.9m above plan in month

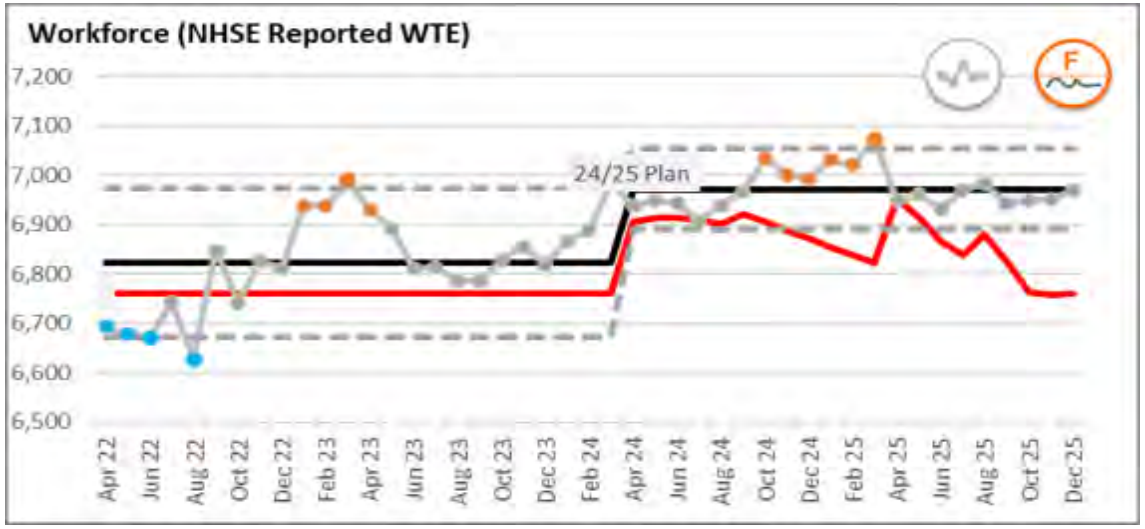
Normalised pay remains static c£34.1m

Normalised quarterly average

Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26
£34.3m	£33.7m	£34.5m	£33.7m	£33.8m	£34.1m

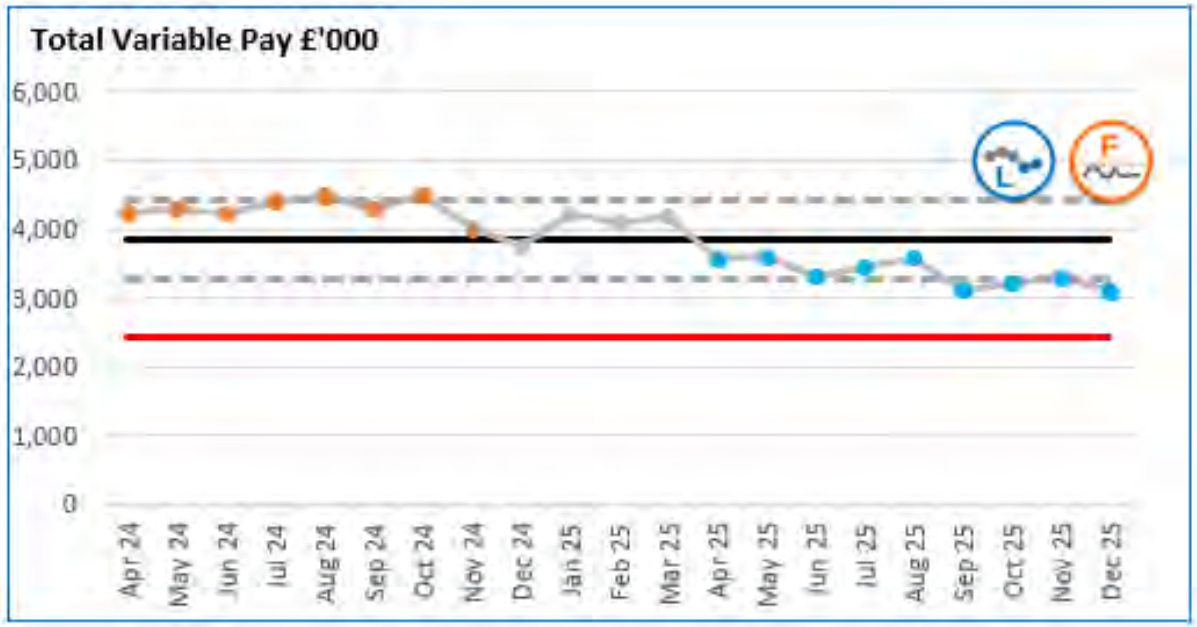
Workforce (WTE)

- Actual workforce 6,970 WTE in December. This is an increase of 19 WTE from last month and is 209 WTE above the workforce plan of 6,761 WTE. Industrial action cover increased WTE by 19 across bank and agency.
  - Substantive staffing has increased by 21 WTE.
  - Bank staffing has decreased by 5 WTE.
  - Agency has increased by 3 WTE compared to last month.



WTE above plan by 209 WTE (at an average WTE cost this equates to £0.8m in month)

Variable Pay



Key messages

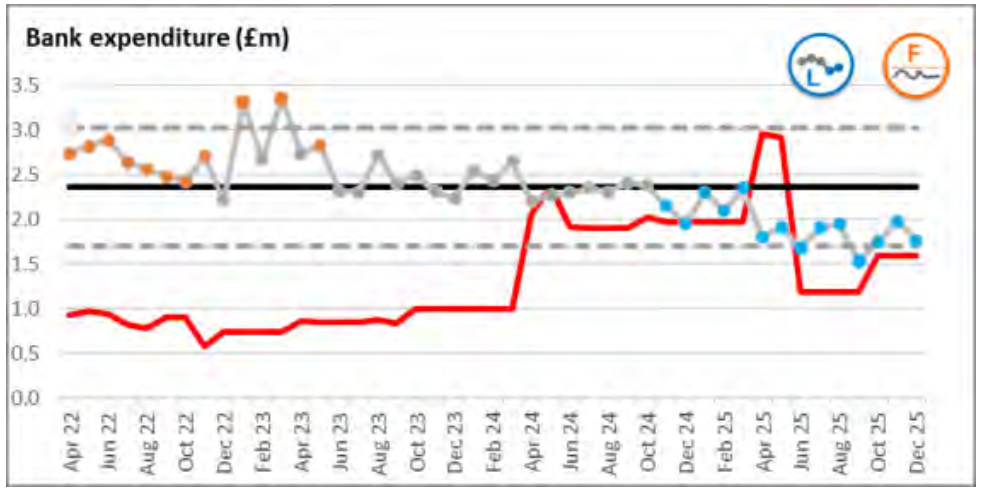
- Overall, SPC trend is positive and shows total variable pay reducing. However, medical variable pay remains static.
- This remains a significant area of opportunity, and links to our recovery plan and CIP delivery.
- Total variable pay is £3.1m in month, £30.3m YTD; an average of £3.4m per month.
- The recovery plan includes several schemes aimed at reducing variable pay.
- Industrial action costs have been excluded £0.4m from December (bank c£0.3m, temporary sessions £0.1m)
- December saw a £0.2m decrease from the prior month, predominantly in medical additional sessions £0.1m and nursing spend £0.1m.
- The spend split by staffing group is Medical £13.9m, Nursing £14.8m and Corporate £1.6m.
- Variable pay oversight taking place via the divisional performance reviews and financial improvement group.

- Note: Variable pay includes bank, agency, additional sessions, overtime, WOS, cost per reporting and LPVs.
- Note: Prior year spend has been normalised for pay award and July, November & December Industrial action costs have been removed

Bank & Agency Staffing

Bank expenditure

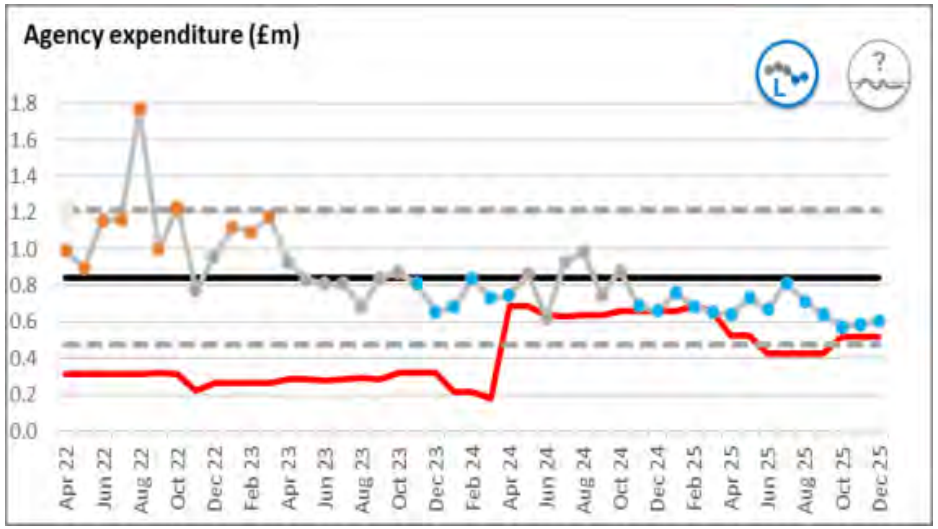
- Bank costs were £1.9m in December, decreasing by £0.1m from last month.
- The chart is showing a special cause improving variation.
- This includes industrial action costs £0.3m, c19 WTE
- In December, Medicine (£0.9m) and Surgery (£0.3m) continue to be the biggest users.
- Bank WTE decreased by 5 WTE.
- Bank spend is showing a cumulative 15% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE.



Positive downward SPC trend

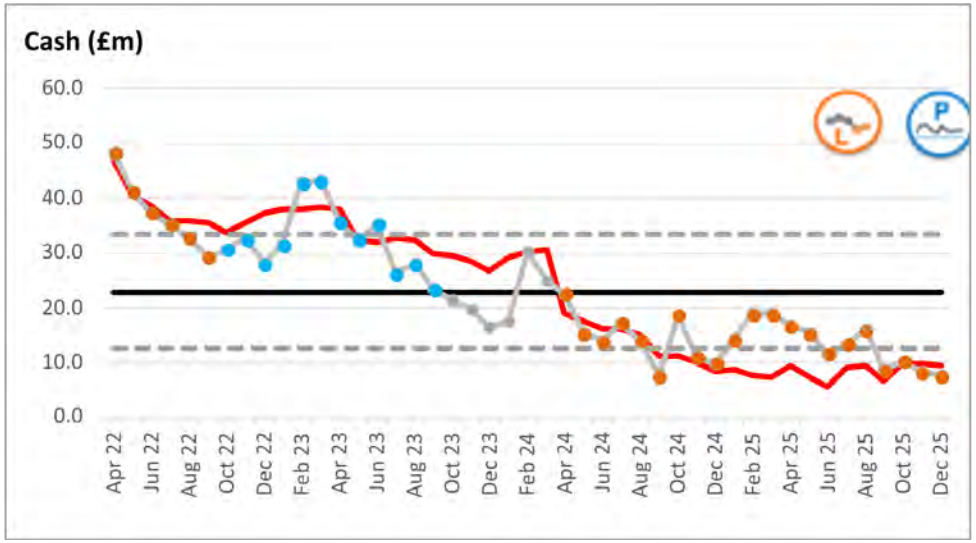
Agency expenditure

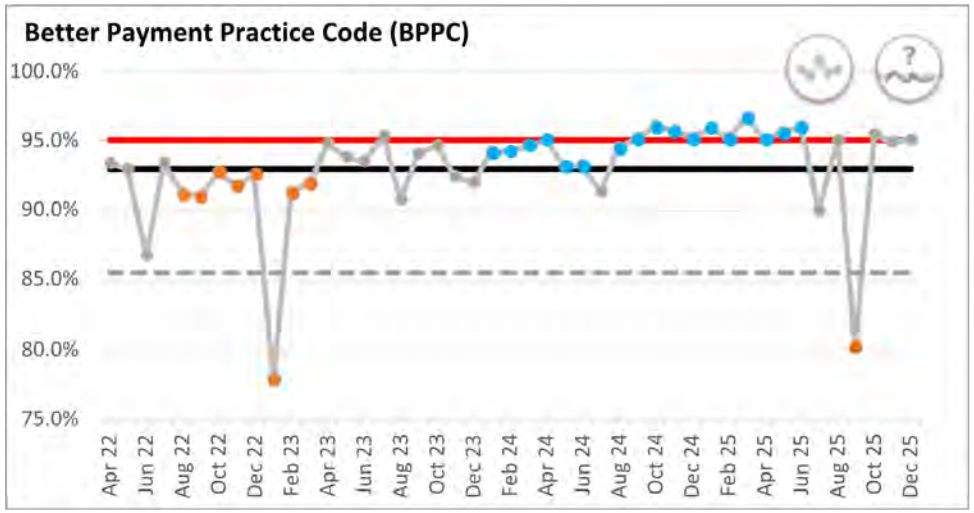
- Agency spend in month is £0.6m, no movement compared to the prior month. The trend is still showing special cause improving variation.
- There has been an increase in junior doctor agency usage following the GM rate standardisation in May, although there is still a net reduction due to the new pay rates, and spend has reduced year-on-year.
- Medicine (£0.3m) continues to have the highest level of agency within the Trust, spend in Specialist is (£0.2m).
- Agency spend is showing a cumulative 6% reduction to the NHSE baseline (adjusted for industrial action costs) (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.



Agency expenditure creeping up in recent months

Cash and BPPC





Current cash position

- Closing cash at the end of December was £7.6m, a decrease of £0.7m from November. This is our lowest cash balance but is higher than forecast. Contributing factors are:
- YTD deficit and slippage on CIP delivery, receipt of PDC capital funding £1m more than forecast, this is a temporary benefit ahead of the contractor payments in subsequent months.
- Operating cash days at the end of December remains at 5 days.

Cash forecast

- Based on the current run rate and cash management mitigations, the forecast indicates that cash balances would improve in Q4 due to capital PDC receipts in advance of cash payments. External cash support is not forecast to be required in Q4 since DSF was awarded (conditionally).

Better Payment Practice Code (BPPC)

- The year-to-date performance is exceeding the target of 95.0% by value, the YTD performance by volume has improved this month.
- The in-month performance was 95.1% by volume and 97.5% by value.
- The YTD performance was 92.5% by volume and 96.7% by value

Capital

Scheme	In Month (£000) Actual	Plan	Var	Year to Date (£000) Actual	Plan	Var	Full Year (£000) Plan	YTD Actual of Full Year Plan (%)
Operational capital programme	357	443	86	10,729	13,049	2,320	14,117	76%
Over programming and over allocation							(672)	0%
Operational capital (CDEL)	**357**	**443**	**86**	**10,729**	**13,049**	**2,320**	**13,445**	**80%**
National funding (PDC)								
Solar Panels	0	215	215	136	1,504	1,368	2,148	6%
Diagnostics prioritisation	0	0	0	134	273	139	393	34%
UEC - Discharge Lounge capacity	269	143	(126)	688	572	(116)	635	108%
Elective prioritisation - Theatres 5&6	42	131	89	273	656	383	1,050	26%
Estates Safety bids (Backlog Maintainance)	66	185	119	2,494	2,267	(227)	2,744	91%
Estates Safety bids (Backlog Maintainance) Phase 2	31	0	(31)	42	0	(42)	595	
UEC (A&E Diagnostics)	374	625	250	3,747	3,747	0	3,747	100%
UEC SDEC	0	224	224	121	671	550	1,341	9%
CDC Pathway - Gynaecology	0	0	0	0	109	109	109	0%
RAAC - Leigh infirmary	39	0	(39)	352	0	(352)	391	90%
EV Chargers	0	0	0	0	12	12	12	0%
CDC Pathway - Urology	2	0	(2)	9	0	(9)	540	2%
Cyber Security Devices (Armis IT)	0	0	0	245	0	(245)	246	100%
Fibroscan	0	0	0	0	0	0	120	0%
ROP Camera	0	0	0	69	0	(69)	69	100%
CBRN Decontamination Equipment	0	0	0	17	0	(17)	17	100%
LED Lighting	0	0	0	0	0	0	2,700	0%
ENT Bundle	0	0	0	0	0	0	206	0%
Sub total national funding	**823**	**1,522**	**699**	**8,327**	**9,811**	**1,484**	**17,063**	**49%**
Total capital programme	**1,180**	**1,965**	**785**	**19,056**	**22,860**	**3,804**	**30,508**	**62%**

Month 9 Headlines

- Total capital expenditure in month 9 is £1.2m which is £0.8m below plan.
- Year to date, total capital expenditure of £ 19.1m is £3.8m behind plan.

Operational CDEL

- Operational capital expenditure in month 9 is £0.4m which £0.1m behind plan mainly due to medical equipment, ERU equipment and windows 11 schemes awaiting delivery.
- The YTD expenditure of £10.7m is £2.3m behind plan, the pharmacy robot phasing not aligned with the scheme implementation scheduled for Q4 (£1.0m) and deferral of 2 equipment leases to 26/27 (£0.3m) and underspends on leases.
- The over programming and over allocation associated with the planning tolerance has been fully mitigated within the capital programme.

PDC funded schemes

- This includes new schemes awarded in month for LED lighting (£2.7m), and ENT equipment (£0.2m).
- Expenditure on PDC funded schemes is £0.8m in month, £0.7m behind plan and £8.3m year to date which is £1.5m behind the plan of £9.8m. The underspend is largely due to delays to the solar panel programme, phasing of Theatre 5&6 and SDEC in Q4.
- MoUs have now been received for all schemes, except the ENT equipment, which facilitates cash drawdown to support expenditure.

Full Year Scenarios

Bridge from straight line forecast to mid case and best case scenario.

Straight line forecast -£2.9m	Remove non-recurrent items and phasing adjustments -£1.5m	Key assumptions +£1.9m	Risk adjusted recovery plan +£1.2m	Mid-case scenario: £1.2m deficit	Best-case scenario: Breakeven
•Extrapolated from £2.1m YTD deficit.	•Non recurrent items, extrapolated impact -£1.5m (includes one-off benefits £5.6m across month 3 to 7). •Upside of national funding for industrial action.	•Cash releasing CIP run rate improvement+£4.0m. •Elective activity contribution +£1.2m. •MARS/redundancy -£1.0m. •Energy/winter -£1.1m. •Corporate financing -£0.7m. •Other smaller items -£0.5m.	•Total recovery plan for remaining months is £2.4m (£0.8m per month) •Risk adjusted 50% included at M9 £1.2m. •Impact required from M10.	•The current mid-case scenario indicates risk of £1.2m. •All other pressures to be mitigated within existing plan.	•Delivery of the recovery plan in full. •Further run rate improvement.

Key actions to achieve plan

- CIP delivery as per M9 risk adjusted divisional tracker.
- Deliver elective activity plan.
- Deliver recovery plan.
- Monthly run rate improvement of £1.0m required (from £0.2m YTD actual average deficit to £0.7m surplus per month)

High level scenarios for full year forecast

Worst Case	Mid Case	Best Case
£5.7m deficit (£5.7m adverse to plan)	£1.2m deficit (£1.2m adverse to plan). Full delivery of the recovery plan is required to close the gap to best case and to ensure delivery of **breakeven position** in line with plan and our forecast to NHSE.	Breakeven (on plan)

The mid case scenario includes 50% (£1.2m) delivery of the £2.4m recovery plan. All scenarios assume no clawback of DSF.

Risk Management and Mitigation

Revenue position

Recovery plan: Fast mobilisation of the recovery plan is essential to deliver our revenue plan.

Recurrent CIP delivery: CIP performance deteriorated in December. Recurrent CIP slippage remains a contributing factor of our adverse variance, with the month 9 position now £5.4m behind the recurrent plan of £16.7m.

API activity: Divisional elective API income was below plan in month 9 and therefore the YTD underperformance has grown to £1.0m. There is a risk that the ICB will seek to use the current position to agree a year end settlement. Active discussion is taking place with the ICB.

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

Deficit Support Funding (DSF) for GM ICS has been secured for Quarter 4, however this is subject to clawback in the event the system fails to deliver the 2025/26 financial plan (alongside further adverse consequences under the NHS business rules).

Other

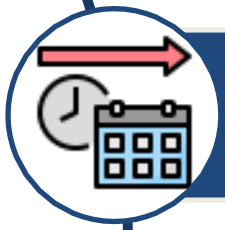
Cashflow: Cash days at month 9 are critically low, cash is expected to improve from January due to capital receipts in advance of expenditure, however this is a temporary reprieve.

Capital programme: Whilst there has been significant process with the MOUs, there remains a delivery risk in Q4 with £11.5m (38%) of expenditure required before 31st March. Oversight is provided via the Operational Capital Group and Capital Strategy Group.

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

Forward look

To deliver our financial plan in year there are three key areas of delivery; elective activity, CIP and the recovery plan. There is a significant improvement needed in our current run rate, equivalent to £1.0m per month. Oversight continues via the divisional performance reviews, Financial Improvement Group and Executive Team Meeting, with fortnightly updates on the recovery plan.



Following the submission of draft plans in December, the final medium term plan is due to be submitted to NHSE on 12 February 2026. This will be presented to the Board of Directors for approval on 4 February 2026. Operational plans are required for 3 years to cover finance, activity, performance and workforce. The Trust has a breakeven control total for 2026/27 and future years following the removal of deficit support funding in full.

Implementation of the new general ledger (Integra Centros) continues to progress across all workstreams. There are no key risks or issues raised around project delivery. Successful appointments have been made to support bringing back in house Order-to-Cash services with start dates agreed for the beginning of February. A GM Ledger Harmonisation Steering Group has been established to provide system-wide leadership and strategic oversight for the design and implementation of the GM Single Ledger. The group, to be chaired by the WWL CFO will steer the programme towards a unified and future-proof ledger service, ensuring strong governance, alignment with GM priorities, and coordinated delivery across all Trusts.

The GM collaborative procurement programme is advancing towards a unified model across all Greater Manchester Trusts, with Northern Care Alliance confirmed as the host organisation. The business case was supported by the Board in December. Anticipated benefits include aggregated purchasing power, standardised processes, improved compliance, and enhanced supplier relationships. The go-live date for the collaborative service is targeted for 1 April 2026, with phased implementation plans in development.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	M9 25/26 Integrated Performance Report
Presented to:	Board of Directors
On:	5th February 26
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 M9 December 25, update of the Trust's Integrated Performance Report (IPR) is presented to the Board of Directors.

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

The metrics within the IPR have been compared to the metrics within the National Oversight Framework (NOF) with a column included to each of the summaries to indicate whether the metric is included within the NOF. A National Benchmarking of NHS Access Standards report has been added as an Appendix.

Month 9 saw significant pressure across the Trust over extended periods. Attendance at our Emergency Department (ED) was 7% higher than the same period last year and there were an additional 226 admissions in month which resulted in a congested Emergency Department and challenges with flow. There was a deterioration in performance against both the 4 hour, and 12 hour standards and the Emergency Department was regularly congested. This was compounded by increasing number of patients who were criteria to reside with a length of stay greater than 21 days, increases in no criteria to reside patients and low discharges.

Patient safety continued to be our priority, although we maximised escalation areas and month 9 saw the start of consistent corridor care. This pressure was reflected in a deterioration in patient experience with an increase in complaints coming from ED and both CQC escalations from staff and media interest. An ICB assurance meeting in December reflected some of these issues in their feedback.
We continue to forensically scrutinise opportunities to improve patient flow through our Better Lives programme working with system partners. We opened our refurbished discharge lounge in December to help with patient flow, and this will relieve the pressure on escalated areas of Bryn Ward.

Whilst the overall number of patients waiting for elective treatment reduced further, we were one of only two trusts in GM with patients waiting more than 65 weeks for treatment. With a target of zero 65 week waiters by the end of December, these breaches have trigged increased scrutiny. 15 of the 23 breaches were due to a single service, plastics, where we are reliant upon another provider through an SLA and all patients were booked with January dates.

The cumulative impact on urgent and emergency care and elective operational pressures as well as further industrial action has represented a significant challenge for staff. Together with seasonal respiratory illness, which arrived earlier in Wigan than other parts of GM, we saw an increase in sickness levels to 6.1%. Higher than forecast sickness levels had an impact on theatre cancellations, where we were a GM outlier. Our sickness task and finish group continue to review levels and themes, and we are developing a series of interventions to support a reduction in sick leave as part of our operational planning approach. A review of departmental stress risk assessments has been requested via divisional assurance meetings to ensure actions are in place focusing on staff wellbeing.

We continued to perform well against the key mortality metrics and have sustained our improvement in responding to complaints. Whilst infection rates are variable, each division now has a robust plan to reduce these, and this is scrutinised through divisional assurance meetings.

Financially, the Trust ended December in a deteriorated position—with a £0.8m in-month deficit and a year-to-date deficit of £2.1m, both materially adrift from plan. Cash levels are at their lowest point (though marginally above forecast), intensifying the need for tight daily liquidity management. CIP delivery remains significantly behind trajectory, with recurring savings particularly underperforming, placing further pressure on Q4 recovery actions. Nevertheless, bank expenditure has reduced ahead of national expectations and agency spend remains below plan, reflecting effective staffing controls. We continue to make progress on reducing our underlying deficit.

The Quarter 2 performance metrics in the National Oversight Framework were published in December, showing a deterioration for WWL, in line with our internal measures. This saw the Trust drop to a rank of 119 out of 134 acute providers and into segment 4.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations

There are no risks currently associated with the report.

Financial implications

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

Legal implications

None currently identified.

People implications

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

Equality, diversity and inclusion implications

None currently identified.

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

IPR Executive meeting 16.1.26, ETM 22.1.26, ETM 29.1.26.

Recommendation(s)

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

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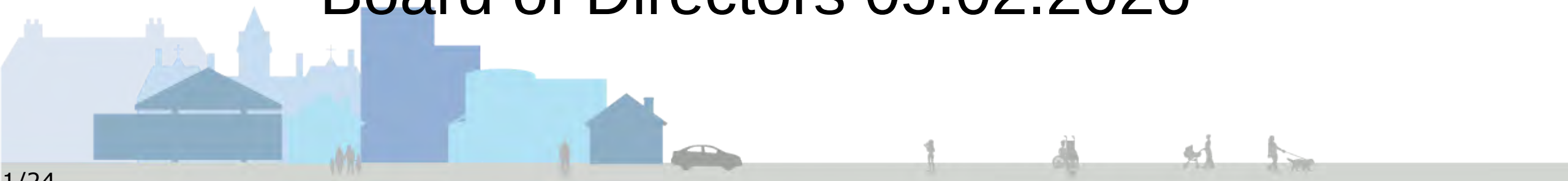
NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

25/26 Integrated Performance Report

Meeting presented to:

Board of Directors 05.02.2026

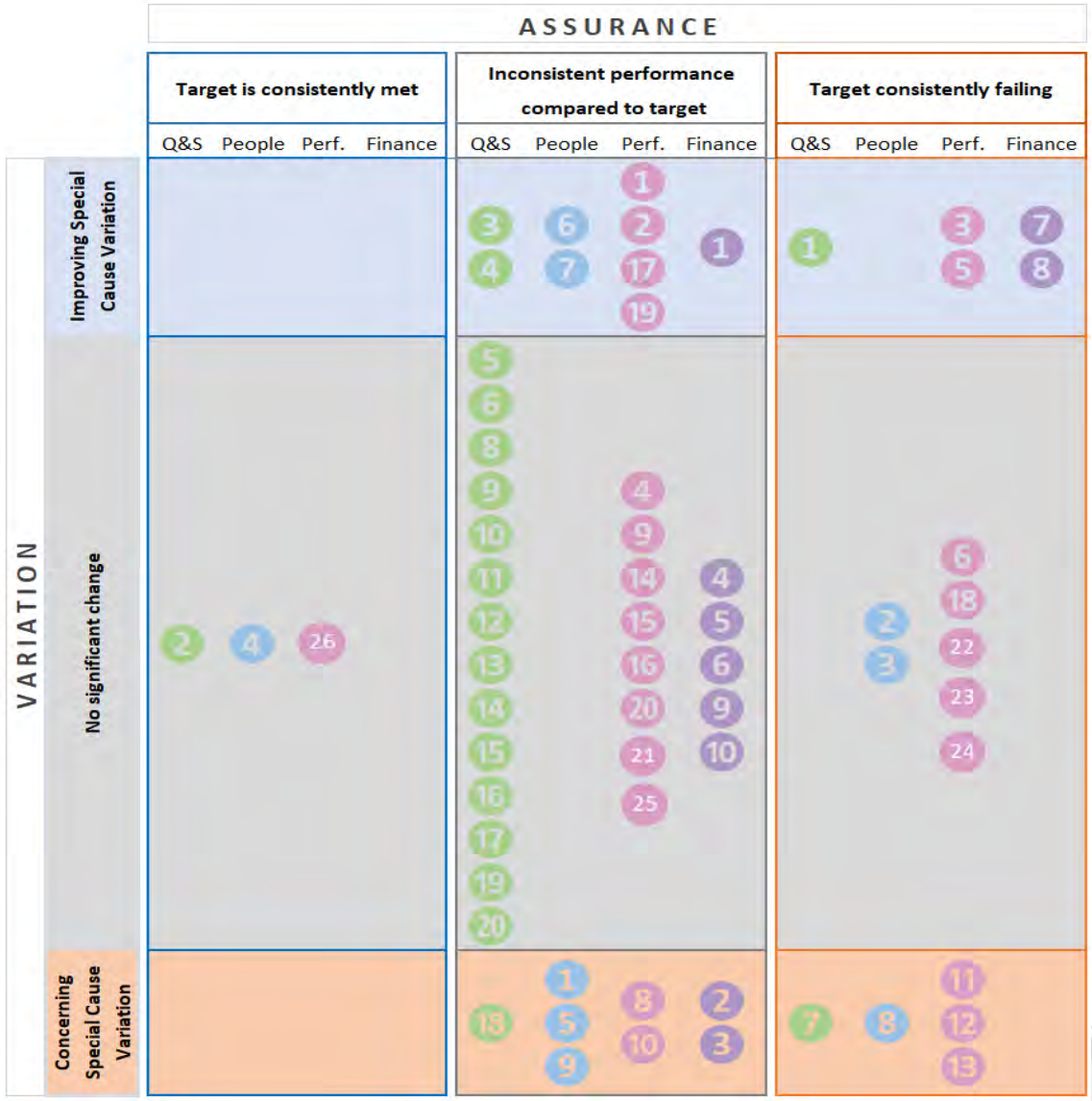


Contents

Trust Matrix : M9 25/26

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

Trust Matrix : M9 25/26



	Q&S-1
1	SHMI Rolling 12 Months
2	HSMR Rolling 12 Months
3	Never Events
4	Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation
5	How Many Incidents Triggered a Patient Safety Review
6	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care
7	Reduction in Category 2 and DTI HAPU and CAPU Overall
8	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care
9	To reduce the total number of falls per 1000 bed days
	Q&S-2
10	Methicillin-Resistant Staphylococcus Aureus (MRSA)
11	Methicillin-Susceptible Staphylococcus Aureus (MSSA)
12	WWL Clostridium Difficile (CDT)
13	Escherichia Coli (E.coli)
14	Klebsiella Species
15	Pseudomonas Aeruginosa
16	Reduction in the Number of Patients who Transfer Between Wards More Than 5 Times
17	Mixed Sex Accomodation Breaches - Non Clinically Justified
18	Reduction in the Number of Complaints
19	Complaints Responses
20	Patient Experience (FFT) - Patients who Would Recommend the Service
	People
1	Mandatory Training Compliance
2	Appraisal
3	Price Cap Compliance - Medical
4	Price Cap Compliance - Non Medical
5	% Turnover Rate
6	Vacancy Rate
7	Number of Whole Time Equivalent Posts
8	Sickness - Percentage Time Lost (%)
9	Time to Hire

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

Using Statistical Process Control (SPC) Charts

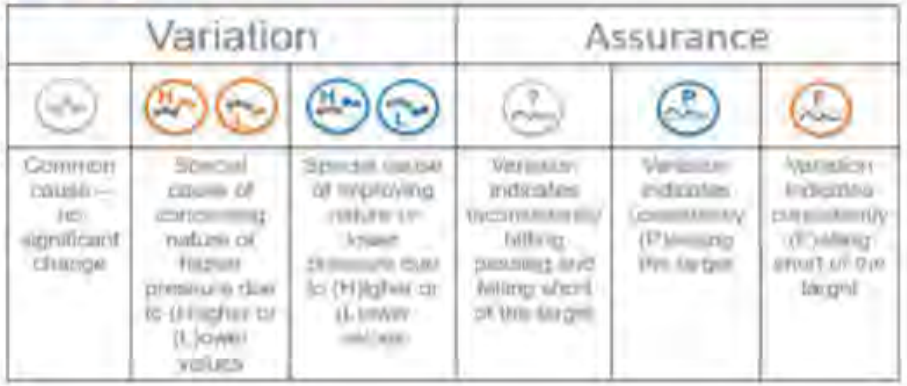
Statistical Process Control (SPC) is a method for viewing data over time to highlight variation. This methodology has long been associated with Quality Improvement and enables us to understand where variation is normal and also where variation is different and requires further actions. This is known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

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

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

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

NHS England's SPC Icons



Understanding the rules of SPC

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

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

These rules indicate *special cause variation*.

Data Quality Assessment Framework Overview

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

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

Trust Holistic Narrative : M9 25/26

Month 9 saw significant pressure across the Trust over extended periods. Attendance at our Emergency Department (ED) was 7% higher than the same period last year and there were an additional 226 admissions in month which resulted in a congested Emergency Department and challenges with flow. There was a deterioration in performance against both the 4 hour, and 12 hour standards and the Emergency Department was regularly congested. This was compounded by increasing number of patients who were criteria to reside with a length of stay greater than 21 days, increases in no criteria to reside patients and low discharges.

Patient safety continued to be our priority, although we maximised escalation areas and month 9 saw the start of consistent corridor care. This pressure was reflected in a deterioration in patient experience with an increase in complaints coming from ED and both CQC escalations from staff and media interest. An ICB assurance meeting in December reflected some of these issues in their feedback.

We continue to forensically scrutinise opportunities to improve patient flow through our Better Lives programme working with system partners. We opened our refurbished discharge lounge in December to help with patient flow, and this will relieve the pressure on escalated areas of Bryn Ward.

Whilst the overall number of patients waiting for elective treatment reduced further, we were one of only two trusts in GM with patients waiting more than 65 weeks for treatment. With a target of zero 65 week waiters by the end of December, these breaches have trigged increased scrutiny. 15 of the 23 breaches were due to a single service, plastics, where we are reliant upon another provider through an SLA and all patients were booked with January dates.

The cumulative impact on urgent and emergency care and elective operational pressures as well as further industrial action has represented a significant challenge for staff. Together with seasonal respiratory illness, which arrived earlier in Wigan than other parts of GM, we saw an increase in sickness levels to 6.1%. Higher than forecast sickness levels had an impact on theatre cancellations, where we were a GM outlier. Our sickness task and finish group continue to review levels and themes, and we are developing a series of interventions to support a reduction in sick leave as part of our operational planning approach. A review of departmental stress risk assessments has been requested via divisional assurance meetings to ensure actions are in place focusing on staff wellbeing.

We continued to perform well against the key mortality metrics and have sustained our improvement in responding to complaints. Whilst infection rates are variable, each division now has a robust plan to reduce these, and this is scrutinised through divisional assurance meetings.

Financially, the Trust ended December in a deteriorated position—with a £0.8m in-month deficit and a year-to-date deficit of £2.1m, both materially adrift from plan. Cash levels are at their lowest point (though marginally above forecast), intensifying the need for tight daily liquidity management. CIP delivery remains significantly behind trajectory, with recurring savings particularly underperforming, placing further pressure on Q4 recovery actions. Nevertheless, bank expenditure has reduced ahead of national expectations and agency spend remains below plan, reflecting effective staffing controls. We continue to make progress on reducing our underlying deficit.

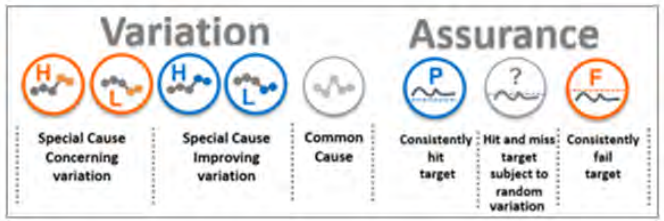
The Quarter 2 performance metrics in the National Oversight Framework were published in December, showing a deterioration for WWL, in line with our internal measures. This saw the Trust drop to a rank of 119 out of 134 acute providers and into segment 4.

Quality & Safety Overview 1 of 2: M9 25/26

	KPI	Latest month	Metric included in NOF *	Measure	Threshold	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	SHMI Rolling 12 Months	Aug 25	Yes	102.29	100	L	F	104.09	102.84	105.34	S	T	P
2	HSMR Rolling 12 Months	Sep 25	No	92.77	100		P	93.64	91.09	96.20	S	T	P
3	Never Events	Dec 25	No	0	0	L	?	0	0	2	S	T	P
4	Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation	Dec 25	No	0	4	L	?	2	0	7	S	T	P
5	How Many Incidents Triggered a Patient Safety Review	Dec 25	No	29	33		?	26	4	48	S	T	P
6	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care	Dec 25	No	0	0		?	2	0	6	S	T	P
7	Reduction in Category 2 and DTI HAPU and CAPU Overall	Dec 25	No	103	46	H	F	78	56	100	S	T	P
8	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care	Dec 25	No	0	1		?	1	0	4	S	T	P
9	To Reduce the Total Number of Falls per 1000 Bed-days	Dec 25	No	6.9	6.1		?	7.0	4.3	9.8	S	T	P

*Please note : NOF denotes the National Oversight Framework

Summary icons key:



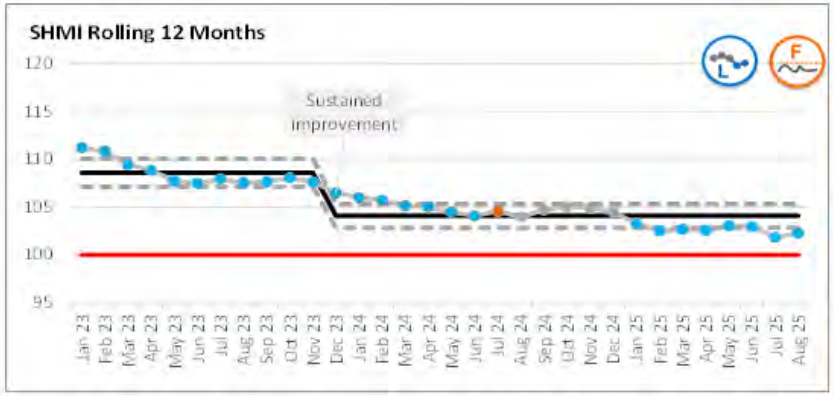
Quality & Safety Overview 2 of 2: M9 25/26

	KPI	Latest month	Metric included in NOF *	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)	Dec 25	Yes	0	0			0	0	0	S	T	P
11	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Dec 25	No	2	0			1	0	5	S	T	P
12	WWL Clostridium Difficile (CDT)	Dec 25	Rate	5	5			6	0	15	S	T	P
13	Escherichia Coli (E.coli)	Dec 25	Rate	7	3			4	0	10	S	T	P
14	Klebsiella Species	Dec 25	No	1	1			1	0	4	S	T	P
15	Pseudomonas Aeruginosa	Dec 25	No	1	0			0	0	2	S	T	P
16	Reduction in the Number of Patients who Transfer Between Wards More Than 5 Times	Dec 25	No	9	8			7	0	14	S	T	P
17	Mixed Sex Accomodation Breaches - Non Clinically Justified	Dec 25	No	22	19			19	4	34	S	T	P
18	Reduction in the Number of Complaints	Dec 25	No	84	40	H		44	20	67	S	T	P
19	Complaints Responses	Dec 25	No	76.9%	90.0%			71.7%	50.1%	93.3%	S	T	P
20	Patient Experience (FFT) - Patients who Would Recommend the Service	Nov 25	No	86.3%	90.0%			87.8%	82.1%	93.6%	S	T	P

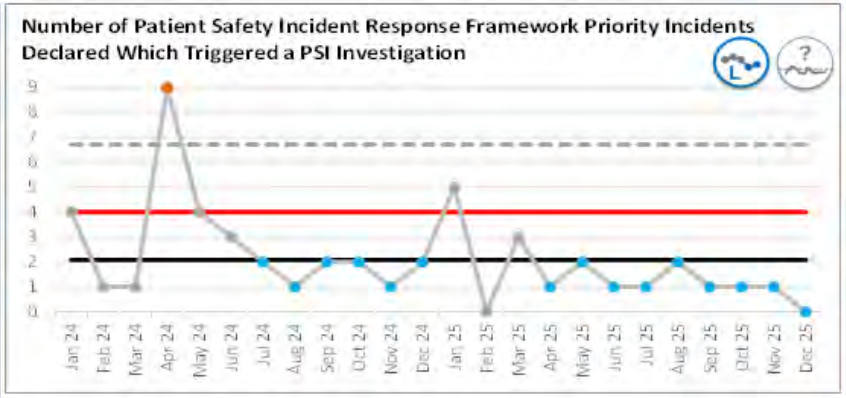
*Please note : NOF denotes the National Oversight Framework

Summary icons key:

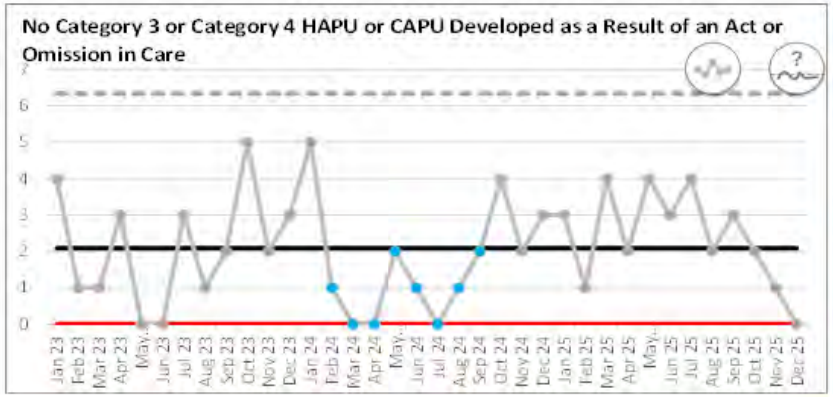
Quality & Safety Insight Report 1 of 2: M9 25/26



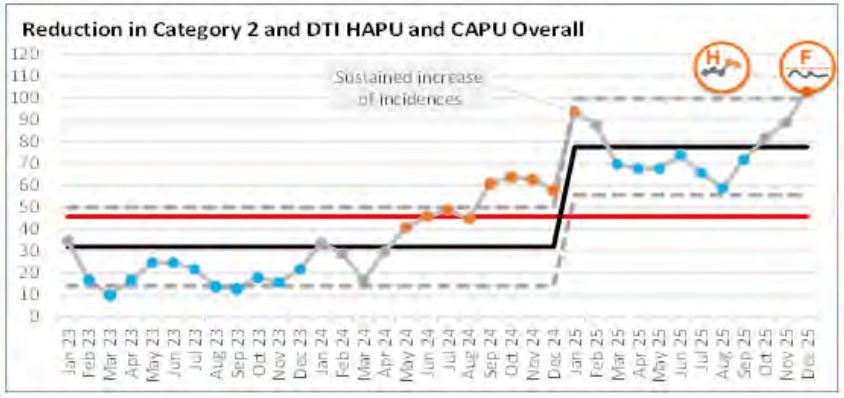
Aug-25
102.29
Variance Type
Special cause improving variation points
Threshold
100
Target achievement
Metric is consistantly missing the target/ threshold



Dec-25
0
Variance Type
Special cause improving variation points
Threshold
4
Target achievement
Inconsistent performance compared to threshold/ target



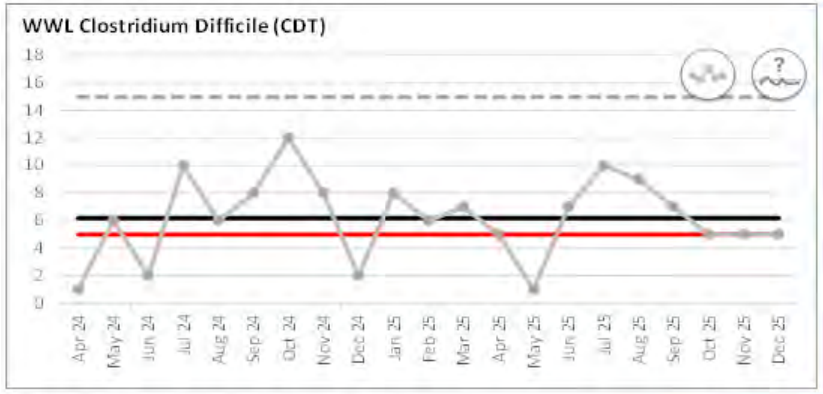
Dec-25
0
Variance Type
Common Cause Variation
Threshold
0
Target achievement
Inconsistent performance compared to threshold/ target



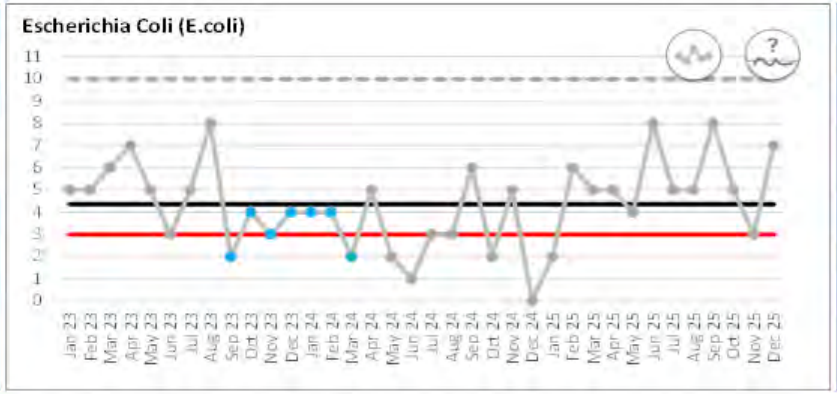
Dec-25
103
Variance Type
Special cause concerning variation points
Threshold
46
Target achievement
Metric is consistantly missing the target/ threshold

Summary:	Actions:	Assurance:
1 . SHMI : Monthly and quarterly mortality review groups continue to review any areas of SHMI that are alerting and seek assurances that these are being managed appropriately. We remain well within the 'funnel' plot for SHMI **2. PSIRF Priority Incidents Triggering a PSI Investigation**: There have been no PSIIs declared during December 25. **3. Category 3 or 4 Pressure ulcers as a result of an act or omission in care**: Whilst there have been no cases declared in December, a case shared at panel in December was identified. This case relates to an incident which occurred in November; therefore, figures have been retrospectively updated. **4. Pressure Ulcers – category 2 and above :** Divisions continue to monitoring their own incidences of category 2 and above pressure ulcers and reporting to the Trust lead.	**1. SHMI :** Continue improvement plans to ensure that patients are appropriately managed. Continue to work with system partners to ensure appropriate discharge placements for patients **2. PSIRF Priority Incidents Triggering a PSI Investigation:** potential PSIIs are reported through to LFPSE, chaired by the Executive Medical Director **3. Category 3 or 4 Pressure ulcers as a result of an act or omission in care:** The Director of Nursing for Corporate Services is currently refreshing the governance architecture for the reporting of learning and assurance from clinical divisions into the Harm Free Care Group. **4. Pressure Ulcers – category 2 and above :** Continue to embed learning from the thematic reviews completed with the actions informing the overarching Trust wide PU improvement work agenda .	**1. SHMI :** SHMI is currently within national expected range 'funnel plot' and has been so for many months. SHMI continues to improve and is consistently better than some other similar sized GM Trusts **2. PSIRF Priority Incidents Triggering a PSI Investigation**: Although none have been declared, 29 incidents were reviewed via the PRS processes. **3. Category 3 or 4 Pressure ulcers as a result of an act or omission in care:** It is important to note that Community have not reported an omission is care for over 24 months. **4. Pressure Ulcers – category 2 and above :** Progress on the pressure ulcer Trust wide action plan continues to be monitored at the Steering Group.

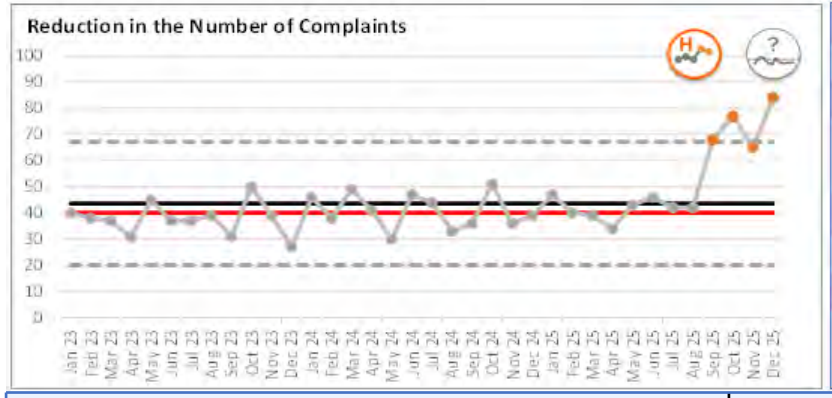
Quality & Safety Insight Report 2 of 2: M9 25/26



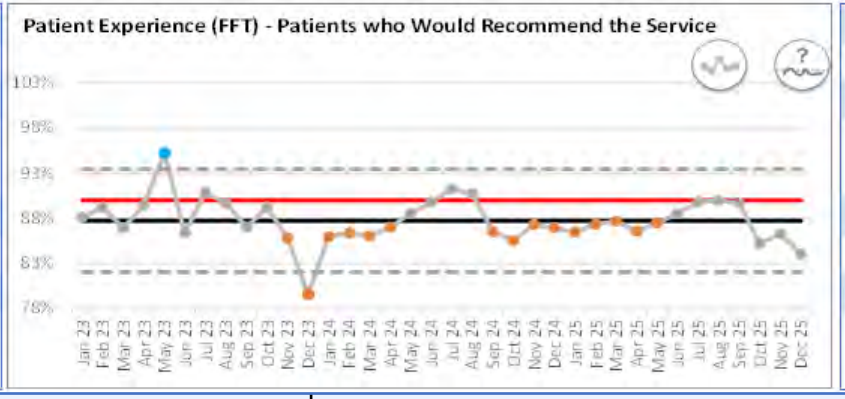
Dec-25
5
Variance Type
Common cause variation
Threshold
5
Target achievement
Inconsistent performance compared to threshold/ target



Dec-25
7
Variance Type
Common cause variation
Threshold
3
Target achievement
Inconsistent performance compared to threshold/ target



Dec-25
84
Variance Type
Special cause concerning variation
Threshold
40
Target achievement
Inconsistent performance compared to threshold/ target



Dec-25
84.0%
Variance Type
Common cause variation
Threshold
90.0%
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. **Clostridium Difficile (CDT) –** the number of cases is the same as last 2 months. 2. **E-Coli –** E.coli count increased in month (December 2025) to Seven cases from Three cases in November 2025. 3. **Complaints** – levels increased in December. 4. **Patient Experience (FFT) –** We recognise there has been a reduction in FFT performance in month.	1. **Clostridium Difficile (CDT) –** The review process continues to identify learning, good practice, and areas for action. . 2. E.coli - Surveillance of E.coli continues, with identification and analysis of themes and trends, with an aim to develop a robust post infection review process. 3. **Complaints Responses** –The Patient Relations Team along with the Corporate Nursing Team meet with clinical division to monitor and support performance. 4. **Patient Experience (FFT) –** The reduction in FFT scores will be addressed via divisional reporting in the Patient Experience Group.	1. **Clostridium Difficile (CDT) –** Reporting and surveillance continues for all Mandatory reportable HCAI organisms. 2. **E-Coli –** Reporting and surveillance continues for all Mandatory reportable HCAI organisms. 3. **Complaints** Any high-level complaints are highlighted weekly at LFPSE. Themes and trends are monitored Trust wide and within clinical divisions. 4. **Patient Experience (FFT) –** performance is reported monthly at PEGG by the Corporate Patient Experience team. Work is underway to review divisional reporting into the corporate group to improve oversight and assurance.

Quality & Safety Narrative: M9 25/26

Operationally at the beginning of M.9 the site remained under significant pressures resulting in the expected delivery of care being compromised. Increased attendances, peaks in seasonal presentations (Respiratory and gastroenterology) saw the Emergency Department becoming over crowed and the increased reliance of the utilisation of escalation capacity both within the Department and across the Site, to mitigate risk. The overcrowding of the Emergency Department saw waits within the Emergency Department increase with patients being cared for in sub-optimal areas for long periods of time, as well as being evident within the operational wait time of the patients within the Emergency Department there was a direct impact in both the number of complaints received with the Trusts complaint Department and those sent directly to the Chief Executive and Chief Nursing Officer, including one that made both local and national media interest. Despite this increase in complaints, there continued to be the commitment to improving the complaints response time with M.9 seeing a 76.9% compliance. There were fundamentals of care themes evident within the complaints which were further highlighted in the ASPIRE accreditation and NHSE ED Assurance visit both of which were undertaken in December, there have been significant actions and additional senior support, oversight, and assurance to the Department to further improve the delivery of the fundamentals of care for our patients.

To support the safe staffing of escalation areas, and senior oversight the Nurse Director of the day role commenced in M.9. to maintain patient safety M.9 saw a significant increase in the number of staff redeployed across the both the RAEI site, and across the Trusts multiple sites. Staff have expressed concerns both internally and via external regulators their concerns and dislike of being redeployed but are being supported to do so by the senior leadership teams and will be further supported with the implementation of a redeployment passport in M.09. The Chief Nursing Officer has met directly with staff who shared concerns. There is some informal intel to suggest that in addition to an increase in seasonal related sickness absence (Flu) there is a correlation with redeployment and absence patterns. In addition to deployment of staff, there has been the need to increase the requesting of temporary staffing to support the opening of the additional capacity and increased sickness, this has been done via NHSP and has had senior oversight which has maintained further reduction in bank spend. Whilst this reduction in spend could be suggestive of increase of unfilled shifts this has been triangulated with an 80% NSHP roster fill rate and the overall roster compliance has seen further improvement.

In addition to local intelligence and foresight, the National oversight framework (NOF) identified an overall increase (Tiering decline) in the number of Clostridium Difficile and E-coli patients, with an increase in cases in M.1 having an overall impact on the full year trajectory. Despite immediate actions seeing a decrease in the number of cases reduced, against the small trajectory set by NHSE there was a slight decline in 0.14 reported in Q.2 NOF reporting in December. revised sample collecting and the recruitment of a substantive Microbiology team with full strengthen the management of patients with these conditions. It is expected that in line with the C-Diff profile and seasonality there will be an increase of cases identified moving into M.10. Cumulatively the Trust are reporting 52 cases against a full year trajectory of 62. The Trust does however remain in a positive position in relation to the number of MRSA cases, having only reported 1 year to date meaning WWL is ranked 1st against national peers.

There has been a significant increase in the number of grade 2 pressure ulcers, detailed reviews of these cases are undertaken and have shown an increase across both the Emergency Department and Aspull, both of which could be suggestive of increased waits within the Emergency Department. There is a direct correlation with long waits within ED over 12 hours who then progress into having hospital acquired harm. A business case has been approved to implement new trolleys in ED which have further supportive pressure relieving mattresses, which are due to be delivered in Q.4 and a deep dive and intensive support team of subject matter experts is being provided to Aspull ward in M.10. Early intelligence of the new process would suggest that whilst there is work to do with the prevention of grade 2 Pressure ulcers in these areas there is improvement trust wide and have been noted. It is also evident that early intervention of Grade 2 pressure ulcers are preventing the development of and reporting of Grade 3 and 4 Pressures as outlined within the IPR. Further triangulation of harms has indicated there has been a reduction in inpatient falls, there has now been the request to provide assurance that this is not due to patients not being mobilised and sat out which could then be suggestive of the increase of grade 2 pressure ulcers.

Our People Overview : M9 25/26

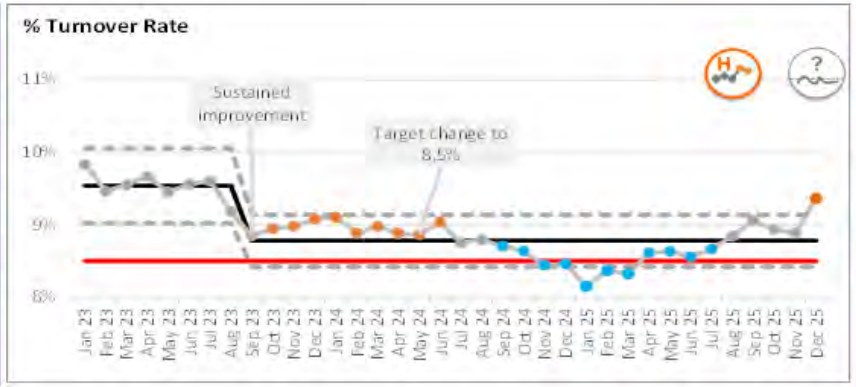
	KPI	Latest month	Metric included in NOF *	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	Mandatory Training Compliance	Dec 25	No	92.8%	95.0%	L	?	94.9%	93.8%	96.0%	S	T	P
2	Appraisal	Dec 25	No	81.6%	90.0%		F	81.9%	80.5%	83.3%	S	T	P
3	Price Cap Compliance - Medical	Dec 25	No	0.7%	60.0%		F	0.6%	-0.6%	1.9%	S	T	P
4	Price Cap Compliance - Non Medical	Dec 25	No	94.6%	80.0%		P	97.2%	88.8%	105.7%	S	T	P
5	% Turnover Rate	Dec 25	No	9.4%	8.5%	H	?	8.8%	8.4%	9.1%	S	T	P
6	Vacancy Rate - Variance to plan	Dec 25	No	4.5%	5.0%	L	?	5.6%	4.5%	6.7%	S	T	P
7	Number of Whole Time Equivalent Posts	Dec 25	No	-209.16	0.00	L	?	-106.27	-222.30	9.77	S	T	P
8	Sickness - Percentage Time Lost (%) - Rolling 12 months	Dec 25	Yes	6.1%	5.0%	H	F	5.6%	5.4%	5.7%	S	T	P
9	Time to Hire	Dec 25	No	64.6	65.0	H	?	59.0	47.9	70.2	S	T	P

Summary icons key:

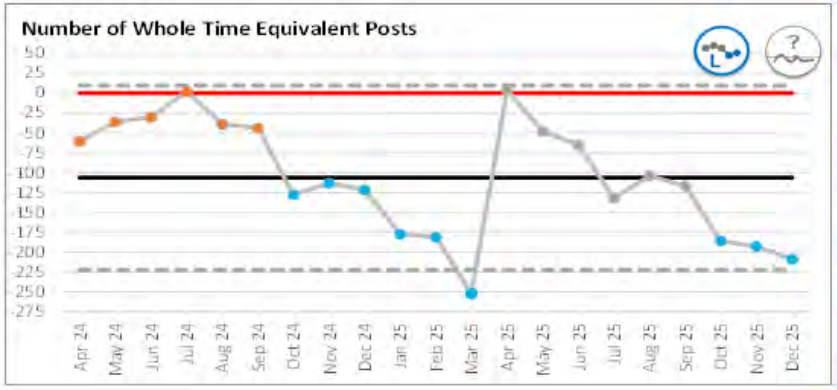
*Please note : NOF denotes the National Oversight Framework

Our People Insight Report : M9 Month Year

Dec-25
92.8%
Variance Type
Special cause concerning variation
Target
95%
Target achievement
Inconsistent performance compared to threshold/ target



Dec-25
9.4%
Variance Type
Special cause concerning variation
Target
8.5%
Target achievement
Inconsistent performance compared to threshold/ target



Dec-25
-209.16
Variance Type
Special cause improving variation
Target
0
Target achievement
Inconsistent performance compared to threshold/ target

Dec-25
6.1%
Variance Type
Special cause concerning variation
Target
5.0%
Target achievement
Metric is consistently missing the threshold/ target

Summary:	Actions:	Assurance:
1. Mandatory training compliance decreased slightly to 92.8% just below the 95% target 2. Turnover has increased to 9.4% from 8.9% 3. Whole Time Equivalent Posts have reduced but remains above plan by 209.16 WTE. Medical Price cap complliance remains a concern 4. Sickness (rolling)- The 12-month rolling sickness absence rate remained stable at 6.1%, whilst in month increased to 6.8%. The leading causes of sickness remain consistent with previous months..	1. Mandatory training is monitored via presentation of the People Dashboard at Wider Leadership Team, Divisional Performance and local senior leadership meetings. The Trust is engaged in the national Stat Mand Programme to reduce the amount of mandatory training staff need to do. 2. Whilst turnover is not of major concern, the Trust continues with delivery of the WWL People & Culture Strategy to support retention of staff. 3. A review of drivers of WTE is underway with divisions to identify plans to bridge the gap by year end. Winter pressures has resulted in an increase in bank spend and plans to reduce back to normal staffing levels are being mapped as pressures start to decrease. A further focus on medical agency is underway to ensure a move to price cap compliance. 4. The Sickness Absence Task & Finish Group is actively implementing its action plan, whilst the HR team continues to lead on long-term sickness monitoring and proactive case management. Given winter pressures and high levels of stress related absence divisions have been tasked with reviewing departmental stress risk assessments to ensure drivers and actions to mitigate are identified and in place.	1. Monthly data circulated; Divisional Assurance Packs; local compliance can be access via the Learning Hub. 2. People Dashboard presented to Wider Leadership Team and discussed further at People Committee 3. Whole Time Equivalent drivers review commenced with interim CPO 4. Sickness Improvement Plan has been shared and supported at the Wider Leadership Team Meeting. The monthly Task & Finish group continues to meet. People Committee reviewed the plan in the October meeting and features as part of the workplan

Our People Narrative : M9 25/26

Appraisals – In M8, appraisal compliance remain stable at 81.6%, which is below the Trust's 90% target. All divisions remain under close scrutiny through Divisional Performance Reviews, with progress monitored against local action plans.

Vacancy Rate – The Trust-wide vacancy rate has increased slightly to 4.5%, remaining below the 5% target. The Executive Vacancy Panel continues weekly oversight. A robust Quality Impact Assessment (QIA) process is in place to ensure any impacts on patient safety and service continuity are fully considered.

WTE –Actual total workforce 6,970.2 WTE in December. This is an increase 19 WTE from last month and is 209.2 WTE above the total workforce plan of 6,761.0 WTE.

- Actual substantive workforce saw an increase of 20.5 WTE and continued to remain above the substantive workforce plan (+156.8 WTE).
- Bank staffing decreased by -4.8WTE, but remains above plan by 57.5 WTE
- Agency has increased by 3.2 WTE compared to last month, this remains below the plan by 5.2WTE

Our Performance Overview – Elective Care : M9 25/26

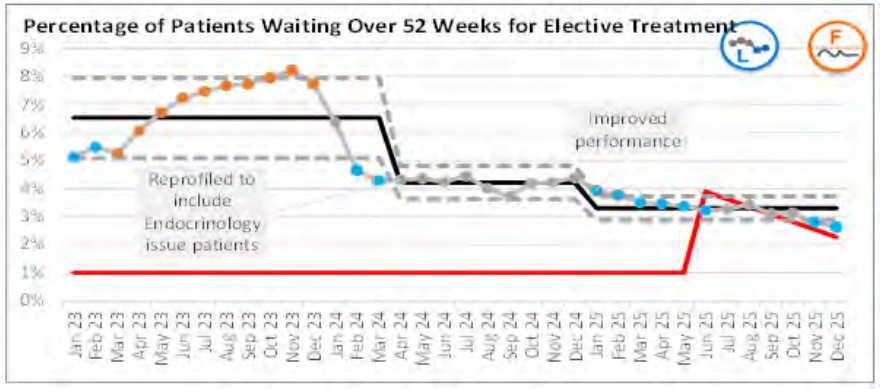
	KPI	Latest month	Metric included in NOF *	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Timely & Complete	Process & System
1	Total Patients Waiting for First Attendance	Dec 25	No	27482	28971			32599	28173	37024			
2	RTT Waiting List	Dec 25	No	46483	48432			49693	48145	51241			
3	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment	Dec 25	Yes	2.6%	2.3%			3.3%	2.9%	3.7%			
4	Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under	Dec 25	No	0.3%	0.3%			0.5%	0.3%	0.7%			
5	Total Patients Waiting Over 65 Weeks	Dec 25	No	23	0			96	40	152			
6	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Dec 25	Yes	57.5%	60.0%			56.9%	54.6%	59.2%			
7	Difference between planned and actual 18 week performance score	Dec 25	Yes	-4.82%	1.00%			0.02%					
8	Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks	Nov 25	Yes	71.6%	80.0%			80.0%	73.8%	86.2%			
9	Cancer 31 Day Treatment Standard Performance	Nov 25	No	89.2%	96.0%			91.7%	83.9%	99.5%			
10	Percentage of Patients Treated for Cancer Within 62 Days of Referral	Nov 25	Yes	67.2%	75.0%			76.7%	65.7%	87.7%			
11	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test	Dec 25	No	35.2%	5.0%			24.4%	16.6%	32.3%			
12	Outpatient New : Follow-up Ratio	Dec 25	No	2.32	2.00			2.23	2.07	2.40			
13	Elective Theatre Utilisation - Capped Touchtime	Dec 25	No	68.9%	85.0%			79.7%	76.3%	83.2%			
14	Elective Recovery Plan : Day Case Activity Performance	Dec 25	No	96.2%	100.0%			96.9%	85.0%	108.8%			
15	Elective Recovery Plan : Inpatient Activity Performance	Dec 25	No	118.8%	100.0%			100.9%	80.6%	121.2%			
16	Percentage of Patients Waiting Over 52 Weeks for Community Services	Dec 25	Yes	0.0%	0.0%			0.1%	0.0%	0.2%			

Summary icons key:

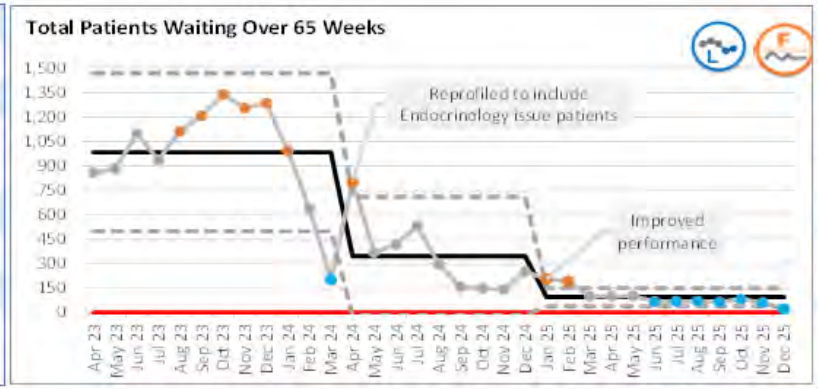
*Please note : NOF denotes the National Oversight Framework

** Cancer Target Metrics are reported 1 month in arrears

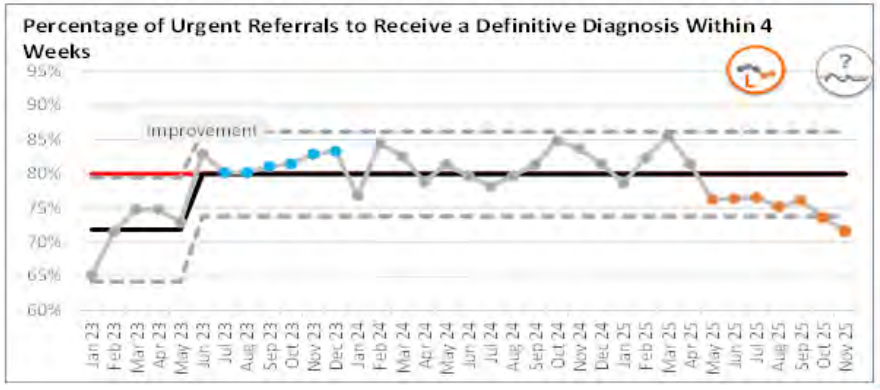
Our Performance Insight Report : Elective Care M9 25/26



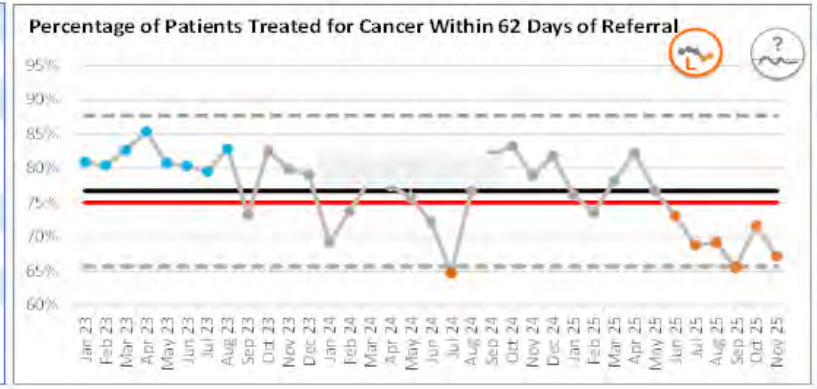
Dec-25
2.6%
Variance Type
Special cause improving variation
Target
2.3%
Target achievement
Metric is consistently missing the threshold/ target



Dec-25
23
Variance Type
Special cause improving variation
Target
0
Target achievement
Metric is consistently missing the threshold/ target



Nov-25
71.6%
Variance Type
Special cause concerning variation point
Target
80%
Target achievement
Inconsistent performance compared to threshold/ target



Nov-25
67.2%
Variance Type
Special cause concerning variation
Target
75%
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1.The overall waiting list is reducing at a steady rate, the unvalidated 52w position is 1.97% with 877 patients forecasted to breach 52w by the end of March. This position does not include the Q4 sprint numbers. 2.The trust reported 23 patients that had waited over 65-weeks for treatment at the end of December 2025. 3. Deterioration due to capacity constraints in Endoscopy and Breast Imaging 4. Deterioration due to constraints across high volume pathways, in particular breast and LGI	1.Specialty action plans are in place to support the delivery of the 52-week position, additional monies have been made available in Q4 to support achievement of the 52-week position. 2. Additional plastics sessions and insourcing to support Dermatology & Plastics 3. Endoscopy insourcing from December 2025 4. Review of treatment capacity in particular surgical treatments for breast cancer. Delivery of recovery actions to comply with FDS performance standard.	1.Weekly PTL/ long waits week meeting with Deputy COO to review and track 65/52/18-week waits 2. Daily tracking of 65-week breach patients and weekly reporting to regional team 3.Anticipated to improve from December due to a combination of additional sessions provided within trust and insourced capacity. 4.Endoscopy insourcing has commenced in December 2025 but will only be evident in the January performance data.

Our Performance Elective Care Narrative : M9 25/26

RTT Waiting List: The overall RTT waiting list continues to decrease, however in December the trust reported 23 patients in breach of the RTT (Referral to Treatment) Waiting List for patients waiting over 65 weeks, this was over the target of 0 breaches at the end of December. The majority of the breaches were under the care of the plastic surgery speciality with all breach patients choosing to defer treatment until January. The remaining breaches were in Endocrinology, Vascular and breast surgery, services which remain an area of concern due to capacity issues, with the Plastics and Vascular services provided by an SLA. (Service Level Agreement). The ongoing insourcing agreements in Dermatology and Plastics have improved the RTT performance, with no plastics patients forecasted to breach 65 weeks in January and February.

Challenges in other areas remain, these are again related to capacity, the operational teams are continuing to review these patients daily, the use of additional sessions, the independent sector, WLI's and reviews of booked patients is undertaken daily, with regular updates provided to the GM elective team.

The trust is forecasting and aiming to achieve the 1% 52-week target, however pressure in key specialties remain, the overall waiting list is reducing at a steady rate, however the unvalidated 52w position is 1.97% with 877 patients forecasted to breach 52w by the end of March. This position does not include the Q4 sprint numbers.
The forecasted 18wk Position at end of March is 61%, if the downward trend of the waiting list continues WWL will maintain the 18-week December 2025 position (26.8k pathways) to achieve 60%, as with the 52-week position this position does not include the Q4 sprint numbers.

Cancer: The 31-day cancer performance for November was 89.2% and remains below the 96% target. There was a minor deterioration in the 28-day performance. The 62-Day performance target decreased by 6%. Capacity/Pathway issues in colorectal and breast services have contributed to the adverse performance. There have been notable improvements in access to straight to test endoscopy which should deliver improved performance against the 28-day target. Clinical and operational agreement has been achieved to re-design the breast pathway with a plan to align clinic and one-stop capacity which will deliver improvement in the FDS metric. There are ongoing issues to undertake timely surgical treatment with plans to review and re-align capacity across the 3 operating sites.

Radiology: Radiology performance has improved across several modalities. NOUS continues to operate with a high volume of 6-week breaches although this has continued to reduce with full deployment of contingent staffing. Mutual aid between Bolton and WWL has proved successful and can be expanded to created additional capacity. There continues to be a concerning level of clinical risk in delivering ultrasound services specifically with a concern about the quality of the services that are being undertaken by external staffing.

Activity for all measured modalities was delivered above the plan in December. CT is experiencing an increasing number of 6-week breaches in CTCA with a plan enacted to commence radiographer led beta blockade from March 2026.The deterioration of MR performance due to an unplanned equipment outage has been evident in the performance but was partially mitigated by the deployment of a mobile asset. The breakdown at the static site (Leigh CDC) has been resolved and there is good levels of capacity available to accelerate backlog recovery. DEXA has delivered high levels of activity to support overachievement of the operational plan which had resulted in a strong recovery and has returned to DM01 compliance at the end of November and December. Leadtime for DEXA has now reduced to 4-weeks.

Elective Theatre Utilisation Capped Touchtime– data is now available following the implementation of the Surgical Care theatre system. Reduction in the metric is not being driven by performance but the changes and the adoption of the new system. Data recording quality issues are currently being investigated to improve the metric.

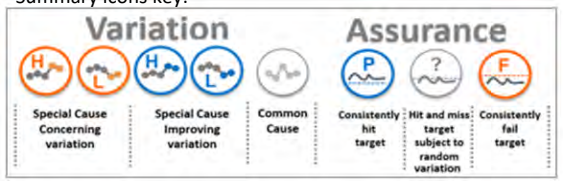
Our Performance Overview – Urgent & Emergency Care: M9 25/26

	KPI	Latest month	Metric included in NOF *	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
17	Average Time to Ambulance Handover	Dec 25	No	00:31:16	00:49:00	L	?	00:37:00	00:16:57	00:57:02	S	T	P
18	Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours	Dec 25	Yes	67.4%	76.0%		F	70.1%	66.1%	74.2%	S	T	P
19	Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department	Dec 25	Yes	18.7%	10.0%	L	F	19.3%	16.0%	22.6%	S	T	P
20	Overnight Total General and Acute Beds and the Number of Which are Occupied	Dec 25	No	91.3%	96.0%		?	92.9%	89.0%	96.7%	S	T	P
21	Virtual Ward Occupancy	Dec 25	No	73.8%	80.0%		?	74.9%	47.8%	101.9%	S	T	P
22	Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days	Dec 25	No	1995	1439		F	1914	1620	2208	S	T	P
23	Average Number of Days Between Planned and Actual Discharge Date (Includes patients discharged on discharge ready date)	Dec 25	Yes	0.9	0.5		F	0.9	0.6	1.2	S	T	P
24	Percentage of Patients who do not Meet the Criteria to Reside	Dec 25	No	22.5%	12.5%		F	23.6%	20.8%	26.4%	S	T	P
25	Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days	Dec 25	No	1194	1560		?	1425	1030	1819	S	T	P
26	Urgent Community Response (UCR) - 2-Hour Performance	Nov 25	Yes	79.9%	70.0%		P	82.5%	74.7%	90.2%	S	T	P

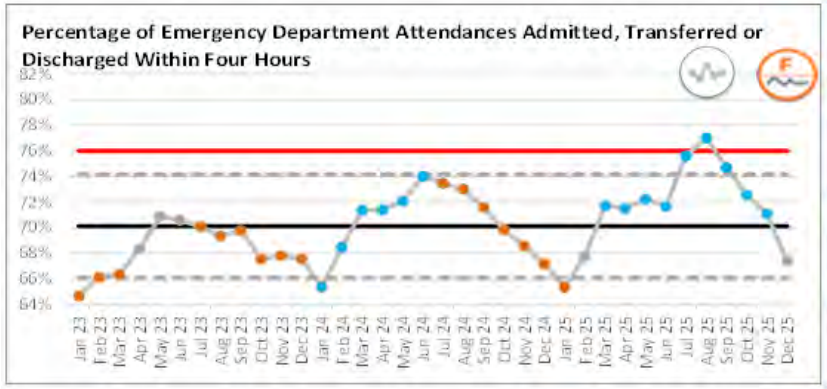
*Please note : NOF denotes the National Oversight Framework

** Urgent Community Response (UCR) - 2-Hour Performance is reported 1 month in arrears

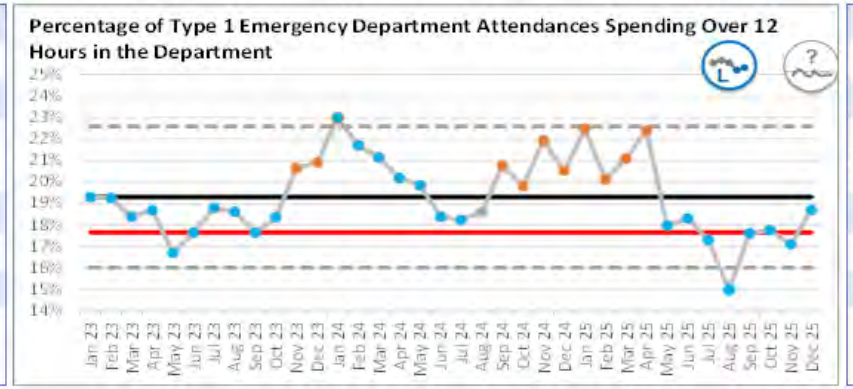
Summary icons key:



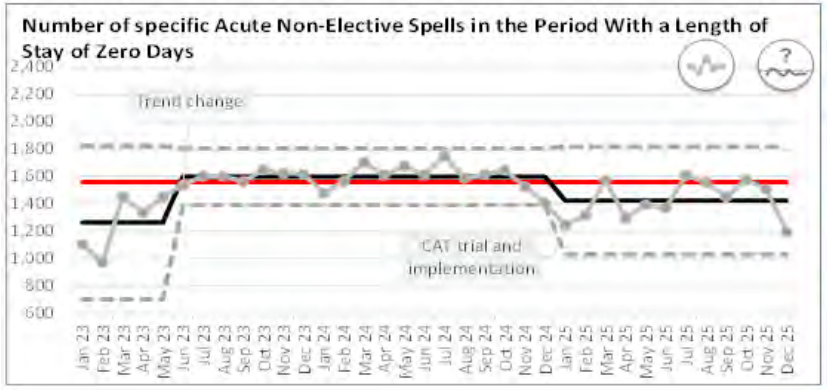
Our Performance Insight Report : Urgent & Emergency Care M9 25/26



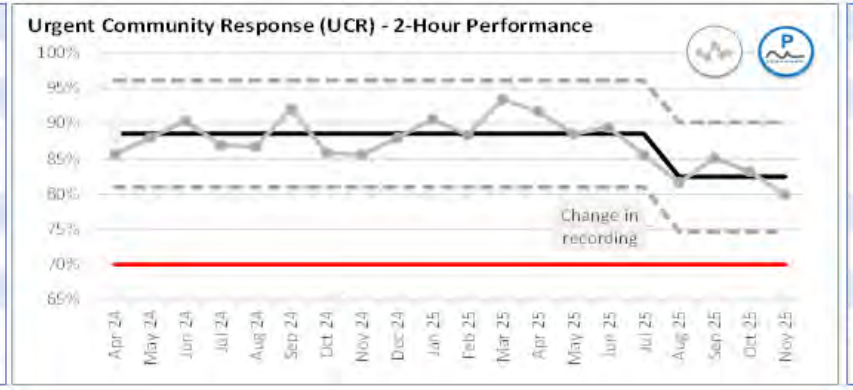
Dec-25
67.4%
Variance Type
Commmon cause variation
Target
76.0%
Target achievement
Metric is consistently missing the threshold/ target



Dec-25
18.7%
Variance Type
Special cause improving variation
Target
17.7%
Target achievement
Inconsistent performance compared to threshold/ target



Dec-25
1194
Variance Type
Commmon cause variation
Target
1560
Target achievement
Inconsistent performance compared to threshold/ target



Nov-25
76.1%
Variance Type
Commmon cause variation
Target
70.0%
Target achievement
Metric is constantly achieving the threshold/ target

Summary:

- There has been further deterioration in the four-hour performance target which is linked to increased ED attendances, acuity and a congested Emergency Department.
- This is again reflected in the 12-hour performance, which in December increased to 18.7% of patients spending over 12-hours in the ED. Increases in in-patient length of stay and the number of patients not meeting the criteria to reside (22.5% of patients in December) have increased the amount of time patients wait for a bed.
- The number of patients with an acute length of stay of zero days has decreased further since October 2025, whilst the number of patients treated via same day emergency care remains on target, the amount of time patients who remain in the ED for treatment has increased.
- The Urgent Community Response 2-hour target remains above the 70% target.

Actions:

- NWAS Direct Access Pathways are also being reinforced for both FSDEC and Medical SDEC to support admission avoidance to the Emergency Department.
- The Operational team are reviewing the increases in Type 1 attendances and the impact this is having on 4-Hour and 12-hour performance, system partners are supporting to identify increases in attendance with primary care data.
- Daily reviews with system partners to review the number of patients not meeting the criteria to reside.
- Clinical Director led MDT approach to length of stays of over 14 and 21 days.
- MADE events with system partners to review all Pathway 1, 2 and 3 patients.
- Increased opening hours in SDEC to support 4 and 12-hour performance.

Assurance:

- Test of change in SDEC which resulted in an extension to their opening hours has been completed. Benefits realisation paper is being completed for review, to be completed by 23/01/26.
- Ambulance Handover Improvement Group re-initiated a direct streaming pathway to both RAEI and Leigh UTC from the 1st December – in November only 3 ambulances were taken to Leigh UTC.
- Daily review of patients with increased length of stay.
- District nurse in-reach to support patient discharge.
- Additional medical staff to support high numbers of medical patients in the Emergency Department.

Our Performance Urgent & Emergency Care Narrative: M9 25/26

The Emergency Department faced significant operational pressures in December, with high numbers of attendances, ambulances and acuity. Despite a brief festive dip in attendances the Emergency Department and Hospital returned to full capacity.

There has been deterioration in the four- and twelve-hour key performance metrics, this is linked to increased length of stay on the speciality medical wards and the number of patients not meeting the criteria to reside resulting in prolonged waits for admission from the Emergency Department. Demand continues to outpace capacity and winter pressures remain acute, with respiratory illnesses, seasonal injuries and chronic condition flare-ups contributing to attendance surges, mirroring national trends.

There has been increases in the number of “walk in “patients attending the emergency department with a high level of acuity, this has resulted in patients experiencing long waits in the waiting room for in-patient admission. The demand for in-patient beds, in particular medical speciality beds has resulted in an over congested Emergency Department that has necessitated the use of Temporary Escalation Spaces, including Bryn Ward North, corridor care and the former Ambulatory Assessment area, the escalation of these spaces has resulted in significant pressure on the nurse workforce to provide care for these patients.

Despite the significant pressures there are ongoing daily actions to mitigate risks and de-escalate the temporary escalation spaces, these include daily calls with system partners, MADE events, daily reviews of long length of stay patients and working on admission avoidance pathways in the Community.

Our Finance Performance Overview : M9 25/26

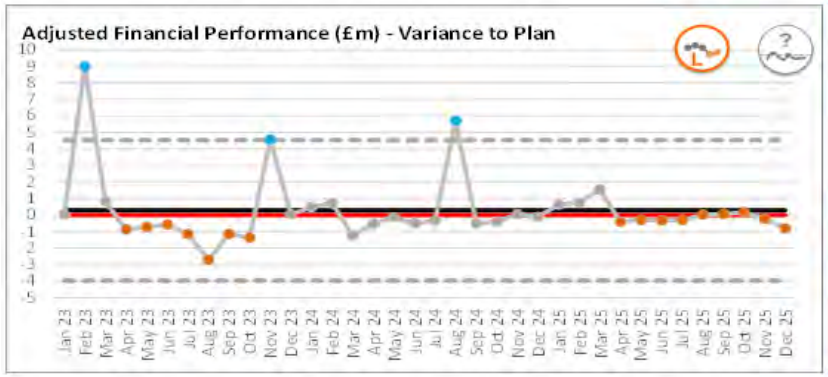
	KPI	Latest month	Metric included in NOF *	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	Variance Year-to-Date to Financial Plan (NOF %)	Dec 25	Yes	-0.54%	0.00%	H	?	-0.93%	-2.04%	0.18%	S	T	P
2	Adjusted Financial Performance (£m) - Variance to Plan	Dec 25	No	-1.0	0.0	L	?	0.3	-4.0	4.5	S	T	P
3	Cash (£m)	Dec 25	No	7.7	9.2	L	?	19.9	9.2	30.7	S	T	P
4	API Income (£m) - Variance to Plan	Dec 25	No	-0.4	0.0		?	-0.3	-1.7	1.1	S	T	P
5	Total Cost Improvement Programme (CIP) (£m) - Variance to Plan	Dec 25	No	-0.6	0.0		?	-0.1	-1.3	1.2	S	T	P
6	Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan	Dec 25	No	-0.6	0.0		?	-0.7	-1.7	0.4	S	T	P
7	Agency Expenditure (£m)	Dec 25	No	0.6	0.4	L	F	0.8	0.5	1.0	S	T	P
8	Bank Expenditure (£m)	Dec 25	No	1.9	1.2	L	F	2.3	1.6	3.0	S	T	P
9	Capital Expenditure (£m) - Variance to Plan	Dec 25	No	-0.9	0.0		?	1.1	-3.4	5.5	S	T	P
10	Better Payment Practice Code (BPPC)	Dec 25	No	0.95	0.95		?	0.93	0.87	1.00	S	T	P

*Please note : NOF denotes the National Oversight Framework

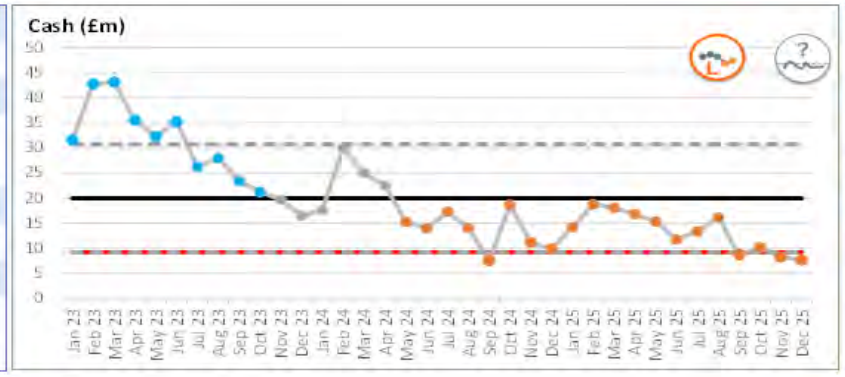
Summary icons key:

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

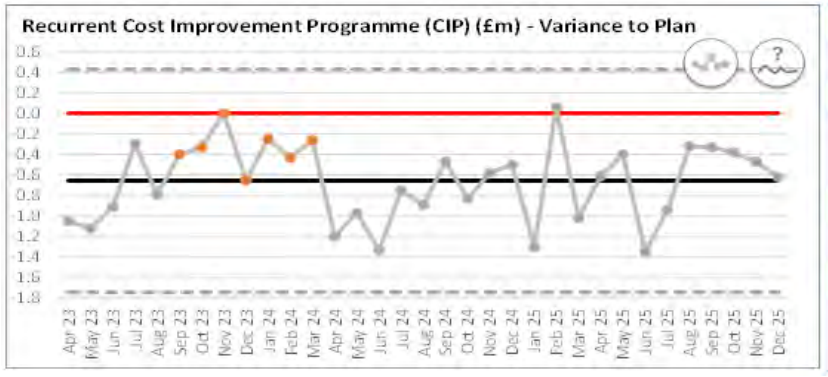
Our Finance Performance Insight Report : M9 25/26



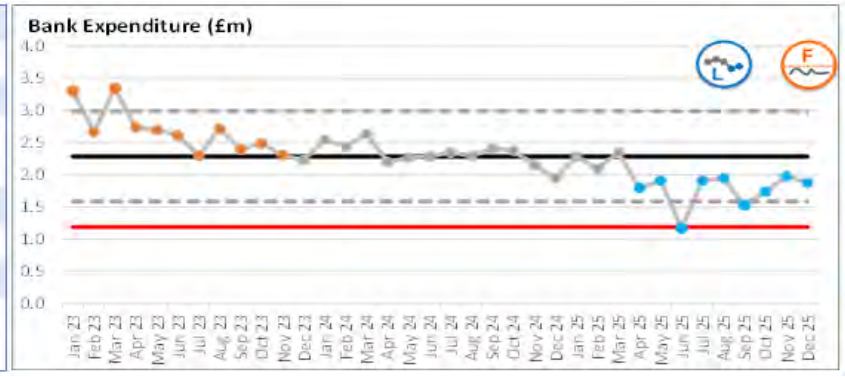
Dec-25
-0.95
Variance Type
Special cause concerning variation
Target
0.0
Target achievement
Inconsistent performance compared to threshold/ target



Dec-25
7.7
Variance Type
Special cause concerning variation
Target
9.2
Target achievement
Inconsistent performance compared to threshold/ target



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



Dec-25
1.9
Variance Type
Special cause improving variation
Target
1.2
Target achievement
Metric is consistently missing the threshold/ target

Summary:	Actions:	Assurance:
1. **Adjusted Financial Performance:** December was a challenging month, ending with a £0.8m deficit – £1.0m worse than plan – and the YTD deficit has grown to £2.1m, £2.3m below target. We are tracking at our mid-case scenario and have yet to see the improvement needed to deliver our plan 2. **Cash**: Closing cash at the end of December was £7.6m, a decrease of £0.7m from November. This is our lowest cash balance but is higher than forecast. Operating cash days are 5 days with cash becoming a critical operating constraint. 3. **Recurrent CIP**: Total CIP delivered in Month 9 is £2.8m, which is £0.6m below plan: £1.5m is recurrent (54%) and £1.3m is non-recurrent (46%). The recurrent delivery year to date is £5.4m behind plan 4. **Bank:** is showing a cumulative 15% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE.	1. **Adjusted Financial Performance:** Quarter 4 is critical: full delivery of the elective programme, achieving CIP targets, and rapid mobilisation of our internal recovery plan are essential to get back on track. Immediate focus and decisive action are non-negotiable. Clinical divisions are being set control trajectories to hit each month. 2. **Cash**: This continues to be closely monitored. A temporary increase is expected in Q4 due to timing of nationally funded capital projects. Approval of cash support application approved by the Board, if it is required in Q4. 3. **Recurrent CIP**: The financial recovery plan is underway. Divisions are presenting their forecast positions including CIP delivery to ETM when escalated. Divisions are now working to control totals to ensure run rate improvements by the end of the year 4. **Bank**: This continues to be closely monitored with the recovery plan targeting reductions in further reductions in bank expenditure. Temporary spend reduction links to CIP delivery.	1. **Adjusted Financial Performance:** Monitored through ETM, FIG, Finance and Performance committee and board. 2. **Cash**: Operational Cash Management Group, Finance and Performance Committee, recent internal audit review of cashflow forecast processes with substantial assurance. 3. **Recurrent CIP:** Divisions are presenting their forecast positions including CIP delivery to ETM. The recovery plan delivery is being monitored at the divisional assurance meetings, FIG and ETM as part of the control total monitoring. 4. **Bank**: Executive Pay Control Group, Divisional Performance Reviews, Finance Improvement Group, Finance and Performance Committee

Our Finance Performance Narrative : M9 25/26

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Red		December was a challenging month, ending with a £0.8m deficit – £1.0m worse than plan – and the YTD deficit has grown to £2.1m, £2.3m below target. This includes a material upside from industrial action funding received to cover November and December (income £1.7m; expenditure £0.8m). We are tracking at our mid-case scenario and have yet to see the improvement needed to deliver our plan. Quarter 4 is critical: full delivery of the elective programme, achieving CIP targets, and rapid mobilisation of our internal recovery plan are essential to get back on track.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Red		The cash balance as at 31st December 2025 is £7.6m, a new low point, which is equivalent to 5 operating cash days. Our cash remains on a downward trajectory linked to the slippage on CIP delivery and static run rate, with cash becoming a critical constraint for operational decision making. A temporary reprieve is expected in Q4 due to timing of capital projects.
API Income	Achieve the elective activity plan for 2025/26	Red		Divisional elective API income is £0.4m adverse to plan in month and did not deliver the recovery forecast by divisions. Unbundled drugs and devices is £0.7m favourable and this includes gainshare and limb salvage prosthesis; the latter is a risk whilst discussions continue with Specialist Commissioners.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Red		CIP performance deteriorated in December. Recurrent CIP slippage remains a contributing factor of our adverse variance, with the month 9 position now £5.4m behind the recurrent plan of £16.7m. The total CIP delivered in month 9 is £2.8m which is £0.6m behind the total plan, the total YTD slippage is £3.6m as non-recurrent CIP has partially mitigated the recurrent under-performance.
	Deliver Recurrent CIP of £23.0m	Red		
Agency expenditure	30% reduction in agency spend.	Red		Agency spend is showing a cumulative 6% reduction to the NHSE baseline (adjusted for industrial action costs) (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.
Bank expenditure	10% reduction in bank spend	Green		Bank spend is showing a cumulative 15% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE.
Capital expenditure	Achieve capital plan for 2025/26.	Amber		Total capital expenditure in month 9 is £1.2m which is £0.8m less than plan. We are forecasting capital expenditure in line with plan with close monitoring in Q4. We have been successful in securing additional national funding for Q4.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Green		BPPC performance in-month was 95.1% by volume and 97.5% by value. YTD performance was 92.5% by volume and 96.7% by value.

National Benchmarking of NHS Access Standards

Based on data published by NHSE

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Elective care	Period	Value	1 Month Change	3 Month Change	National Rank	Lower Quartile	Median	Upper Quartile
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Nov-25	58.40%	0.70	1.90	94/129	57.4%	60.8%	65.1%
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Nov-25	3.10%	-0.40	-0.70	107/122	2.7%	1.8%	1.1%
Percentage of patients waiting over 52-weeks for community services	Nov-25	0.20%	-0.10	-1.10	59/134	8.5%	1.4%	0.0%
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	Nov-25	30.60%	-4.00	-8.00	108/133	27.8%	14.9%	8.3%
Cancer Care								
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Nov-25	71.6%	-2.00	-3.56	119/142	74.9%	78.3%	82.6%
Percentage of patients treated for cancer within 62 days of referral	Nov-25	67.20%	-4.30	-0.60	99/142	65.8%	72.8%	81.1%
Urgent and Emergency Care								
Percentage of emergency department attendances admitted, transferred or discharged within 4 hours (All Types)	Dec-25	66.80%	-4.00	-7.80	87/123	66.4%	71.3%	76.0%
Percentage of emergency department attendances spending over 12 hours in the department (Type 1 & 2)	Dec-25	18.68%	1.80	1.40	113/122	14.2%	10.6%	6.0%
Average ambulance handover time (minutes)	Dec-25	31.7	1.10	6.90	88/121	33.25	24.60	19.30

- 62 day Cancer has deteriorated. Based on the publicly available data Breast is ranked lowest compared to other tumour groups (includes private providers)
- NOUS is the leading modality reducing WWL's performance and national ranking.
- WWL's AE Performance has reduced in recent months and in relation to national. Worth noting is the increase in Type 1&2 attendance for the 3 months to December 2026. Representing a 9% increase compared to the previous quarter (July – September). Attendance volumes not seen at WWL since winter 22/23

1.10
-4.00

Red represents deterioration in performance, also indicted by arrow.
Green represents improved performance, also indicted by arrow.
The number represents the value change in performance

High Performing
Above Average
Below Average
Low Performing

Note: some figures may vary from previously reporting metrics within the IPR due to further validation taking place prior to national publication.

Total Waits	Waits <18w	Waits >52w
47,410 Pathways	**58.4** %	**3.1** %
Rank: 69th	Rank: 94th	Rank: 107th

Metric	Total Waits		Waits <18w		Waits >52w	
Trauma & Orthopaedics	**8,657** Pathways	(100th)	**60.9** %	(38th)	**2.4** %	(55th)
Other - Surgical	**5,091** Pathways	(74th)	**56.8** %	(93rd)	**4** %	(94th)
Gastroenterology	**4,950** Pathways	(102nd)	**55.4** %	(95th)	**3.4** %	(105th)
Ear, Nose and Throat	**4,770** Pathways	(62nd)	**46** %	(88th)	**3.9** %	(83rd)
Dermatology	**3,464** Pathways	(58th)	**51.6** %	(86th)	**3** %	(83rd)
Gynaecology	**2,989** Pathways	(34th)	**59.5** %	(49th)	**2** %	(57th)
Cardiology	**2,746** Pathways	(61st)	**75.2** %	(31st)	**0.4** %	(64th)
Other - Paediatric	**2,694** Pathways	(84th)	**57.7** %	(85th)	**3** %	(105th)
Respiratory Medicine	**1,864** Pathways	(92nd)	**63.7** %	(82nd)	**0.9** %	(90th)
General Surgery	**1,772** Pathways	(43rd)	**48.4** %	(97th)	**4.7** %	(98th)
Urology	**1,623** Pathways	(16th)	**73.3** %	(25th)	**2.7** %	(82nd)
Other Medical	**1,602** Pathways	(30th)	**49.2** %	(119th)	**6.7** %	(120th)
Oral Surgery	**1,338** Pathways	(25th)	**65.8** %	(22nd)	**1.4** %	(44th)
Ophthalmology	**1,253** Pathways	(8th)	**78.4** %	(18th)	**1.2** %	(75th)
Plastic Surgery	**1,149** Pathways	(46th)	**40.3** %	(72nd)	**15.7** %	(81st)
Rheumatology	**819** Pathways	(56th)	**79.4** %	(45th)	**0.1** %	(60th)
Elderly Medicine	**442** Pathways	(104th)	**55** %	(110th)	**0** %	(1st)
General Internal Medicine	**139** Pathways	(61st)	**89.2** %	(36th)	**0** %	(1st)
Cardiothoracic Surgery	**37** Pathways	(22nd)	**45.9** %	(44th)	**0** %	(1st)
Neurosurgical	**8** Pathways	(6th)	**75** %	(6th)	**0** %	(1st)
Other - Other	**3** Pathways	(1st)	**66.7** %	(81st)	**0** %	(1st)

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

RTT by Speciality

- Breakdown of benchmarked speciality performance for RTT supports understanding of service pressures
- Other Medical – Endocrine
- Ranked out of 129

62 day cancer benchmark by tumour site (November 2025). Ranked out of 118

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Total Treatments	Treatments <62 Days
135.5 Patients	67.2 %
Rank: 90th	Rank: 77th

Metric	Total Treatments		Treatments <62 Days	
Breast	36 Patients	(51st)	47.2 %	(103rd)
Urological - Prostate	25 Patients	(78th)	84 %	(31st)
Lower Gastrointestinal	15 Patients	(83rd)	56.7 %	(79th)
Skin	14.5 Patients	(92nd)	96.6 %	(18th)
Urological - Other (a)	12.5 Patients	(55th)	84 %	(22nd)
Lung	9 Patients	(98th)	66.7 %	(50th)
Haematological - Other A	5.5 Patients	(59th)	100 %	(1st)
Gynaecological	5 Patients	(81st)	60 %	(57th)
Head and Neck	5 Patients	(70th)	30 %	(90th)
Haematological Lymphoma	3 Patients	(91st)	0 %	(108th)
Upper Gastrointestinal - Hepatobiliary	2 Patients	(106th)	75 %	(74th)
Other - A	1.5 Patients	(90th)	100 %	(1st)
Upper Gastrointestinal - Oesophagus & Stomach	1.5 Patients	(109th)	66.7 %	(63rd)

Total Waits	Waits >6w
13,278 Patients	**30.6** %
Rank: 83rd	Rank: 108th

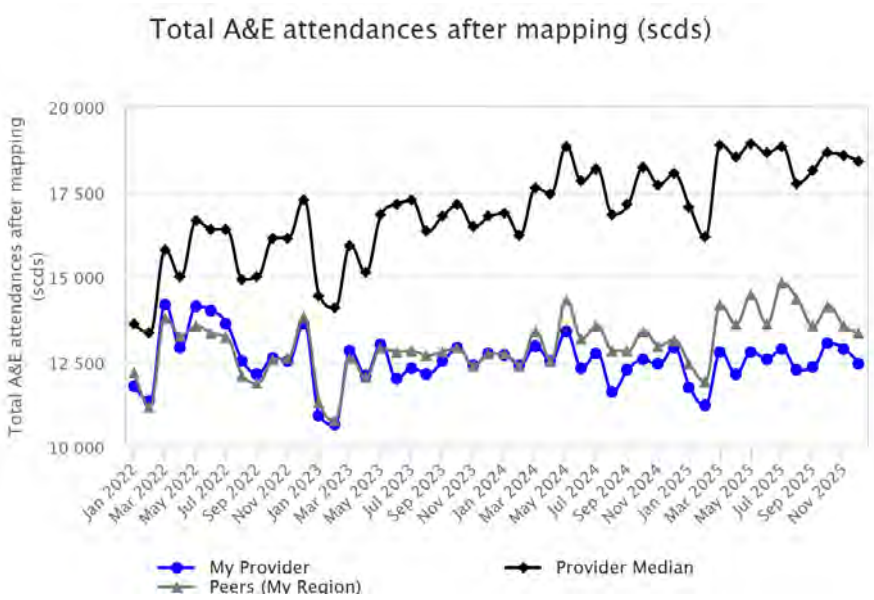
Metric	Total Waits		Waits >6w	
Imaging - Non-obstetric Ultrasound	**5,325** Patients	(95th)	**44.2** %	(127th)
Imaging - MRI	**2,984** Patients	(89th)	**12.5** %	(81st)
Physiological Measurement - Echocardiography	**2,166** Patients	(118th)	**46** %	(108th)
Imaging - CT	**985** Patients	(58th)	**13.7** %	(107th)
Imaging - DEXA Scan	**392** Patients	(77th)	**1.3** %	(56th)
Endoscopy - Colonoscopy	**375** Patients	(64th)	**10.1** %	(55th)
Endoscopy - Gastroscopy	**307** Patient	(52nd)	**25.7** %	(82nd)
Physiological Measurement - Audiology	**288** Patients	(48th)	**0.7** %	(15th)
Endoscopy - Flexi Sigmoidoscopy	**160** Patients	(85th)	**32.5** %	(88th)
Physiological Measurement - Sleep Studies	**130** Patients	(66th)	**12.3** %	(55th)
Endoscopy - Cystoscopy	**75** Patients	(37th)	**0** %	(1st)
Physiological Measurement - Peripheral Neurophpysiology	**50** Patients	(54th)	**10** %	(43rd)
Imaging - Barium Enema	**19** Patients	(89th)	**0** %	(1st)

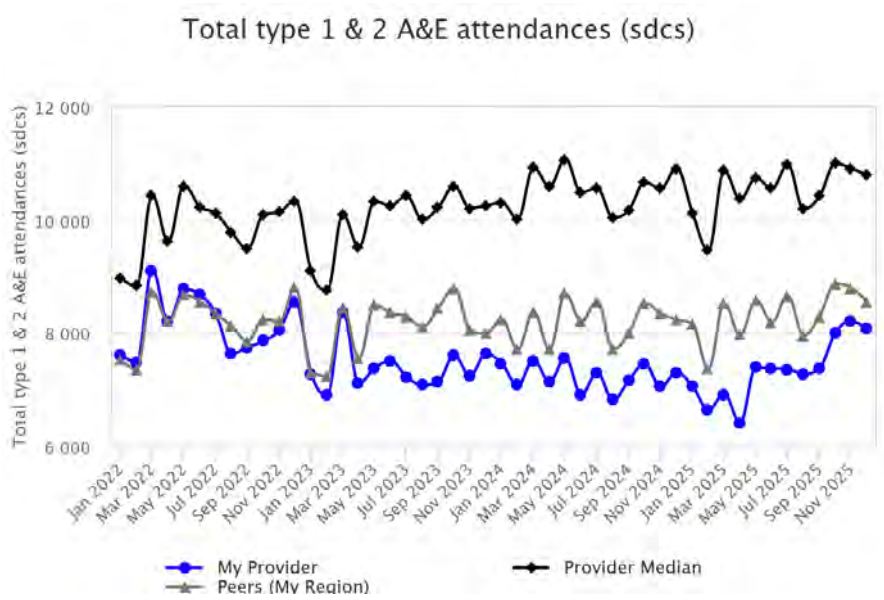
Diagnostics

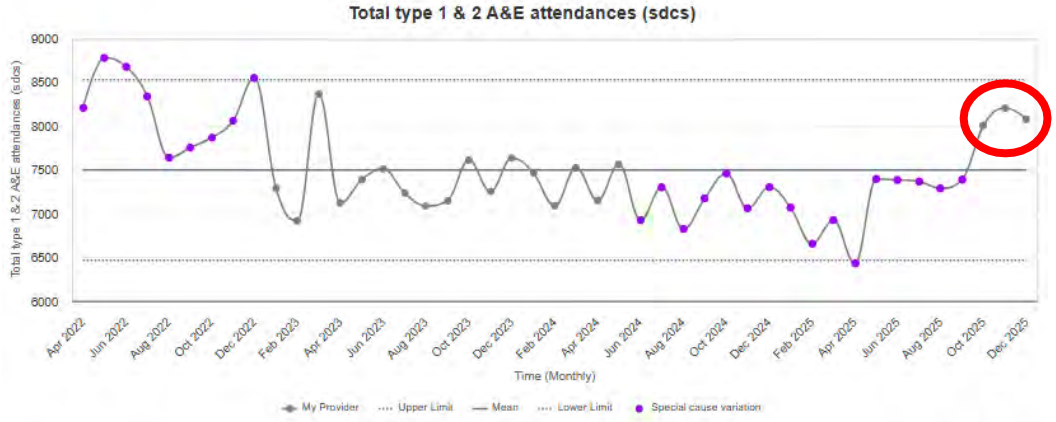
- Breakdown of benchmarked modality
- Ranked out of 133

All Type AE Attendances have reduced at WWL, against a growing trend nationally and regionally. However, following an increase in May 2026 there was a further sustained increase from October to December 2026 in Type 1&2 attendances – with 8,000 + attendances against a mean of 7500 for the last 3 years.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust







Title of report:	Board Assurance Framework (BAF) 2025/26
Presented to:	Board of Directors
On:	4 February 2026
Item purpose:	Approval
Presented by:	Director of Corporate Governance
Prepared by:	Head of Risk Director of Corporate Governance
Contact details:	E: steven.parsons@wwl.nhs.uk

Executive summary

The trust's key strategic risks to the achievement of the annual corporate objectives 2025/26 are presented here for the committee's review and approval.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations

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

Financial implications

There is one strategic financial performance risk identified within this report.

Legal implications

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

People implications

There is one strategic people risk identified within this report.

Equality, diversity and inclusion implications

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

Which other groups have reviewed this report prior to its submission to the committee/board? Finance & Performance, Quality & Safety, People, Executive Team Meeting.

Recommendation(s)

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

1. Introduction

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

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

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

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

2. BAF Review

The trust's key strategic risks to the achievement of the annual corporate objectives 2025/26 are presented here for the committee's review and approval.

3. New Risks Recommended for Inclusion to the BAF

No risks have been added or removed from the BAF since the last board meeting.

4. Review Date

The BAF is reviewed bi-monthly by the Board. The next review is scheduled for April 2026.

5. Recommendations

5.1 The Board of Directors are asked to:

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

Appendix 1

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Board assurance framework

2025/26

The content of this report was last reviewed as follows:

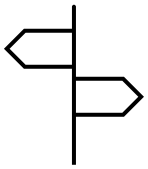
Board of Directors	December 2025
Quality and Safety Committee:	February 2026
Finance and Performance Committee:	January 2026
People Committee:	January 2026
Executive Team:	January 2026

“ **assurance** (/əˈʃɔːrəns/) *noun*

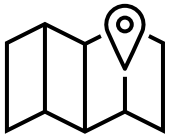
The process by which a board of directors gains confidence in the organisation's governance, risk management, and internal control frameworks. It involves evaluating the effectiveness of these frameworks and identifying areas that need improvement to ensure the organisation achieves its objectives. ”

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

How the Board Assurance Framework fits in

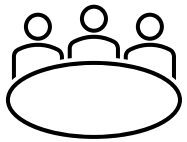


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how we will deliver against these. The strategy signposts the general direction which we need to travel in to achieve our goals and sets out where we want to go, what we want to do and what we want to be.

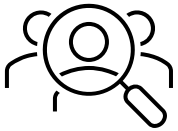


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives focus on delivery of the strategy and what the organisation needs to prioritise and focus on during the year to progress the longer-term ambitions within the strategy.

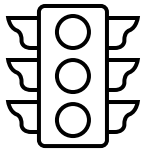
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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



Seeking assurance: To have effective oversight of the delivery of our corporate objectives, the Board of Directors uses its committee structure to seek assurance on its behalf. Whilst individual corporate objectives will cross a number of our strategic ambitions, each is allocated to one specific strategic ambition for the purposes of monitoring. Each strategic ambition is allocated to a monitoring body who will seek assurance on behalf of, and report back to, the Board of Directors.



Accountability: Each strategic risk has an allocated director who is responsible for leading on delivery. In practice, many of the strategic risks will require input from across the Executive Team, but the lead director is responsible for monitoring and updating the Board Assurance Framework and has overall responsibility for delivery of the objective.



Reporting: To make the Board Assurance Framework as easy to read as possible, we use visual scales based on a traffic light system to highlight overall assurance. Red indicates items with low assurance, amber shows items with medium assurance and green shows items with high assurance.

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

Almost certain 5	5 Moderate	10 High	15 Significant	20 Significant	25 Significant
Likely 4	4 Moderate	8 High	12 High	16 Significant	20 Significant
Possible 3	3 Low	6 Moderate	9 High	12 High	15 Significant
Unlikely 2	2 Low	4 Moderate	6 Moderate	8 High	10 High
Rare 1	1 Low	2 Low	3 Low	4 Moderate	5 Moderate
↑ Likelihood	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Critical 5**
	Impact →				

DIRECTOR LEADS

CEO:	Chief Executive	DCA:	Director of Corporate Governance
COO:	Chief Operating Officer	DCE:	Deputy Chief Executive Chief Officer for Strategy, Partnerships and Digital
CFO:	Chief Finance Officer	CPO:	Chief People Officer
CN:	Chief Nurse	MD:	Medical Director
DCSE:	Director of Communications and Stakeholder Engagement		

DEFINITIONS	
Strategic ambition:	The strategic ambition which the corporate objective has been aligned to – one of the 4 Ps (patients, people, performance or partnerships)
Strategic risk:	Principal risks which populate the BAF; defined by the Board and managed through Lead Committees and Directors
Linked risks:	The key risks linking the corporate risk register, the BAF and the system risk register, which have the potential to impact on objectives
Controls:	The measures in place to reduce either the strategic risk likelihood or impact and assist to secure delivery of the strategic objective
Gaps in controls:	Areas which require attention to ensure that systems and processes are in place to mitigate the strategic risk
Assurances:	The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively. 1st Line functions which own and manage the risks, 2nd line functions which oversee or specialise in compliance or management of risk, 3rd line functions which provide independent assurance and external assurance. Overall assurance level for each risk is summarised as high, medium or low.
Gaps in assurance:	Areas where there is limited or no assurance that procedures and processes are in place to support mitigation of the strategic risk
Risk Treatment:	Actions required to close the gap(s) in controls or assurance, with timescales and identified owners. Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity.
Monitoring:	The Board and its Sub Committees which will monitor completion of the required actions and progress with delivery of the allocated objectives

Our approach at a glance

Our strategy 2030

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

25/26 Corporate Objectives

Strategic Ambition

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

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

25/26 Corporate Objective

Strategic Ambition

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

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

25/26 Corporate Objectives

Strategic Ambition

To consistently deliver efficient, effective and equitable patient care

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

25/26 Corporate Objective

Strategic Ambition

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

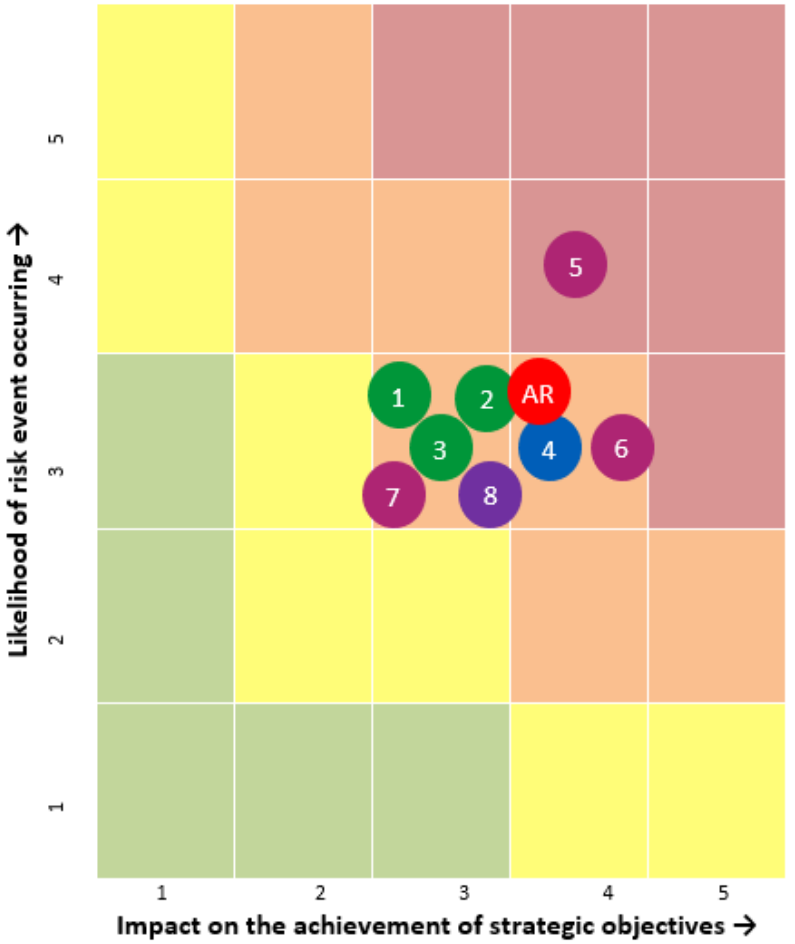
To further strengthen existing partnerships and develop new ones to complement and support our NHS services and research activities

Risk management

Our risk appetite position is summarised in the following table:

Risk category and link to principal objective	Threat		Opportunity	
	Optimal	Tolerable	Optimal	Tolerable
Safety, quality of services and patient experience	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Data and information management	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Governance and regulatory standards	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Staff capacity and capability	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Staff Engagement	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Staff wellbeing and safety	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Estates and Facilities	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Financial Duties	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Performance Targets	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Hospital Demand, Capacity and Flow	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Sustainability / Net Zero	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Technology	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Adverse publicity	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Contracts and demands	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Strategy	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Transformation	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager

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



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

Patients

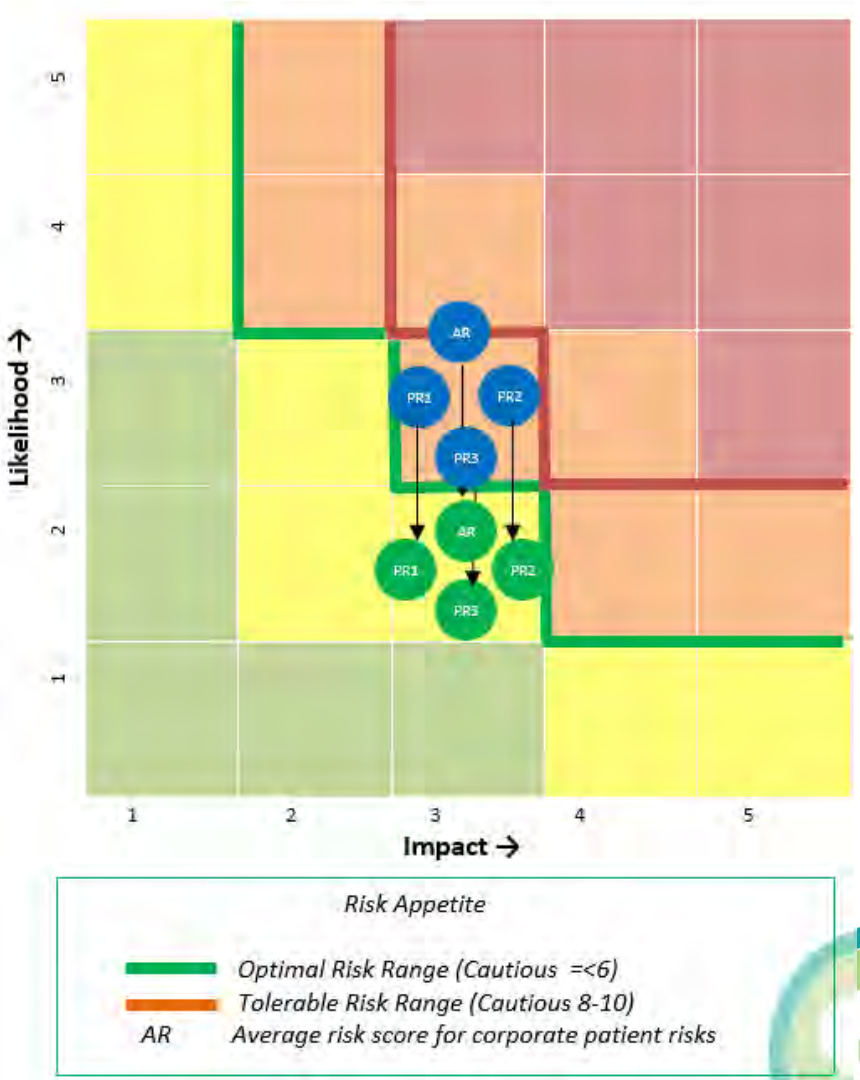
To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

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

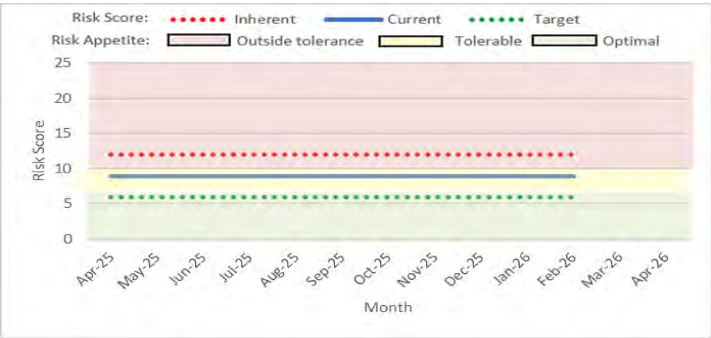
Ref.	Purpose of the objective	Scope and focus of objective	How will be know if it has been achieved?
CO1	To improve the quality of care for our patients and residents.	• Right patient, right ward, right professional, right time for 80% of patients with heart attack, stroke, acute abdomen or fractured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

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



BOARD ASSURANCE FRAMEWORK 2025/26		
BAF RISK PR 1: Quality of Care There is a risk that quality of care across the Trust may deteriorate, due to resource limitations restricting our ability to improve, resulting in increased patient delays, incidents of avoidable harm, reputational damage and an increase in complaints.	**Executive Director Lead:**	MD / CNO
	Strategic Aim:	CO1 To improve the quality of care for our patients and residents
	Risk Category:	Strategic / Safety, quality of services & patient exp.
	Risk Opened:	30.07.2025

BAF Risk Journey 2025/26



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	9	9	9	9		6	6-10
	3x3	3x3	3x3	3x3		2x3	
	LxC	LxC	LxC	LxC		LxC	
Risk Appetite	Within	Within	Within	Within			Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q3 remains at a high score of 9. It is possible that the risk outlined in the risk statement may happen and it will have a moderate impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q4: Deteriorating
Stable
Improving

Rationale: Stable
Risk score remains stable at 9.

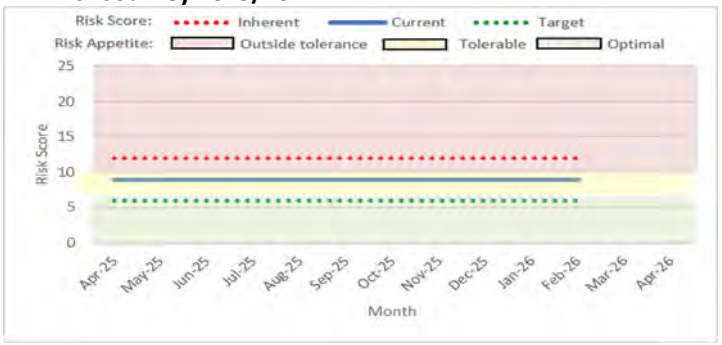
CONTROLS →	ASSURANCES →	EVIDENCE
• **Right Patient, right ward:** Further work presented, comparing Professional Body recommendations for timely admission to the right ward.	• 2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – Nov 2025
• **ASPIRE Accreditation (quality improvement):** Significant improvement in ward environments, collaborative learning, electronic process, triangulation with other assurance. All score improving with lowest scoring wards (White) demonstrating improvement. Personal assurance via feedback from clinical staff with meeting.	• 2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – Nov 2025
• **Maternity Safety standards (Ockenden, CNST):** Compliance with training, minimal staffing vacancies, ongoing audit, no Regulation 28, complaints managed on time and litigation by value and cost lowest in GM.	• 2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – Nov 2025

• **Oxygen prescribing**: Compliance above target, ongoing monitoring, successful PDSA cycles.	•2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – Nov 2025
• **Organisational restructure:** Transition to new divisional structures continue on track, further work ongoing progressing clinical models and pathways.	•2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – Nov 2025
• **Patient Safety:** The trust has made good progress in transitioning to the new Patient Safety Incident Response Framework.	•3rd Line – MIAA Audit	Positive assurance received following internal audit by MIAA.
• **Incident response and investigation:** policies, procedures and processes in place.	• 2nd Line – SAFEty Meeting – Daily • 2nd Line – LFPSE Meeting – Weekly • 2nd Line – Patient Safety Group - Monthly	Daily Safety Log LFPSE Minutes Patient Safety Group AAA Report

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Right Patient, right ward: Poor compliance with timely admission to specialist wards for heart attack, stroke, fractured neck of femur and acute abdomen.	Realistic targets to be reviewed within the BAF, noting seasonal variation. Mitigations to be linked to Better Lives Programme and the use of the escalation policy.	CNO	31.03.26	Q&S Committee	Action underway
Safe Medical Staffing: Locum spend is high in acute areas, less than full-time doctors causing rota gaps, risk of unsafe staffing on certain wards, strike action may exacerbate issues.	Referral to People Committee to triangulate with the absence policy.	CNO	31.03.26	Q&S Committee / People Committee	Action underway
Sepsis Performance: Risk of missed timely care due to A&E congestion and HO45 ambulance handover process.	New process recently implemented for timely blood culture testing. Metrics to be triangulated with HO45 to identify possible impact.	CNO	31.03.26	Q&S Committee / People Committee	Action underway

BOARD ASSURANCE FRAMEWORK 2025/26		
BAF RISK PR 2: Patient Experience There is a risk that residents and patients may have a negative experience of our care, due to seasonal variations in operational pressures, delays in treatment, poor information flows to and from patients and other partners, poor attitudes displayed to patients, not learning from incidents and complaints, resulting in an increase in complaints and a reduction in patients who would recommend WWL as a place to be treated.	**Executive Director Lead:**	MD / CNO
	Strategic Aim:	CO2 To ensure that our patients and residents have the best possible experience of our care
	Risk Category:	Safety, quality of services & patient exp.
	Risk Opened:	30.07.2025

BAF Risk Journey 2025/26



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	9	9	9	9		6	6-10
	3x3	3x3	3x3	3x3		2x3	
	LxC	LxC	LxC	LxC		LxC	
Risk Appetite	**Within**	**Within**	**Within**	**Within**			**Within**

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q3 remains at a high score of 9. It is possible that the risk outlined in the risk statement may happen and it will have a moderate impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q4: Deteriorating
Stable
Improving

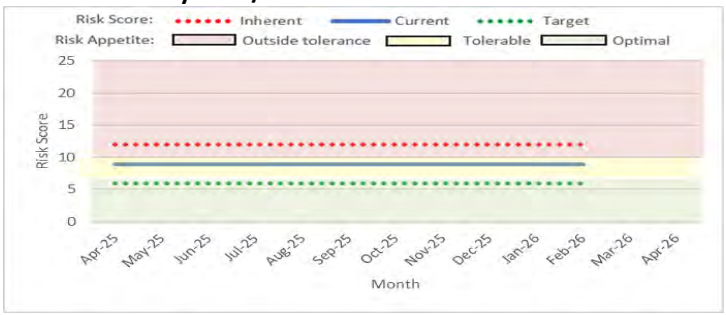
Rationale: Stable
Risk score remains stable at 9.

CONTROLS →	ASSURANCES →	EVIDENCE
• **Patient Stories** shared at Quality & Safety Committee to share and learn from patient experiences of using WWL services. Positive outcome, reduced hospital admissions, improved patient alertness, effective MDT working.	• 1st Line - Divisional Patient Safety Group – monthly • 2nd Line - Quality and Safety Committee – bi-monthly	Quality and Safety Committee AAA Report – Nov 2025
• **Patient Relations:** Complaints review panel process in place, providing an annual review of complaints across all divisions with monthly meetings.	• 2nd Line - LFPSE – weekly • 2nd Line – Q&S Annual complaints report - yearly	Complaints annual report Weekly Complaints Report for LFPSE meeting.
• Complaints Standard Operating Procedure (SOP) in place with defined roles, processes and timescales.	• 2nd Line - Quality & Safety Committee – bi-monthly	Complaints Standard Operating Procedure
• Lived Experience Forum implemented.	• Complaints report – quarterly	Complaints annual report

• Senior Leadership walkabouts triangulate any complaints themes which have been noted. • 85% increase in compliments in 2024/25 compared to 2023/24 following introduction of web link for staff to enter compliments received.	• Patient Experience and Engagement Group – quarterly	Weekly Complaints Report for LFPSE meeting.			
Gaps in Controls / Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
• **Patient Relations:** The overall Trust response rate for responding to complaints within 60 days in 2024/25 was 67%, which has not met the Trust's Performance Target.	Supportive integrated governance and key stakeholder weekly review of complaints compliance implemented.	CNO	31.03.26	Q&S Committee	Action underway
• **Patient Experience and Engagement Group:** Complaints and PALS data notes underrepresented patient voices within our communities.	National Oversight Framework metrics to be included in reporting going forward. Action plans in place, improvement trends noted.	CNO	31.03.26	Q&S Committee	Action underway

BOARD ASSURANCE FRAMEWORK 2025/26		
BAF RISK PR 3: Early Detection and intervention, preventing avoidable ill-health There is a risk that there may be avoidable admissions to the Trust's services, due to ineffective engagement with Primary Care and Local Authority through 'place' and external policies that do not support preventing avoidable ill health, resulting in avoidable ill-health.	**Executive Director Lead:**	MD / CNO
	Strategic Aim:	CO3 To promote early detection and intervention, preventing avoidable ill-health
	Risk Category:	Safety, quality of services & patient exp.
	Risk Opened:	30.07.2025

BAF Risk Journey 2025/26



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	9	9	9	9		6	6-10
	3x3	3x3	3x3	3x3		2x3	
	LxC	LxC	LxC	LxC		LxC	
Risk Appetite	Within	Within	Within	Within		Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q3 remains at a high score of 9. It is possible that the risk outlined in the risk statement may happen with a moderate impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Stable
The risk score has not changed from Q1 to Q3. Robust control measures and assurances are in place. However, there are still outstanding actions to reduce this risk to a moderate target score of 6.

CONTROLS →	ASSURANCES →	EVIDENCE
• Report highlighted that Wigan's population has a lower average age of death compared to wealthier areas, reflecting significant health inequalities.	•2nd Line - Quality & Safety Committee – bi-monthly	Bi-annual mortality/learning from deaths report.
• IPC annual report issued presented to Quality and Safety Committee.	2nd Line - Quality & Safety Committee – bi-monthly	Infection Prevention and Control (IPC) Annual Report

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Mortality data, particularly regarding patients in A&E, would be useful for the Better Lives Programme.	A&E Mortality data to be considered as part of Better Lives programme.	MD	31.03.26	Q&S Committee	Action underway
C-diff identified as a concern in the IPC annual report.	Rationalise testing to exclude symptomless patients.	IPC Team	31.03.26	Q&S Committee	Action underway

People

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

Monitoring: People Committee

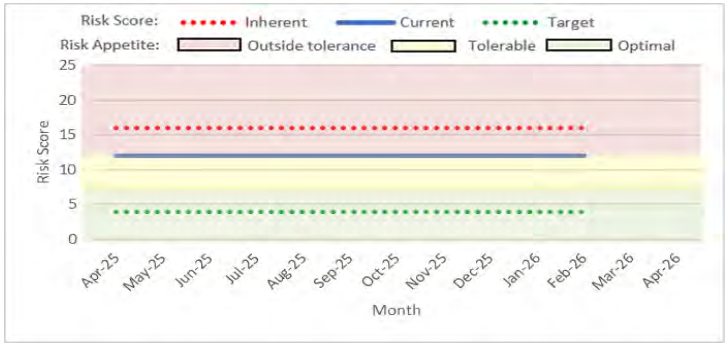
The following corporate objectives are aligned to the **people** strategic priority:

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

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

BOARD ASSURANCE FRAMEWORK 2025/26		
BAF RISK SR4: Workforce Sustainability There is a risk that we may not deliver a financially sustainable workforce plan. In 2025/26 WWL is required to reduce headcount by c200. This will be managed with compassion and in line with Trust policy however there is a risk that these actions will negatively impact on staff wellbeing and motivation.	**Executive Director Lead:**	CPO
	Strategic Aim:	C04: Make WWL a great place to work and ensure that our staff feel valued
	Risk Category:	Staff Capacity & Capability, Staff Engagement
	Risk Opened:	30.07.2025

BAF Risk Journey 2025/26



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	12	12	12	12		4	8-12
	3x4	3x4	3x4	3x4		2x2	
	LxC	LxC	LxC	LxC		LxC	
Risk Appetite	Within	Within	Within	Within		Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q3 remains at a high score of 12. It is possible that the risk outlined in the risk statement may happen with a major impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q4: Deteriorating
Stable
Improving

Rationale: Stable
Risk score remains stable at 12.

CONTROLS →	ASSURANCES →	EVIDENCE
Target agreed with all Divisional Triumvirates, including Bank and Agency Reduction Plans	2nd Line – Establishment Control Group (Medical and Non-Medical) 1st Line – Divisional Performance Review Meetings	Reported through to Finance Improvement Group Monthly KLOE response and slide pack Transformation Board
Trust Wide Transformation Schemes agreed with associated workforce reduction plans	2nd Line – Monthly Transformation Board Meeting 2nd Line – Individual Scheme workstream meetings	Reported through to Executive Team Meeting (AAA Report) Highlight reports at Transformation Board
Continued implementation of deliverables outlined within the WWL People & Culture Strategy	2nd Line – Wider Leadership Team 2nd Line – People Services Senior Leadership Team 3rd Line – Partnership Forum / LNC	Minutes and papers Action logs Minutes and papers

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Not all Divisions have fully worked up schemes of work to reduce headcount	Support for Divisional leaders and Corporate Directors in relation to the implementation of workforce plans.	CPO	31.03.26	Divisional Performance Reviews	Meeting held with Divisions and Executive Team 25/11/25 to accelerate discussions.
	Requirement to reprofile workforce changes that will be met by 31st March 2026 based on current schemes and provide guidance on ways to mitigate gap. E.g. full vacancy freeze, further MARS	CPO	31.03.26	ETM/WLT	On track
	Run MAR Scheme to support acceleration of workforce movement	CPO	31.03.26	People Committee	Complete
Operational pressures, meaning patient safety must be prioritised across the Trust preventing some actions taking place	Continue to hold robust grip and control measures in place to ensure no unplanned workforce growth and vacancies are managed within establishment	CPO	31.03.26	Finance Improvement Group People Committee	Completed and to continue throughout year
Sickness absence continues to be above the Trust target meaning increased use of bank and agency usage, limiting ability to meet workforce planning numbers	Increased accountability for booking of bank staff through rostering system	CPO/CNO	Complete	Finance Improvement Group	
	Increased monitoring of bank usage	CPO/CNO	31.03.26	Wider Leadership Team	
	Increased scrutiny of medical agency usage	CPO/CMO	31.03.26		
	Refer to actions within Trust Sickness Absence improvement plan	CPO	31.03.26	People Committee	
Prolonged or escalating industrial action by Resident Doctors will impact morale.	Ensure WWL prioritises relationships with Resident Doctor workforce through implementation of the NHS England 10 Point Plan	CMO	31.03.26	People Committee	Improving Resident Doctors Working Lives group established to drive forward actions

Performance

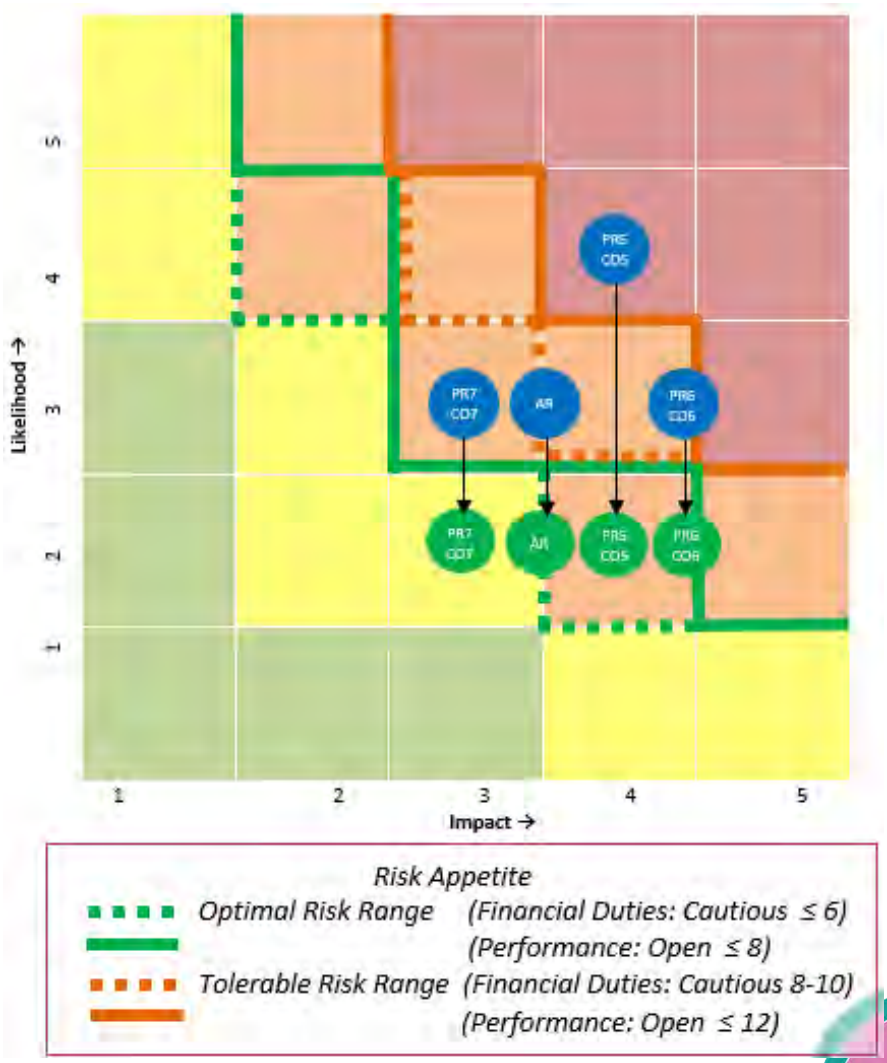
To consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

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

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



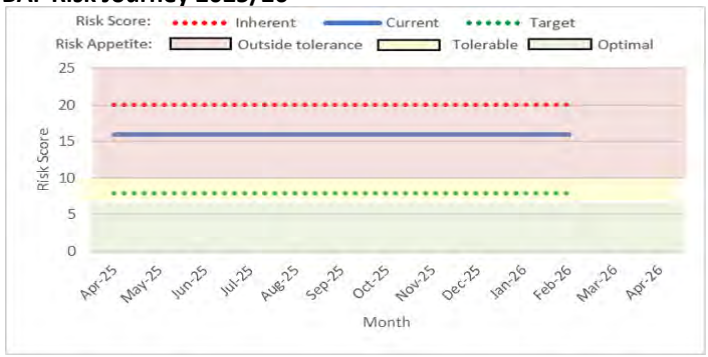
BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK PR 5: Delivery of the Financial Recover Strategy

There is a risk that the Trust may fail to deliver the Financial Recovery Strategy, due to issues with the revenue, capital and cash position, failure to deliver CIP and issues with productivity metrics and the underlying financial position, resulting in breaches in financial statutory duties.

Executive Director Lead:	CFO
Strategic Aim:	CO5 Foster a sustainable, efficient and productive financial environment
Risk Category:	Financial Duties
Risk Opened:	30.07.2025

BAF Risk Journey 2025/26



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	16	16	16	16		8	6-10
	4x4	4x4	4x4	4x4		4x4	
	LxC	LxC	LxC	LxC		LxC	
Risk Appetite	Outside	Outside	Outside	Outside		Within	Outside

RATIONALE FOR CURRENT RISK SCORE:

Revenue and capital positions YTD are off track but forecasting to hit plan. Cash position is deteriorating. CIP is behind plan YT but expect to deliver FYE. Improvement in underlying position compared to 2024/25 exit run rate. Q2 implied productivity metric has not yet been released.

Projected Forecast Q4: Deteriorating
Stable
Improving

Rationale: Stable
Risk score remains stable at 16.

CONTROLS →	ASSURANCES →	EVIDENCE
• Revenue position: • Final plan signed off by Board and submitted to NHSE – April 25. • Draft and final plans scrutinised through monthly Provider Oversight meetings with GM ICB. (Ext) • Draft and final plans discussed through Executive Team Meetings, Board Away Days and Board meetings including risks to delivery, consequences of a deficit plan and difficult decisions. • External scrutiny of approach and assumptions within the draft plan took place through NHSE commissioned consultancy (Seagry) during Mar 25 (Ext) • 2025/26 is year 2 of the WWL Financial Sustainability Plan (FSP). • GM agreed allocation of deficit funding of £8.9m, included within 2025/26 plan. • Executive oversight and challenge of CIP & Financial performance through Divisional Performance Review Meetings, Financial Improvement Group, Transformation Board. • Establishment control groups ongoing for non-medical and medical staffing with scrutiny and rigour over agency spend in line with national agency controls • Discretionary non-pay controls ongoing for specific categories of spend. • Stringent business case criteria remains to ensure only business critical investments are approved.	• 1st Line - Monthly Performance Review meetings for all clinical divisions and Finance Improvement Group (FIG) • 2nd Line - Finance & Performance Committee January 2026 • External - Monthly Provider Oversight Meeting with GM ICB (Ext)	F&P Performance Report

• Finance Improvement Group meeting monthly, chaired by Chief Finance Officer and attended by Chief Executive • Monthly Provider Oversight Meetings ongoing (Ext) • GM Controls remain in place for new expenditure above £100k not within plan (STAR process) (Ext) • All headcount increases are required to be taken through an Exec led process • GM vacancy control panel established (Ext) • 2025/26 contract signed in line with planned activity and income • Deficit Support Funding (DSF) confirmed for Q2 (not subject to clawback) • Robust forecasting and Scenario Modelling - Year-end forecasts include worst, mid, and best-case scenarios, reported through the Trust Finance Report from M3 • Divisional escalation to Exec team in place for divisions materially off track • Strengthening Financial Management resources released by NHSE setting out expectations for in-year financial management and the interventions that will help us collectively deliver • Forecast risk stratification submitted monthly to NHSE NW • NHSE led review of forecast risk return (Ext) • Monthly financial position including forecast scenarios reported to TPC monthly (Ext) • Board approved recovery plan being implemented to support delivery of the financial position		
• CIP: • Robust CIP divisional delivery approach and governance. • Monitored via Divisional CIP groups, reporting through Divisional Performance Review Meetings with additional escalation to Finance Improvement Group (FIG) • Further oversight at Executive Team, Finance Improvement Group, Transformation Board, F&P Committee and Board of Directors. • CIP plan for 2025/26 was developed through review of NHSE productivity packs, local priorities aligned to national themes (Transformation schemes), Exec led opportunities and core divisional CIP • CIP Handbook providing guidance and oversight processes • Previous MIAA review gave substantial assurance • Transformation Board input & oversight of strategic programmes. • GM Provider CIP meeting established and meets monthly reviewing all schemes and potential opportunities (Ext) • Clinical leadership ongoing reviewing benchmarking opportunities for quality improvements through model hospital and GIRFT and reported through CAB, ETM and Divisional Assurance Meetings. • System savings group ongoing across Wigan locality, chaired by Deputy Place Based Lead • Finance Improvement Group meeting monthly with agreed workplan • Established QIA process led by Chief Nurse and Medical Director • Cross divisional CIP group ongoing and to be chaired by COO from November 25	• 1st Line - Monthly Divisional Performance Review meetings and monthly finance improvement group (FIG) • 2nd Line - Finance & Performance Committee January 2026 • External - Monthly Provider Oversight Meeting with GM ICB (Ext)	F&P Performance Report

• GM Sustainability Plan endorsed by NHS GM Board to ensure appropriate management of finances and use of resources across GM (Ext) • Weekly CIP risk categorisation reported to NHSE (Ext) • CIP oversight through monthly Provider Oversight Meetings with the GM ICB (Ext) • Weekly huddles established with divisions to drive achievement • 98% of CIP schemes categorised as implemented or fully developed • CIP WTE reduction on track to deliver		
Capital: • Capital priorities agreed by Executive Team & Trust Board throughout the planning round with final plan approved. • Cash for Capital investments identified within plan. • Strategic capital group meeting monthly with oversight of full capital programme. • Operational capital group meeting monthly to manage the detailed programme. • GM Capital Resource Allocation Group (CRAG) ongoing to support development of ongoing capital strategy, collaboration and prioritisation of capital spend. (Ext) • Programme Boards established for major capital schemes. • Exploring options with commercial partners to facilitate capital investments outside of CDEL in line with strategy. • Cash balances split between revenue and capital, with capital plans below depreciation, to ensure there is sufficient cash balances to support the capital plan. • Five year forward view developed internally to support medium term capital planning and prioritisation • Strategic scheme governance document developed to provide guidance and support decision making. • Leases and operational CDEL plan is combined from 2025/26 • WWL capital plan is within operational CDEL envelope including a 5% planning tolerance to be managed locally during 2025/26. • 10 year infrastructure plan completed and submitted to GM in 2024/25. • GM CDEL plan balanced (Ext) • PDC business cases approved by WLT and Board August 2025 • GM ICB has supported £9.7m of WWL schemes against national capital programmes (PDC) included within the 2025/26 plan • MOU received for UEC A&E diagnostics PDC business case	• 1st Line - Monthly Capital Strategy Group • 2nd Line - Finance & Performance Committee January 2026	F&P Performance Report
Cash: • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT. • Enhanced balance sheet reporting including cash metrics to SFT and within monthly finance report.	• 1st Line – Cash management group • 2nd Line - Finance & Performance Committee January 2026.	

• Internal cash management group established and strategy being reviewed in line with national changes to cash support. • Opening cash balance higher than plan due to receipts of cash during Q4 of 2024/25. • Cash forecast reviewed with no support required in Q1 or Q2 of 2025/26 • Cash is a standing item on the F&P Committee agenda with papers providing an assessment of the cash position, forecast and mechanism for accessing cash support. • GM cash planning ongoing through Finance Advisory Committee and individual discussions with the ICB (Ext). • GM ICB continue to make contract payments on 1st of month (rather than 15th) to support cash management. (Ext) • All GM ICB payments outside of contract to be made in a timely manner (Ext) • Ongoing treasury management processes • CUF change notified July 25 to account for pay award cash impact (Ext) • Cash management mitigations have been developed for implementation if required to ensure the minimum cash balance is maintained (deferring creditor payments, invoicing upfront, management of the capital programme) • NHSE confirmed the 2025/26 PDC revenue support guidance and application process in its Strengthening Financial Management document and toolkit August 25 (Ext) • FIG supported establishment of a cash management steering group to be chaired by Associate Chief Nurse • Cash forward look presented to FIG from November 25 • Governance process followed through F&P and Board in November for application for NHSE revenue cash support in a worst case scenario • MIAA internal audit of cash flow forecasting and management review provided substantial assurance (Nov 25)		

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
• DSF now needs to be earned for Q3 and Q4 based on specific criteria and is subject to clawback even if paid	• Organisational wide communication of the financial position, challenges and controls	CFO	Throughout 2025/26	F&P Committee	Action underway
• Limited mechanisms to facilitate delivery of system wide savings. • Limited PMO resource internally to support delivery of CIP plans	• Monthly updates on CIP presented to Executive Team, with regular updates to Divisional Teams.	CFO / COO	Throughout 2025/26	F&P Committee	Action underway
• PDC Business cases awaiting formal approval by NHSE.	• Close monitoring of Capital spend in line with trajectory.	CFO	Throughout 2025/26	F&P Committee	Action underway
• GM Cash Group to be re-established (Ext.) • Development of a memorandum of understanding between the ICB and GM providers which sets out a staged approach to cash flow mitigations to preserve cash availability in 2025/26 (Ext)	• Close monitoring and forecasting of the cash balance	CFO	Throughout 2025/26	F&P Committee	Action underway

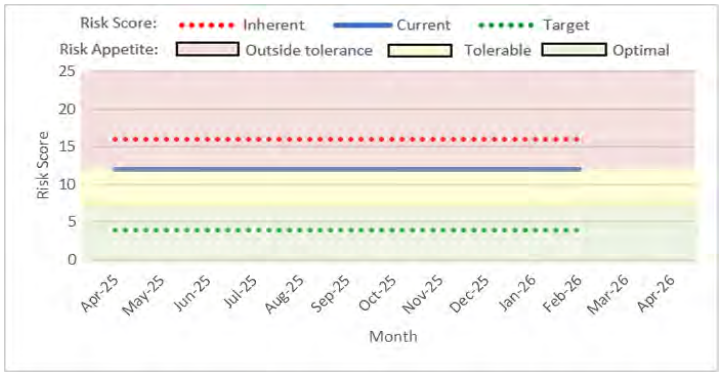
BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK PR 6: Performance

There is a risk that performance will not improve, due to lack of capacity to drive improvement, limited resourcing requiring priority decisions, failure to take patient priorities and views into account when reaching decisions on improvement and use of legacy IT systems with potential for cyber-attacks, resulting in poor performance, adverse publicity, business continuity disruptions and patients not choosing WWL as their first choice for any future treatment.

Executive Director Lead:	COO
Strategic Aim:	CO6 Drive improvement in our overall performance, placing patients at the centre of everything we do. Take our opportunities to be outstanding.
Risk Category:	Financial Duties
Risk Opened:	30.07.2025

BAF Risk Journey 2025/26



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	12	12	12	12		4	8-12
	3x4	3x4	3x4	3x4		2x2	
	LxC	LxC	LxC	LxC		LxC	
Risk Appetite	Within	Within	Within	Within		Within	Within

RATIONALE FOR CURRENT RISK SCORE:

The risk score at Q3 remains at a high score of 12. It is possible that the risk outlined in the risk statement may happen with a major impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q4: Deteriorating
Stable
Improving

Rationale: Stable

The risk score has not changed from Q1 to Q3. Robust control measures and assurances are in place. However, there are still outstanding actions to reduce this risk to a moderate target score of 4.

CONTROLS	ASSURANCES	EVIDENCE
• Getting It Right First Time (GIRFT) productivity metrics are being received, reviewed and acted upon, with assurance that improvement actions are underway.	• 2nd line – Finance & Performance Committee – January 2026	Finance and Performance Committee AAA Report
• Strong delivery against the digital strategy. With high system uptime, good cyber security and progress on key projects.	• 2nd line – Finance & Performance Committee – January 2026	Finance and Performance Committee AAA Report
Weekly monitoring of elective recovery performance indicators. Specifically 65 week, 52 week and 18 week RTT performance.	• 2nd line – Finance & Performance Committee – January 2026	National submission to GM long waiters

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Challenges in key specialty areas have resulted in an increase in the forecasted RTT long wait position.	Weekly reviews of PTLs. Use of outsourcing / insourcing. Use of independent sector. Additional use of WLI's to due patient waits. Capacity and Demand review of pressured services.	DCOO	31.03.2026	Weekly meetings chaired by DCOO.	
• Community waiting lists are reducing overall, but the children's autism pathway remains a high risk.	• Review of capacity and demand.	DDO	31.03.2026	F&P Committee	
• School-age autism pathway waiting times (97 weeks) are a significant concern, with slow progress on commissioning solutions and little assurance of any additional funding being available.	• Review of capacity and demand.	DDO	31.03.2026	F&P Committee	

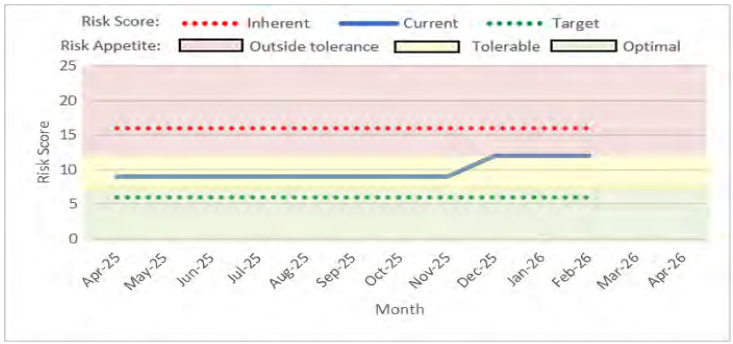
BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK PR 7: Delivery of our elective and non-elective services

There is a risk that demand for elective and non-elective services may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting improved UEC flow, insufficient diagnostic capacity to deliver elective waiting times, poor management of winter demand with partners and ICB not delivering elective work to Wrightington, resulting in missed A&E performance targets, reduced discharge/NCTR performance, increased usage of escalation areas, underutilisation of elective hubs and a negative impact on staff morale and patient experience.

Executive Director Lead:	COO/ CFO
Strategic Aim:	CO7 Optimise delivery of our elective and non-elective services
Risk Category:	Performance Targets
Risk Opened:	30.07.2025

BAF Risk Journey 2025/26



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	9	9	12	12		6	8-12
	3x3	3x3	4x3	4x3		2x3	
	LxC	LxC	LxC	LxC		LxC	
Risk Appetite	Within	Within	Within	Within		Outside	Within

RATIONALE FOR CURRENT RISK SCORE:

It is likely that the risk outlined in the risk statement may happen with a moderate impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q4: Deteriorating
Stable
Improving

Rationale: Stable

The risk score remains at 12, having increased from 9 to 12 in quarter 2. Robust control measures and assurances are in place. However, there are still outstanding actions to reduce this risk to a moderate target score of 6.

CONTROLS →	ASSURANCES →	EVIDENCE
• Trauma and orthopaedics recovery plan is in place.	2nd line – Finance & Performance Committee – January 2026	Finance and Performance Committee AAA Report
• The Better Lives Programme is ongoing, with phase two underway and all system partners engaged, further assurance will be provided at the next informal board workshop.	2nd line – Finance & Performance Committee – January 2026	Finance and Performance Committee AAA Report
• Gastro business case approved.		

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
• Elective activity plan and waiting times remain a challenge	•Long waiters require ongoing monitoring	COO	Throughout 2025/26	F&P Committee	Action underway
• Gastroenterology workforce and activity issues are a real risk to planned delivery.	•Insourcing gastro activity at Leigh.	COO	Throughout 2025/26	F&P Committee	Action underway
• Non-elective performance remains challenging linked to increasing attendances and patient acuity.	Progress BetterLives programme Development of admission avoidance pathways.	COO	31.03.26	F&P Committee	Action underway
• 'No criteria to reside' remains a stubborn challenge, with potential impact on urgent and emergency care and winter planning.	Progress Discharge and Flow Programme	COO / CFO	31.03.26	F&P Committee	Action underway

Partnerships

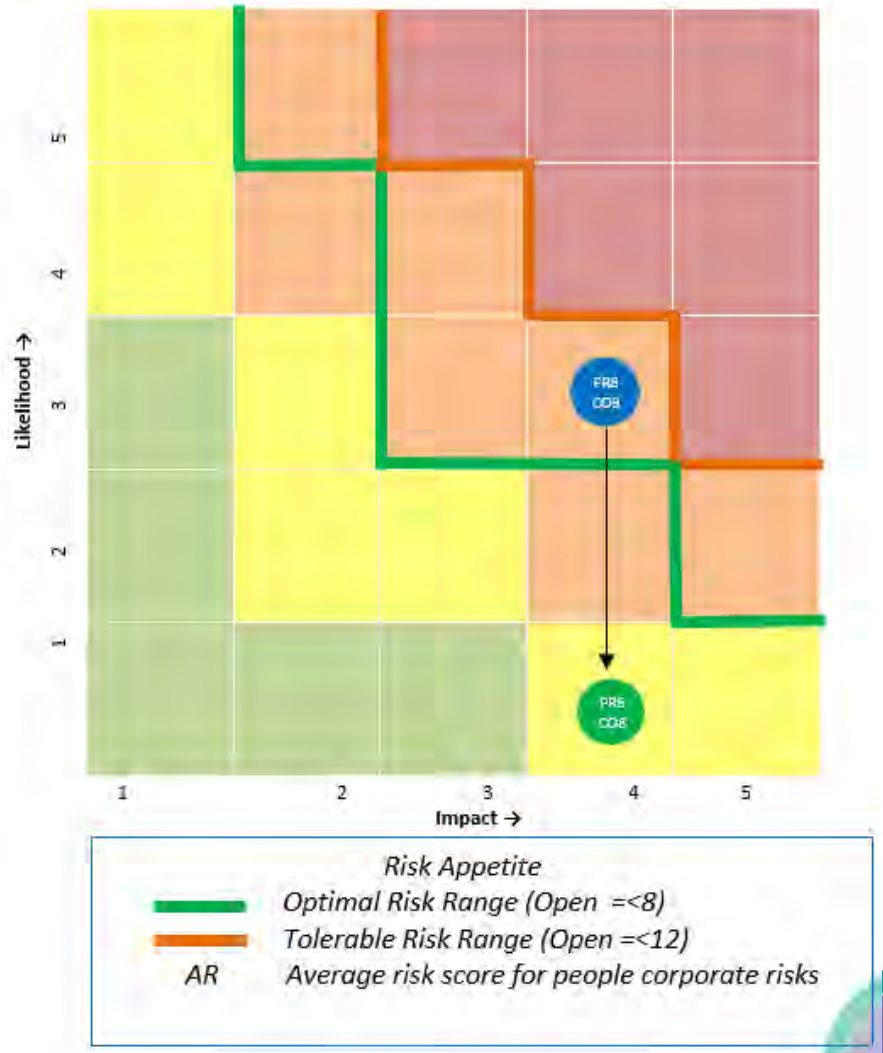
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

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

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

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



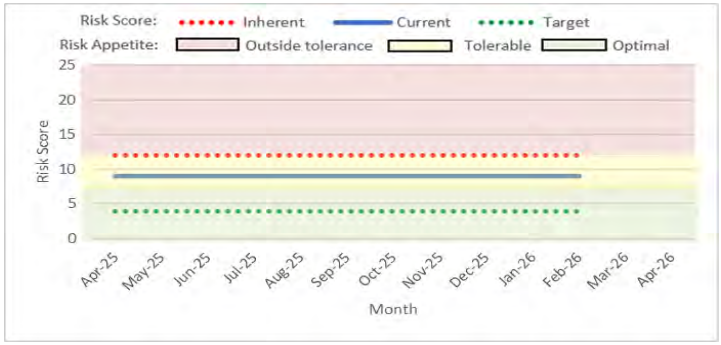
BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK PR8: Partnership working

There is a risk that working more closely with local health and care partners may not fully deliver the required benefits, due to instability at ICB and NHSE/DHSC, lack of engagement from relevant local authorities, not being able to meet the requirements to have University Hospital status, resulting in resulting in unclear patient pathways, uncertainty regarding partnership working, negative impact on commercial and research income and the Trust's overall financial position.

Executive Director Lead:	DCE
Strategic Aim:	CO8 To further strengthen existing partnerships and develop new ones, to complement and support our NHS services and research activities.
Risk Category:	Strategy
Risk Opened:	30.07.2025

BAF Risk Journey 2025/26



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	9	9	9	9		4	8-12
	3x3	3x3	3x3	3x3		2x2	
	LxC	LxC	LxC	LxC		LxC	
Risk Appetite	Within	Within	Within	Within		Within	Within

RATIONALE FOR CURRENT RISK SCORE:

The risk score at Q3 remains at a high score of 9. It is possible that the risk outlined in the risk statement may happen with a moderate impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q4: Deteriorating
Stable
Improving

Rationale: Stable
Risk score remains stable at 9.

CONTROLS →	ASSURANCES →	EVIDENCE
• Alignment of Our Strategy 2030 with partners across the Wigan locality alongside considering strategies at a Greater Manchester level.	• Our Strategy 2030 • Annual Corporate Objectives	Bi-annual Partnership report to Board – Oct 2025
• Participation in NHS Greater Manchester ICS • Delivery of key programmes in partnership with providers across GM, including pathology, procurement and recruitment.	• Several of the Executive Team have key roles within the GM Trust Provider Collaborative.	Bi-annual Partnership report to Board – Oct 2025
• Collaboration with Bolton NHS FT with oversight of projects to improve efficiency and service sustainability.	• Bolton and WWL Collaboration Board.	Bi-annual Partnership report to Board – Oct 2025

• WWL Executives have an active role in the Healthier Wigan Partnership Board. • Joint appointment of a Consultant in Public Health providing visible leadership across organisational boundaries.	• Healthier Wigan Partnership Board	Bi-annual Partnership report to Board – Oct 2025			
•We continue to be committed to the work of the Wigan Anchor Partnership, recognising that community wealth leads to strong community health.	• Wigan Anchor Partnership	Bi-annual Partnership report to Board – Oct 2025			
Working collaboratively with Wigan Council and the ICB to support our residents to live independently and transform urgent and emergency care.	• Better Lives Programme	Bi-annual Partnership report to Board – Oct 2025			
• Research Assurance Framework continues to show good performance, with good recruitment of patients to participate in trials.	• Research Committee	Research Committee AAA Board Report – Oct 2025			
•Good progress has been made so far to meet the criteria set out by the UHA to achieve University Hospital Status with the Education Team gathering a wealth of evidence for the criteria listed under sections 3 to 6.	• University Hospital Status Project Group	University Hospital Status: Progress Report – Oct 2025			
Gaps in Controls / Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
•The potential impact of significant cost reductions that's ICBs are being required to make on effective partnership working and the ICB operating model which supports effective working 'in place' are not yet clear.	•Attendance at System Board meetings with Partners.	DCE	31.03.26	Board	Action underway
• The Research Committee failed to have a quorum to discharge business for two meetings this year.	• Appointment of a further Non-Executive Director to the Committee.	DCE	31.03.26	Board	Action underway
• Trust is not achieving criterion 1ciii regarding Research Capacity Funding for UHA application, resulting in a challenge to achieve the next successful NIHR grant.	• Plan required to mitigate against the challenges posed by criterion 1ciii – Research Capacity Funding	MD	31.03.26	Board	Action underway
• Trust requires a total of 13 consultants to meet criterion 1ci regarding a core number of university principal investigators for UHA application.	• The group have developed a plan to mitigate against the challenges posed by criterion 1ci	MD	31.03.26	Board	Action underway

Title of report:	EDI Annual Report 2024-2025
Presented to:	Board of Directors
On:	4th February 2026
Item purpose:	Approval
Presented by:	For consent agenda
Prepared by:	Debbie Jones, EDI Lead (Patient Services), Angelique Hartwig, Head of Staff Experience
Contact details:	Angelique.hartwig@wwl.nhs.uk

Executive summary

This report aims to provide an overview of the Trust's EDI journey in the financial year 2024-25, highlighting the data collected between 1st April 2024 and 31st March 2025, and the actions taken to enhance EDI within this timeframe.

At the beginning of the financial year 2024/25, we developed an EDI plan to make EDI core business of the organisation and to enable sustained culture change and positive impact on reducing inequalities in experience and health at WWL and the Wigan Borough. A new EDI Strategy Group chaired by our Chief Executive, Mary Fleming, was launched in April 2024 to oversee the implementation of the EDI Strategy and drive improvements and provide assurance to the Board. All EDI workstreams which report into the EDI Strategy Group have been embedded and have started to make significant progress towards improving our staff and patient's experience and ensuring we meet the NHS EDI Improvement plan priorities.

In 2024/25, our focus has been on strengthening staff voice to truly understand our diverse staff's experience and work in partnership with our staff in inequalities they may experience due to their protected characteristics. This included a series of listening events, focus groups and staff network sessions to inform our priorities for EDI and to co-shape programmes of work. As a direct result of staff feedback, we have created a new foundational leadership programme to enable our leaders to lead inclusively and compassionately, introduced new career and professional development programmes for our Global Majority nurses, and have created new resources and policies to support our staff with long-term health conditions at work.

During 2024/25 WWL has continued to enhance patient experience, by engaging and involving patients, and their families. By engaging with patients and communities, we can better understand what matters to them, their experience and their perspectives. The recruitment of Lived Experience Partners has enabled us to drive forward service user quality improvements based upon the needs of our local communities. Our Lived Experience Partners work alongside clinical and non-clinical staff, patients, and carers, drawing upon personal experience and expertise to provide insight into the design, improvement and delivery of the services provided by the Trust.

Over the past 12 months, the Trust has continued to work in partnership with patients, staff and local authority, engaging with patients across all protected characteristics. WWL continues to work in partnership with AccessAble creating, developing and updating detailed access guides for patients to all the Trust's sites.

WWL continues to undertake 3 yearly reviews of existing Equality Impact Assessments (EIAs) for all divisions. Recent patient experience surveys have included, Wigan Pride 2024, Orrell Ward, Neonatal Unit and Emergency Department. A review of our Friends and Family Test Card, has now enabled us to collate more patient demographics in a more accessible format

WWL has continued to review the effectiveness of our interpretation and translation services. The fundamental and unprecedented combined effects of COVID 19 and the cost of living crisis has had an impact across the entire interpretation industry around the national availability of linguists, especially those who traditionally provided face to face services. We have implemented an improvement plan to increase fulfilment rates and efficiencies. The implementation of additional interpreting methods has been reviewed, and video remote will be implemented during 2025/26.

A new dedicated workstream for Patient Access and Experience was implemented to review WWL's approach to providing reasonable adjustments for service users, incorporating the requirements of the NHS England's Reasonable Adjustments Digital Flag Information Standard and Accessible Information Standard (AIS).

A comprehensive summary of EDI activities and key achievements are included within the report.

Link to strategy and corporate objectives

People and Culture Strategy
EDI Strategy 22-26

Risks associated with this report and proposed mitigations

No risks associated with this report.

Financial implications

N/A

Legal implications

The Trust has a legal obligation under the Public Sector Equality Duty (under the Equality Act, 2010). A public authority in the exercise of its functions must have due regard to the need to:

- eliminate any form of unlawful discrimination (including direct or indirect discrimination, harassment, victimisation, and any other conduct prohibited under the Act)
- advance equality of opportunity between people who share a relevant characteristic and people who do not
- foster good relations between people who share a protected characteristic and people who do not.

People implications

Improving Equality, Diversity, and Inclusion at WWL has evidenced positive effects on staff engagement, wellbeing and retention. There is also an established link between higher staff engagement and positive patient care and safety outcomes. There is a significant risk to staff experience and wellbeing, if we do not progress plans to create an inclusive culture for all.

Equality, diversity and inclusion implications

Improving the experience of our staff and patients with protected characteristics means that we provide equity for all and ensure the best possible experience at our organisation. Changes to our systems, processes and behaviours will allow us to put our people and patients at the heart and that their needs are met.

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

The EDI annual report has been reviewed and approved by People Committee.

Recommendation(s)

The Board is asked to note the content of the report and approve the publication of the EDI annual report 2024-25 on our Trust website.

Equality, Diversity and Inclusion Annual Report 2024-25

Introduction

Wrightington Wigan and Leigh (WWL) Teaching Hospitals NHS Trust is committed to promoting equality, diversity and inclusion - as an employer, in the services we provide, in partnerships, and in the decisions we make. We are continuing with our ambition to embed equality, diversity, and inclusion as a golden thread into everything that we do.

This report aims to provide an overview of the Trust's EDI journey in the financial year 2024-25, highlighting the data collected between 1st April 2024 and 31st March 2025, and the actions taken to enhance EDI within this timeframe.

At the beginning of the financial year 2024/25, we developed an EDI plan to make EDI core business of the organisation and to enable sustained culture change and positive impact on reducing inequalities in experience and health at WWL and the Wigan Borough. A new EDI Strategy Group chaired by our Chief Executive, Mary Fleming, was launched in April 2024 to oversee the implementation of the EDI Strategy and drive improvements and provide assurance to the Board. All EDI workstreams which report into the EDI Strategy Group have been embedded and have started to make significant progress towards improving our staff and patient's experience and ensuring we meet the NHS EDI Improvement plan priorities.

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Over the past 12 months, the Trust has continued to work in partnership with patients, staff and local authority, engaging with patients across all protected characteristics. WWL continues to undertake 3 yearly reviews of existing Equality Impact Assessments (EIAs) for all divisions. Recent patient experience surveys have included, Wigan Pride 2024, Orrell Ward,

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Further Details of these key achievements are included within this report.

Key EDI Progress 2024-25

EDI Strategy Group and Workstreams

The EDI Strategy Group, chaired by our Chief Executive, is now well established and have been meeting at a bi-monthly basis to oversee the implementation of the EDI plan. Progress is detailed in the people and patient sections later in the report.

Workstream	Link to NHS England Plan	Chair
Disability Confident Scheme	NHS England High Impact Action 6	Associate Director of OD and Inclusion
Anti-Racist Framework, including civility & respect	NHS England High Impact Action 6	Chief People Officer
Inclusive Recruitment	NHS England High Impact Action 2	Deputy Chief People Officer
Supporting global majority colleagues	NHS England High Impact Action 5	Chief Nursing Officer
Pay Equality	NHS England High Impact Action 3	Medical Director
Health equality	NHS England High Impact Action 4	Health Inequality Lead
Patient access and experience	NHS England High Impact Action 4	Associate Chief Nurse
Working in partnership with people and communities	NHS England High Impact Action 4	Associate Chief Nurse

Below we highlight the progress made in relation to the work to support the delivery of Equality, Diversity and Inclusion (EDI) People objectives within WWL. At the beginning of the financial year 2024/25, we developed an EDI plan to make EDI core business of the organisation and

to enable sustained culture change and positive impact on reducing inequalities in experience and health at WWL and the Wigan Borough.

Significant work has been undertaken to show our commitment to improving our staff and patient's experience and to meet our strategic EDI objectives set at the start of 2024-25 including:

EDI priorities for 2024-25	Progress update
EDI governance: Set up an EDI Strategy Group (CEO Chaired) to oversee actions and drive forward improvements. This must be in place no later than April 2024 and will be led by the Chief People Officer. Establish workstreams to report into EDI Steering Group aligned to NHS England Six High Impact Objectives.	EDI Strategy Group in place, four meetings have been held since April 2024 and all workstreams are up and running.
EDI as core business- Mainstream EDI as the responsibility of all: a. Ensure all sub-Committees of the Board have EDI as a standing agenda item. b. Ensure all report templates have a specific section confirming EDI Impact and consideration with the report. c. Roll-out Equality Impact Assessment Training to all staff with responsibility for authoring policies	Actions a and b have been completed with all templates updated. An EDI section has also been added to business case application process
Active Bystander Training should be rolled out to Matrons, Ward Leaders and other Ward Staff.	Active Bystander Training roll out has started in June 2024, will continue until July 2025. Over 700 nurses and midwives have since attended the training.
Oliver McGowan Mandatory Training: Roll out of training for our staff and improve compliance with mandatory training	Lead trainers and experts by experience upskilled, have established partnership with local supplier to support the roll out of training and demonstrating continued progress with compliance
Anti-Racist campaign: We will launch our commitment to becoming an Anti-Racist Organisation in line with the North West BAME Assembly Anti-Racist Framework.	Anti-Racist organisation commitment statement was launched in June 2024; WWL currently is working towards submission of application to become Bronze accredited as part of the Northwest BAME Assembly Anti-Racist Framework. Request for assessment will be made in October 2025.
Freedom to Speak Up- Following the appointment of the WWL Freedom to Speak Up Guardian we will launch a "Speak Up Safely" campaign ensuring that the visibility and welcoming of speaking is celebrated and championed from Board to Floor.	Freedom to Speak Up campaign has been undertaken and a cohort of Freedom of Speak Up champions has been recruited and trained to support our "Speak up safely" campaign.

Staff diversity networks: We will continue on the journey of developing and growing our Staff Networks	Staff network development session has taken place in September 2024 to reset our visions for the network and build communities of inclusion which will be open to all colleagues to join, learn and share. All communities have established quarterly inclusion forums and are working towards increasing engagement with staff. New event calendar and comms campaign around staff networks was launched in January 2025.
WWL Trust values: Launch of organisational Trust values laying the foundation for inclusive culture	New Trust values were launched in April 2024 and behavioural framework was launched in January 2025 to provide our people with behavioural examples of how to demonstrate our shared values; further work to follow to embed values into processes such as recruitment, appraisal and career development
EDI awareness: Raise awareness and develop EDI related expertise among our senior leaders	WWL was taking part in the NHS Confederation Diversity in Health and Care Partners Programme which launched in September 2024;

Key EDI frameworks and progress in 2024/25

The following table provides an update on the key EDI reporting frameworks and actions progressed during 2024/25:

People Services (April 2024 – March 2025)

NHS England equality, diversity and inclusion (EDI) improvement plan

The NHS England equality, diversity and inclusion (EDI) improvement plan was published in June 2023. The aim of the EDI improvement plan is to improve equality, diversity and inclusion and to enhance the sense of belonging for NHS staff. The EDI improvement plan sets out six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

Key actions to demonstrate progress against the NHS EDI improvement plan include:

NHS high impact action 1: Measurable EDI objectives at Board level	• Established an EDI Strategy Group and associated workstreams • Launch of EDI related Corporate People Objective "We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish" • Implementation of specific EDI section on all Board and Committee report templates along with ensuring that EDI is a standing item on sub committees of the Board. • EDI related risks are monitored via Board Assurance Framework
NHS high impact action 2: Inclusive recruitment processes and talent management strategies	• Band 5 – Band 6 Nursing development programme advertised to global majority staff with positive action to improve participation rate • Global Majority Fellowship programme launched to support career progression for Global Majority Staff • Talent for Care Lead role funded by Wigan and Leigh College and key work undertaken to strengthen apprenticeship uptake, improve access to employment via the Sector-based work academy programme and career events
NHS high impact action 3: Pay gap improvement plan	• Refreshed flexible working policy in place which has been advertised widely across the Trust Inclusive Recruitment workstream to be set up to increase diversity and reduce bias

	• Pay gap improvement plan in place, including standardised approach to starting salary negotiations for Medical staff, fair competition for additional renumeration, flexible working promotion for female medical staff with caring commitments, set up of a female medical peer group
NHS high impact action 4: Health inequalities	• Wellbeing conversations training roll out across the Trust • Self-assessment against NHS health and wellbeing framework • Partnership working with council and colleges/universities to support pathways into healthcare • Establishment of Health Inequality working group
NHS high impact action 5: Onboarding and development programme for internationally educated staff	• Dedicated pastoral support for our global majority staff • Support with induction and onboarding, new welcome day for all staff • Nursing development programme proactively advertised to global majority staff and application process simplified to make process more inclusive • Global Majority Fellowship programme with acting up opportunities for 5 Global Majority Nurse fellows • Shiny Minds development programme for new staff and Global Majority Nurses to increase confidence, self-compassion and wellbeing • Participation in the National NHSE Chief Nursing Officer 90 Global Challenge programme to provide focussed support for multi-ethnic colleagues
NHS high impact action 6: Elimination of conditions for bullying, discrimination, harassment and violence	• New values launched to set out expected behaviour for all staff and foster civility culture • Regular review of ER cases to ensure consistency and fair treatment • Renewed Freedom to Speak Up Guardian policy and strengthened engagement strategy • Psychological support for staff affected by bullying, harassment, discrimination or violence • Roll out of Trauma Risk Management model and assessments for staff who may benefit from risk assessment following traumatic incidents at work

Workforce Race Equality Standard and Workforce Disability Equality Standards

WRES (Workforce Race Equality Standard) 2025

WWL's latest WRES report and associated action plan is located at:
WWL Teaching Hospitals NHS Foundation Trust | Workforce Race Equality Standard.

This year's WRES metrics relate to data collected as of 31st March 2025 and show some areas of improvement and some areas of continued concern, highlighting key priorities for us to improve the experience for our colleagues from Black, Asian and Minority Ethnic groups. Key findings include:

Areas of improvement

- **Improved recruitment equity:** The disparity in appointment from shortlisting between White and BME applicants has reduced from 2.41 to 1.85, showing small improvement but disparity remains.
- **Sustained equity in training access**: The relative likelihood of White staff accessing non-mandatory training compared to BME staff remains at 0.9, indicating continued equity in development opportunities.

Areas of focus

- **Disciplinary disparity:** BME staff are 1.53x more likely to enter disciplinary processes — a worsening trend with fluctuating past data.
- **Bullying & harassment** (Staff): 31.6% of BME staff report bullying from colleagues vs. 18.9% of White staff — worse than last year and above NHS benchmark.
- **Discrimination at work**: 23.7% of BME staff report discrimination from managers/colleagues vs. 6.6% of White staff — significantly worse than benchmark and deteriorating.
- **Career progression perception**: Only 46.9% of BME staff feel there are equal opportunities vs. 55.2% of White staff — below benchmark and declining.

WDES (Workforce Disability Equality Standard) 2025

The latest WDES report and associated action plan can be found at:
WWL Teaching Hospitals NHS Foundation Trust | Workforce Disability Equality Standard.

This year's WDES metrics relate to data collected as of 31st March 2025 and suggest that our position against some indicators has improved whilst others since 2024. People who are disabled or have long-term health conditions still have a less positive work experience across all People Promises compared to other staff and remain a key focus for our effort to eliminate inequalities and create an inclusive workplace culture. Key findings include:

Areas of improvement

- **Recruitment equity**: The likelihood of non-disabled staff being appointed from shortlisting has reduced from 1.47 to 1.23, showing small improvement but disparity remains.
- **Harassment from colleagues**: Slight improvement for disabled staff (22.59%, down from 24.36%), now better than NHS benchmark.
- **Career progression perception**: Disabled staff perception improved to 51.99% (up from 48.71%), now aligned with NHS benchmark.
- **Managerial pressure to attend work**: Disabled staff reporting pressure dropped to 25.86% (from 29.38%), now better than NHS benchmark.

Areas of focus

- **Harassment from patients/public**: Increased for disabled staff (25.33%, up from 23.27%), significantly higher than non-disabled staff (16.75%).
- **Harassment from line managers**: Persistent disparity (15.45% vs. 7.79%), stable since last year.
- **Workplace adjustments**: 66.95% of disabled staff say adjustments are adequate—unchanged and below NHS benchmark (73.98%).
- **Capability process disparity:** Disabled staff are 3.09x more likely to enter formal capability process, similar to last year.

Gender Pay Gap

The most recent Gender Pay Gap Report, available on publication of this EDI annual report, relates to data collected as of 31st March 2024 (see full report on our Trust website using this LINK

Key Points to note are:

- The Trust workforce is 81% female and 21% male.
- The Trust Medical & Dental workforce is 65% male and 35% female with 25% of the Trust`s overall male workforce being constituted within the Medical & Dental staff group.
- If we exclude Medical and Dental staff from the Trust wide gender pay gap figures, the Trust`s mean average gender pay gap is 2.4% which equates to females earning £0.43 less than male staff per hour.

- As at March 2024 the Trust has a 26.82% mean average gender pay gap with females earning £6.54 an hour less than males. The mean average gender pay gap in 2024 is comparable to 2023 data when, as at 31st March 2023, females earned £6.46 an hour less than males with a 27.46% mean average gender pay gap.
- As at March 2024 the Trust has a 11.14% median hourly rate gender pay gap with females earning £2.02 an hour less than males. The median hourly rate gender pay gap in 2024 has slightly improved in comparison with 2023 data when as at 31st March 2023 females earned £2.19 an hour less than males with a 12.69% median gender pay gap.

During this reporting period, there is acknowledgement that a key factor underpinning the Trust`s gender pay gap is due to a significant proportion of male staff being constituted within the Medical and Dental Staff Group which is within the higher earning quartiles. The Gender Pay Gap may decrease once there is a shift to higher recruiting rates of female consultants and senior managers at WWL. This will take time, but the Trust is committed to engaging with female staff to ensure that there is equitable career development opportunities and policies are family friendly.

National Staff Survey 2024

Data from the National Staff Survey 2024 was analysed for experiences of staff from minority groups. The results highlight continued disparity between the experiences of staff who are white compared to those from a black or minority ethnic background and staff who have a disability or long-term health conditions, compared to those who do not. You can find our organisation's results on the National Staff Survey website: Local results for every organisation | NHS Staff Survey

Key findings include:

- Disabled staff score lower on every People Promise and Theme compared to the Trust average. They also score lower than staff from ethnic minority groups.
- Staff from minority ethnic groups score lower than Trust average for the People Promise 'We are compassionate', 'We are recognised and rewarded', 'We each have a voice that counts', 'We work flexibly' and higher for 'Staff Engagement' and 'We are Always Learning'.
- Highlighting the disparity between white, non-disabled staff and disabled and ethnic minority groups (in particular black staff) regarding the organisation acting fairly about career progression/promotion.
- We have a disproportionate amount of bullying occurring to those with protected characteristics.

Key actions we are taking to address these themes are below:

- Commitment towards becoming an anti-racist organisation
- Launching a core leadership development programme to equip our managers in promoting inclusion, role-modelling compassionate leadership and addressing incivility, bullying and abuse
- Developing new wellbeing policy and guidance for managers and staff, including refreshed health adjustments guidance and training
- Continue to develop career pathways, personal and professional development which are inclusive and ensure equality of opportunity for all staff;

Northwest BAME Anti-Racist Framework

Over the past financial year, the Trust has committed to working towards Bronze accreditation of the NW BAME Assembly Anti-Racist Framework. Key actions taken in 2024/25 include:

- Anti-racism as mission critical: Development of Anti-Racist Strategy and anti-racism statement has been produced and published detailing organisational commitment to racial equity.
- Anti-racism, civility and respect workstream has been set up by Chief People Officer to design and implement culture change initiatives to create an inclusive, anti-racist workplace for all staff
- Listening events taking place between our CEO and our global majority colleagues who have been recruited overseas
- Global Majority Integration Programme led by Chief Nursing Officer has been launched, includes recruitment of Global Majority Practice Development Nurse and tailored development opportunities for Global Majority Nursing Fellows and Shiny Minds programme to support development of confidence and wellbeing
- Reducing health inequalities in our community:
    - Health Outreach and Inclusion Service (HOIS) has taken significant steps to reduce health inequalities affective vulnerable migrants in the borough by supporting with GP registration and health assessments and screening for blood-borne viruses. HOIS has worked in partnership with housing providers, voluntary organisations, and community services to mitigate the wider social and structural determinants of health — including poverty, isolation, and stigma.
    - WWL's Community Midwifery / Enhanced Care Midwifery Teams have continued to provide enhanced support and education to vulnerable women and socially excluded groups. WWL recognises the increased risk of maternal mortality in our Black and Asian Ethnic community and continues to provide individualised care plans for these patients
    - WWL's Breast Screening Services have taken steps to reduce some of the health inequalities that ethnic minority groups face. An action plan was developed, including promotional video and resources being made available in other top languages.

NHS Sexual Safety charter

NHS Sexual Safety Charter

In alignment with the statutory duty of care for its employees and patients and to prevent harassment and abuse at work, WWL aims to proactively foster a positive workplace culture where everyone feels safe and supported when experiencing unwanted sexual behaviour. To this end, WWL has signed up to the NHS England Sexual Safety Charter which was first launched in September 2023 in collaboration with key partners across the healthcare system. Organisations signing up the charter commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace to create a safe environment for staff working in the healthcare system.

An action plan has been developed to address these gaps and to support our ambition to fully adhere to the ten principles of the Sexual Safety Charter. Progress highlights include:

1. New Sexual Misconduct policy and anonymous reporting route
2. New e-learning training offer on sexual harassment and abuse, disclosure
3. Continued roll-out of active bystander training
4. Design of new Sexual Safety Charter intranet resource

Patient Services (April 2024 – March 2025)

Objective	Progress
Understand and improve the experience of patients across all protected characteristics. **Identify variations in patient access, safety and experience of our services and develop plans to address these.**	During 2024/25 WWL has continued to enhance patient experience, by engaging and involving patients, and their families. By engaging with patients and communities, we can better understand what matters to them, their experience and their perspectives. **Lived Experience Partners** In 2024 the Trust commissioned a Lived Experience Partnership to work with Staff across the organisation to listen to patient/service user voice with a purpose of ensuring that healthcare professionals, can provide the best quality care and support, ensuring that the people receiving the service are at the heart of everything that is done. Lived Experience Partners help bridge the gap, contributing to the design, improvement, and delivery of our healthcare services. Over the past year we have recruited 10 LEP's from various healthcare backgrounds who live in the Wigan borough. Their wealth of lived experience of using our services has enabled the organisation to ground our work and fulfil our commitment to ensuring that our patients and communities are at the heart of everything we do. Over the past year our 10 LEP's have supported the following: • Stakeholder engagement panels for the appointment of Executive posts such as, The Chief Nurse, The Associate Chief Nurse, The Deputy Chief Executive Officer. • Attendance on the Deteriorating Patient group • Attendance on the Complaints Review Panel • Attendance at the Corporate Patient Experience and Engagement Group • Undertaken OWLL visits • Attendance at the Equality, Diversity and Inclusion Strategy Group • Undertaken improvement work with clinical teams to improve the environment in Paediatric A&E for children and young people who have Learning Disabilities, who are Autistic or who are Neurodiverse • Fundraising events • Speaking at Trust wide events and training EDI is a key stakeholder in this group.

	Collaborative Partnerships Over the past year, The Wigan Equality, Diversity and Inclusion Steering group (A voluntary, community, faith, public and social enterprise network to champion equality within the borough), supported by Wigan Council, and the projects facilitators (Happy Smiles CIC and Everything Human Rights) worked with residents, partners, and community voices to co-produce a new set of 'All Different, All Equal' promises, These reflect what matters most to Wigan communities and which build a fairer, more inclusive borough. WWL's EDI Service Lead was delighted to be involved with the engagement project and discussions regarding proposals for the way forward. **Access** We have continued to work in partnership with **AccessAble** developing and updating detailed Access Guides for patients to all the Trust's sites. Seven Access Guides were reviewed during October 2024. These included all areas within the Accident and Emergency Department, Urgent Treatment Centre, Diabetes and Endocrinology Care Centre, Cancer Care Centre and Clock Tower Restaurant. All venues were visited and assessed by a trained AccessAble Surveyor. In addition, funding was sourced for a new speaker system with built in hearing loop for the Reception of the Help Desk at Wrightington Hospital. This was installed in January 2025. During 2024, when a BSL Interpreter did not attend an out-patient appointment at Thomas Linacre centre, it became apparent that not all staff were aware that a video remote BSL on demand service is available on dedicated IPADs throughout the Trust. Access to this provision was not available at Thomas Linacre Centre. During March 2025, three IPADs were sourced for this site and the on demand BSL video remote App uploaded. Two IPADs are now located in General Office on this site, for use if required and one based in the Paediatrics Out-Patient Suite. Communication and children's gaming apps have also been uploaded to this IPAD for patients with autism and other disabilities to assist with blood taking and other tests. **Learning Disability & Autism & Neuro Diversity Effectiveness Group** During 2024, the All Age Learning Disability (LD)/ Autism & Neurodiversity Effectiveness Group was established to develop a strategy and vision that can be effectively delivered across the organisation to meet the requirements and needs of people who have a diagnosis of learning disability, autism and/or neurodiversity. A dedicated Operational Group was then launched to oversee any LD, Autism and Neurodiversity operational issues. This is a new group who will

	receive and contribute to data and activity reports to gain additional understanding of themes and trends, disseminate learning and consider areas for development. EDI Leads, Lived Experience Partners and Head of PEE are core members of this group. **Friends and Family Test Cards** During August 2024, the FFT Card template was reviewed. It was written in a more accessible format and five protected characteristics are now collated. **Wigan Pride 2024** On 11 August 2024, Wigan Pride returned for a ninth year to Wigan Town Centre, celebrating equality and diversity. Despite the unrest caused by the anti-immigration demonstrations and riots across the UK, on the week leading up to Wigan Pride, the event still went ahead and was a success. As in previous years, WWL had a stand in the Town Centre and proudly marched in the parade. Our Chief Nurse, True Colours Staff Network, Patient Experience Team were there, along with representatives from other services. Our patient experience and engagement team actively engaged with the local community to ascertain their feedback about hospital services, reinforcing the message that WWL is an anchor institution which plays an active part in Wigan's local community and works continually to ensure that services are accessible. 45 people participated in the survey. A report was produced and feedback shared with the divisions. Overall, WWL provided a good experience to our service users. 80% (36 patients) had a 'very good' and 'good' experience. **Equality Impact Assessments** WWL continues to undertake 3 yearly reviews of existing Equality Impact Assessments (EIAs) for all divisions. During 2024, Equality and Diversity became a key consideration requirement in all Business Case Applications. Applicants are now required to consider how their proposal advances the EDI agenda and whether any health inequalities/equalities are addressed. **Staff Training** All new starters must attend Trust Induction training. This is held on a monthly basis. In November 2024, the EDI presentation delivered at Trust Induction was reviewed and updated, to enable key EDI messages to be delivered in a more impactful way

Meet the information and communication requirements of patients, their families & carers with a disability impairment, or sensory loss.	**Patient Access and Experience Workstream** (Reasonable Adjustments) A new dedicated workstream for Patient Access and Experience was implemented to review WWL's approach to providing reasonable adjustments for service users, incorporating the requirements of the NHS England's Reasonable Adjustments Digital Flag Information Standard (and outstanding requirements of the Accessible Information Standard (AIS)). We recognise the importance of making reasonable adjustments to ensure everyone, including those with disabilities or special needs can access and benefit from services. Although a number of controls have now been implemented to demonstrate compliance with the AIS, currently there is no consistent approach Trust wide (across all standalone systems). Patients could have their information and communication needs met for some services, but not for others. From April 2024, it is a requirement of the NHS England's Reasonable Adjustments Digital Flag Information Standard that organisations must have a process in place to identify, record and flag reasonable adjustments for patients with a disability using currently available local systems. Although patient's needs are reviewed as part of their individual care plans, this information is not centrally recorded, alerted and shared. Having IT Systems in place to record and alert reasonable adjustments across all services within the Trust has been a key focus for WWL during 2024/25 and has remained a key challenge. At a HIS Advisory Board Meeting in January 2025, it was agreed that the recording of reasonable adjustments should be captured, via WWL's main Patient Admin System (PAS) in the first instance. Progress however, has been stalled, due to the need for an upgrade to PAS before the alignment of national RA codes can be enabled. Although focus is still on having IT having systems in place to record and alert, it was agreed that this should not be main barrier to progress. During 2025/26 a further working group will be established to raise awareness and review how reasonable adjustments can be delivered. RNIB have offered their support to help progress, along with support from Lived Experience partners. Pilots In Ophthalmology and Breast Screening will be implemented to review best practice.
To review the effectiveness of our interpreter and translation services.	**Interpreter & Translation Services** During 2024/25 WWL continued to review the effectiveness of our interpretation and translation services to ensure that service users can be communicated with appropriately and effectively as timely as possible. The fundamental and unprecedented combined effects of COVID 19 and the

	cost of living crisis has had an impact across the entire interpretation industry around the national availability of linguists, especially those who traditionally provided face to face services. Kurish Sorani, Vietnamese and eastern European languages continue to be a challenge and recruitment drives on-going. We have implemented an improvement plan to increase fulfilment rates and efficiencies and continue to meet monthly with our current Provider DA Languages to monitor progress. We have reviewed the implementation of additional interpreting methods during 2024/25 and will be piloting video remote interpreting within Cardiology and Maternity Services during 2025. These include the 'Interpreter on Wheels' (IOW), a tablet mounted to a rolling platform that connects to an on-demand / pre-booked video remote interpreter, along with a dedicated video remote app on mobile phones, which can be used on site and within the community. During 2024/25, WWL continued to have access to on-demand video remote interpreters for patients requiring instant access to a British Sign Language Interpreter. Staff can access this service via an 'App' on a dedicated IPAD in A&E, Urgent Treatment Centre at Leigh and Maternity Services. This is an additional interpreter service which is not intended to replace face to face BSL Interpreters, but to provide instant access in an emergency environment, when a face to face cannot be accessed. This video remote BSL App has since been uploaded on to all compatible ward / department IPADs . During 2025, WWL agreed to participate with participating NHS Contracting Authorities of the Greater Manchester Health and Social Care Partnership with a tender for the delivery of collaborative Interpretation and Translation services. WWL was involved with the review of service specification and standards for the tender and will be involved with the tendering process during 2025/26.
To improve the patient experience for **patient's changing gender identity,** who require their medical records updating.	Although the Trust acknowledges there are current gaps with the updating of patient records (both electronic and paper) and awaits the release of national guidance for Acute Trusts, WWL have continued to ensure patient requests for gender identity requests are managed. NHS England have advised that until guidance is implemented, Trusts are to continue with current in-house protocols (updating demographics of current record). The process of receiving and

	actioning patient requests is currently overseen by the EDI Service Lead within the Patient Experience Team. A process mapping exercise was undertaken to identify what actions were required to update a patient's records with their new gender identity (retaining previous medical history) and a draft operational procedure produced. Risks / implications and proposed mitigations have been formally recorded.

Equality Delivery System (EDS) 2024

The EDS is an accountable improvement tool for NHS organisations in England – in active conversations with patients, public, staff, staff networks and trade unions – to review and develop their services, workforces and leadership. It is driven by evidence and insight.

The EDS 2024 is commissioned by NHS England and NHS Improvement with support from the NHS Equality and Diversity Council (EDC).

The EDS comprises eleven outcomes spread across three domains, which are:

Domain 1 Commissioned or provided services
Domain 2 Workforce health and well-being
Domain 3 Inclusive leadership

The outcomes are evaluated, scored and rated using available evidence and insight. It is the ratings that provide assurance or point to the need for improvement. The EDS is designed to encourage the collection of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

Below is a summary of how WWL performed on EDS2022 in 2024-25. To read our full EDS2024 Report, please visit our WWL website at:
EDS 2023 Report Final 8.4.2024.pdf

Assessment results

The outcome of each domain and an overall rating is as follows.

- **Overall rating:** Developing (19 – three points off 'Achieving')
- **Domain 1:** Commissioned or provided services: Score 12 out of 12 (excelling) – middle score of the three services reviewed.
- **Domain 2:** Workforce health and wellbeing: Score of 5 out of a possible 12 (Developing)
- **Domain 3:** Inclusive Leadership: Score of 2 out of a possible 9 (Undeveloped)

Please see score card below to see where our scores fit on a scale.

The 'Scores' Table below shows where WWL Scores sit within the national scoring criteria:

Score card	
Each Outcome	**Overall – adding all outcome scores in all domains**
Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 30,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **31 or more,** adding all outcome scores in all domains, are rated **Excelling**

It is important to understand that the results WWL has achieved this year are a baseline and will give us greater understanding of where we need to focus our attention for 2025-26.

Action plans and next steps

Domain 1

As three different patient services are identified every year for inclusion in our EDS Assessment submission, it is difficult to measure year on year score comparisons, like we can for Domain 2 and 3. Each service will have their own specific improvement recommendation proposals. It is also to be noted, only one of the services can be included in the final EDS Assessment.

Stakeholder demographics highlight the need for more engagement from stakeholders from all protected characteristics, to enable us to gain further insights from people with lived experience. There is an opportunity here to expand our lived experience partnership by recruiting more members across all 9 protected characteristics. It is through community and patient engagement that WWL will obtain insights to seek to remove or minimize disadvantages suffered by people due to their protected characteristics. Where there are any inequality of access, experience and outcomes, WWL will continue to take steps to meet the needs of people from protected groups where these are different from the needs of other people.

There is a need to continue to closely monitor patient feedback methodologies to measure improvement work going forward. To continue to work with Divisional Service Leads to educate them about the requirements of the EDS and the importance of equality and diversity monitoring. To give regular EDI updates at Divisional Patient Experience and Engagement Meetings and share EDI initiatives and feedback. There is still a need to strengthen divisional accountability for conducting Equality Impact Assessments for service provisions. Ensure reasonable adjustments are considered and adhered to.

The need for dedicated funding to be allocated to support the delivery of future engagement events continues to be apparent. Acknowledged that although EDS is an NHS Contractual requirement, no funding allocated to deliver on the engagement requirements for Domain 1.

Domain 2

The outcome scores for Domains 2 have only marginally improved since last year. The Outcome 2C, referring to staff's access to independent support and advice was scored "achieving activity" this year by the stakeholders, an improvement from "developing activity" last year. This is due to the strengthened Freedom to Speak Up Guardian provision and changes to the staff networks which provide a more inclusive space for all staff.

The Domain 2 assessment has identified key remaining gaps in the provision of staff health and wellbeing support, such as:

- Accessibility of health and wellbeing services
- Targeted support for staff with following health conditions which align with areas of focus of the national health inequality agenda (obesity, diabetes, asthma and COPD)
- Proactive support for staff before and during sickness absence
- Embedding interventions that foster civility culture

The stakeholders proposed improvement actions which could increase the scoring for Domain 2 next year, including:

- Embedding proactive, accessible health and wellbeing support for all staff
- Providing more targeted support for staff living with specific health conditions such as obesity, diabetes, asthma, and COPD
- Providing workplace adjustment guidance and support to enable staff to stay healthy at work
- Improving usage of data insights on staff experience for those from the LGBTQIA+ community
- Strengthen organisational processes to protect staff from racism, discrimination and violence from all sources

Domain 3

The outcome scores for Domains 3 have improved in some areas and decreased in others since last year. Outcome 3A on the Board's commitment and understanding of equality and health inequalities has downgraded by the independent reviewer from "developing activity" to "underdeveloped activity", mainly due to the absence of financial investment in a permanent EDI Lead resource which would demonstrate that EDI is central to business activities and the lack of evidence on the Board members have embedded the leadership framework for health inequalities improvement. Outcome 3C referring to the Board members and system leaders' activities to manage performance and monitor progress has slightly improved from "underdeveloped activity" to "developed activity". This is due to the implementation of a robust governance structure for EDI and set up of a dedicated steering group and workstreams.

The assessment of inclusive leadership Domain 3 has identified continued areas of improvement to make EDI core business, including:

- Investment in EDI resource to support the implementation of EDI strategy
- Board and senior leadership taking proactive approach to EDI by developing own EDI objectives and implementing the Leadership Framework for Health Inequalities Improvement

- Need for measurable improvements against EDI objectives as part of our EDI national reporting requirements.

The implementation of the above actions will be key to improving EDS in 2025/2026 and improving the experience of WWL’s staff and patients.

Celebrating EDI across WWL

This year, we continued to celebrate key annual EDI events, some of these included

Wigan Pride 2024

On 11 August 2024, Wigan Pride returned for a ninth year to Wigan Town Centre, celebrating equality and diversity. Despite the unrest caused by the anti-immigration demonstrations and riots across the UK, on the week leading up to Wigan Pride, the event still went ahead and was a success.

As in previous years, WWL had a stand in the Town Centre and proudly marched in the parade. Our Chief Nurse, True Colours Staff Network, Patient Experience Team were there, along with representatives from other services. Our patient experience and engagement team actively engaged with the local community to ascertain their feedback about hospital services, reinforcing the message that WWL is an anchor institution which plays an active part in Wigan's local community and works continually to ensure that services are accessible.

WWL has been one of the early adopters of the new Oliver McGowan Mandatory Training on Learning Disability and Autism which is an important learning for our staff to contribute to our duty of care for all our patients. We are the leading Trust in GM to be successfully implementing this training and are working closely with NHS GM and the NHS England Regional Lead to effectively deliver the learning across our WWL workforce.

WWL is proud to have three diversity and inclusion staff networks. Our networks exist to empower staff through their collective voice, to provide peer support, a community of shared learning and development and to provide valuable insights into lived experience of their members that we can learn from and make improvements to the experiences of our staff and help us develop as an organisation. Staff networks are mini communities that help us form connections with each other and support each other. The phrase 'strength in unity' means that we are more powerful when we work together which is the essence of what makes a good staff network and has led to the new branding of Communities of Inclusion networks

WWL community
Celebrating our diversity – together

FAME community

The WWL **For All Minority Ethnicity (FAME) Network** has gone from strength to strength this year and increased its membership by over 100 members and allies during a road show in the spring. The network continues to celebrate cultural diversity

TRUE COLOURS community

True Colours Network is WWL's LGBTQIA+ Network. The True Colours Network is WWL's LGBTQIA+ Network. Members and allies of the network have been involved with Wigan Pride and will continue to have an

important presence at this event to celebrate diversity but also to address health inequalities of the LGBTQIA+ community. The network has set out plans to engage their members in theory of change workshops and run LGBTQIA+ awareness sessions across the Trust in the new financial year to increase membership and create more positive experiences for their members.

WWL's Disability and Long-Term Conditions Network has rebranded itself as Disability and Wellbeing Network and have been a major influence on Trust wide programmes of work to inform the new suite of resources on workplace adjustments and support with specific health conditions. They continue to raise awareness of disabilities amongst staff and have held listening events for their members to inform the Trust's wellbeing strategy.

The Year Ahead – EDI Strategy

For our People

This year, our priority remains on creating conditions for an inclusive, compassionate culture for all, by developing our leaders in becoming consciously inclusive, making our policies and processes more person-centred and creating more inclusive career development opportunities.

The focus will very much be on embedding EDI into everyday practice, getting governance structures right, and empowering divisional leads to lead on EDI improvement in their areas. The Trust is in a stronger place by having an EDI Strategy Group and workstreams to help deliver key actions that aim to improve staff experience and key EDI indicators associated with:

- Bullying and Harassment
- Inclusive Recruitment
- Health Inequalities
- Pay gap disparities
- Reasonable Adjustments
- Supporting global majority colleagues
- Working in partnership with our patients and communities

We continue to take actions to make EDI core business of the organisation in 2025/26, including:

1. Becoming intentionally anti-racist: Creating new policies and processes that support our staff in addressing inappropriate or racist behaviour by colleagues or patients
2. Launch of civility response framework- encouraging our people to seek support and informal resolutions when incidents of incivility occur
3. Launch of core leadership development programme- equipping all our leaders to role-model values and challenge problematic behaviour respectfully
4. Launch of Sexual Safety Policy and training to encourage speak up culture, address incidents of sexual misconduct and improve support options for those affected
5. Promote inclusive recruitment practices and introducing value-based recruitment
6. Launching our new wellbeing policy and supporting our disabled colleagues to stay well at work through activities that improve the implementation of health adjustments
7. Roll-out of Active Bystander Training to all staff to empower them to challenge poor behaviors and role-modelling our values

This year's EDI action plans aim to improve our continued areas of focus, particularly around creating an inclusive culture free from bullying and harassment and working towards more inclusive policies and processes which allow for all staff to feel they belong and have equally positive experience at work and opportunities to develop or progress in our organisation. In line with what staff have told us would make the biggest difference to them, we plan on focusing on empowering staff to speak up and challenge unprofessional behavior in a respectful way and providing education and shared learning for our leaders to role model compassionate and inclusive leadership. We will also continue to prioritise improving inclusive recruitment processes and career development opportunities.

We will also continue to work with our staff inclusion networks to help them grow and thrive. We want our colleagues to feel valued and their voiced being heard through the networks. This will be achieved by creating engaging, inclusive network events throughout the year with growing membership and wide attendance from staff across our organisation. We will also

introduce new processes ensuring that any strategic initiative impacting our staff will include an engagement with the networks to understand any impact on protected groups.

The implementation of the EDI strategy and progress updates continue to be overseen by the EDI Strategy Group.

For our Patients

In 2025/26 the Trust will continue to embed and integrate the EDS2022 in terms of both service provision for patients and employment practice for staff. In line with the requirements of EDS2022, the Trust will aim to continuously improve services for all service users and especially those that are categorised as having protected characteristics and underrepresented groups. This will be done in partnership with staff, service users and local interest groups.

We will continue to work in partnership with staff, patients and our lived experience partners. For staff, this means continuing to raise awareness of initiatives and engaging with protected groups to ensure that all staff feel valued, respected and able to progress through the organisation. It also means the opportunity to share and build on areas of good practice whilst addressing areas for development. For patients and carers, this means being able to access our services, receive care and support and be treated with respect and dignity. We will continue to actively recruit Lived Experience Partners who are reflective of our local communities' needs, to work with our staff to drive forward service user quality improvements. We will develop and build the LEP into all aspects of Trust business. Over the next 12 months, they will be working with the Head of Patient Experience to co-produce a Lived Experience Strategy for WWL NHS FT.
We recognise that people in our community have different needs and qualities. Understanding the diversity and needs of our local population can help us to plan and deliver services better. We will continue to engage with our communities to better understand their needs based on their protected characteristics. We recognise the importance of equality monitoring. Data enables us to identify if any patients with a protected characteristic are facing any barriers to healthcare.

We will continue to review the Trust's approach to providing reasonable adjustments for service users and meeting the requirements of the Reasonable Adjustment Digital Flag and Accessible Information Standards. Reasonable adjustments are crucial for ensuring that patients with disabilities or health conditions can access and benefit from healthcare services on an equal basis with others. Although focus is still on having IT having systems in place to record and alert, it was agreed that this should not be main barrier to progress. During 2025/26 a further working group will be established to raise awareness and review how reasonable adjustments can be delivered. RNIB have offered their support to help progress, along with support from Lived Experience partners. Pilots In Ophthalmology and Breast Screening will be implemented to review best practice.

We will continue to review the effectiveness of our interpretation and translation services to ensure that service users can be communicated with appropriately and effectively as timely as possible.
Improvement plans to increase fulfilment rates and efficiencies will be monitored monthly. During 2025/26 we will be implementing additional interpreting methods, including video remote interpreters. 'Interpreter on Wheels' (IOW) will be trialled in Cardiology and Maternity Services, along with a dedicated video remote app on mobile phones, which can be used on

site and within the community. A tender for the delivery of collaborative Interpretation and Translation services will be undertaken during 2025/26. WWL will be involved with this as part of Greater Manchester Health and Social Care Partnership

We are committed to tackling health inequalities and understand that some groups of people, including protected characteristic groups, experience different access, experience, and outcomes when they use NHS services.

WWL recognises that the UK faces significant maternal health inequalities, particularly for black women. Our Patient Engagement strategy will include a specific action within the next 12 months to explore the experiences of black people who have accessed our Maternity services. This will be part of a wider engagement project which will involve our Global majority colleagues to understand experiences of care for patients / families who are BAME.

The recruitment of a Consultant in Public Health working across Public Health, Wigan Council and WWL from June 2025 will be fundamental in driving forward action plans to address and preventing health inequalities

We will continue to undertake Equality Impact Assessments (EIAs) to help us to understand how our policies and services may affect different groups of people. We will continue to pursue the culture of EIAs, reviewing how they can become more meaningful, rather than being seen as a ‘tick-box’ exercise. Educating staff to embed them in decision-making as a genuine tool for improving outcomes.

Appendix 1 Diversity Demographic Data

Having a clear profile of our staff and patients helps to advance equality of opportunity and meet the needs of our patients and staff in designing our services and employment practice.

Workforce:

Workforce data is collected routinely by the Trust:

- Age
- Disability
- Ethnicity
- Sex
- Marital Status
- Maternity
- Religion & Belief
- Sexual Orientation

In terms of workforce data, we have reviewed the data which is available to us with regards to age, disability, ethnicity, sex, marital status, maternity, religion and belief and sexual orientation. Other than in respect of Recruitment and Selection statistics, the Trust does not hold workforce data on gender reassignment

Summary of Headline Data:

- **81.5% of the workforce is of White Ethnicity**. This figure remains slightly lower than the Wigan borough figure of 95%. 15.7% of the workforce profile is from Black and Minority Ethnic Groups, with 6.7% of Trust Board being BAME, this is over representative of the Wigan population.
- **The split between staff aged 50 and under and over 50 has remained comparable.**
- **5.1% of the workforce declared they are living with a disability**. This is under representative of the Wigan population (20%). Trust representation has increased slightly compared to the 2024 figure (4.2%). Undeclared rates are gradually decreasing year on year and are now at 15.5%
- **The workforce profile remains predominantly female at 80%** whereas the local population is 51% female. However, this is in keeping with the gender profile of the healthcare profession in general and the NHS in particular.

- **60% of staff who have disclosed their religion and belief and describe themselves as Christian compared to 2021 Census Wigan borough figure of 63%.** 16% of Trust staff have not disclosed their religion and belief, a decrease compared to the previous year at 19%.
- **84% of staff describe themselves as heterosexual.** However, 13% of staff have not disclosed their sexual orientation, this is slightly less than last year's rate of 16%

See Appendix 2 for Full Details.

Service Users (Patients)

The Trust has historically only had very limited information on the protected characteristics of the people who use our services. As a consequence, it can be difficult for us to determine the extent to which we are providing services which are responsive to individual needs. The following patient demographics are collected routinely by the Trust:

- Age
- Sex
- Ethnicity
- Religion and Belief

For the purposes of this report, we have reviewed the data which is available to us in terms of age, sex, ethnicity and religion and belief, along with local data and reports. Where we do not have sufficient data in terms of disability, sexual orientation, marriage and civil partnership and transgender, we have used regional or national data as an estimate.

Summary of Headline Data:

- **Overall picture of WWL patient service access continues to reflect broad similarity to local demographics** (Census 2021 Wigan Borough statistics).

- The population of England and Wales has increased by more than 3.5 million in the 10 years leading up to Census 2021. **In Wigan, the population size has increased by 3.6%, from around 317,800 in 2011 to 329,300 in 2021.** This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.

- **Levels of deprivation in Wigan are significantly worse than the England average -** Within the most deprived 20% in UK. People living in the most-deprived areas of Wigan have a life expectancy nearly a decade shorter than the least-deprived areas.

Ethnicity

- Census 2021 Wigan Borough data reported that 95% of the local population were of British White ethnicity, 2% identified as Asian, 1% identified as mixed or multiple ethnicity; 1% identified as black; 1% identified as other. **Over the years, Wigan has become more ethnically diverse, and this is increasing as the years go by and** in line with the growth in Wigan Borough's migrant worker population and numbers of refugees / asylum seekers.
-
- **2024/25 Data shows that a higher % of Black and Minority Ethnic Groups are using Emergency Department (11%) and Maternity Services (23%) in comparison with overall out-patient / in-patient activity (7%). A higher A&E and maternity usage in not necessarily a reflection of a larger local population size, but rather a result of systemic inequalities in healthcare access socioeconomic conditions. In A&E, socioeconomic deprivation and poorer access to primary care can lead to increased usage. In maternity age structure of ethnic minority and migration can lead to increased usage.**

- **In Wigan, the % of people who did not identify with at least one UK national identity increased from 2.2% in 2011 to 4.1% in 2021.** During the same period, the % increased from 5.4% to 9.5% in Bolton. Although figures are lower in Wigan, the borough has received a sizeable number of refugees and migrants over the last decade and it is likely that the population will become more diverse over the coming years.

- **The top languages interpreted during 2024/25 were:** Kurdish Sorani; Arabic, Romanian, Farsi, Polish, Cantonese, British Sign Language, Urdu, Portuguese, Vietnamese.

Sex

- **As with most healthcare services in the UK, women are more likely to use hospital services than men** – 58% of out-patients during the last 12 months were female.

Age

- **The population has continued to age.** Census 2021 results reported 19.3% of residents were aged 65 years and over (16.3% a decade earlier). The proportion of Wigan residents aged 65+ was higher than the national average (18.6%) with Wigan also experiencing a higher rate of growth over the last decade (23%) compared to the national average (20%) Maintaining the health and resilience of older people is important both for the individuals themselves and in ensuring the sustainability of local health and adult social care services. The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs. During 2024/25 36% of patients accessing WWL services were aged 65 years and over. 44% aged 31-64 years.

Disability

- **Wigan Census 2021 showed that 20.2% of Wigan residents are living with a limiting long-term illness, health problems or disability** – higher than the national average 18%. 1 in 6 (16%) of the local population are living with hearing loss (60,500 residents). 10,500 Wigan Residents are estimated to be living with sight loss. Figures are expected to rise over the next 10 years.

- **Census 2021 data reported over 74,000 people in Wigan who have been diagnosed with a long-term condition. Long-term conditions or chronic diseases are conditions that currently have no cure, and are managed with drugs and other treatment**, for example diabetes, COPD, asthma, pulmonary disease, arthritis, and hypertension.

Sexual Orientation

- **ONS data shows 6,773 people in Wigan identified as a sexual orientation other than heterosexual when the Census was undertaken in March 2021 (2.5% of respondents).** The most common LGB+ sexualities were gay or lesbian (57%) and bi sexual (35%). Data on sexual orientation is limited to those who responded, so data is expected to be higher. 84,983 people living in Greater Manchester do not identify as heterosexual (3.8% of the population aged 16 and over).

- **Census 2021 reported that 95% of resident's gender identity was the same as registered at birth.** 11,946 residents did not respond; 470 resident's gender identity was different from sex registered at birth; 372 residents identified as trans man/trans woman; 66 residents identified as non binary; and 57 residents identified as other gender identities. Data on gender identity is still currently limited, although data collection methodology and question design are developing. **Despite laws and attitudes towards people who identify as LGBTQI+ changing significantly in even just the last decade, discrimination remains. Research evidence demonstrates that LGBTQI+ people experience significant health inequalities in terms of health outcomes, health care service provision and health risk factors in comparison to cis-heterosexual populations.**

See Appendix 3for Full Details.

Appendix 2 – Headline Data

Our People (Workforce)

Age

As at 31 March 2025 WWL Trust staff breakdown was:

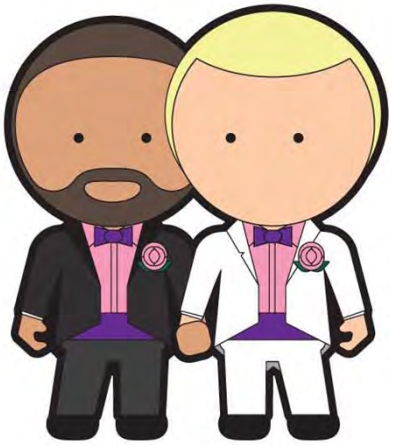
63% Age 50 or under **37%** Age 51 +

The proportion of staff in each age bracket has remained comparable to last year.

Performance management were representative of the Trust's age demographic.

Disciplinary cases for the age 50 and under age group were over representative compared to the Trust's age demographic.

Marriage and Civil Partnership



As at 31 March 2025

53% of staff were **Married**

2% were in a **Civil Partnership**

33% single, 7% divorced / legally separated, 1% widowed, 3% unknown.

Figures have remained relatively static over a period of several years.

Disability

As at 31 March 2025

5.1% of the Workforce have declared that they are living with a disability.

This has increased slightly compared to the 2025 figure (4.2%) although there is still a large amount of undeclared data at 15.5%, this is decreasing year on year.

For Non-Clinical Staff there is an under representation of disabled staff in bands 8d and above. There is over representation of disabled staff in band 1.

For Clinical Staff there is an under representation of disabled staff particularly in Medical & Dental and VSM.

Pregnancy and Maternity

As at 31 March 2025, a snap shot from the Electronic Staff Record indicated that:

2.15% of female staff were on **Maternity Leave**

This is comparable to the previous year.

Religion and Belief

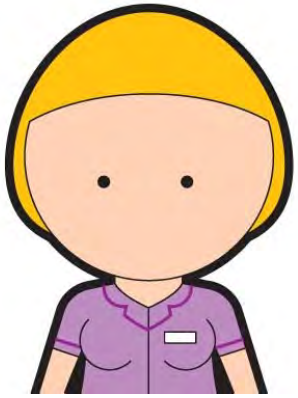
As at 31 March 2025

60% Christian **9%** Other **18%** Unknown

Remaining staff split across a range of religions and beliefs with the highest number being in Atheism category (8%).

A significant proportion of staff have not declared their religion and belief although this has decreased slightly from last year.
(2021 Census, The Wigan borough figure for Christianity is 63%)

Sexual Orientation



Workforce as at 31 March 2025:

84.2% Heterosexual
1.5% Gay or Lesbian
1% Bisexual
0.1% Other

13.1% did not wish to disclose
(a decrease from last year's figure of 15.7%)

Wigan population 8.5% Lesbian, Gay or Bisexual.

Ethnicity

As at 31 March 2024:

83.6% of Staff of White Ethnicity
(2021 Census, Wigan Borough White representation is 95%)

14.7% of Staff from Black & Minority Ethnic Groups

1.8% Not Stated

6.3% of the Trust Board membership is BME.

37.5% of **Performance** cases were in respect of BAME staff members which is over representative of the workforce profile.

21.9% of **Disciplinary** cases were in respect of BAME staff members which is above the workforce profile.

Sex

Workforce as at 31 March 2025:

80% Female

20% Male

(2021 Census, 51% female / 49% male within Wigan population)

24.7% of disciplinary cases were against male staff. Historically disciplinary cases have been over representative of male staff members, however this is continuing to decrease over the years.

Gender Reassignment

Transgender information for current staff is not recorded on ESR so we cannot therefore undertake workforce profile monitoring at present.

Appendix 3 – Headline Data on Service Users/Patients

Our Service Users (Patients)

Ethnicity (Out-Patients & In-Patients)

During 2024/25

87.9% of Patients of British White Ethnicity

6.8% of Patients from Black & Minority Ethnic Groups (BAME)

5.3% Not Stated

During last 12 months, British White Ethnicity % remains the same. 1.1% increase in patients of Black & Minority Ethnic Origin. 1.3% decrease in those not stated.

Over last 13 years steady increase in BAME activity 2012/13: 2.6% / 2024/25: 6.8%.

Ethnicity (Accident & Emergency)

During 2024/25

87.9% of Patients of British White Ethnicity

10.5% of Patients from Black & Minority Ethnic Groups (BAME)

1.6% Not Known

During last 12 months, 0.4 decrease in patients of British White Ethnicity. 0.4% increase in patients of BAME Origin.

Over last 13 years steady increase in BAME activity in A&E. 2012/13: 3.1% / 2024/25: 10.5%

Ethnicity (Maternity Admissions)

During 2024/25

76% of Patients of British White Ethnicity

23% of Patients from Black & Minority Ethnic Groups

1% Not Known

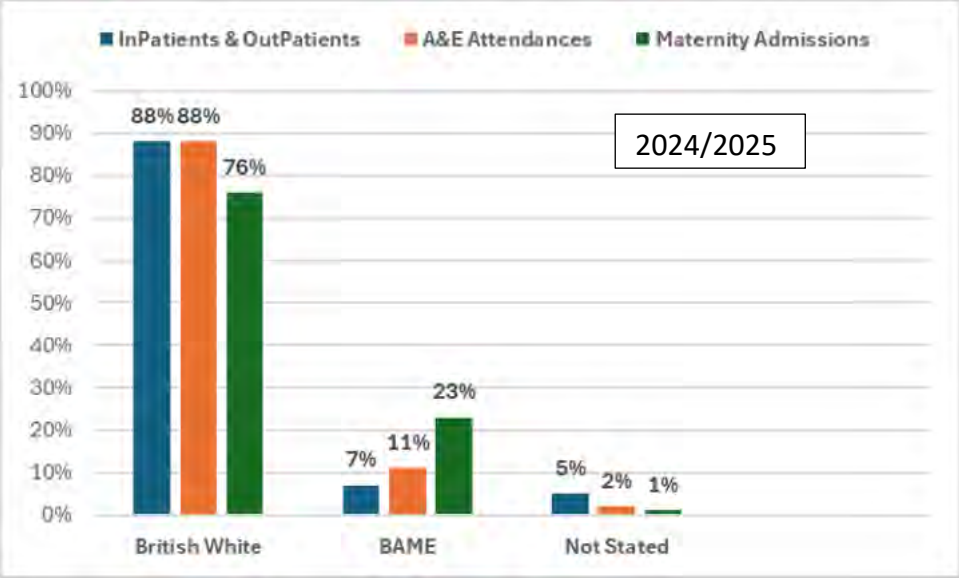
Higher % of Black and Minority Ethnic Groups using maternity services than overall out-patient / in-patient activity. Data in line with significant growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers.

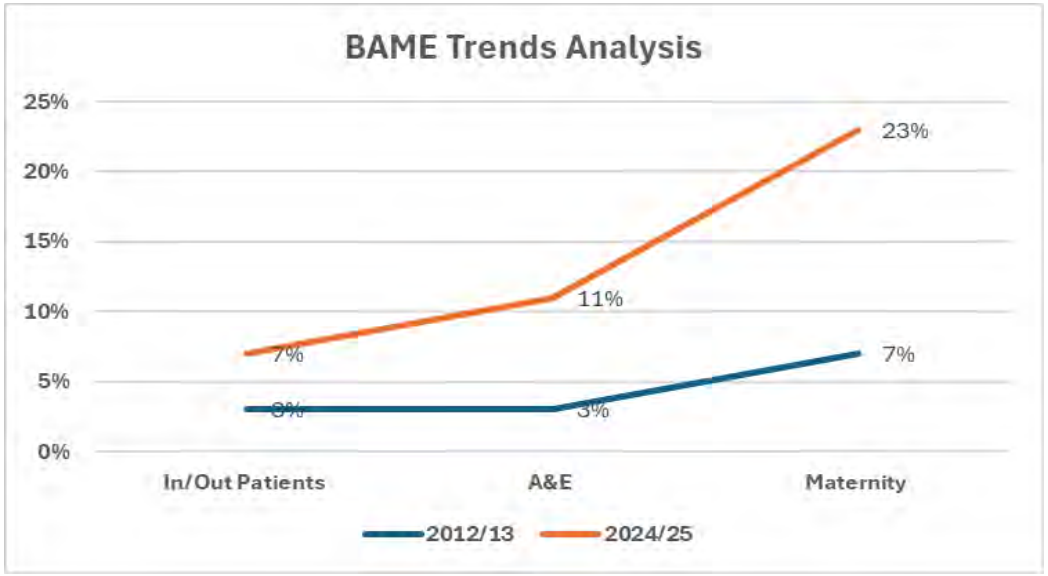
During last 3 years notable increase of patients from African Backgrounds
2022/23: 2%
2023/24: 5%
2024/25: 7%

Ethnicity overall reflective of local population – Census 2021 Wigan Borough data reported that 95% of the local population were of British White Ethnicity, followed by the Asian ethnic group 2%, mixed multiple ethnic groups 1%, Black 1% and Other 1%.

In England more broadly the portion of the population that is white is 81%. 10% are Asian and 4% are Black.

Over the years, Wigan has become more ethnically diverse, and this is increasing as the years go by. Higher % of Black and Minority Ethnic Groups using Emergency Department and Maternity Services in comparison with overall out-patient / in-patient activity. Over last 13 years, steady increase in % of patients of Black and Minority ethnicity attending A&E. Data in line with growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers. Significantly Higher % of Black and Minority Ethnic Groups using maternity services(data historical). During last 12 months at WWL, 76% of patients were of British White ethnicity; 23% from black and minority ethnic backgrounds; 1% not stated. Since 2012/13: 17% decrease in patients of British White Ethnicity. 16% increase in patients of Black and Minority Ethnic Backgrounds.





Interpreter & Translation Services

During 2024/25 Top Languages Requested
Kurdish Sorani; Arabic, Romanian, Farsi, Polish, Cantonese, BSL, Urdu, Portuguese, Vietnamese

During 2024/25:

38 Translations into other languages / 2 Other formats - Audio requested
This will continue to increase with the implementation of the Accessible Information Standard and review of reasonable adjustments.

Ethnic Population in Greater Manchester

In Wigan, the percentage of people who did not identify with at least one UK national identity increased from 2.2% in 2011 to 4.1% in 2021. During the same period, the % increased from 5.4% to 9.5% in Bolton. In 2021, over 95% of the population was White British. This compares to just under 80% in England as a whole. Although figures are lower in Wigan, the borough has received a sizeable number of refugees and migrants over the last decade and it is likely that the population will become more diverse over the coming years.

Ethnic minority populations living in Wigan include Long-term resident ethnic minority population and asylum seekers and refugees, migrants, Gypsies and Travellers, European Roma and Overseas students. Although the numbers are small compared to the size of the total population and some only stay for a short period of time, some will have specific health needs that need to be addressed.

Local Authority (Census 2021)	White British	Mixed	Asian or Asian British	Black or Black British	Other
Wigan	95%	1%	2%	1%	1%
Bolton	71.9%	2.2%	20.1%	3.8%	1.9%
Salford	82.3%	3.1%	5.5%	6.1%	2.9%
Manchester	56.8%	5.3%	20.9%	11.9%	5.1%
Oldham	68.1%	2.5%	24.6%	3.4%	1.4%

Sex (Out-Patients)

During 2024/25
58% Female
42% Male

2021Census Wigan Borough figures: 51% of the local population female

As with most healthcare services in the UK, women are more likely to use hospital services than men.

Age

During 2024/25
% of patients accessing hospitals services

9% Under 18
11% 18-30 Years
44% 31-64 Years
36% 65+ Years

1 in 6 residents in Wigan are now aged over 65 years.

Set to increase over the next 20 years

Age overall reflective of local population – Wigan Census 2021 reported 19.3% of residents were aged 65 years and over (16.3% a decade earlier). **The proportion of Wigan residents aged 65+ was higher than the national average (20%)**

Maintaining the health and resilience of older people is important both for the individuals themselves and in ensuring the sustainability of local health and adult social care services.

The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs.

Religion and Belief

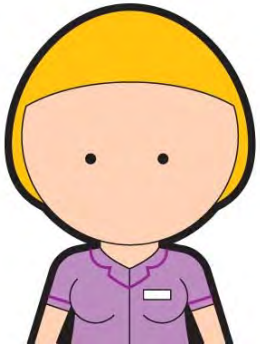
During 2024/25
% of patients accessing out-patient services

62% Christian	**20%** Unknown
15% None	**0.3%** Hindu
0.8% Muslim	**0.2%** Atheist
0.1% Buddhist	**0.3%** Islam
0.1% Jewish	**0.0%** Unitarian
0.1% Spiritualist	

Trust Data affected by the high proportion of religion not known (141,002 patients).

Religion overall reflective of local population – 2021 Census Wigan Borough figure reported that 63% of the population were of Christian Belief

Sexual Orientation and Gender Identity



Census 2021 Data

6,773 Wigan Residents (2.5%) identified as a sexual orientation other than heterosexual.

Most common LGB+ sexualities were gay or lesbian (57.4%) and bisexual (35.2%)

Data on sexual orientation is limited to those who responded, so data is expected to be higher.

Census 2021 Data

255,782 Residents (95%) Gender identity is the same sex as registered at birth

11,946 Residents (4.5%) Chose not to answer

470 Residents Gender identity different from sex registered at birth (no specific identity given)

216 Residents Trans man

156 Residents Trans woman

66 Residents Non-binary

57 Residents All other gender identities

Data on gender identity is still currently limited, although data collection methodology and question design are developing. Despite laws and attitudes towards people who identify as LGBTQI+ changing significantly in even just the last decade, discrimination remains. Research evidence demonstrates that lesbian, gay, bisexual, and trans (LGBTQI+) people experience significant health inequalities in terms of health outcomes, health care service provision and health risk factors in comparison to cis-heterosexual populations.

84,983 people living in Greater Manchester do not identify as heterosexual (3.8% of the population aged 16 and over)

In response to national research, NHS England is spearheading a collective drive to improve the experience of trans and non-binary people when accessing health and care services.

Disability

Wigan Census 2021 showed that 20.2% of Wigan residents are living with a limiting long-term illness, health problems or disability – higher than the national average 18%.

The Royal National Institute for Deaf People (RNID) estimates that

1 in 6 (16%) of the population are living with hearing loss.

60,500 Wigan Residents (RNID, 2020a).

Improving Health & Lives (IHAL) estimate that

1.9% (6,170 residents) have learning disabilities.

Royal National Institute for Blind People estimates that

10,500 of Wigan Residents are living with sight loss (**1,730** registered blind or partially sighted)

By 2032, figures are expected to rise to

12,600 of Wigan Residents living with sight loss

1 in 5 people will start to live with sight loss in their life time / Every day **250 people** start to lose their sight (UK Stats)

Patients with disabilities often report barriers to using health services, in terms of transport difficulties, distance and needing someone to accompany them. Poor communication leads to non-attendance for appointments. These are issues currently being reviewed within Wigan Borough Locality Plan.

The Accessible Information Standard

A law to ensure that people who have a disability, impairment or sensory loss are given information they can easily read or understand. Making information easier to understand for people living with communication and information needs.

Under the Equality Act 2010 health and care staff have a legal duty to provide reasonable adjustments – take steps to remove the barriers individuals face because of their disability

WWL is committed to working towards meeting these requirements for everyone we serve.

Census 2021 Wigan Borough reported

20% of Wigan Residents living with a limiting long-term illness, health problems or disability which limits daily activities at work.

Higher than national average 18%

The 5 most common conditions which account for 54% of DLA Claims

Arthritis; Learning Disabilities; Heart Disease; Disease of muscles, bones & joints; Hyperkinetic syndromes

1 in 4 people experience a mental health problem during their life. Having a long-term condition increases the risk that an individual will have a mental health.

The number of people who are at risk of having poor mental wellbeing in Wigan is high because of the high levels of deprivation.

Marriage and Civil Partnership (aged 16 and over)

Census 2021 Wigan Borough reported

43.8% Wigan Residents are **Married or in a registered Civil Partnership**

37.2% Wigan Residents have **never been Married or in a registered Civil Partnership**

386 Wigan Residents are or have been in a **Registered Civil Partnership (opposite sex and same sex), this includes 219 people currently in a same sex civil partnership. 625 were in a same sex marriage.**

Complaints

494 Complaints Received during 2024/25

282 Female **212** Male **0** Unknown

458 British White Ethnicity

21 Black & Minority Ethnic Background

15 Not Stated

5 Main Subject Complaints

- Clinical treatment
- Communications
- Patient Care
- Admissions and Discharges
- Value and Behaviour

54% Aged 50 years or above

No trends in relation to protected characteristics noted – Data reflective of Wigan Borough Demographics

Wigan Borough Population

The population of England and Wales has increased by more than 3.5 million in the 10 years leading up to Census 2021.

In Wigan, the population size has increased by 3.6%, from around 317,800 in 2011 to 329,300 in 2021. This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.

In 2021, Wigan ranked 31st for total population out of 309 local authority areas in England, which is a fall of six places in a decade.

At 3.6% increase, Wigan's population is lower than the increase for the North West (5.2%)

As part of the 2021 census, households in England and Wales were classified in terms of four different "dimensions of deprivation"; based on unemployment, health, education, and type of dwelling. Analysis from the Office for National Statistics recorded that 53.4% of households in Wigan and Leigh were classed as being deprived.

Levels of deprivation in Wigan significantly worse than England average.

Within most deprived 20% in UK.

People living in the most-deprived areas have a life expectancy nearly a decade shorter than the least-deprived areas.

Title of report:	Safeguarding Annual Report 2024-2025
Presented to:	Board of Directors
On:	4th February 2026
Item purpose:	Information
Presented by:	Chief Nurse
Prepared by:	Associate Chief Nurse for Safeguarding
Contact details:	T: 0300 707 2320 E: carlene.baines@wwl.nhs.uk

Executive summary

This is the fourth Annual Report following the establishment of the Think Family Safeguarding Service and illustrates the maintaining of clear, constant leadership and vision to promote and respond to emerging safeguarding issues and concerns within an ever-changing climate of safeguarding across the Trust. Alignment of safeguarding drivers with the Trust's Corporate objectives is outlined against consideration of wider partnership and local strategies with a focus on the safeguarding agenda as it presents for the population of Wigan Borough.

Progress against Key Priorities identified within the 2023/2024 Annual Report are presented with an outline of next steps and future areas of focus for 2025/2026.

Link to strategy and corporate objectives

Trust Safeguarding Strategy 2023-2025
WWLTH Nursing, Midwifery and AHPs Strategy 2025/26

Risks associated with this report and proposed mitigations

None

Financial implications

WWLTH have a statutory obligation to safeguard adults, children & young people and children in care & care experienced adults; not adhering to statutory requirements could have financial implications due to potential negligence complaints and detrimental media interest.

Legal implications

WWLTH has a statutory responsibility for ensuring that the services provided by the organisation have safe and effective systems in place which safeguard individuals at risk of abuse, neglect, and exploitation. Safeguarding is integral to complying with legislation, regulations and delivering cost effective care.

People implications

Safeguarding focuses on the safety and well-being of all patients but provides additional measures for those least able to protect themselves from harm or abuse. Safeguarding practice is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS and as such having a competent and confident workforce is essential.

Equality, diversity and inclusion implications

This report considers the diverse nature of our patients and staff in articulation of how safeguarding within this context ensures equality and inclusion when discharging statutory responsibilities.

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

Safeguarding Effectiveness Group - Approval
Quality and Safety Committee – Information

Recommendation(s)

The Board of Directors is asked to receive this report for information and assurance. The report has been approved by Safeguarding Effectiveness Group (SEG) on 25th July 2025 in order that wider dissemination can be considered, inclusive of internal boards and committees and external forums to provide evidence and assurance of WWLTH discharge of statutory and regulatory responsibilities in regard to safeguarding.

Following approval, and via sharing of this report, the content will be accessible to the public to promote confidence in WWLTH as an organisation that is safe and effective in supporting our patients who require additional support and protection to live a life free from abuse, harm and exploitation.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Think Family Safeguarding Annual Report 2024-2025

(Forward Plan 2025-2026)

Contents

Foreword

Welcome to this, the fourth Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust (WWLTH) Safeguarding Annual Report. This report provides insight into the evolving and complex safeguarding activity across the Organisation during the period April 2024 to March 2025 whilst demonstrating the Trusts commitment to WWLTH patients. service users and staff in line with statutory duties.

The Think Family Safeguarding Service (TFSS) continues to advance our corporate objectives outlined in the 2024–2025 WWLTH Safeguarding Strategy. The approach remains firmly aligned to the Trust's 4P priorities**;** **Patients, People, Performance**, and **Partnerships**. These priorities, along with the WWLTH values and strategic goals, underpin all TFSS workstreams, ensuring that progress is measurable and impactful. The service is further guided by the WWLTH values; ***People at Heart*****, Listen and Involve**, and being **Kind and Respectful,** which embody the principles of *Making Safeguarding Personal*, *Understanding Lived Experience*, and genuinely hearing the *Voice of the Individual*. The final Trust value, **One Team**, reinforces the message that safeguarding is *everyone's business*. This collective ethos helps to empower staff, foster resilience, and build the confidence and competence needed across the organisation to positively impact the lives of those we aim to advocate for, support and protect.

In early 2025 the *Delivery of Fundamentals Strategy for Nursing, Midwifery and Allied Health Professionals* was launched by our WWLTH Chief Nursing Officer (CNO) and outlines six ambitions of WE CARE. These ambitions fit readily within both the Trust's Safeguarding Strategy and the Think Family Safeguarding Service Mission and Vision supporting the alignment of key focus areas in terms of the Organisation's *Journey to Excellence – Quality of Care 2025/26* and help support identification of the coming year's safeguarding priorities.

The TFSS has continued with its ongoing commitment to ensure that all unborn, children, young people and adults at risk are protected from abuse, neglect and exploitation. Across the Trust, safeguarding work has been shaped by several key themes and trends. These include a continued increase in concerns related to domestic abuse, mental health and self-neglect across the family setting, impacting both adults and children. The complexity of safeguarding is noted, often involving multiple intersecting risks across the family and requiring a multi-agency and cross boundary approach. In response to these challenges the TFSS has persisted in focusing on service development and has taken proactive steps throughout the year to strengthen safeguarding systems and improve practice which are integral to ensuring effective safeguarding arrangements are in place.

As a key partner within the Wigan Borough Partnership, WWLTH frequently leads on development and improvement initiatives that can be adopted and embedded by others to enhance safeguarding provision across the Borough. We recognise that meaningful progress in safeguarding is only possible through the dedication and commitment of our staff. Their efforts are clearly reflected in the significant improvements in safeguarding compliance and assurance seen across the organisation.

Review and evaluation of the past year offers a valuable opportunity to renew our shared sense of responsibility and accountability. This moment of reflection also allows us to realign with our safeguarding mission and vision and refresh our priorities for the year ahead. At WWLTH, our behaviours and values are central to everything we do and serve as a foundation for delivering our strategic ambitions. This ethos is clearly reflected in our approach to safeguarding patients, supporting our workforce, strengthening partnerships and improving performance. By promoting consistency, efficiency, and equity, we ensure a high standard of safeguarding practice across the organisation.

Reflecting Back

Key Priorities for 2023/2024	
Key Priority	**Progress against Priority**
➢ Develop a data system and dashboard that can articulate the breadth of safeguarding activity and intervention by all Divisions and Services across the Trust	Progress has been made towards developing a Safeguarding data dashboard; the challenges faced by the service are driven by the multiple IT systems and different Electronic Patient Records (EPR) in use within the organisation. Datix has now been aligned to the categories of abuse and SystmOne optimisation is ongoing. In addition to this, an improvement proposal has been endorsed by the Safeguarding Effectiveness Group (SEG) and has now been submitted to the HIS advisory board. The SystmOne Optimisation project, to support data quality around Children in Care Team activity, went 'live' in December 2024. Unfortunately, the Data Analytics and Assurance (DAA) Team have experienced challenges therefore outputs are not yet able to fully replace manual data activity.
➢ To contribute to the Least Restrictive Practice agenda promoting the principles of Safe, Effective, & Acceptable Care via a Safeguarding Lens	The Least Restrictive Practice agenda has remained a Trust and TFSS priority over the past year. The established Least Restrictive Working Group leads key actions from the WWLTH improvement plan. There has been a strong focus on ensuring staff have accessed Crisis Prevention Intervention (CPI) Training which is locally mandated with increased investment supported by Associate Chief Nurse for Education, Workforce and Professional Practice to add to the existing CPI Facilitator cohort. Strong working relationships with Learning and Development Colleagues have further enhanced delivery.
➢ To launch a 'Think Family' approach to mandatory safeguarding training package inclusive of Intercollegiate standards for adults, children & children in care.	The TFSS Think Family Safeguarding Level 3 mandatory training package has been developed and piloted in 2024/2025 ready for launch this year with full roll out from July 2025. Whilst this training is in its infancy, this will be further developed and supported by the Think Family Safeguarding Training Strategy 2025-2028 to be implemented in Quarter 2 2025/26. We continue to build on a culture of continuous improvement by ensuring training is rooted in learning from safeguarding reviews be those internal, partnership or national. Consideration of national mandatory training drivers and professional safeguarding competence frameworks are central.
➢ To review and refresh the suite of Safeguarding Policies in line with Think Family Principles	Last year, work was undertaken to refresh the Think Family agenda. This was achieved by the Think Family Safeguarding Policy being implemented to drive the approach with consideration of the holistic needs of the family across the organisation. This work was supplemented by the update, renew and refresh of several associated policies and Standard Operating Procedures (SOPs) in line with Think Family principles.

Strategy

The WWLTH Safeguarding Strategy remains guided by a robust operational workplan that outlines the TFSS and wider Trust approach to achieving the agreed safeguarding objectives, all of which remain aligned with the Trust's overarching priorities. Each objective is framed within the context of the '4Ps' framework, clearly articulating the specific goals of the TFSS. These goals are supported by defined aims that reflect the service's commitment to deliver meaningful outcomes for the unborn, children, adults, and families.

Achievements

Key Objectives	*Achievements in 2023/24*
Patients	✓ The TFSS have been key members of divisional and organisational Patient Safety Groups, Harm Free Care program and Learning from Patient Safety Events (LfPSE) to ensure cross-population of learning from reviews to support richer action plans which are shared and implemented on a wider footprint ✓ In alignment with the NHS Patient Safety Incident Response Framework (PSIRF), the TFSS has undertaken several After Action Reviews[1] (AARs) to explore safeguarding-related incidents and identify opportunities for learning and improvement. AARs promote constructive engagement of staff, whose openness to reflection and learning from a safeguarding perspective, demonstrates a commitment to a positive safety culture and continuous improvement ✓ Relevant learning from statutory and partnership reviews has been embedded into WWLTH mandatory training with key elements from two Safeguarding Adult Reviews (SAR), Domestic Abuse Related Review (DARR) 10 and published Child Safeguarding Practice Review 'Isaac'[2] being disseminated across the Trust ✓ A new ICON pathway was developed and embedded within WWLTH Maternity Services to ensure robust individualized care plans. This was additionally supported by the implementation of body maps in all personal child health records ensuring comprehensive documentation and information sharing of the newborn and infant Physical examination (NIPE) ✓ The Antenatal Pathway Group was established which developed and implemented improvements in special circumstances referral form (SCRF) sharing across WWLTH services namely maternity and 0-19 ✓ Pathway for Initial health Assessments (IHA) for Children in Care (CiC) has been revised to successfully improve statutory timescales. Liaison between agencies has strengthened with clear escalation processes developed to address delays. The Pathway now also includes an Introductory Visit to the child and carer by a Children in Care Nurse prior to IHA clinic appointment enabling the child to be seen outside of a clinical setting to help allay any fears or anxieties offering the opportunity to ask any questions with any information gathered provided to the Paediatrician prior attendance for health assessment
People	✓ The implementation of the Safeguarding Operational Group (SOG) as a subgroup of SEG provides an additional layer of governance and enables divisional level reporting to a much wider audience of practitioners, creating a greater depth of insight into emerging trends in safeguarding ✓ Ensuring our workforce have clear guidance on expectations in respect of recognition and response to particular safeguarding concerns has been

[1] learning-handbook-after-action-review.pdf
[2] Reviews - Wigan Safeguarding Children's Partnership

	provided via a suite of policies and SOPs updated and ratified in line with changes to national and regional guidance ✓ The TFSS has continued to enhance the supervision offer to WWLTH staff, improving practice by promoting compliance, awareness, support and accountability across all levels of the organisation. A structured framework of reflective safeguarding supervision remains available on an individual basis for caseload holders, and group basis for staff who do not carry a caseload, in which a real-life case scenario is reviewed ✓ In response to improving Least Restrictive Practice across WWLTH, a Trust wide Least Restrictive Action Plan saw the development of a Least Restrictive Improvement Plan managed by the newly established Least Restrictive Working Group who are responsible for the implementation of actions and dissemination of learning from incidents, investigations and audit. TFSS has driven and supported delivery of CPI training to promote the safety and dignity of WWLTH patients. This training was strengthened by the addition of Mental Capacity Act (MCA) and Medicines Management knowledge and competencies to the CPI training program
Performamce	✓ WWLTH has again been recognised across Greater Manchester (GM) as having the highest compliance achieved with the Integrated Care Board (ICB) Safeguarding Contractual Standards ✓ A robust process has been implemented to ensure TFSS oversight of restrictive practices within the organisation, ensuring the effective triangulation of data from Datix, security logs and patient records to enable extensive and meaningful review of incidents. Publication of a de-escalation pyramid was produced and distributed to staff to support the application of CPI principles *(see appendix 1)* ✓ Continued strong compliance with mandatory Safeguarding Training metrics ✓ Excellent performance maintained against the health metrics of the national statutory return for Children in Care – SSDA903[3]
Partnerships	✓ Continued and consistent engagement and participation in partnership subgroups of Wigan Safeguarding Children Partnership (WSCP) and Wigan Safeguarding Adult Board (WSAB) ✓ A Maternity Pathway for Care Leavers was created across agencies; the aim is to support care leavers with targeted individualised support throughout pregnancy and parenthood ✓ The TFSS supported the development and implementation of the new WSCP Joint pathway for injuries in non-mobile children protocol[4] ✓ The CiC Team have developed stronger links with Wigan Council Leaving Care team; weekly visibility in the Care Leavers hub; in addition to monthly 'drop in' and a dedicated CiC Nurse as 'Care Leavers Champion'

[3] Children_looked_after_return_2025_to_2026_guide.pdf
[4] WSCP-Injuries-in-Non-Mobile-Children-Protocol-February-2025.pdf

Introduction

This is the fourth annual report since the founding of the Think Family Safeguarding Service and illustrates the maintaining of clear, constant leadership and vision to promote and respond to emerging safeguarding issues and concerns within an ever-changing journey of safeguarding across the Trust

This report will provide assurance and transparency that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of unborn babies, children, young people, adults at risk and their families or carers who encounter WWLTH services. A summary of safeguarding activity from April 2023 to March 2024 in relation to safeguarding our patients is provided with an overview of data and performance relating to acute and community services inclusive of maternity provision and the explicitly commissioned Children in Care (CiC) health offer. Consideration of internal and system challenges are explored with a solution focused approach to making a differed articulated.

The TFSS continues to transition and transform with a successful recruitment period seeing new members of staff employed within the service. Our new safeguarding specialist, both clinical and administrative, come with an array of differing experiences arising from their varied and unique professional backgrounds which both complement and enhance the skills and expertise on offer to support equally patients and the WWLTH workforce. The TFSS works in collaboration utilising our Midwifery, Adult, Children and Children in Care Teams alongside our Complex Safeguarding Nurse, Children First Partnership Hub[5] (CFPH) Nurses and Health Independent Domestic and Sexual Abuse Advisors (HIDSVA) in a holistic and truly 'Think Family' approach.

The Safeguarding Annual Report 2024/25 will provide the WWLTH Trust Board with a local, regional, and national context of safeguarding practice within the organisation, including progress and developments that give assurance we are meeting our statutory obligations. Key priorities for the year ahead will be determined to offer a level of confidence around the commitment of WWLTH and the TFSS moving into 2026.

A summary of mandatory safeguarding training compliance, as reported at year end is provided whilst key themes and trends arising from statutory safeguarding reviews and internal patient experience events are detailed demonstrating how embedding lessons learnt is vital in ensuring improvements in care by understanding when things have gone wrong. Throughout the year internal governance and reporting arrangements ensure that operational detail regarding safeguarding is scrutinized with analysis of risk alongside monitoring and oversight of improvement workstreams utilised to drive progress. As we move forward the Trust remains committed to a culture of continuous learning, accountability and collaboration to ensure that safeguarding remains at the heart of high-quality person-centred care. There is a clear link between improving safeguarding practice and the six ambitions of the fundamentals strategy thus providing a tool to anchor workforce focus.

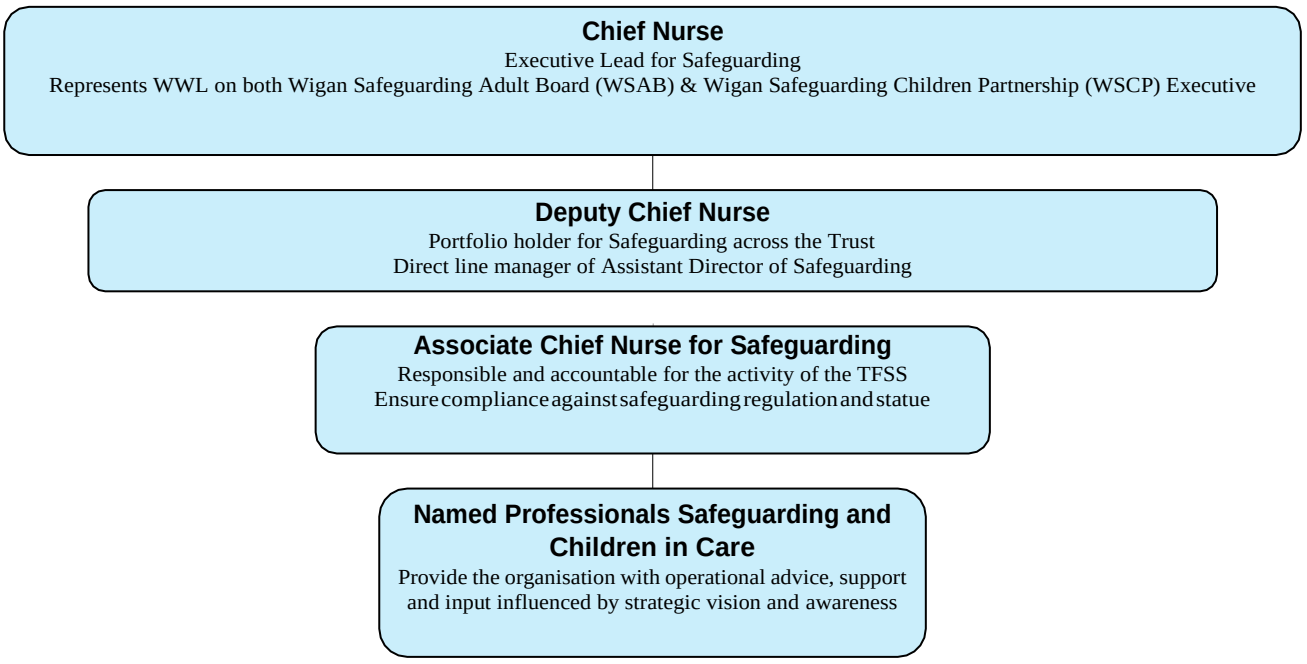
Safeguarding will always be complex and challenging but as a Trust, we have a clear picture of our safeguarding priorities to capture evidence of positive patient experience, improved health outcomes and keeping unborn babies, children, young people and adults at risk, safe. Every contact should count; safeguarding must be at the central in every assessment ensuring excellent communication to support recognition and response to any concerns. Whilst safeguarding remains at the core of what we do as an organisation it is implicit that as a provider of healthcare within the borough of Wigan we share with external agencies and partners a real purpose that embeds kindness, openness, inclusivity and compassion for those in our communities who require additional support be that from a preventative or protection perspective. Just like our WWL Delivery of Fundamentals Strategy we must ensure that we deliver safeguarding intervention right, every time, advocating for both patients and staff to avoid and reduce the impact of harm

[5] The CFPH is the first point of contact for professionals and members of the public to report concerns for a child. It's a co-located resource comprising of professionals from a range of disciplines and agencies. The team undertake a number of functions, including a Multi-Agency Safeguarding Hub (MASH) as well as access and signposting to Early Help Services.

Governance Arrangements for Safeguarding

In line with the statutory requirements of *Section 11 Children Act (2004), Working Together to Safeguard Children (2023),* the *Mental Capacity Act (2005)* and *The Care Act (2014)* the TFSS work alongside wards, departments, outpatient and community services to support high quality safeguarding care. In addition to the requirements of legislation, WWLTH as a registered provider with the Care Quality Commission (CQC), must have regard for the regulations established under the *Health and Social Care Act (2008)*.

WWLTH accountability for ensuring that its own safeguarding structure and processes meet the required legislative requirements is unchanged. The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding; these have been fulfilled throughout 2024/25. Governance aligned to specific roles and responsibilities is summarised below with further detail of the TFSS structure, inclusive of Named Safeguarding Doctor provision found in *Appendix 2*.



The TFSS senior leadership team has undergone change with the recruitment of two new Named Nurses for Safeguarding Adults and Safeguarding Children respectively. The promotion from the Think Family Service has supported a wider understanding of separate safeguarding team pressures with an appreciation of priorities for work plan objectives. The individual teams, part of the wider TFSS, have benefitted from corporate away days to celebrate achievements and focus on future plans and productivity.

The visibility and reputation of the safeguarding service has continued to grow both internally and externally throughout this reporting period generating a sense of shared responsibility, which is nurtured to support advanced improvements to protect patients, service users and staff from abuse or harm. Safeguarding governance arrangements include the WWLTH Safeguarding Effectiveness Group (SEG) held quarterly and chaired by the Chief Nurse. SEG has membership comprising, but not limited to, Non-Executive Director with lead for Safeguarding, Divisional Directors of Nursing and Allied Health Professionals (AHPs) and ICB GM place based Designated Safeguarding Professionals

Throughout 2024/25, SEG has provided a platform to share best practice, celebrate positive patient outcomes, and highlight areas of concern or those requiring improvement. This process ensures that key stakeholders are promptly conversant in any concerns whilst gaining assurance relating to statutory responsibilities.

Since April 2024, Safeguarding Operational Group (SOG) as a sub-group of SEG has commenced via monthly meetings. SOG continues to be used to improve safeguarding communication of emerging themes, trends and learning across the organisation. The group has adopted the Chief Nursing Officer's '*Fundamentals of Care Strategy 2025'* to maintain focus on key workstreams with SOG agendas aligned to the 'fundamentals' topic of the month which assists in facilitating productive discussion. Participation is encouraged and supports improved experiences and outcomes for patients, services users, and staff. Feedback from participants of SOG remains positive with members reporting an improved understanding of the safeguarding topics reviewed. In general, commitment to SOG across WWLTH divisions is positive, with a growing number of regular participants. Contribution within the meetings however, rests mainly with the Think Family Safeguarding Service practitioners facilitating the session. It is acknowledged that it will take time to develop the group, although positives can be taken from the implementation of SOG in the context of activity associated with safeguarding communication across the Trust. SOG is responsible for continued review of actions arising from internal investigations, incidents, and audits with a safeguarding element, plus local partnership safeguarding reviews, to ensure the embedding of practice change at the frontline to prevent repeated or increased episodes of harm. Absolutely, the implementation of SOG has widened the exposure of safeguarding governance to more varied staff groups across the Trust.

Safeguarding Champions is a further key resource for the sharing of safeguarding information and updating staff, but disappointingly there is minimal attendance from colleagues within our Acute Divisions (medicine, surgery and specialist services). Lack of engagement and attendance limits opportunities for information dissemination reducing the ability to garner wider staff participation and engagement that promotes better understanding of safeguarding from a professional, organisational and locality perspective. The TFSS continue to be proactive and steadfast in promoting the value of these forums and utilise senior leadership support to endorse the internal governance and engagement model that facilitates safeguarding activity and assurance.

An additional layer to safeguarding governance comes via an 'in reach' offer to divisional quality and safety groups which is further bolstered via improved divisional level safeguarding reporting into SEG. Historically the opportunities to feed into and out of these groups via either a divisional lens, or a purely safeguarding one, was limited. The requirements for reports that articulate divisional level safeguarding activity, improvements or concerns has provided welcomed supplementary insight into ward and divisional challenges and opportunities. Likewise, the ability for the TFSS to feed into divisional meetings with specific focus has been beneficial creating an added opportunity, in what would ordinarily be a very specific divisionally focused meeting, to share cross-divisional learning alongside local safeguarding board and partnership workstreams.

As part of the TFSS commitment to maintaining high standards of safeguarding practice across the organisation was a significant piece of work for 2024/25 in the development and update of several key Think Family Safeguarding policies and standard operating procedures. This activity formed part of the 'Think Family' workplan to support a trust wide holistic family focused approach that, at the heart, embeds integrated response to multifaceted risks across the whole family ensuring our workforce has clear guidance on the expectations in respect of recognition and response to safeguarding concerns. The updated policies and SOPs have been disseminated widely and have been accompanied by targeted communications inclusive of training updates along with being advocated through Think Family Safeguarding Supervision processes.

Robust safeguarding governance is vital to support and promote accountability, continuous improvement and high standards of care. In terms of safeguarding governance, the current structure facilitates readily the ability to share audit outcomes and create agreed monitoring and performance systems that maintain efforts on effectiveness, operational activity, compliments and complaints and crucially patient experience and service user voice. When considering this in the context of 'Safeguarding as everyone's business' WWLTH has worked hard to embed the safeguarding agenda throughout the organisation and with it a greater understanding of lived experience, voice of the individual, trauma informed care and think family perspectives which hold a sense of commitment and compassion that is shared by 'One Team'.

Our Patients - Safeguarding Activity

The TFSS has continued to capture safeguarding notifications to our safeguarding teams to identify and quantify activity via alerts, used by acute services, on the HIS system. While this provides an overview of safeguarding activity within the acute areas of the Trust this data does not capture outcomes or community safeguarding inputs. These notifications, through TFSS facilitated review, working in collaboration with WWLTH services and the partnership identify SMART action plans and provide assurance of appropriate interventions leading to positive outcomes and improvements in safeguarding practice.

HIS notifications to the TFSS in 2024/25 regarding both adults and children have decreased for the third successive year however, this is not demonstrative of reduced safeguarding activity or safeguarding incidence in the borough, nor should this reducing metric invoke a level of concern suggestive of 'missed' safeguarding incidents by WWLTH staff. The Think Family Safeguarding Service continued 'live time' accessibility, visibility and support across divisions is considered a driver in this reduction. This offer improves expert input via case review, supervision and debrief opportunities providing an ability to recognise and respond to safeguarding issues in advance of what would trigger a notification that generates post-identification or incident review by a safeguarding practitioner.

The capture of safeguarding activity within maternity services remains a challenge in the absence of an end-to-end electronic patient record system. However, data captured from the maternity Special Circumstances' Referral Forms (SCRFs) is utilised by the TFSS to monitor and support safeguarding activity across maternity caseloads. The Antenatal Pathway Group, established this reporting year, supported the development and implementation of improvements to the format of SCRFs which has increased the accuracy and validity of safeguarding information shared. Throughout the year, maternity SCRFs have highlighted that over half of all notifications of safeguarding concerns relate to presentations of additional need as opposed to risk and/or harm thus highlighting the requirement of midwifery staff to provide preventative intervention to those families where vulnerabilities have been identified. This required whole family response is reflective of the Think Family approach to safeguarding embedded within WWLTH.

Paediatric Emergency Care Centre (PECC) and the Emergency Department (ED) are consistently the main entry points to WWLTH and therefore remain the highest notifiers of safeguarding concerns to the TFSS. There has been a reduction in notifications from PECC by **9%** and while there is no hard data to confirm the hypothesis, this is considered to be indicative of staff feeling more confident in their safeguarding decisions and no longer using the HIS notification process as a safeguarding safety net.

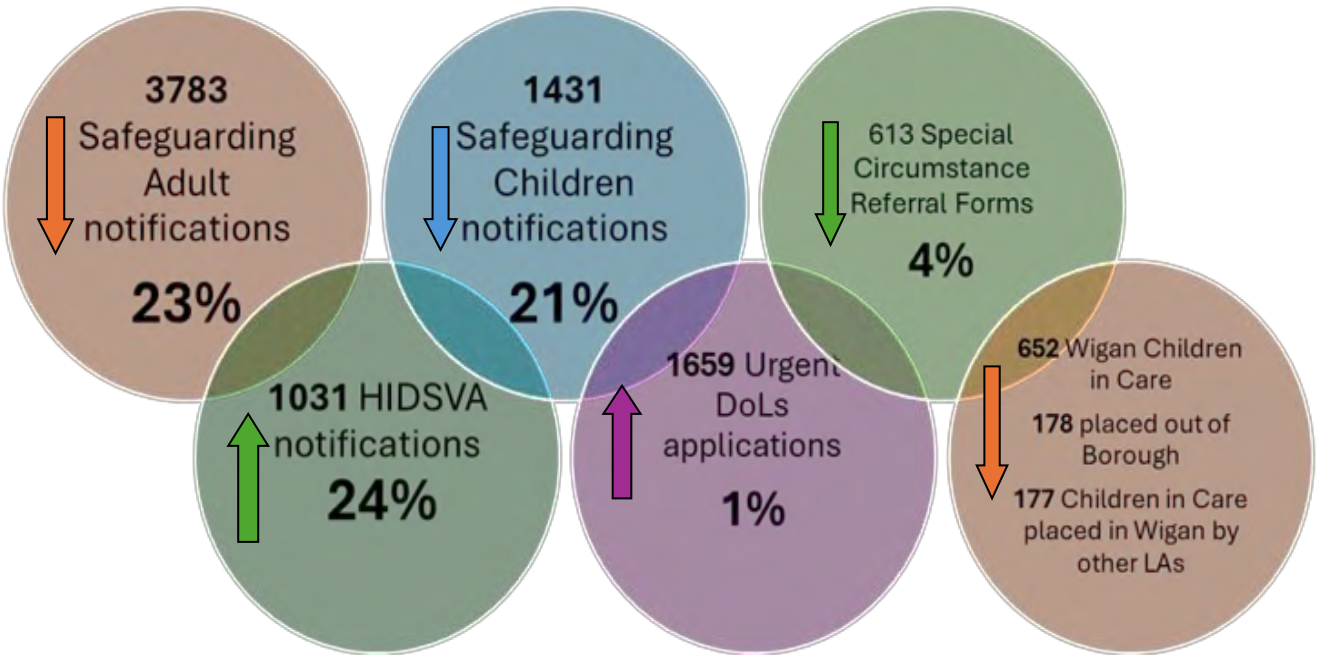
The number of notifications received by the TFSS Safeguarding Adult Team from the Emergency Department (ED) in 2024/2025 has followed a similar trend to the previous year, with the primary reason continuing to be concerns around an individual's ability to meet their own care and support needs. This highlights that whilst there is a requirement for wider education on the principles of *The Care Act (2014)*, there is also a workforce who is able to identify a person at risk and therefore recognises the value of preventative intervention.

In line with national data the second most common reason for safeguarding notifications was concerns relating to mental health, with **861** notifications received in 2024/2025; of which only **17** resulted in an onward referral to Adult Social Care (ASC) Services and **26** resulted in an onward referral to Children's Social Care (CSC). Self-neglect continues to be the biggest reason for onward referrals to ASC, reinforcing the need for this to be a TFSS focus in 2025/2026, with **63** onward referrals made directly by the WWLTH Safeguarding Adult Team following HIS notifications being received by the TFSS from Trust staff. What is unknown however is the number of direct referrals to ASC, and/or CSC, by practitioners who identify or recognise safeguarding concerns, whatever their nature negating the need for direction and support of safeguarding practitioners. Whilst there is an ability to receive some level of WWLTH safeguarding referral data from Local Authority partners this is often inaccurate and subjective; categorisation of referrals by referrer is very broad with WWLTH practitioners forming part of a wider group of professionals under a 'health' umbrella. Again, caution is

to be applied as to the disadvantage or negative perceptions of this limited data set – the action of generating a safeguarding referral is merely that; it doesn't not provide detail of safeguarding intervention or appropriateness of requirement for statutory intervention, nor does it capture outcomes that provide assurance as to the practitioners, and by virtue of their employer, the Trust's ability to discharge its safeguarding duties. There remains internal work ongoing with Business Intelligence colleagues and Data Analytics Teams the TFSS to promote a clearer view of outcome measures alongside an ability to understand safeguarding themes and trends be they at an individual patient, population or presentation type level.

There remains challenge that there is no way to consistently and accurately capture community safeguarding activity due to limitations within SystmOne, however, TFSS provide oversight via mandatory supervision across WWLTH monitoring the effectiveness and quality of community safeguarding interventions. Throughout 2024/25, there have been periods of significant pressure across the Trust in terms of presentation and capacity within ED, acute bed capacity, staff resource across services and divisions with periods of critical incident however, despite pressures, recognition and response to safeguarding concerns has consistently remained high with support from TFSS being maintained.

Safeguarding notifications from Leigh and Wigan Urgent Treatment Centres (UTC) and community services in relation to children remain relatively static while Rainbow Ward HIS notifications have increased by **47%** potentially in line with increased safeguarding complexities and an increase of a **42%** in non-accidental injury. Not all non-accidental injuries progress to identification of a baby being physically hurt, some result in recognition of birth trauma or birth marks, however ongoing analysis following data capture and review by the TFSS Safeguarding Children Team is a priority workstream. From a partnership perspective, and internally, the higher figures are indicative of the application of WSCP Non-Mobile Protocol (which was updated in April 2025) being followed by staff and wider partnership professionals.



Our Patients- Safeguarding Presentations

Nationally poor parental mental health has for the first time has overtaken Domestic Abuse (DA) as the most common factor in children's social care assessments. WWLTH safeguarding presentation data is reflective of this, with the main concerns for children and adults relating to mental health issues; for children there is an added complexity in those concerns often relate to not just their own mental health, but that of their parents/carers. Whilst there is a decreasing trend overall in terms of quantity of presentations at the 'front door' this conveys only where staff have required additional safeguarding service support. The patients who require admission regarding their mental health are increasingly complex and require secondary support that is often difficult to access, implement or transition to.

The 'Think Family' approach continues to be embedded across the organisation, with increasing recognition of how parental or carer mental health difficulties and substance misuse can significantly impact physical health, heighten social concerns, and affect the wellbeing of children and the wider family unit. WWLTH works closely with Greater Manchester Mental Health NHS Foundation Trust (GMMH), the primary provider of mental health services in the borough, to promote integrated working that prioritises patient safety while ensuring safeguarding needs are considered holistically across the family. However, the existence of separate Trust policies and procedures, combined with a lack of clarity around roles and responsibilities, has presented challenges in terms of accountability and escalation pathways. To address this, both organisations are actively engaged in strengthening joint working arrangements. A key focus of this ongoing work is the development of shared expectations and clearer operational guidance, underpinned by the continued collaboration between the respective safeguarding services.

WWLTH safeguarding children data highlights an increase in the number of HIS notifications for Physical injury of the non-mobile child **↑70%** compared to last year. There is a pathway in place to underpin the assessment of all these children and explore and identify in conjunction with multi-agency partners if any safeguarding concerns are present. However, learning from WSCP Rapid Reviews, identified a lack of use or inconsistencies in approach by partners. As such the TFSS supported the development and implementation of the new WSCP joint pathway for injuries in non-mobile children protocol to ensure a clear and consistent process for professionals identifying any bruise/injury which has no plausible or recorded cause.

WWLTH Children in Care (CiC) Team are responsible for delivery of health activity for this cohort of children[6] as outlined in statutory guidance and commissioned service specification. The team are accountable for delivery of Key Performance Indicators (KPIs) related to Wigan CiC, regardless of placement in or out of borough, together with any CIC placed into Wigan by other local authorities (CiCOLAs).

Local profile of Children in Care

Cohort Descriptors	Wigan 23/24	Wigan 24/25	Trend	SN 23/24	NW 23/24	Eng 23/24
No. CLA 31st March 2025	741	652	↓	-	-	-
Rate of CLA 31st March 2025	105	92	↓	91	94	70
No. UASC 31st March 2025	60	24	↓	-	-	-
% CLA who are UASC 31st March 2025	8%	3%	↓	6%	5%	9%
Rate of CLA becoming looked after	40	26	↓	28	31	28
Rate of CLA ceasing to be looked after	30	37	↑	30	31	28
CLA placed outside borough	257	178	↓	-	-	-
% CLA placed outside borough	35%	27%	↓	37%	41%	45%
CLA with a recorded EHCP	144	117	↓	-	-	-
% CLA with a recorded EHCP	19%	18%	↓	-	-	-

CLA – Child Looked After, UASC – Unaccompanied Asylum-Seeking Child, EHCP – Education Health Care Plan, SN – Statistical Neighbours

[6] Children in Care (CiC) are referred to in legal terms as 'Looked After Children'. In England and Wales, the terms is defined in law under the Children Act 1989

Alongside the statutory health interventions for CiC is a requirement to recognise and respond to incidents of increased safeguarding concern requiring additional support. Research outlines the increased likelihood of poor social and mental health outcomes for children in care and care experienced adults therefore early activity to help to address emerging or longstanding, but previously unmet need, is crucial. The CiC Team utilise a RAG rating system to rate the complexity of need for health interventions, associated risk, and safeguarding. The number of Children in Care who required additional support and intervention (those rated as red or amber) in addition to statutory health assessments, accounts for **64%** of the CiC Team caseload.

53 children rated RED	**312** children rated AMBER	**204** children rated GREEN

There is a noted high proportion of CiC with neurodiversity, often part of the SEND (Special Educational Needs and Disability) cohort, with several CiC also open to the Complex Safeguarding Team due to concerns around risk of, or actual criminal and/or sexual exploitation. Pregnancy information is now shared with the WWLTH Children in Care Team by our maternity services to support with care planning and preventative interventions for any woman or father of the unborn who is recognised as a child in care or care experienced adult under twenty-five years of age. This activity is as a direct result of recognition of increased support, care and intervention required to ensure preventative approaches to safeguarding both the parents and the child, the need for which has been evident within recent local safeguarding reviews.

Response to identification of safeguarding concerns is crucial in protecting individuals from further harm and in ensuring improved outcomes. There has been continued extensive input throughout 2023/24, led and supported by WWLTH Safeguarding Service, in relation to the Harm Free Care agenda with activity relating to Pressure Ulcers, Unsafe Discharge and Falls being a focus of improved data collection and analysis. Similarly, from a children, children in care and maternity safeguarding perspective there has been initiation and involvement in a number of internal rapid reviews and After-Action Reviews (AAR) which often pre-empt the statutory safeguarding review processes to ensure swift learning and implementation of changes to practice, improving care delivery and assuring against repeated incidents of harm.

Unfortunately, WWLTH has not met its 2024/2025 objective to eliminate category 3 and 4 hospital-acquired pressure ulcers (HAPUs) and community-acquired pressure ulcers (CAPUs), nor achieved the targeted **10%** reduction in category 2 and deep tissue injury (DTI) HAPUs and CAPUs. Despite this, pressure ulcer prevention continues to be a central component of the Trust's wider strategy to reduce avoidable harm and improve patient safety. In response, the Pressure Ulcer Prevention Steering Group is actively reviewing and adjusting its workplan at the end of each quarter, ensuring that competing operational priorities do not impede progress. This need for scrutiny was exemplified through two extraordinary after-action reviews (AARs) conducted in relation to pressure ulcer incidents. Each AAR adopted a comprehensive, multidisciplinary approach to examine the patient journey in detail. Safeguarding input proved instrumental in both reviews, supporting a more holistic analysis of root causes and enabling the identification of robust, patient-centred improvement actions.

In a separate safeguarding review, a significant lapse in safeguarding practice was identified following an incident involving the transfer of a child from Leigh Urgent Treatment Centre (UTC) to the Paediatric Emergency Care Centre (PECC). While clinical documentation and liaison were appropriately undertaken, there was a lack of evidence that safeguarding considerations informed the decision-making process. Additionally, the established safeguarding protocols were not followed, and critical safeguarding information was not shared effectively between services. Learning from this incident, particularly in relation to professional curiosity, effective communication, and the handover of safeguarding concerns, has been disseminated through the Learning from Patient Safety Events (LfPSE) system. Associated action plans are now being overseen by both the relevant clinical divisions. This case, among others, highlights the ongoing need for strong governance, effective support structures, and a culture that empowers staff to uphold high standards of safety and accountability.

To further strengthen safeguarding practice, the implementation of a digital solution to facilitate timely and secure information sharing across systems is recommended. Such a solution would support the seamless transfer of safeguarding concerns and enhance the Trust's ability to respond to risk in a timely and coordinated manner and remains a focussed priority for the TFSS.

Domestic Abuse

Safeguarding notification data illustrates that domestic abuse remains a significant concern across adult, children and maternity safeguarding. As a result, addressing domestic abuse has been a core priority for the Think Family Safeguarding Service. 2024/25 has seen a **24%** increase in the number of domestic abuse victims identified by WWLTH staff and subsequently referred for specialised HIDSVA support; the majority of these referrals, **42%,** coming from acute episodes where patients have attended the Emergency Department. Whilst this provides assurance in terms of front-line practitioners professional curiosity and recognition of victims of domestic abuse, there is an acknowledgement that more work needs to be done to support and monitor staff responses to those patients accessing other Trust services but also outside of the core hours of the Safeguarding Service where HIDSVAs cannot directly to respond in person. This is reflective within the data with a large percentage (**44%)** of identified victims of domestic abuse receiving bespoke safety planning whereas **4%** of victims were identified via the CAADA-DASH[7] risk assessment as being high risk and referred to Multi Agency Risk Assessment Conference (MARAC)[8]. Building on work already undertaken this year a key priority for 2025/26 will be increased and improved domestic abuse training in areas such as response and recognition, safety planning and completion of DASH risk assessments in order to extend support to patients presenting with domestic abuse who may not require or decline specialised and specific HIDSVA support.

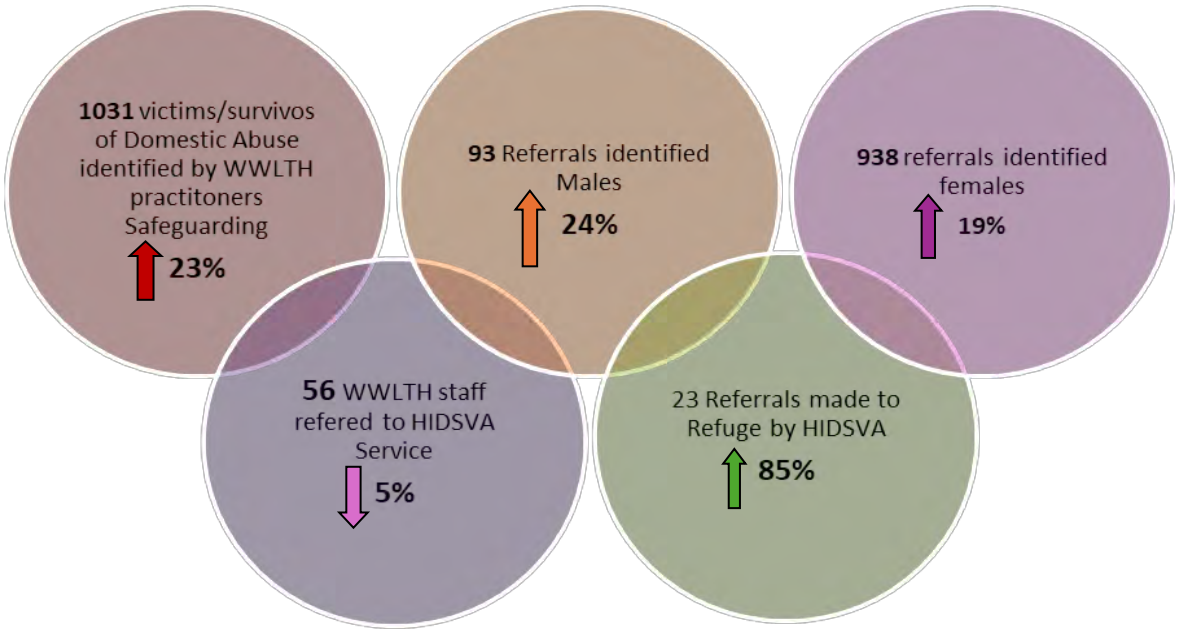
This year a key change in legislation of the *Victims and Prisoners Act (2024)* amended the name of Domestic Homicide Reviews contained within the **Domestic Violence and Crimes Act (2004)** to Domestic Abuse Related Death Reviews (DARRs) to reflect the range of the deaths which fall within the scope of a review, such as suicides related to domestic abuse, and other domestic abuse related deaths. This change has subsequently increased the number of reviews, which has inevitably impacted upon the capacity of the TFSS in relation to information gathering, representation at panel meetings, and reports. The facilitation of reflective learning from these cases has been invaluable to supporting practitioner development and improving standards of care whilst strengthening multi-agency shared learning. Throughout this year **4 DARRs** have been undertaken with two reaching completion and a further two ongoing; of note is that three of the DARRs undertaken have been for male victims of domestic abuse. This corresponds to a shift in WWLTH safeguarding data trends which has seen a **24%** increase in the identification of male victims of domestic abuse and the TFSS continues to promote an approach to safeguarding that is gender inclusive and nonjudgmental, with safeguarding training encouraging all practitioners to be alert to the signs of male victimisation, avoid gendered assumptions and responding with diligence and empathy. Learning in relation to professional curiosity and using a Think Family approach to understand the lived experience of victims of domestic abuse and their children has been included in the recently revised and merged Think Family level 3 Safeguarding Training.

The TFSS continues to work in collaboration with local safeguarding boards and community partners to promote a system-wide response to domestic abuse. The TFSS continues to play a key role in MARAC and Multi Agency Tasking and Coordination[9] (MATAC) meetings whilst supporting from a Community Safety perspective the Prevent agenda through participation in Channel Panel. Challenges however remain in securing coordinated support for individuals with complex needs, such as those facing homelessness, disability, or mental health issues, particularly where cross-boundary or multi-agency responsibilities overlap. While the *Domestic Abuse Act 2021* places a duty on Local Authorities to provide all eligible homeless victims of domestic abuse with 'priority need' status for homelessness assistance challenges of cross boundary working, with a lack of clear agency responsibility, has impacted upon the safe discharge of WWLTH patients. The TFSS has been

[7] Dash risk assessment resources for professionals - SafeLives
[8] Learn more about the Marac - SafeLives
[9] Multi-agency tasking and coordination domestic abuse programme | College of Policing

heavily relied upon to manage the complexities surrounding discharge, especially in cases where individuals are seeking refuge from domestic abuse. This places a strain on the available safeguarding resources at WWLTH, when the primary challenges lie with Local Authorities. WWLTH has escalated these cases, in principle, to the Domestic Abuse Oversight Board and Community Safety Partnership, seeking clarity on partner's responsibilities to prevent discharge delays and ensure vulnerable patients/service users are supported appropriately prior to, during and post access to WWLTH services.

Additionally, the HIDSVA service continues to offer support to staff who experience domestic abuse and sexual violence (including sexual harassment within the workplace) with **56** WWLTH staff referred to HIDSVA this year. There remains close and positive working relationships between safeguarding, HIDSVA and Human Resources colleagues in ensuring effective support is available to any member of WWLTH staff who experiences domestic abuse. The TFSS and HIDSVAs remain crucial to the delivery of the NHS England Sexual Safety Charter[10] supporting the development of a WWLTH Sexual Safety Policy but more importantly providing input into the response and action at both an individual and organisation level in commitment of the zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours in the workplace.



Child Death

Process around Child Death continues to be overseen by the Named Nurse Safeguarding Children supported by the Safeguarding Children Team working closely with WWLTH Designated Doctor for Child Death. The Designated Doctor for Children Death is jointly responsible for contributing to the Child Death Overview Panel (CDOP) processes, which for Wigan is convened in partnership with Bolton and Salford. Sadly, there were **21** child deaths during the reporting year; this number has increased by three from the previous year.

Whilst the death of any child is tragic with an often long and difficult process for parents in terms of understanding what has happened, in terms of safeguarding seven of these deaths were expected due to the presence of life-limiting conditions or complex heath needs. Fourteen children, where their death was determined 'unexpected' sadly died due to a variety of causes with no clear or emerging trends.

The introduction of the key worker role (to act as a single point of contact for the family) working in conjunction with the WWLTH Bereavement Team and Chaplaincy Service now provides increased support to parents in navigating the statutory child death process.

[10] NHS England » Sexual safety in healthcare – organisational charter

Our People – Support, Supervision, Training

Support

The TFSS has continued to prioritise training, supervision, and accessible safeguarding advice for all WWLTH staff, with the aim of supporting professional development and ensuring the early identification of safeguarding concerns. This proactive approach enables timely and effective responses to potential abuse and neglect.

Over the past year, the TFSS has enhanced its training and supervision offer across the organisation. This has included targeted initiatives to improve staff compliance, awareness, and accountability at all levels. A significant development was the ratification of the **TW24-058 Think Family Supervision Policy**, which provides a structured framework for reflective safeguarding supervision. This includes individual supervision for staff holding safeguarding caseloads and group supervision for non-caseload holders. In addition, reactive, ad hoc advice and supervision is available daily through the Think Family Safeguarding Duty and Consultation offer, ensuring continuous access to safeguarding support.

Collaborative working with local authority partners has also been strengthened, particularly through the facilitation of joint agency supervision for complex and escalating cases. These sessions, led by Named Safeguarding Professionals and the local authority service lead, promote a coordinated approach to safeguarding with agreed joint actions to support families.

During the reporting period, six Rapid Reviews[11] were submitted by WWLTH TFSS to the Wigan Safeguarding Children Partnership (WSCP) for consideration of a Child Safeguarding Practice Review (CSPR). While two cases progressed to full CSPR, all six have contributed valuable learning, informed the content of Think Family Level 3 training and shaped a revised approach to embedding safeguarding practices. Recurring themes identified through statutory and non-statutory reviews include insufficient multi-agency working, ineffective information sharing, limited professional curiosity, and a failure to consider children's voices or patient's lived experiences, particularly through a trauma-informed lens.

Not all rapid reviews result in formal multi-agency learning; however, the use of AARs and restorative group supervision has proven highly effective in ensuring learning is retained and translated into practice. These reflective sessions bring patient journeys to life, enhancing understanding and recall of key safeguarding concepts. A fundamental principle of AARs and restorative supervision is the creation of a safe space, where all participants can contribute openly and without fear of blame—fostering a culture of learning rather than accountability.

A further development this year has been the strengthening of maternity safeguarding. Two Specialist Safeguarding Practitioners within the TFSS, both holding midwifery registration, have been instrumental in extending safeguarding visibility and support to maternity services. Through internal restructuring and post rotation within the Children's First Partnership Hub (CFPH) as the multi-agency front door, safeguarding support traditionally focused on adult and child pathways has been broadened to better address the needs of maternity teams. This has significantly improved staff confidence, enhanced multidisciplinary relationships, and led to more positive outcomes for unborn babies, neonates, and their families. A structured framework of supervision for maternity staff has now been implemented, supported by increased contact, training, and targeted education.

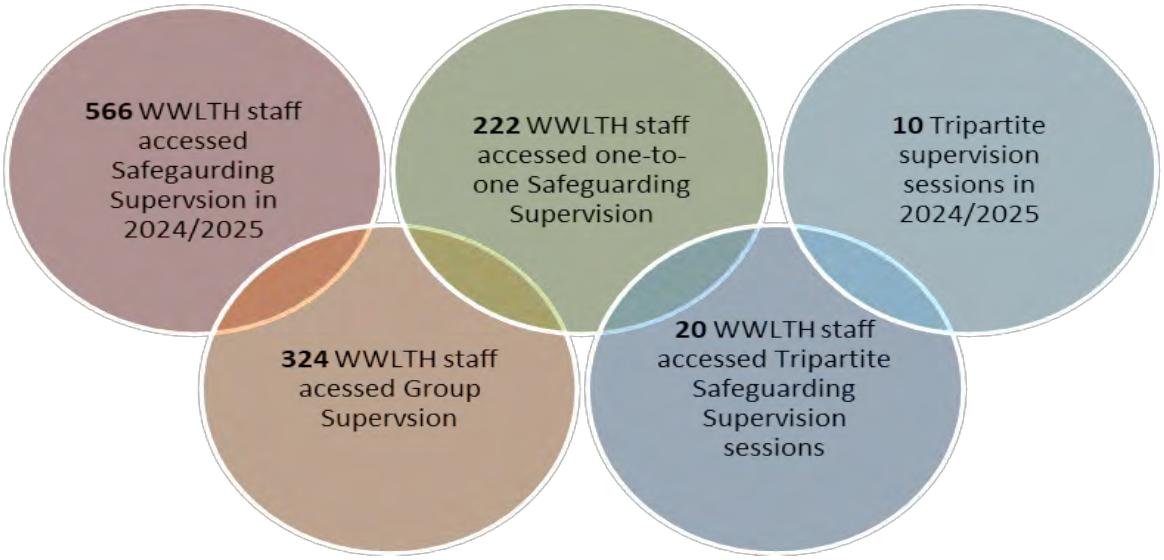
Evidence consistently shows that access to timely safeguarding support enhances staff confidence and responsiveness, leading to better outcomes and improved patient experiences. The TFSS remains highly visible and responsive, supporting teams across the Trust in managing urgent and emerging safeguarding concerns effectively.

[11] CSPRP_guidance_for_safeguarding_partners.pdf page 17

In response to findings from an internal safeguarding audit of Enhanced Care in May 2024, the TFSS identified the need to improve understanding and application of least restrictive practice across the organisation. The audit highlighted frequent use of restrictive interventions without adequate exploration of less restrictive alternatives, as well as limited awareness of the potential negative consequences of such practices—including delayed discharges and diminished patient outcomes. As a result, dedicated training on least restrictive practice has been prioritised for delivery throughout 2024/2025 to address these gaps and promoting evidenced based care.

Supervision

Throughout the year, the Think Family Safeguarding Service has continued to progress the supervision offer to WWLTH staff, improving practice by enhancing compliance, awareness, support and accountability across all levels of the organisation. The ratification of the Think Family Safeguarding Supervision Policy has created a structured framework of reflective safeguarding supervision to support equitable access to all, across all divisions. Safeguarding Supervision is offered both on an individual and group basis for case load holders, with reactive supervision offered daily via the service. Throughout this year the TFSS has built upon progress of previous years extending the effective supervision sessions already embedded into children's community services to maternity community case load holders. Direct supervision sessions have led to the development of joint SMART action plans with practitioners to improve outcomes for escalating safeguarding cases. The Safeguarding Adult Team continues to be dynamic in its approach to supervision responding to targeted areas such as community Health Outreach and Inclusion Service (HOIS) to strengthen safeguarding responses. A review of the supervision offer to adults with mapping of requirements across the workforce in line with the new policy has also been undertaken to support 2025/26 work streams.



Training

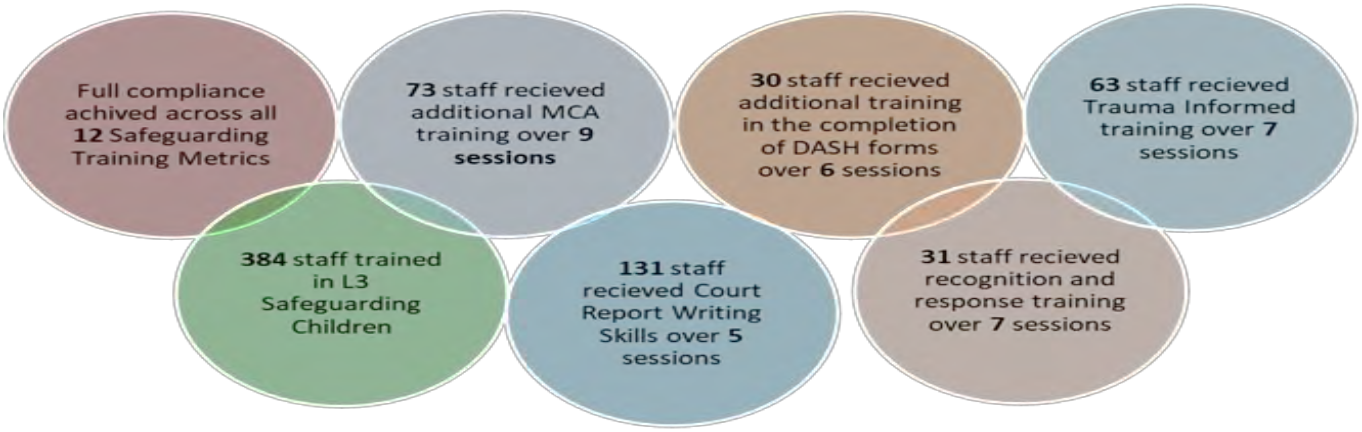
A Think Family Safeguarding Training Strategy and associated Training Needs Analysis has been devised and refreshed to support ongoing developments ensuring WWLTH effectively maintains compliance against mandated safeguarding training targets whilst establishing a confident and competent workforce able to safeguard children and adults at risk. The newly developed Think Family level 3 Safeguarding Training was piloted in November and December 2024; a model that will ensure learning is delivered in a cohesive and accessible format by merging previously lengthy and outdated separate Safeguarding Adult and Safeguarding Children modules.

A full day session will be initially offered to new members of staff to the Trust, or those new to Level 3 learning, with half day annual Think Family level 3 updates being provided for existing staff. A 3-year programme was mapped to ensure compliance is maintained in all safeguarding categories supporting the transition from

separate adult and child training programs at this level, whilst allowing the addition of previously missing training in relation to Children in Care. This change will promote adherence to competencies outlined in all three Intercollegiate Documents and will focus on learning from local reviews to support and embed necessary changes in practice that demonstrate additional assurance against delivery of safeguarding obligations across the Trust. The combined annual required level 3 offer will cover all aspects of safeguarding over what was an every 3-year event and is anticipated to support staff in obtaining and maintaining skills and knowledge across multiple areas of safeguarding recognition and response in an action and expertise context.

To mirror and complement the level 3 Think Family Safeguarding Training, mandatory training across paediatric and maternity services will now be scenario-based across the lifespan; this approach allows reflection on opportunities to improve practice and outcomes. Updates to local Mental Capacity Act (MCA) training and PREVENT have been considered, adapted and modified to ensure adherence to national and local drivers with reference to the expectations of the NHS E Statutory and Mandatory Training (StatMand) programme.[12]

Mar-25		WWL Mandatory Training Compliance Figures				
WWL Compliances	**Target Compliance**	**Total Staff**	**Compliant Staff**	**% Compliance**	**Non Compliant Staff**	**% Non Compliant Staff**
Mental Capacity Act Level 1	85%	1101	1044	**95%**	57	5%
Mental Capacity Act Level 2	85%	3167	2944	**93%**	223	7%
Prevent Basic	95%	7142	6884	**96%**	258	4%
Prevent Clinical	85%	3390	3186	**94%**	204	6%
Safeguarding Children Level 1	95%	2554	2507	**98%**	47	2%
Safeguarding Children Level 2	85%	3819	3665	**96%**	154	4%
Safeguarding Children Level 3	85%	760	669	**88%**	91	12%
Safeguarding Children Level 4	85%	8	8	**100%**	0	0%
Safeguarding Vulnerable Adults Level 1	95%	2289	2211	**97%**	78	3%
Safeguarding Vulnerable Adults Level 2	85%	1583	1556	**98%**	27	2%
Safeguarding Vulnerable Adults Level 3	85%	3261	2959	**91%**	302	9%
Safeguarding Vulnerable Adults Level 4	85%	8	8	**100%**	0	0%



[12] NHS England » Statutory and mandatory training (StatMand) programme

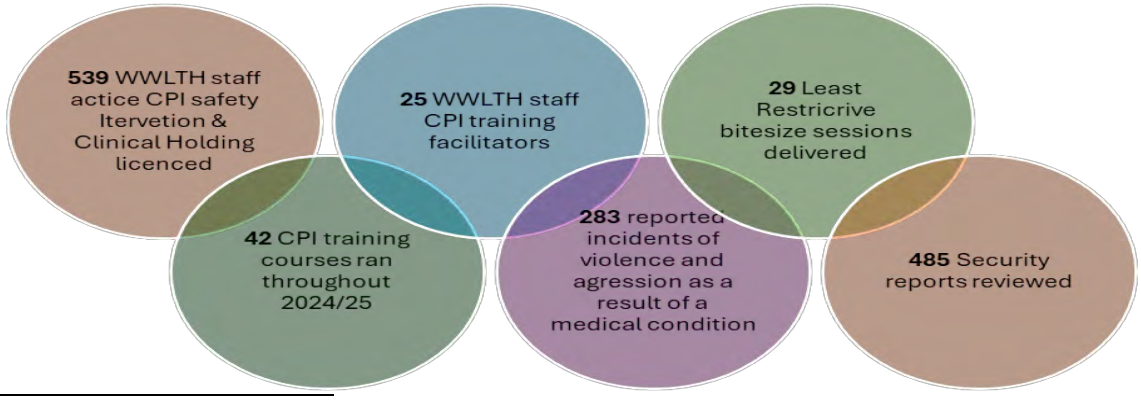
Least Restrictive Practice

Throughout 2024/25 the TFSS has made significant progress in supporting the implementation and promotion of least restrictive practice values across the organisation. Least restrictive practice is a core principle of both safeguarding and the *Mental Capacity Act 2005*, requiring any intervention which limits a person's rights or freedoms is the minimum necessary, proportionate and in the person's best interest. Promoting this approach is essential to upholding the rights, autonomy and dignity of patients particularly those who lack capacity, have learning disabilities, mental health conditions or who are deprived of their liberty.

During the previous year 2023/24 the development of WWLTH least restrictive policy provides direction for delivering least restrictive care interventions to children and young people (CYP) up to the age of eighteen, and adults. This year, to further support practice, standard operating procedures that provide guidance in relation to specific situations such as **TW-23-046 Rapid Tranquilisation**, **TW13-039 Assessment of Mental Capacity, TW24-082 Best Interest Meetings/Decisions** have been developed and implemented by the TFSS. The updated protocols ensure our workforce have clear direction on expectations in respect of least restrictive practice in addition to consistent language around necessity, proportionality and evidenced based defensible decision making when restrictive practices are required. Supplementary quick reference tools such as the de-escalation pyramid (*see appendix 1*) were developed, implemented and distributed across the organisation to support staff to consider alternative person-centred trauma informed approaches interfaced with risk management.

To provide assurance to our patients, staff, and partners, the Trust have committed to workforce training and development for all front-line practitioners in acute and community settings, in the Crisis Prevention Institute (CPI) Safety Intervention Foundation and Clinical Holding Training[13], which is certified as meeting the Restraint Reduction Network training standards. Twenty-five WWLTH staff are active CPI safety intervention and clinical holding training facilitators, having successfully completed the CPI instructor's facilitator course. This 'in house' model of training alongside limiting associated financial implications of external training has had the additional benefit of tailoring training to meet local population need. Strengthening the approach to least restrictive practice this year mental capacity and medicines management were added to CPI training program supporting implementation of the new standard operating procedures and ensuring a complete approach to person centred least restrictive care. During 2024/2025 **29** CPI training courses were run in addition to **13** annual update courses ensuring continued standards of accreditation. At the end of 2025 WWLTH boasted **539** active CPI safety intervention and clinical holding licensed staff

There were **283** incidents reported under the category 'violence & aggression as a result of a medical condition' in 2024/2025; a positive increase in reporting from 2023/2024 which only saw **181** incidents reported. While challenges remain, the shift towards person centred trauma informed practice is evident in training, policy, case work and governance activity. Review and escalation of least restrictive cases are supported via divisional and corporate patient safety groups with input from the TFSS to ensure consistency of learning and linking theory to practice.



[13] institute.crisisprevention.com/UK-IR-3rd-Edition-Training/

A thematic review was commissioned by the Trust's learning from patient safety experience (LfPSE) group following a reported increase in incidents involving restrictive interventions used during the management of patient violence and aggression. These incidents identified through patient safety groups, complaints, and incident reports, frequently involved patients lacking capacity, raising concerns about the proportionality and legality of staff and security responses under frameworks such as the *Mental Capacity Act (2005)* and *Deprivation of Liberty Safeguards (2019)*. The review examined whether restrictive practices were clinically justified and aligned with least restrictive principles. It also analysed the role and responses of the Trust's security provider to assess the appropriateness of interventions and escalation processes.

Findings from the above audit, in conjunction with the April 2024 Enhanced Care Audit and a focused medication audit, indicated restraint inequalities and inconsistent application of preventative and diversionary measures. Concerns were raised about the potential for disproportionate or routine use of restrictions, highlighting the risk of unlawful deprivation of liberty and organisational abuse as defined by the *Care Act (2014)*. The combination of thematic review called for urgent action to ensure restrictive practices are lawful, proportionate, and used, when necessary, with a stronger emphasis on early intervention, staff training, and safeguarding oversight. The resultant Least Restrictive Action Plan provided a high-level overview of necessary activity that was required to provide assurance that the Trust was not at risk of committing Organisational Abuse with executive and senior leadership oversight of progress against the set actions. All areas of the action plan were completed with a recognition that this was the start of a process that required strategic and operational intervention to ensure a change in culture around restrictive practices. Therefore, a detailed improvement plan was devised to maintain momentum around a number of key areas; this plan is managed by the Least Restrictive Working Group utilising the skills and expertise of multi-disciplinary staff from across the organisation to drive improvements.

Our Partnerships – Contribution to Multiagency Safeguarding

As a direct result of insights gained from recent case reviews and thematic analyses, the WSAB has undertaken a strategic realignment of its priorities to better address emerging safeguarding challenges. This has led to the establishment of four dedicated subgroups focused on key areas: Self-Neglect, Risk & Complexity, Mental Capacity & Deprivation of Liberty Safeguards (DoLS), Organisational Safeguarding, and Learning & Quality. Each subgroup is tasked with driving focused workstreams that promote multi-agency collaboration, enhance understanding, and develop targeted interventions. These subgroups play a critical role in shaping policies, improving practice standards, and ensuring that safeguarding efforts are responsive, effective, and aligned with both local needs and national safeguarding frameworks.

The WSCP priorities have focused on professional curiosity, critical thinking & challenge, impact & analysis, voice of the child and SMART action planning. The TFSS co-developed and delivered with two children's services staff the **'How to write a SMART action plan training'**. Multi-agency attendance at these sessions has been variable therefore the TFSS has delivered bespoke sessions internally to the Community division 0-19 service and TFSS practitioners, plus multi-agency MARAC professionals. It is beneficial that professionals working with Wigan children and families are able to offer the same approach to SMART planning, which will not only improve relationships with families and professionals but provide those involved with common goals and objectives.

Bitesize Professional Curiosity and Voice of the Child sessions have previously been delivered to WWLTH staff by the TFSS but despite these sessions, children safeguarding practice reviews (CSPR) continue to identify learning around these areas. Considering the ongoing themes, the TFSS have revisited embedding lessons learned and have developed training scenarios associated with real life cases. The scenarios are delivered to promote flexible learning to inspire confidence and encourage participation and self-belief, giving participants the opportunity to test ideas promoting teamwork and collaboration. These approaches support strengthening knowledge as a collective group to enhance our care delivery. Scenario based learning has also been adopted into mandatory training days for maternity and paediatrics, group safeguarding supervision and Safeguarding Champions meetings. Similarly, AAR's have been utilised to review the outcomes of cases to improve future safeguarding decisions and actions. Following the delivery of WSCP Escalation and Resolution Protocol[14] bitesize training, the escalation process anecdotally presents now as being embedded into care planning for children where there are safeguarding concerns. The protocol is used effectively with positive outcomes for children and families and is often resolved at stage two.

The Think Family Safeguarding Service have been involved in partnership multi-agency audits to assess the effectiveness of multi-agency collaboration within the context of safeguarding children. In 2024/2025 the partnership has completed audits of school attendance, parental vulnerabilities, obesity and early help assessments and plans. Likewise, the TFSS has been engaged in audit activity as requested and directed by WSAB in regard to adult safeguarding themes and trends. Partnership audits often give rise to the need for internal thematic deep dives whilst promoting opportunities to respond to practice change preventatively as opposed to reactionary.

A key priority for Wigan Children in Care is *Stability and Support* and Weekly Placement Stability panel, attended by Named Nurse CiC, recognises the value of muti agency working in supporting placement permanency. Agencies work together to ensure that children only move in a planned way and at a time that is right for them. When children do move, it is important to reflect and help support children and carers with the emotional impact of moves. As all agencies continue to develop their understanding of childhood trauma, the WWLTH CIC team ensure that all interactions are therapeutic opportunities that help support children to feel safe and secure and hopefully heal from their experiences. In 2023, Wigan Council commissioned Meadows Psychology Service to deliver a service designed for CiC and care leavers, known as 'Our Safe Space.' The CiC team have developed stronger links with Our Safe Space to highlight child specific concerns, and whilst we are unable to refer directly to the service, they agree to offer consultation and/or training via Placement Stability Panel. The CiC nurses are now regularly included in consultation meetings as their knowledge and trusted relationship with the child is highly valued.

WWLTH remains fully compliant with the requirements of the *Mental Capacity Act (MCA) 2005*, including its Deprivation of Liberty Safeguards (DoLS) provisions. These safeguards are a critical legal framework designed to protect some of the most vulnerable individuals in our care and underpin the least restrictive workstream. The Trust maintains a robust working relationship with the supervisory body, Wigan Council, to ensure all DoLS applications are lawfully applied and proportionate. This ongoing liaison between the managing authority (WWLTH) and the supervisory body ensures that any restrictive practices implemented are legally justified.

[14] Resolution-Protocol-May-2024.pdf

Right Care, Right Person (RCRP)[15] as a national approach, from the National Police Chiefs' Council, went 'live' this year with a focus on police forces working with partners to ensure that individuals receive the right support by the right organisation, at the earliest opportunity. Under RCRP, when a concern for welfare is reported, Greater Manchester Police will identify the nature of the concern and signpost the caller to the most appropriate agency to meet the need. However, there have been challenges experienced by WWLTH associated with the implementation of the RCRP in relation to WWLTH's Missing Patient (Absconding) Policy increasing pressures within the Emergency Village. The misaligned responsibilities and expectations of agencies associated with a misunderstanding of roles and responsibilities for absconding patients or hospital 'walkouts' has increased incidents of concern and safeguarding for WWLTH. The Trust has escalated these challenges to the Domestic Abuse Oversight Board and Community Safety Partnership, seeking clarity of WWLTH responsibilities to ensure vulnerable patients/service users are safeguarded appropriately.

Partnership in Action

The TFSS has maintained a position of collaboration with multi-agency professionals, to support a broader depth and range of safeguarding information sharing and interventions. The TFSS continues to host co-located 'Health' roles via the employment of a Complex Safeguarding Nurse within the Complex Safeguarding Team (part of the wider REACH Team[16]) based at Wigan Police Station, and Specialist Nurses Safeguarding Children based within the Children First Partnership Hub. Whilst these post holders have a specific remit in terms of the multi-agency approach to exploitation of children and the 'Front Door' to Safeguarding, practice is embedded widely in terms of the Think Family method embraced by the WWLTH safeguarding service.

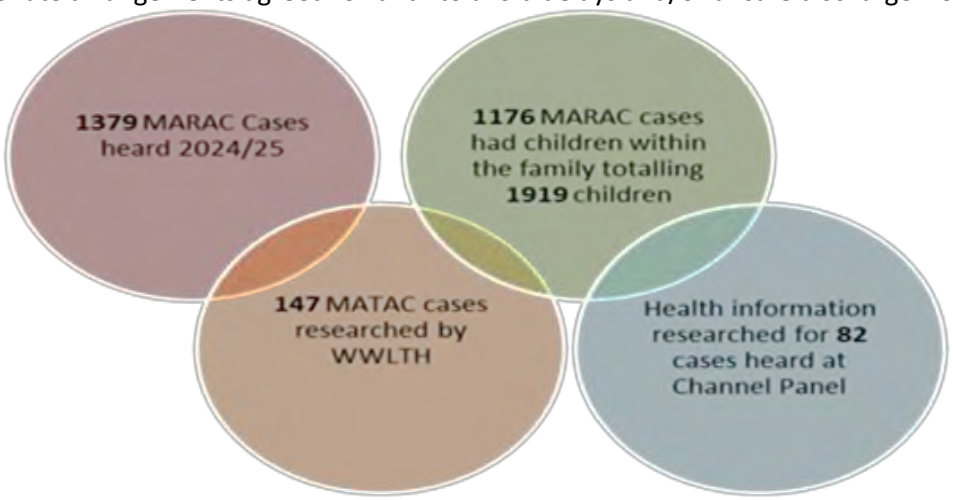
The Complex Safeguarding Team (CST) Nurse post sits within the CiC Team, utilising an assertive outreach model of health intervention working with adolescents open to complex safeguarding. This year a Greater Manchester peer review Tackling Child Exploitation (TCE) was undertaken with all WWLTH cases reviewed identifying the importance of the CST Nurse role in the multiagency response and as a conduit to facilitation and engagement of the wider health services involved with the child. All cases demonstrated good health information sharing, notification and liaison by the CST Nurse to GP, school nursing colleagues, Mental Health Services, Paediatricians, Sexual Assault Referral Centre (SARC), local sexual health services and others. A tenacity of approach, supporting continuation of care over geographical boundaries, to support the needs of the child was noted, along with good CST Nurse representation at multiagency meetings as a statutory partner. The CST Nurse continues to plan, coordinate delivery and evaluate public health intervention focusing on the prevention of escalation of complex cases.

There is also TFSS representation at the newly formed WASP (Wigan Adolescent Safety Panel). Although it is early days, the purpose of the panel is to provide additional and sustained multi-agency oversight at a strategic level to help achieve safety for individual children, groups of children and vulnerable care leavers identified as being at significant risk of exploitation or are already being exploited. Each child is subject to a strategic review by the Independent Chair, and partner agencies, to ensure they are receiving support to reduce the risk of child exploitation. Where the panel is not satisfied with current care planning to mitigate risk or provide support it can act as an escalation route.

The role of the WWLTH health practitioners within the CFPH is to undertake immediate health information sharing and attend initial strategy meetings. Activity in relation to attendance at strategy meetings, sharing health information and health screenings sheds light on the volume of activity related to the partnership and the vital role of Health Practitioners in supporting multi-agency assessments and interventions to safeguard children and families. In 2024/25 health information was screened and shared on **1726** cases, in addition to attendance at **150** strategy meetings (**113** reaching threshold for *Section 47*) by the TFSS.

[15] Right Care Right Person (RCRP) national guidance launched | College of Policing
[16] REACH Safeguarding Adolescent Service

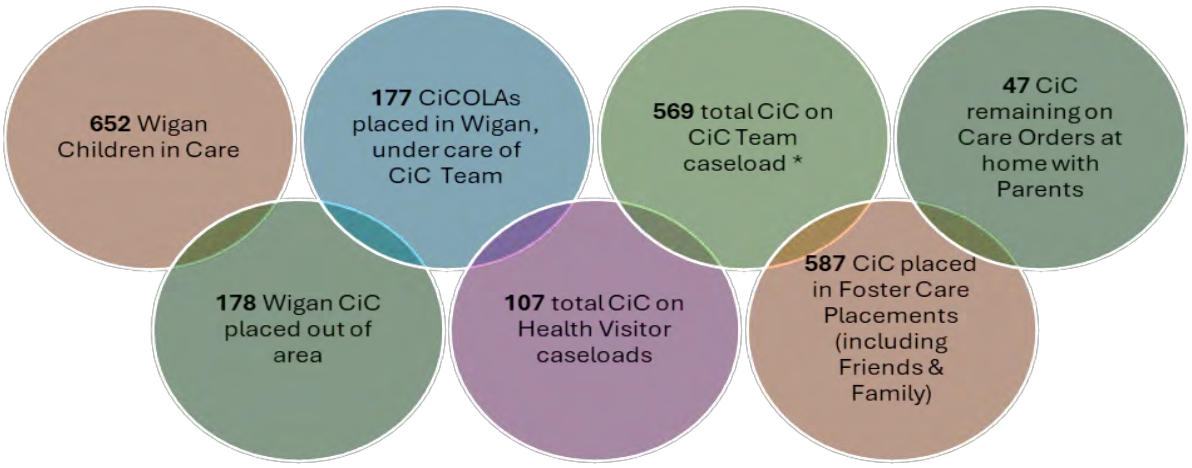
Pre-birth protocol meetings, supported by the Named Midwife Safeguarding, provide a collaborative approach to pre-birth assessment plans for unborn babies in a timely and effective manner, with robust and proportionate arrangements agreed for birth to avoid delays and/or unsafe discharge from the maternity unit.



WWLTH as a Corporate Parent

When a child comes into care, the Local Authority becomes the 'Lead Corporate Parent'. The term 'corporate parent' means the collective responsibility of the council, elected members, employees, and partner agencies, for providing the best possible care and safeguarding for the children who are in the care of the Local Authority; WWLTH therefore has this duty.

The Named Nurse CiC sits on Operational Corporate Parenting Group, and other forums such as Placement Stability Panel, Permanence Panel, Vulnerable Care Leavers Panel, Separated Children and Young People's Panel (which is focused exclusively on ensuring a coordinated approach to supporting Unaccompanied Asylum-Seeking Children) and Residential Managers Care Provider Forum. The Associate Chief Nurse for Safeguarding, as Corporate Parenting Lead for WWLTH, sits on Corporate Parenting Board. There is a senior and strategic level of commitment from WWLTH to ensure the holistic needs of our CiC and Care Leaver cohort are recognised, acknowledged and responded to. Recognising that care leavers are vulnerable, due to their history of trauma and the challenges of transitioning to adulthood, the Named Nurse CiC attends a monthly multi agency Vulnerable Care Leavers panel.



*includes CiC placed out of area but remains under caseload responsibility of Wigan CiC team due to commissioning arrangements

Our Performance –Assurance

The priorities outlined in the 2023/24 annual report set clear objectives for the TFSS and while these priorities have remained central, the service has also responded flexibly to emerging needs influenced by the wider political landscape, evolving social contexts, and local system priorities. Statutory safeguarding responsibilities have remained paramount, with strategic oversight maintained through the Safeguarding Executive Group (SEG), ensuring a continued focus on the complex and dynamic nature of safeguarding. Regular reporting to internal and external governance structures, including committees, boards, and partner forums, has provided ongoing assurance to executives, governors, and key stakeholders regarding service performance and responsiveness.

The Patient Safety Incident Response Framework (PSIRF) is now fully embedded within the governance structures at WWLTH, and the TFSS continues to align all learning and improvement activity with this framework. Throughout the year, the TFSS has conducted several AARs in response to incidents where safeguarding-related learning was identified. These reviews have proven valuable in fostering reflective practice among practitioners and supporting a culture of continuous learning from a safeguarding perspective

Contractual Standards

The WWLTH Think Family Safeguarding Service has been audited against statutory safeguarding responsibilities as a provider service by GM ICB Wigan Locality. During the year WWLTH has been recognised as having the highest compliance achieved across Greater Manchester against GM Safeguarding Contractual Standards. Sixty-three standards have been reviewed by the ICB Designated Safeguarding Nurses utilising submission of evidence and validation visits. There were **sixty** standards assessed as **GREEN** and fully compliant at the end of 2024, and only **three** rated **AMBER** with ongoing actions being completed by TFSS.

Audit

Participation in a range of internal audits and reviews, shared and ratified through the Safeguarding Executive Group (SEG), has driven the development and implementation of policies and procedures aimed at improving outcomes. This process has also fostered the sharing of best practice and data, strengthening both WWLTH's internal safeguarding approach and broader partnership working. A culture of collaboration has been actively embraced, contributing to the development of a confident and capable safeguarding workforce.

The TFSS has also engaged in multi-agency audits led by the Wigan Safeguarding Children Partnership (WSCP) and Wigan Safeguarding Adults Board (WSAB) throughout the year. Learning from these audits has informed targeted action plans, which have been embedded across WWLTH through established forums and focused workstreams to ensure a consistent and informed safeguarding response.

Children in Care – Key Performance Indicators overview

The CiC Team is commissioned by NHS GM ICB Wigan, under an agreed service specification, with performance measured against a number of locally defined outcomes, which in the main are reflective of national performance indicators reportable by the Local Authority. These indicators (SSDA903) provide performance data that is required by central government from Childrens Social Care departments. Performance of the service is determined via agreed Key Performance Indicators (KPIs) and scrutiny of the adherence to the agreed standards for Children in Care. The current KPI schedule is collated quarterly and presented to the GM ICB Wigan Safeguarding and Relationships Group (formally IQSG) following approval at SEG. Delivery against KPIs is codependent on the performance of external services and partner agencies therefore the workstreams of the CiC Team focus heavily on internal improvements whilst facilitating external discussions to overcome system challenges.

Initial Health Assessments (IHA) are required to be completed within twenty working days of a child entering care. The WWLTH CiC Team and Named Doctor CiC, along with Local Authority colleagues and supported by GM ICB Wigan, have prioritised performance against this metric in acknowledgement of its importance in ensuring children new into care have the best opportunity to overcome any health adversity.

The number of children who have been in care for a period of twelve months or more is identified as the qualifying cohort for the SSDA903 return to Central Government. SSDA903 data tables are published yearly and provide an overview of national, regional, and local performance against a wide range of indicators inclusive of those specially designed to demonstrate health outcomes. A national overview for comparative considerations will not be published until late 2025 therefore provision of Wigan CiC Team contribution to this dataset is provided as a measure of assurance and performance.

Data in relation to completion of Review Health Assessments, Development Checks, Immunisation status, Dental Checks, Substance Misuse concerns and Strengths and Difficulties Questionnaires (SDQs) are all captured. A cohort of **515** Wigan children were identified as being 'Looked After' for a period of more than one year and therefore eligible for reporting within the SSDA903 return.

	Wigan 23/24	Wigan 24/25	Trend	SN 23/24	NW 23/24	Eng 23/24
Children who had their teeth checked by a dentist	91%	92%	↑	76%	83%	79%
Children who had their annual health assessment	100%	100%	↔	90%	92%	89%
Children looked after for at least 12 months aged 4 to 16 with an SDQ score	77%	79%	↑	77%	85%	77%
Children looked after whose development assessments were up to date	100%	100%	↔	97%	86%	88%
Number of children whose immunisations were up to date	91%	92%	↑	87%	90%	82%
Identified as having a substance misuse problem during the year	3%	2%	↓	3%	5%	3%

Deprivation of Liberty Safeguards

The MCA/DoLS Lead for WWLTH, an integral team member within the Think Family Safeguarding Service, provides oversight on all DoLS, supporting staff to rescind the application when it is no longer applicable. During the 2024/2025 reporting period **1,659** patients were subject to DoLS authorisations while under the care of WWLTH. Of these, 162 patients sadly died while the safeguards were in place. Reviews of these were undertaken, and no concerns were identified. This reflects the Trust's commitment to upholding the dignity, rights, and safety of individuals who lack capacity.

DoLS supporting processes and procedures to further strengthen Trust compliance with mandated requirements is planned for 2025/26. Whilst quality of MCA completed by WWLTH nursing and medical staff are good there is recognition that areas for improvement exist. This workstream will be further enhanced by digital solutions that will aid practitioners in ensuring compliance with the legislative requirements of the DoLS authorisation process. Staff engagement with any change in process or implementation of procedures to enhance patient care is of paramount importance, conveying the TFSS continued 'one team' approach.

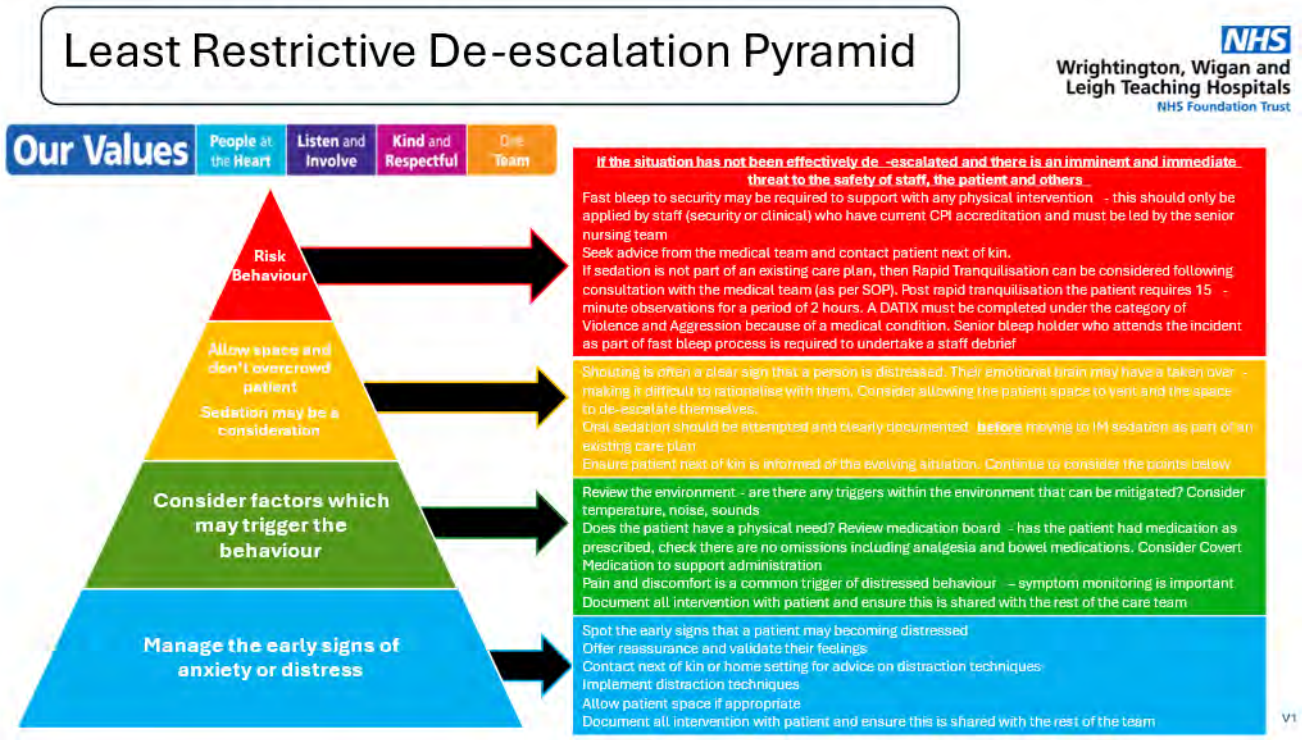
Next Steps – Looking Forward to 2025/2026

Key Priorities for 2025/2026	
➢ **Think Family Level 3 Safeguarding Training & implementation of Safeguarding Training Strategy**	New Think Family Mandatory level 3 Safeguarding training was officially in July 2025. Feedback from pilots has been positive, and staff are finding real case scenarios impactful to support them to feel empowered to promote the protection of WWLTH patients. However, compliance against the new delivery model needs careful review and oversight along with consideration of evidence of how training improves the skills, knowledge and competence of the WWLTH workforce
➢ **Utilisation of Audit and Review**	While much of this year has been spent implementing new approaches and styles to learning, 2025/2026 will concentrate on auditing the effectiveness of embedding the learning. There is a plan to complete a survey on the effectiveness of SOG. Data gathering will capture participant satisfaction while providing opportunity to influence future sessions. Further surveys will support evidence of information dissemination and provide assurance for equity and inclusion to the WWLTH workforce.
➢ **Think Family Safeguarding Service peer review and Bolton Foundation Trust & WWLTH Safeguarding Service Collaboration**	It is important that WWLTH staff receive equitable advice and supervision which will ensure a quality service to safeguard patients and service users. Peer review will support assessment, monitoring and judgement about the quality of the information provided to our workforce. Constructive feedback will promote standards of care empowering colleagues and evoking change as needed
➢ **Development of TFSS resource/information platform**	Next year the TFSS want to develop a one stop resource platform accessible to all colleagues within WWLTH. This would allow staff to have access to up-to-date safeguarding resources including training, learning from reviews, new changes to legislation and priorities within local safeguarding partnerships. Ther are plans to build into this platform activity review which would provide assurance that staff are utilising the resources
➢ **Lived Experience is key to improving our service**	Use lived experience to develop our offer and improve our service to CiC. Plans are already underway for Care leavers to speak at Safeguarding Champions, use their voice to deliver training and included on interview panels when recruiting new staff. Develop a survey to capture the voice of the child. Embed the 'pre assessment' questionnaires
➢ **HIS Optimisation**	Completion of HIS optimisation to streamline safeguarding activity, whilst capturing the voice and lived experience of the patient. The work around HIS optimisation will be the foundation for the TFSS data dashboard providing assurance of safeguarding recognition and response across WWLTH

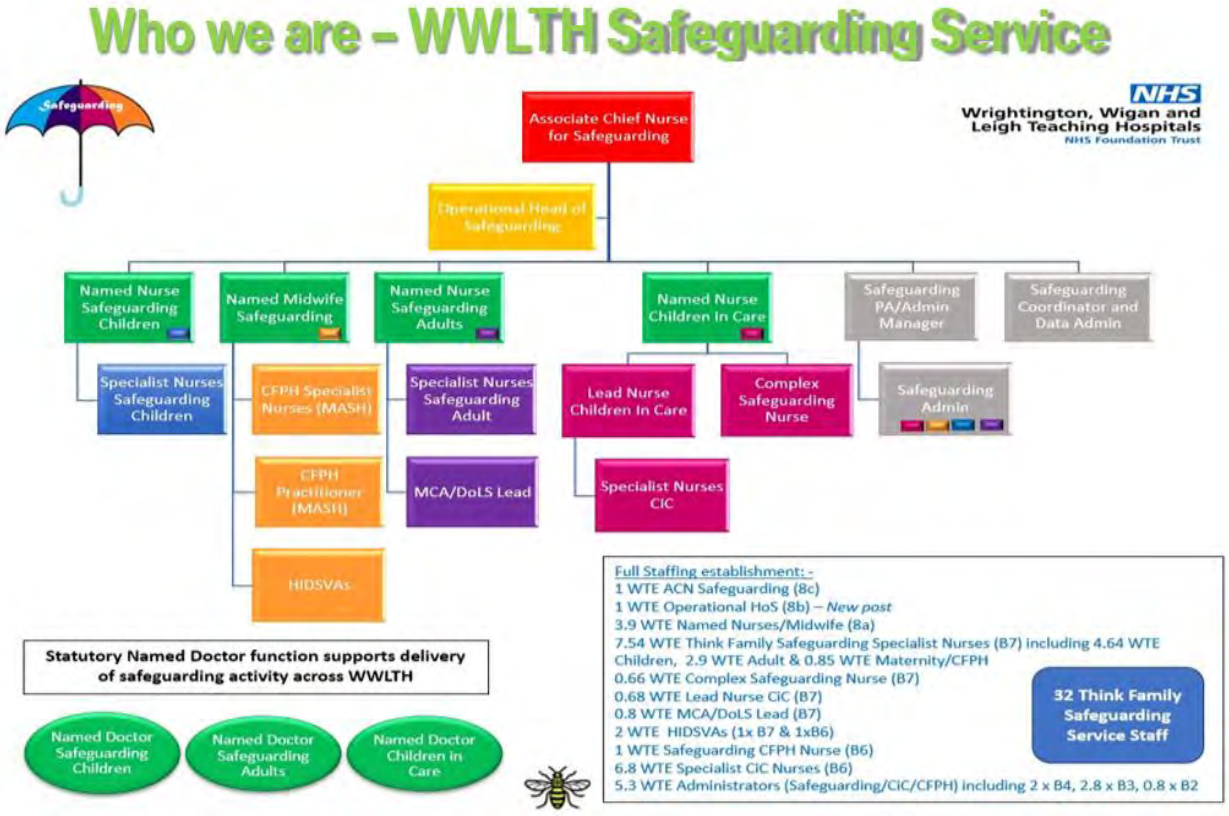
As this report concludes it is important to highlight its contents provides on a snapshot of safeguarding within WWLTH. The level of commitment, professionalism, compassion and care at every level of the organisation is to be commended as we move from safeguarding being everyone's business to a priority for all.

Appendices

Appendix 1



Appendix 2



Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	GOSWH Quarterly Report (Apr- Jun 2025) Quarter 4
Presented to:	Board of Directors
Date of paper:	04 February 2026
Item purpose:	Information
Presented by:	N/A- Consent agenda
Prepared by:	Abigail Callender-Iddon, Guardian of Safe Working Hours
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Executive summary

For the period Apr-May 2025 (Quarter 1), there have been:

- 48 exception reports submitted by 22 doctors (78 ERs & 20 doctors respectively for Q4).
- 39 hours and 10 minutes of overtime claimed (63h 4min for Q4).
- 73% submitted by FY1 doctors and 12% submitted by FY2 doctors (76% FY1; 10% FY2 for Q4).
- General Medicine (65%) had the most exception reports followed by General Surgery (19%).
- The main reasons for exception reported for overtime included: high workload and clinical pressures, staffing shortages/rota gaps, clinical emergencies/deteriorating patients, missed breaks/insufficient rest and missed teaching/ training opportunities. A few reports highlighted System and process inefficiencies. However overall, the resident doctors consistently demonstrated professionalism and prioritised patient safety despite systemic pressures.
- 3 Immediate Safety Concerns (ISCs): (4 ISCs in Q4).
- 2 Breaches: 2 fines levied (5 breaches in Q4).
- £316.15 to be added to the Guardian Pot for this period.

Resident doctors submitted exception reports predominantly citing excessive workload, rota gaps, and inadequate staffing across medicine, surgery, and paediatrics, often leading to extended hours, missed breaks, and missed teaching. Many reports described managing acutely unwell or complex patients without sufficient senior or peer support, resulting in unavoidable overtime to maintain patient safety. Recurrent issues included single-doctor ward cover, lack of sickness or locum cover, and reduced staffing on bank holidays. The cumulative effect has been fatigue, reduced morale, and erosion of training opportunities. Targeted actions are needed to address rota design, staffing resilience, break protection, and preservation of training time.

Link to strategy and corporate objectives

The safety of patients is a paramount concern for the Trust. The well-being of staff is also important to the trust with ‘People at the Heart’ being one of the Trust’s values. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of resident

doctors are designed to ensure that this risk is effectively mitigated, and that this mitigation is assured.
Currently the BMA is working along with the NHS Employers to finalise the Reform Framework Agreement which puts an emphasis on minimising perceived detriment to resident doctors for engaging with the exception reporting process.

Financial implications

Fines are levied against the Trust when working hours breach specific conditions outlined in the 2016 Terms and Conditions of Service.
There are proposed fines in the Reform Framework Agreement aimed at reducing difficulties experienced by resident doctors in accessing the exception reporting platform and incidents of breach of confidentiality (£500 per doctor per instance) which could lead to perceived detriment.

Legal implications

Exception Reports were introduced in the 2016 Resident Doctors' contract. The GOSWH monitors the working hours of resident doctors through exception reports. Exception reports could be submitted by residents whose working hours or patterns deviate from their work schedules. Where exceptions form a pattern, steps should be taken to prevent recurrences. The GOSWH oversees the safety of resident doctors working and provides assurance in the system of exception reporting and rest monitoring.
The Reform Framework Agreement due to be introduced in September 2025, will revamp the exception reporting process.

People implications

Resident doctors are a vital part of the Trust's workforce. It is important that they are sufficiently rested as it impacts safe and quality patient care and resident doctor well-being. Resident doctors require educational opportunities that enable them to learn and progress.
There was an end to the resident doctor strikes in September 2024 with the acceptance of the new pay deal. There was also a change in the BMA communications introducing the term 'resident doctors' in their references to junior doctors. There is also a wider focus on the well-being of the resident doctors.
To address the perception of detriment to resident doctors engaging with the exception reporting process, exception reports will no longer be shared with the clinical teams (Clinical Supervisors) from September 2025. The Reform Framework Agreement proposes that the medical workforce arm of the Human Resources team, will now automatically process any exception report < 2 hours.

Wider implications

Resident doctor burnout is associated with increased levels of staff sickness, staff attrition and dissatisfaction with the working environment.

Equality, diversity and inclusion implications

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

People Committee

Recommendation(s)

1. The GOSWH Quarterly and Annual Reports will be presented to LNC, JDF, TMEC and People's Committee. It will also be shared with the departmental leads who will consider the implications for their department and staff.

2. Each speciality/area to be represented at the JDF by at least 1 resident doctor. The GOSWH will liaise with the medical education department and rota coordinators for each area.
3. Rota and Staffing Review: Prioritise fair cross-cover arrangements. Review frequency of single-doctor cover on Lowton, Astley, and LD wards.
4. Workload Monitoring: Identify wards with repeated high exception frequency for escalation to service managers.
5. Break Protection: Implement structured bleep-holding arrangements for breaks.
6. Reinforce safe staffing levels on bank holidays.
7. System Improvements: Address practical inefficiencies (e.g., ward laptops, access issues).

1. Introduction

This is the 1st Quarterly report for the financial year 2025/2026, based on a national template, by the Guardian of Safe Working. THE GOSW's primary responsibility is to act as the champion of safe working hours for resident doctors and to provide assurance to the Trust that they are safely rostered and that their working hours are compliant with the 2016 Terms and Conditions of Service. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. It also highlights missed training opportunities.
The Reform Framework Agreement (based on principles agreed in the 2024 pay deal) has proposed significant changes to the ER process due to be implemented from September 2025. It will be important to plan for a smooth transition to reduce the impact of the potential fines around access to the ER platform and breaches of confidentiality.

2. High Level Data for the Period April- June 2025

Total number of doctors/dentists in training on 2016 TCS: 208
Total number of Full-time doctors/dentists in training: 163
Total number of Less than Full-Time doctors/dentists in training: 45
Total number of locally employed junior doctors: 110
International Training Fellows: 31.
Amount of time available for the Guardian to do the role per week: 4 hours.
Administrative support provided to the Guardian per week: 3 hours.
Amount of job planned time for Educational Supervisors: 0.25 PA.

3. Exception Reports- Quarter 1 (Apr- Jun 2025)

Quarter 1 (Apr-Jun 2025)	**Quarter 4 (Jan- Mar 2025)**
Total number of ERs: 48	**78**
Breach Type	
Hours/Overtime: 42	**57**
Educational: 3	**9**
Service support: 3	**2**
Pattern: 10	**0**

The number of doctors who engaged with Exception Reporting for Q1: 22 doctors (10.6% of doctors in training in the Trust) generated 48 exception reports in Q1 (Q4: 20 doctors, 10%, generated 78 exception reports in Q4).
Number reported as an Immediate Safety Concern: 3 (4 in Q1)
Total number of work schedule reviews: 0
2 Breaches this quarter (5 in Q4): 1 in General Medicine, 1 in Paediatrics.

a. Exception Reporting by Speciality:

Quarter 1(Apr-Jun 2025)

General Medicine – 65% (31 ERs)

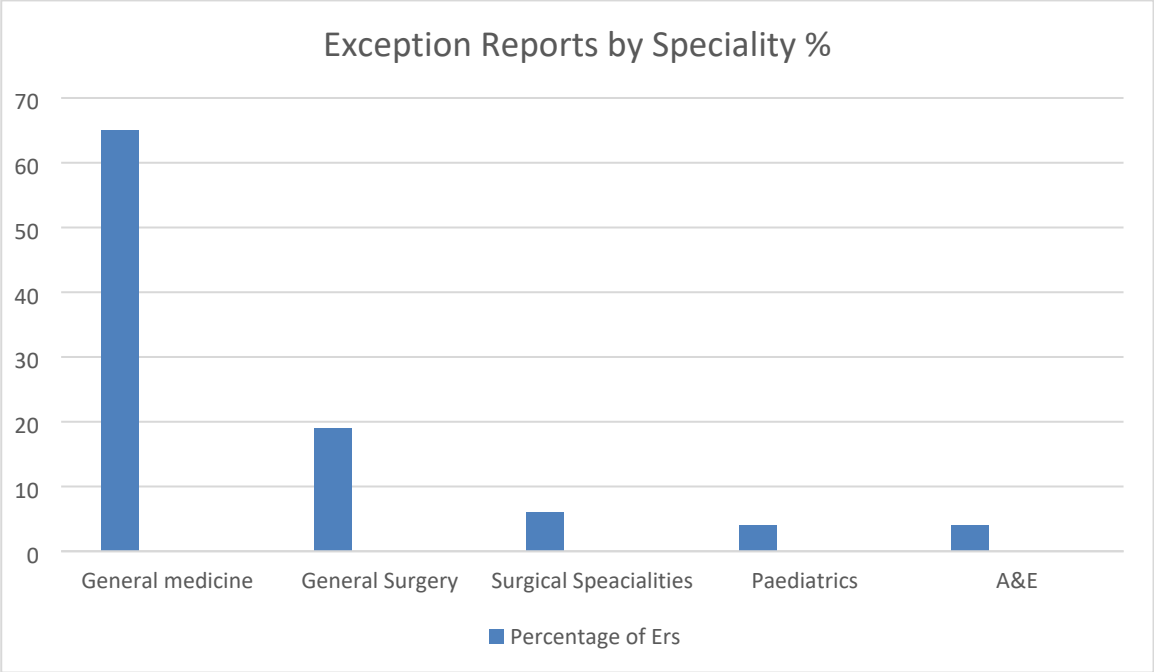
General Surgery- 19% (9 ERs)

A&E- 4% (2 ERs)

Acute Medicine- 2% (1 ER)

Paediatrics- 4% (2 ERs)

Surgical Specialities- 6% (3 ERs)



The top 2 specialities generating the highest number of exception reports were General Medicine and General Surgery 65% and 19% respectively.

b. Exception Reports by Doctor's Grade

Quarter 1 (Apr-Jun 2025) 48 ERs

Foundation Year 1- 73% (35 ERs)

Foundation Year 2- 12% (6 ERs)

Specialist Trainee 1- ST3- 15% (7 ERs)

ST4-ST8- 0% (0 ERs)

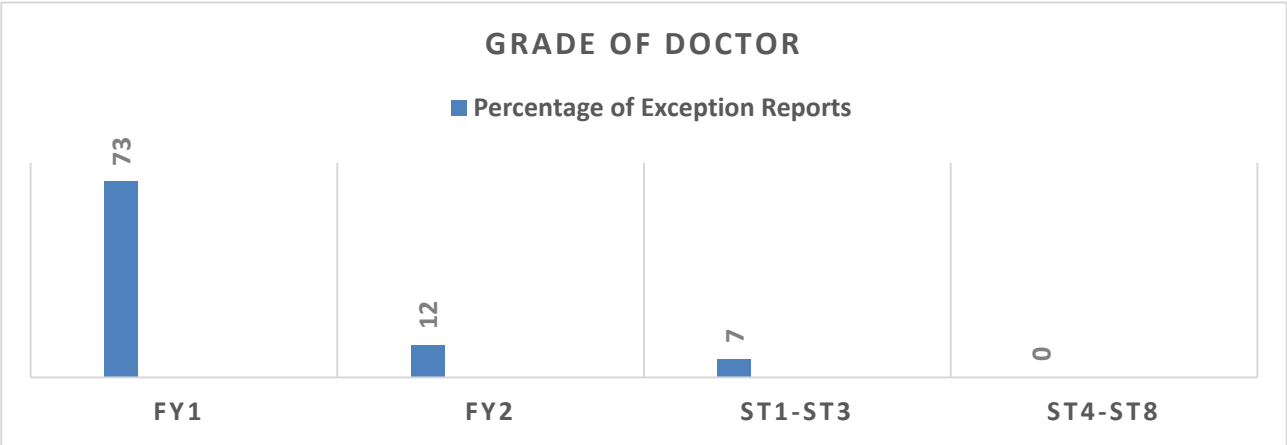
Quarter 4 (Jan- Mar 2025) (78 ERs)

Foundation Year 1- 71% (57 ERs)

Foundation Year 2- 14% (11 ERs)

Specialist Trainee 1- ST3- 11% (9 ERs)

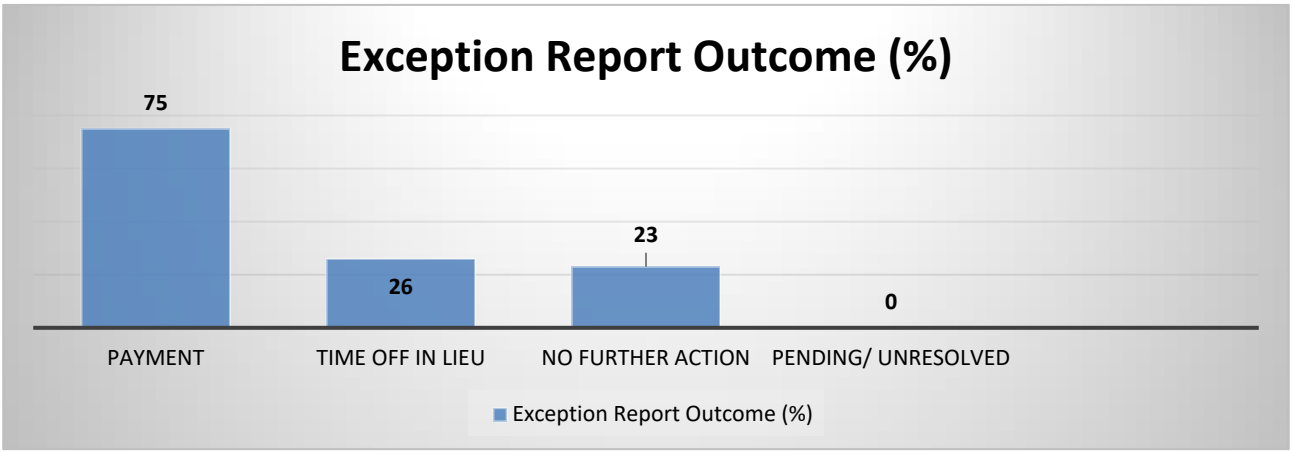
ST 4-ST8- 4% (3 ERs)



FY1 doctors continue to submit the most ERs.

c. Exception Report Outcomes

Payment- 75% (36)
Time off in Lieu- 2% (1)
No further Action- 17% (11)- mostly ERs highlighting missed breaks + Educational ERs+ Service Support



Total number of overtime hours claimed:

- Extra normal hours: 33 hours (60 h 9 min in Q4)
- Extra premium hours: 6 hours 10 minutes (2 h 55 min in Q4)
- Total 39 hours 10 minutes (63 h 26 min in Q4)

On average doctors were working an extra 8 minutes per week per doctor (14.5 min in Q4).

d. Reasons for Exception Reports in this period

Overview

- **Departments represented:** A&E, Acute Medicine, General Medicine, General Surgery, Urology, ENT, Paediatrics.
- **Common pattern:** Almost all exceptions related to **working beyond rostered hours**, with multiple mentions of **missed breaks** and **missed teaching**.
- **Duration of overruns:** Typically, **30 minutes to 2 hours**, with some extended periods (e.g. 4 hours extra work due to covering sickness).

Theme 1: High Workload / Clinical Pressures (Most Frequent)

Examples:

- “Worked 1.5 hours past the scheduled end of my shift due to the volume of work.”
- “Extremely heavy workload and ill patients.”
- “Workload necessitated overtime to manage this.”

Contributing factors:

- Large numbers of unwell or complex patients.
- Multiple referrals, deteriorating patients, and complex discharge processes.
- Lack of senior presence or delay in decision-making.

Impact:

- Frequent late finishes, job handovers delayed, inability to attend teaching.
- Patient safety cited as a reason for staying late.

Theme 2: Staffing Shortages and Rota Gaps

Examples:

- “Only F1 on service.”
- “Reduced staffing on this day due to sickness.”
- “LD NNU/postnates SHO had called in sick... had to do 4 hours of work for 2 SHOs.”
- “No locum SHO arranged to cover for the gap.”

Patterns:

- Gaps due to **sickness**, **no locum cover**, or **rota design flaws**.
- Some wards (Lowton, Astley, MAU) appear repeatedly short-staffed.
- Surgeons reporting lack of SpR cover

Impact:

- Unsafe workload distribution, missed breaks, increased stress.
- Escalation of risk to patient safety.

Theme 3: Clinical Emergencies / Patient Deterioration

Examples:

- “Patient in DKA… had to initiate management before transfer.”
- “Stayed late to assess unwell patient who dropped their GCS.”
- “Had to urgently refer a patient to dermatology ?Toxic epidermal necrolysis.”
- “Patient was having a stroke and in managing this acutely, other jobs were delayed.”

Impact:

- Unpredictable emergency workload → unplanned overtime.
- Junior doctors demonstrating strong patient safety awareness but at cost to rest and work-life balance.

Theme 4: Missed Breaks and Rest Periods

Examples:

- “Unable to take a break in order to eat some food.”
- “Missed lunch due to workload.”
- “<11 hrs rest between shifts as clocks went forwards.”

Pattern:

- Particularly prevalent in **night shifts**, **bank holiday weekends**, and **surgical on-calls**.
- Some reports about *no safe bleep-free time to take a break*.

Impact:

- Fatigue risk and diminished morale.
- Concerns raised about patient safety implications and sustainability.

Theme 5: Missed Teaching and Training Impact

Examples:

- “Couldn’t attend mandatory teaching due to high workload.”
- “Unable to leave the ward to go to Grand Round due to staffing issues.”
- “Had been due to discharge a patient before teaching, but situation escalated.”

Impact:

- Training opportunities lost.

Theme 6: System or Organisational Factors

Examples:

- “Delayed CT scan and specialty discussions prolonged tasks.”
- “Department does not have a designated ward laptop.”
- “Door for Swinley Seminar Room was broken—locked belongings for >1 hour.”

Impact:

- Inefficiencies and infrastructure failures wasting clinical time.

Theme 7: Professionalism and Patient-Centred Care

Examples:

- “Did not feel appropriate to terminate this conversation with the patient early.”
- “Stayed to ensure patient safety was not compromised.”
- “Stayed late for relative update with consultant due to limited flexibility.”

Positive indicators:

- Staff consistently prioritised patient safety and family communication over personal time.
- Reflects high professionalism and duty of care.

e. Immediate Safety Concern

There were 3 ISCs in this quarter Apr- Jun 2025: 3 General Medicine. There were 4 ISCs in quarter 4.

1. General medicine- “My safety concern relates to the lack of midweek support and the knock-on effect this then had for the weekend where there is less staffing available. I worry this may cause issue for new F1s doing this shift in August so I feel I have to report this matter.”
2. General medicine- “No Flexi Fy1 from 9-4 PM, and significant volume of workload throughout the day. Clerking team were very helpful but I did not think the volume of work was safe for patients. No natural breaks adhered to.”

3. General medicine- " Patient safety compromised due to short staffing and new junior doctor unable to cope with clinical pressure."

f. Breaches that attract Financial Penalty

Fines are levied when working hours breach one or more of the following situations:

i. The 48 hours average working week.
ii. Maximum 72 hours worked within any consecutive period of 168 hours.
iii. Minimum of 11 hours continuous rest between rostered shifts.
iv. Where meal breaks are missed on more than 25% of occasions.
v. The minimum non-residential on call overnight continuous rest of 5 hours between 22.00 – 07.00 hours.
vi. The minimum 8 hours total rest per 24 hours non-resident on call shift
vii. The maximum 13 hours shift length
viii. The minimum 11 hours rest between resident shifts

Breaches for the Period Jan-Mar 2025: Breaches of the Maximum 13-hour shift

- 4 for this quarter 4 (Jan-Mar 2025); 14 for Quarter 3 (Oct-Dec).
- General Medicine- 3
- Trauma and Orthopaedics- 1

3.6.1

A proportion of the fine, apart from fines for breaks where payment is 100%, is paid to the Guardian of Safe Working, as specified in the 2016 Terms & Conditions of Service (TCS) (see penalty rates and fines below). The TCS also specifies that the JDF is the body that decides how accrued monies are spent within the framework identified within the TCS.

	Total Value of Penalty	**Hourly Penalty Rate Paid to the Doctor**
Additional hours worked attract a basic rate	X 4 the basic hourly rates	X 1.5 of the basic hourly locum rate
Additional hours worked attract an enhanced (night) rate	X 4 the enhanced hourly rate	X 1.5 of the enhanced hourly locum rate

Breaches and Fines to be Levied for Quarter 1 (Apr- May 2025)

Date	**Department**	**Time/min**	**Doctor (£)**	**Guardian Fund (£)**	**Total Fine (£)**
12/04/2025	Paediatrics	90	85.02	141.69	226.71
04/06/2025	Medicine	45	33.54	55.90	89.44
			Total	**197.59**	**316.15**

Total addition to Guardian Fund- £197.59
Total fine to trust- £316.15

g. Speciality Specific Trends: Key Issues Reported

1. Accident & Emergency (A&E)- 4% (2 ERs); 4% in Q4

Key issues:

- Missed teaching due to prolonged discussions with a patient who was being discharged.
- Conflict between clinical duties and teaching commitments — trainees felt unable to leave patient interactions unfinished for teaching.
- Emotional and communication demands (extended patient/relative conversations) not factored into time allocation.

Impact:

- Minor time overruns (≈40 minutes)
- Potential training time erosion.

2. Acute Medicine 2% (1 ER); 1% in Q4

Key issues:

- Persistent high workload in assessment units with acutely unwell patients.
- Highlighted requirement to stay late (1–2 hours) to stabilise deteriorating patients or complete urgent referrals.
- Poor staffing ratios — often only one or two junior doctors for a heavy caseload.
- Complex multidisciplinary coordination (dieticians, psychiatry, mental health teams).

Impact:

- Breach of scheduled hours, fatigue risk.

3. General Medicine- 65% (45 exception reports) 58% in Q4

Key issues:

- Very high ward workload and complex case mix (DKA, hypoglycaemia, potential TEN, unwell patients).
- Short staffing due to sickness, rota gaps, or single junior covering large wards.
- Frequent overtime (30–120 minutes), often unavoidable for patient safety.
- Repeated reports of missed lunch breaks, missed teaching, and late finishes.
- Poor weekend and bank holiday staffing leading to patient deterioration and unsafe workload for nights.

Impact:

- Significant fatigue risk; compromised rest and recovery.
- Missed training opportunities and reduced morale.
- Concern raised about patient safety.

4. General Surgery 19% (9 ERs); 58% in Q4

Key issues:

- Inability to take breaks on long on-call days due to very high demand.
- Doctors reporting that they are managing both ward and emergency referrals with minimal support.

Impact:

- 12+ hour shifts without breaks; overtime of 30–90 minutes common.
- Risk to wellbeing and decision-making from fatigue.
- Junior staff having to prioritise service over learning opportunities.

5. Urology & ENT

Key issues:

- "Hot week" workload repeatedly exceeded capacity.
- Only one junior available to manage high referral volume and inpatients.
- ENT ward with 14 inpatients and limited staff support.
- Documentation inefficiencies — no dedicated ward laptop, requiring retrospective notes.
- Recurrent overrun of 1–2 hours beyond scheduled finish.

Impact:

- Repeated late finishes, unsustainable expectations.
- Potential for burnout and incomplete documentation.
- Junior doctors proposing system fixes (e.g., dedicated laptop) showing awareness but lack of structural support.

6. Paediatrics 4%

Key issues:

- SHO absences (sickness) left uncovered — no locum or redeployment.
- One doctor covering multiple clinical areas (LD ward, NNU, postnatal, delivery bleep).
- Exception reports for 4 hours' additional workload for two roles simultaneously (LD ward SHO and LD neonatal SHO)
- Additional exception for staying late to complete safeguarding (Child Protection) proforma.

Impact:

- Unsafe cross-cover workload and risk of clinical oversight.
- Increased stress and decreased morale.
- Administrative safeguarding duties adding unrecognised workload.

Recommendations

1. The GOSWH Quarterly and Annual Reports will be presented to LNC, JDF, TMEC and People's Committee. It will also be shared with the departmental leads who will consider the implications for their department and staff.
2. Each speciality/area to be represented at the JDF by at least 1 resident doctor. The GOSWH will liaise with the medical education department and rota coordinators for each area.
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