Board of Directors - Public Meeting

Wed 01 April 2026, 10:15 - 14:45

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Agenda

1. Chair and quorum

Information *Robina Shah*

2. Patient Story

Information *Kev Parker-Evans, Sophie Banks*

02. Patient Story JHRU - Feb 2026_.pdf (3 pages)

3. Apologies for absence

Information *Robina Shah*

Sarah Brennan

Anne-Marie Miller

4. Declarations of Interest

Information *Robina Shah*

4.1. Register of directors' interests

Information *Robina Shah*

5. Minutes of the previous meeting

Approval *Robina Shah*

05. Minutes_Board of Directors - Public Meeting _040226 (2).pdf (12 pages)

6. Action Log

Assurance *Robina Shah*

6.1. University Teaching Hospital progress report

Information *Sanjay Arya*

06.1. University Hospital Status Progress Report April 2026 v4.pdf (3 pages)

7. Chair's report and stakeholder update

Information *Robina Shah*

Verbal item

8. Chief Executives report

Information *Mary Fleming*

08. CEO Board Report_Public_ March26_FINAL.pdf (4 pages)
08a. Additional actions to virtually eliminate corridor care 4 March 2026.pdf (4 pages)

9. System Partnerships report

Information *Richard Mundon*

09. Board - Partnerships Report April 2026.pdf (7 pages)

10. Committee chairs' reports

Information *Non Executive Directors*

10.1. Quality and Safety

Information *Francine Thorpe*

10.1. AAA QS Mar 2026.pdf (2 pages)
10.1a. AAA Q&S Feb 2026.pdf (2 pages)

10.2. Finance and Performance

Information *Julie Gill*

10.2. AAA - FP - Mar 2026.pdf (2 pages)

10.3. People Committee

Information *Mark Wilkinson*

10.3. People Committee AAA March 2026.pdf (2 pages)
10.3a. People Committee AAA January 2026.pdf (1 pages)

10.4. Research Committee

Information *Clare Austin*

10.4. AAA - Research - Mar 2026.pdf (2 pages)

10.5. Audit Committee

Information *Simon Holden*

Break

11. National Staff Survey

Discussion *Rachel Gleave*

11. NSS 2025 Results and Engagement Plan March 2026 for Public Board 01042026.pdf (10 pages)
11a. Staff Survey Board Presentation.pdf (51 pages)

12. Medium term plan 2026/27 re-submission to NHS England

Information *Richard Mundon*

12. Public Board MTP Final Plan Resubmission 01.04.26.pdf (5 pages)

13. Finance Report

Assurance *Tabitha Gardner*

13. Board Cover Sheet - Finance Report M11.pdf (2 pages)
13a. Trust Finance Report 25-26 February Month 11 Board.pdf (16 pages)

14. National Oversight Framework Q3

Information *Tabitha Gardner, Kev Parker-Evans, Joanne Bark & Sanjay Arya*

14. NOF Q3 25-26.pdf (4 pages)

15. Integrated Performance Report

Approval *Richard Mundon*

15. Board of Directors IPR M11 2526.pdf (3 pages)
15a. IPR_M11_2526.pdf (24 pages)
15b. M11 2526 Benchmark Access Standards.pdf (5 pages)

16. Board Assurance Framework

Approval *Julie Dawes*

16. BAF Report Board April 2026 FINAL.pdf (30 pages)

17. Proposed Corporate Objectives 2026/2027

Approval *Richard Mundon*

17. Corporate Objectives - Cover Sheet - Trust Board 01.04.26.pdf (2 pages)
17a. Appendix 1 - 2026-2027 Corporate Objectives - Master Copy for Trust Board 01 04 2026.pdf (11 pages)

18. Annual Risk Appetite Statement

Approval *Julie Dawes*

18. Risk Appetite 26-27 v2.pdf (7 pages)

19. Strategy 2030 refresh

Information *Richard Mundon*

Verbal item

Consent Agenda

20. Gender pay gap report

20. Gender Pay Report - Board April 26.pdf (9 pages)

21. Standing Financial Instructions

Approval

21. SFI amendments.pdf (4 pages)
21a. SFIs 25-26 February 2026.pdf (65 pages)

22. 7-day services report

Information

22. Seven Day Services Audit 2025 2026 Board Report.pdf (14 pages)

23. Meeting Evaluation

Discussion *Robina Shah*

- Equality and health inequalities reflections
- Is the agenda appropriately focussed?
- Where the papers appropriate
- Was the discussion appropriate?

Break

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Patient Story – Jean Hays Unit Leigh

The focus of this presentation is on system processes at Jean Heyes Reablement Unit which contributed to Mr B's poor experience.

Mr B

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

- Mr B is a 91-year-old who attended ED on 7th July 2025 with acute abdominal pain. He was diagnosed with a bowel obstruction which was conservatively managed.
- During his admission Mr B had over 20 ward transfers, 5 of these were from JHRU back to ED (unplanned transfers).
- Due to one of the unplanned transfers, Mr B further experienced 48 hours without medication due to system issues.
- Mr B sustained a category 3 pressure ulcer and moisture damage whilst in our care
- When the number of moves experienced was recognised, Mr B was cared for on Standish Ward and did not experience any further ward transfers before his discharge.
- Mr B and his family were kept updated throughout his stay at JHRU and the purpose of the unplanned transfers explained

Learning & Improvement

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

- After Action Reviews and Audits have been carried out and any appropriate learning has been put into action. Further support is needed to ensure that no other patient will have this experience.

- **Pressure Care -** An AAR was conducted with all involved wards. Whilst in this case there was no omissions found to the care at JHRU, the unit manager continues to prioritise pressure care and the high level of work that goes into this was recognised recently at the serious and moderate hard pressure ulcer panel. Continual review, actions and learning around this is taken seriously at JHRU.

- **Unplanned Transfer Audit -** An audit has been conducted by the Matron for the area(CQL) to establish whether there are areas for improvement, or recognisable patterns to better inform learning.

- **Risk Register (4277 & 3633) -** JHRU are unable to fully mitigate clinical safety due to limited medical cover and the functionality of HIS Allscripts (Electronic Patient Record). Approximately 65% of patients who experience an unplanned transfer from JHRU are returned without medications prescribed on the electronic system. JHRU have been supported with the secondment of an ACP for a 3 month period to part mitigate the limited medical cover.

Board of Directors - Public Meeting

Wednesday 4 February 2026, 10:30 - 13:45

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Board members

Robina Shah (Chair), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Sarah Brennan (Chief Operating Officer), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Simon Holden (Non-Executive Director), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Mary Moore (Non-Executive Director), Emma Newton (Chief People Officer), Kevin Parker-Evans (Chief Nursing Officer), Francine Thorpe (Non-Executive Director), Mark Wilkinson (Non-Executive Director)

Absent: Sanjay Arya (Chief Medical Officer), Richard Mundon (Deputy Chief Executive)

In attendance

Abdul Ashish (Deputy Medical Director), Chris Clark (Director of Strategic Transformation), Nina Guymer (Head of Corporate Gov & Deputy Company Secretary), Steve Parsons (Director of Corporate Governance), Cathy Stanford (ivisional Director of Midwifery and Neonates), Amit Verma (Consultant, Maternity and Neonates), Member of the public 1, Member of the public 2, Member of the public 3, Member of the public 4

Meeting minutes

1. Chair and quorum

Information

Robina Shah

Dame R Shah took the chair, declared that a quorum was preset and that the meeting was duly convened and constituted.

2. Apologies for absence

Information

Robina Shah

Apologies were noted from two colleagues:

- Richard Mundon
- Sanjay Arya

3. Declarations of Interest

Information

Robina Shah

The register included with papers was noted and no further declarations were raised.

3.1. Register of directors' interests

Information

Robina Shah

03.1. Public - Directors DoIs - Feb 2026 - CROSS CHECK DECLARE.pdf

4. Minutes of the previous meeting

Approval

Robina Shah

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

04. Minutes_Board of Directors - Public meeting _031225.pdf

5. Action Log

Assurance

Robina Shah

The action log was reviewed:

166/25

Maternity - C Section

The Chief Nursing Officer provided an update confirming that caesarean section activity is not currently reviewed on a per-consultant basis. He advised that, going forward, this will be monitored per consultant and per clinical grade, in line with the Robson classification criteria, to strengthen oversight and understanding of practice patterns.

05. Public Board Action Log 2026.pdf

6. Chair's report and stakeholder update

Information

Robina Shah

The Chair reflected on the recent joint session held by WWL with its Board and senior colleagues from partner organisations. She noted that the group was able to engage in open, constructive discussion characterised by positivity, a shared focus on achieving a genuine “left shift,” and thoughtful consideration of how best to address health inequalities across the borough. She emphasised that the session demonstrated the value of reflecting both on the journey so far and on collective ambitions for the future. Her key message was that when clear purpose is aligned to strategic intent, meaningful progress follows.

The Chair reiterated WWL’s ambition for patients to receive care that they feel happy, safe and confident with, and acknowledged that this is only possible when staff themselves feel supported, valued and able to thrive. She linked this directly to the organisation’s values and behaviours framework, noting that strengthened partnership working and integration across services mirrors the behaviours WWL seeks to embed internally.

She reflected that as care pathways become more integrated across the locality, organisations will increasingly adopt a pathway identity rather than an organisational one a positive and necessary change for population-level improvement. She reaffirmed the Trust’s commitment to working in this collaborative way.

The Chief Operating Officer added that the current system pressures continue to influence staff values and behaviours, particularly in how leaders show up. She stressed the importance of maintaining this awareness and ensuring compassionate, values-based leadership remains central during such challenging periods.

The Board received and noted the update.

7. Chief Executive's report

Information

Mary Fleming

The Chief Executive summarised the key points in her report:

- She acknowledged that this winter had been particularly difficult, with high demand and long waiting times. Despite this, she expressed her pride in WWL staff and the wider community, noting that patient safety had remained a clear priority throughout.
- She reported a sense of renewed optimism as the organisation enters 2026, supported by the ongoing organisational redesign, which is strengthening WWL’s ability to meet future challenges
- She recognised that significant pressures and operational demands remain for senior leaders, particularly during the transition period linked to the redesign.
- The Trust unfortunately moved into Segment 4. This was primarily driven by feedback from the national patient inpatient survey, specifically regarding:
    - corridor care
    - patients being moved between wards

She reiterated that these are priority issues within the Better Lives programme, which is focused on eradicating such practices.

She thanked staff for their response during multiple critical incidents and recognised the improvement in flu vaccination uptake compared to the previous year, although more progress is needed.

Finally, she noted significant organisational changes underway, including:

- creation of new clinical divisions
- continued focus on urgent and emergency care transformation
- improvements to infrastructure such as the emergency imaging suite
- ongoing work on the 3-year plan and alignment with the Wigan locality strategy

The Chair echoed the thanks to staff on their achievements throughout this period.

Mr S Holden asked when the Board will see the staff survey results, appreciating that it is embargoes until March 2026.

The Chief Executive noted that there would be a brief discussion on this in the private meeting later in the day but that there lack of a full set of comparative data available currently.

Mrs F Thorpe noted that the flu vaccination rate is positive but still indicated that under half the workforce have been vaccinated and asked if there has been any work to establish why staff have not been.

The Chief Nursing Officer noted that some feedback indicates that the flu outbreak locally happened sooner than expected leading staff to believe that there would be no benefit from vaccinations received after having contracted the virus. Further, moving forwards there will be a more joined up approach which identifies key places where vaccinations can be received. He was keen that the preventative agenda be given focus in spring and summer in preparation for the flu season.
The Board received and noted the update.
07. CEO Board Report_Feb26_PUBLIC_FINAL.pdf

8. Annual Sustainability report

Information

Chris Clark

The Director of Strategic Transformation presented the Annual Sustainability Report, noting a small increase in carbon output driven largely by estates developments without matching sustainability investment. He highlighted the encouraging level of staff engagement in green initiatives across the Trust, whilst acknowledging the challenges associated with securing sufficient capital funding to support these schemes.

Prof C. Austin asked about the balance between empowering motivated teams and ensuring that the necessary investment was in place to enable progress.

The Director of Strategic Transformation confirmed that both elements were critical, emphasising that teams were highly passionate about sustainability and that enabling them to innovate locally remained an important driver, but that investment was equally essential to deliver meaningful change at scale.

Mr S. Holden queried whether WWL might adopt a ‘gloves off’ campaign similar to those seen elsewhere now that COVID-related practices have reduced.

The Chief Nursing Officer agreed that this would be helpful and could generate both environmental and financial benefits, noting that reducing unnecessary glove use may also minimise clinical infection risks.

Mrs F. Thorpe asked whether work had been undertaken to align the Trust's environmental plans with those of the local authority and primary care.

The Director of Strategic Transformation advised that the Scope 3 emissions workstream would be central to this, but that there was further work required to fully assess and integrate the impact across the wider system.

Lady R. Bradley asked whether achieving a fully 'Net Zero' position was realistic, or whether incremental reduction was a more likely trajectory.

The Chair noted that, while the mandate remained clear, there was currently no formal mechanism to monitor the impact of actions being taken. She highlighted improvements already seen in procurement processes and suggested that elements within the Trust's direct control should be clearly reflected in future Board updates to support meaningful assurance.
The Board received and noted the update.
09. Annual Sustainabilty Report 25 26.pdf

9. Committee chairs' reports

Information

Non Executive Directors

9.1. Quality and Safety

Information

Francine Thorpe

Mrs F. Thorpe provided feedback from the Committee meeting held the previous day. She reported that a number of the papers presented highlighted how operational pressures were affecting patient safety; however, where incidents had occurred, the Committee had received assurance that appropriate action plans were in place. Issues relating to point-of-care testing were noted, with work underway with Salford NHS FT as the provider to resolve these. She advised that the demand for maternity information was expected to increase significantly in the coming months, noting the associated risk for WWL given the volume of data required and the impact this had in pulling staff away from clinical care. Further assurance had been requested in relation to asset management following an incident caused by obsolete equipment.

Turning to areas of assurance, Mrs Thorpe highlighted positive progress against the 2024/25 strategic objectives. The QIA process continued to be robust, with evidence of appropriate challenge. The Committee was assured by the Trust's strong reporting culture around medication incidents, including clear improvement actions in the small number of moderate and severe harm cases. Positive assurance was also received on maternity services, which would be discussed later in the meeting. The mortality report had been well received and demonstrated a reduction in ambulance admissions, which she welcomed as evidence of the Better Lives programme and wider community work taking effect.

The Chair asked whether the Committee was confident that the BAF continued to reflect the current risk position, which Mrs Thorpe confirmed. Dame R. Shah was also pleased to hear that neurodivergent children's services had been identified as an area requiring further assurance.

The Deputy Medical Director echoed the positive impact of recent initiatives such as the "call to convey" scheme, noting reductions in ambulance attendances, and confirmed that work was progressing on other related schemes.

The Chief Executive added that she shares every A&E congestion-related complaint with the place-based leads to ensure system visibility of the pressures. She also reiterated the importance of balancing

operational achievements with awareness of the patient experience, including sustaining improvements in ambulance handover times.

The Chief Operating Officer emphasised the need to champion the resources and transformation required to shift more care into the community, noting that MDT-focused models were expected to drive further progress over the next 12 months.

The Chair concluded by noting that WWL does not treat data as an abstract exercise; colleagues clearly recognise that it reflects real people and remain focused on the impact on patients and staff at all times.

9.2. Finance and Performance

Information

Julie Gill

Mrs J. Gill provided a summary of the Committee meeting held the previous week. She noted that Mr K. Parker-Evans had confirmed that all long-wait patients would undergo a full harm review, which would also consider equality, diversity and inclusion impacts, with findings to be reported through the relevant Divisional Assurance Meetings (DAMs).

The Chair emphasised that this approach would require validation and that the Board would need clear assurance that the harm-review process was being applied consistently and robustly across divisions.

The Chief Executive explained that there would be escalation from DAMs to the appropriate Board committees, and that future iterations of the IPR should reflect this more explicitly, drawing together feedback from committee chairs to provide a single, triangulated view of performance and risk.

Mrs F. Thorpe shared her reflections on the flow of issues across committees, noting that when concerns emerged in one committee, they were appropriately referred to the most relevant committee for oversight; Mr M. Wilkinson confirmed that such referrals were captured formally on the referrals log.

10.2. AAA - FP - Jan 2026 F.pdf

9.3. People Committee

Information

Mark Wilkinson

Mr M. Wilkinson provided his summary of the meeting held the previous week. He advised that the current Freedom to Speak Up (FTSU) contract would shortly come to an end and suggested that the forthcoming staff survey results should be triangulated with how staff feel about their ability to speak up, noting that the Trust continues to receive a comparatively high proportion of anonymous concerns relative to other organisations. He also highlighted the continuing gap in the workforce plan and drew attention to concerns identified within the gender pay gap analysis. He confirmed that he would be discussing the relevant BAF workforce risk with the Chief People Officer.

The Chair emphasised the importance of the Board receiving assurance that staff feel confident and safe to raise concerns, and noted that triangulation of staff survey data, FTSU information and committee-level intelligence will be essential to provide the Board with a clear view of organisational culture and risk.

The Chief Executive advised that the position regarding the FTSU service had been unexpected, explaining that decisions taken by the ICB's provider had influenced the availability of the service. She noted that this would require the Trust to stabilise local arrangements and strengthen internal assurance mechanisms while a longer-term solution is identified.

9.4. Research Committee

Information

Clare Austin

It was noted that this had been reported at the previous meeting.

The Board received and noted the updates.

10. Maternity updates

10.1. CNST update assurance presentation

Decision

Cathy Stanford

The Divisional Director of Midwifery and Neonates presented the report.

The Chief Operating Officer confirmed that she had attended the Maternity Incentive Scheme (MIS) meeting and had observed robust governance processes in place to support the assurance being provided.

The Chair referred to an ongoing action noted on page 8/18 and sought clarification.

The Divisional Director of Midwifery and Neonates advised that an action plan had been presented to the Board several times, which included the establishment of a rota. Although the rota is now in place, an ongoing review is being conducted to assess its effectiveness and ensure that gaps do not arise. She confirmed that the action will be recorded as “completed” (“yes”) within the submission.

Mr S. Holden asked whether further detail could be shared on the mortality element, comparable to the format used within existing mortality reporting

ACTION: Chief Executive

Prof C. Austin queried one additional ongoing action on page 6/18.

The Consultant from Maternity and Neonates responded that agreement had been reached between clinicians on the relevant matter.

The Chief Executive emphasised the need to balance the available resource with what is required to meet the standard safely.

The Chief Nursing Officer highlighted that Local Maternity and Neonatal System discussions had introduced triangulation of financial pressures with the safety position, noting that, in the current environment, strict risk-mitigation—rather than full risk elimination—is expected nationally. He further noted that the Quality & Safety Committee will be responsible for reviewing the external maternity-related reports expected over the coming year, recognising that this forms part of the phased national requirements and aligns with the forthcoming wave of external assurance activity.

Dame R. Shah acknowledged that the position reported was accurate and appropriate but requested that the wording within the submission be refined to reflect this more clearly.

Lady R. Bradley observed that the mitigations described within the action plans demonstrate how the Trust meets the standard through appropriate rotas and staffing arrangements, though in practice this may not always be achieved consistently. She emphasised the need for checks to ensure safe care is being provided and suggested that the Safeguarding Effectiveness Group review this at its upcoming meeting.

The Board **AGREED** to submit the completed declaration pending minor changes discussed.

Information

10.2. Maternity dashboards

Cathy Stanford

The Divisional Director of Midwifery and Neonates summarised the report, explaining that it brought together all perinatal quality surveillance requirements, including:

- Saving Babies' Lives (SBL)
- Continuity of carer updates
- Perinatal mortality and morbidity review elements
- Maternity and neonatal safety measures
- Compliance against national standards

Mrs F. Thorpe highlighted the positive improvements in maternity outcomes, noting in particular the reduction in smoking at the time of delivery and the increase in breastfeeding rates.

The Chair queried the recent births in which fractures had occurred. The Chief Nursing Officer advised that the three cases were being reviewed in line with the patient safety incident response framework, with consideration being given to whether an external review would be appropriate. He confirmed that the incidents had occurred in July, October and December.

The Consultant from Maternity and Neonates added that all three cases had occurred during caesarean sections, and two had involved patients with significant clinical complexity.

The Chief Executive asked what was being done to educate women on the benefits of vaginal delivery compared to elective caesarean section, expressing concern about increasing wound-infection related readmission and the rising rate of planned caesareans at WWL.

The Consultant from Maternity and Neonates advised that women are provided with information on the risks and consequences of caesarean section as part of their care.

The Chief Executive encouraged the team to explore how organisations with lower rates achieve this, and raised a concern that learning from the initial incident may not have been fully embedded, potentially contributing to the second case.

The Divisional Director of Midwifery and Neonates responded that the learning had been reviewed and incorporated.

The Chief Executive also queried whether any themes around role clarity had emerged.

The Divisional Director of Midwifery and Neonates and the Consultant from Maternity and Neonates advised that no such theme had been identified; however, they acknowledged that during obstetric emergency calls significant numbers of staff often attend in an effort to support, and that this could benefit from refinement.

The Chief Operating Officer supported the need for better antenatal education and suggested that the Director of Public Health could support this work.

The Divisional Director of Midwifery and Neonates advised that several initiatives are being developed to improve the quality and accessibility of patient education, while acknowledging that public health input is required.

The Board recognised the challenge of engaging with hard-to-reach communities but heard that the maternity team is focusing on this as part of wider improvement work.

Mr Parker-Evans noted the importance of understanding why maternal choice for elective sections is increasing, highlighting the reading age of the local population and the need for communications that are accessible and effective, suggesting the use of apps and video resources.

Mrs M. Moore added that recent public inquiries may have contributed to women perceiving caesarean section to be safer than vaginal birth.

The Board noted that many women are making well-informed choices in line with national guidance, including NICE advice that women may be discharged as early as two days post-section.

The Chair emphasised that the Trust's role is to ensure safe, high-quality care for mothers and families, and that these complexities must be considered through a patient-centred quality lens.

The Chief Executive commented that whilst the positive elements of the report were clearly highlighted, she was concerned that the negative aspects—such as complaints—had been presented as isolated with minimal apparent impact. She asked that future reports ensure this is not minimised.

The Divisional Director of Midwifery and Neonates agreed and undertook to feed this back for consideration in future reporting.

The Board **AGREED** that the Chief Executive could sign off the required paperwork on it behalf.

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

10.3. Perinatal quality oversight report

Information

Cathy Stanford

It was appreciated that this report had been discussed with the previous item.

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

11. Freedom to Speak Up guardians report

Information

Selina Morgan

The Freedom to Speak Up Guardian summarised the report which had been circulated in advance of the meeting.

The Chief People Officer highlighted that the People Committee had noted an increase in anonymous Freedom to Speak Up reports and had therefore asked that consideration be given to what is driving this trend and how it might be addressed.

The Freedom to Speak Up Guardian advised that the anonymous concern e-form captures sufficient information to enable full investigation and that feedback is provided to the relevant division to support learning and any required changes in practice; she therefore felt less concerned about the anonymity itself.

The Director of Communications and Stakeholder Engagement noted that it would be helpful to triangulate both the thematic issues emerging from FTSU reports and the staff groups raising them with the outcomes of the staff survey. It was agreed that this had been reported previously and could be incorporated in the next report. Prof C. Austin commented that understanding the length of time taken to close cases would be valuable, with enough detail to judge whether any delays were reasonable given the nature of concerns raised.

The Chief Finance Officer thanked the Freedom to Speak Up Guardian for her positive engagement with estates and facilities teams, noting that her visits and conversations had resulted in an increase in reporting from that staff group. Mrs M. Moore echoed these observations.

The Chief Executive asked whether the launch of Martha's Rule had reduced the extent to which staff approached the FTSU Guardian, emphasising the importance of triangulating this to ensure the Board retains a full picture of speaking-up routes and cultural indicators.

The Chief Nursing Officer agreed, confirming that he would work with the Freedom to Speak Up Guardian on this, noting that he had recently met with four teams regarding patient safety concerns and had been able to resolve issues directly - potentially reducing the need to use FTSU as a route. He added that rising Datix reporting, for example, may correlate with reductions in FTSU usage.

Mrs F. Thorpe endorsed the triangulation approach.

The Chief People Officer further noted that, in addition to the increase in anonymous concerns, there was also a lack of reporting of protected characteristics; understanding these characteristics is important to identify whether concerns may be linked to them. The Chair noted that NEDs would shortly be visiting Estates and Facilities teams, which would support further triangulation and visibility.
The Board received and noted the report.
12. FTSU Quarterly Report Q3 2025 for Board v2.pdf

12. Finance Report

Assurance

Tabitha Gardner

The Chief Finance Officer presented the report which had been shared in advance of the meeting. She highlighted the underlying position of £24.5m at the end of 2024/25, noting that the current year shows a £17.2m deficit, representing a significant improvement, with work ongoing to reach the planned £11.9m year-end position.

Mr S. Holden raised concerns regarding the pay-bill reduction and whole-time equivalent (WTE) trajectories, questioning whether MARS was achieving the intended impact or whether further issues should be considered.

The Chief Executive agreed with the concerns regarding pay-bill reduction, noting the need to balance financial requirements with the organisation's responsibilities as an employer and anchor institution. She emphasised the importance of managing this sensitively and strategically as the Trust progresses through its redesign.

Mrs J. Gill stressed the importance of fully understanding the delivery profile of the Trust's Cost Improvement Programme (CIP) to ensure the Board can assess whether the scale and phasing of required efficiencies are achievable.

The Chair noted the need for the Board to maintain clarity on its priorities, emphasising that whilst financial performance is critical, the Board's foremost responsibility is to protect patients and ensure the delivery of safe, high-quality care.

The Board received and noted the report.

13. Board Cover Sheet - Finance Report M9.pdf
13a. Trust Finance Report 25-26 December Month 9 Board.pdf

13. Integrated Performance Report

Approval

Sarah Brennan

The Chair introduced the item and asked the Board to focus on areas that had not yet been discussed in detail during the meeting.

The Chief Operating Officer noted that the significant operational pressures across the Trust had adversely affected performance metrics, emphasising that care had not always been delivered in the way staff aspire to deliver it, impacting both patient experience and staff morale.

The Chair stressed the importance of maintaining a strong patient focus in all circumstances and commented that the Integrated Performance Report (IPR) helpfully grounded the discussion in the lived experience of patients and staff, reinforcing the need for compassion in leadership and decision-making.

Mr S. Holden questioned whether the time taken to hire staff could be reduced through improved efficiency.

The Chief Nursing Officer responded that some of the data required cleansing, as certain cases related to newly qualified nurses whose start dates were set by qualification timelines, and others involved staff working required notice periods at their previous organisations.

Mr M. Wilkinson asked to what extent the Board felt the Better Lives Programme was appropriately weighted, suggesting that some of the issues described might reflect variation in the quality of primary care.

The Chief Executive advised that locality leadership was proud of the progress made, particularly noting that non-require-to-reside (NRTR) patients were finally reducing. However, she acknowledged that while the programme was making a meaningful difference for some patients, it had not yet done so for all. She reiterated the senior team's support for shifting care into the community and highlighted that Better Lives had created the necessary platform for this work to gain traction.

Mrs F. Thorpe asked about the quality of primary care and adult social care within the borough and whether comparable metrics to the National Oversight Framework existed for those services.

The Chief Executive advised that relationships with primary care were positive but could be strengthened, noting that community services provided an important bridge and that further work was needed to integrate system assets and manage public expectations about receiving care in the right place. She emphasised the need to shift cultural expectations around urgent care usage and to reduce dependency on hospital-based services.

The Chief Operating Officer added that data is shared at the relevant system forums and advised that she did not have concerns about the quality of care being delivered in primary care, though she acknowledged the ongoing challenges in joining up pathways and ensuring stronger integration between primary and secondary care.

14. Board of Directors IPR M9 2526.pdf
14a. IPR_M9_2526.pdf
14b. Benchmark Access Standards - Jan 2026.pdf

14. Board Assurance Framework

Approval

Steve Parsons

In introducing the Board Assurance Framework (BAF) item, Mr S. Parsons asked the Board to confirm that the document continued to reflect the current level of risk and the mitigations in place. He drew particular attention to SR4 (Workforce Sustainability), noting that the score should either be maintained at its current level or potentially increased, given the pressures and indicators discussed during the meeting.

The Board **AGREED** that the BAF and risk scores were appropriate.

15. BAF Report Board February 2026 FINAL.pdf

15. Reflections on equality, diversity and inclusion

Discussion

Robina Shah

In concluding the meeting, the Chair invited reflections on equality, diversity and inclusion. The Board acknowledged that ED&I considerations had been woven throughout the discussions and that these continued to be central to the Trust's approach to leadership, culture, and patient care. The Board agreed that colleagues consistently demonstrate an understanding that data is not abstract, but represents the lived experience of patients, families and staff.

The Chief People Officer reiterated the earlier concern from the People Committee regarding the lack of protected characteristic data within Freedom to Speak Up reporting. It was agreed that the FTSU team would continue work to gather and analyse this information to support the early identification of any issues linked to protected characteristics, ensuring concerns can be fully understood and addressed.

The Board also noted the referral from the Finance & Performance Committee to the Quality & Safety Committee regarding access to care for neurodiverse children, recognising this as an important area for future assurance and triangulation.

Members reflected on the extensive discussions held regarding caesarean section rates, agreeing that actions would continue to be taken forward to better educate borough residents, with a particular emphasis on accessible information formats and tailored communication to support informed choice. This included recognising the differing levels of literacy and the value of using apps, videos, and digital messaging to engage effectively.

The Board placed further emphasis on the need for consistent access to BSL interpreters and welcomed work underway to strengthen this provision across services.

Finally, the Board acknowledged concerns about inconsistencies in approach across services, particularly where variation may impact the equity of experience or access. Members agreed that committee-level triangulation, continued visibility of soft intelligence, and inclusive leadership behaviours remained essential to ensuring a fair and equitable culture across the Trust.

The Board turned to the items on the consent agenda, having consented to them appearing thereon.

Consent Agenda

16. Equality, diversity and inclusion annual report

Approval

The Board **APPROVED** the content of the report for publication on the Trust's website.

17. EDI Annual Report 2024-2025 Executive Summary for Board approval.pdf
17a. EDI Annual Report 2024-2025 Final.pdf

17. Safeguarding annual report

Information

The Board received and noted the report.

18. Safeguarding Annual Report 202425 Front Cover Board of Directors Feb 2026.pdf
18a. WWLTH Safeguarding Annual Report 2024 2025.pdf

18. Guardian of Safe Working Hours report

Information

The Board received and noted the report.

19. GOSWH Quarter 1 Apr to Jun 2025.pdf

Agenda item: 6.1

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	University Hospital Status: Progress Report
Presented to:	Board of Directors
On:	1st April 2026
Item purpose:	For Assurance
Presented by:	Prof Sanjay Arya, Consultant Cardiologist
Prepared by:	Madeleine Jackson, Service Development Manager
Contact details:	E: Madeleine.Jackson@wwl.nhs.uk

Executive summary

Becoming a University Teaching Hospital has been a long-held aspiration for the Trust. We have been working toward this ambition since 2021 via the University Hospital Group (UHG) chaired by Professor Sanjay Arya and comprising of key members of WWL's Board, Research and Education Teams and Edge Hill University (EHU).

To achieve University Teaching Hospital status, Trusts must apply to the University Hospital Association (UHA) and meet all the criteria regarding research and education set by the UHA.

The criteria have recently been reviewed and rewritten by the UHA and are due to be released in April 2026.

- We have received the draft criteria
- The WWL research and education teams have been able to comment on the proposed new criteria (alongside other stakeholders) due to our ongoing engagement with UHA led by Professor Arya supported by the project team
- We are on track for September 2026 to submit our application, subject to UHA timescales and capacity within WWL and EHU

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations

There is low level risk of not meeting the criteria or not meeting our deadline of September 2026 due to circumstances outside of our control e.g. delays to the launch of the new criteria, capacity of EHU colleagues and our own internal capacity to complete the application and gather the evidence required by the UHA. To mitigate we will continue to monitor progress via regular University Hospital Group and project team meetings.

Financial implications

None

Legal implications

None

People implications

The Trust will continue supporting staff across all groups to be more research active and build on our medical education with partnership with EHU and other universities.

Equality, diversity, and inclusion implications

None

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

None

Recommendation(s)

The Board is asked to note the progress made, acknowledge the plan to submit our application in September 2026 and provide any additional direction to support our submission.

Report

Background

The Trust have been working towards University Hospital Status since 2021. During which time we have worked via the UHG to meet and gather evidence to show we have met the criteria set out by the UHA. The criteria have changed significantly since we began our journey to become a University Teaching Hospital. The key areas we struggled to meet previously were as follows:

1c i. A core number of university principal investigators. There must be a minimum of 6% of the consultant workforce with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question.

1c iii. For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.

However, the criteria have been reviewed and rewritten by the UHA, the consultation on the new criteria took place earlier this year (in which WWL participated). The UHA Lead has advised that the new criteria should be released in April 2026 to coincide with the launch of their new host organisation “The NHS Alliance”; formed by the merger NHS Providers and NHS Confederation.

Whilst the updated criteria remain embargoed until formal publication, early indications from the consultation suggest that the revised framework is more inclusive and considers individual Trust’s organisational sizes and profiles alongside their research and education activity.

As a Trust we work in close partnership with Edge Hill University, along with Manchester Medical School and University of Greater Manchester Medical (Bolton) school to deliver high quality, multiprofessional clinical placements supported by strong educational governance and effective supervision. These collaborative arrangements ensure a positive student experience and continuous enhancement of placement quality, in line with the revised UHA criteria for modern, inclusive multiprofessional education. Taken together with our research activity, infrastructure, and income, the UHG is confident that we will be able to submit a high-quality application in September 2026.

Next Steps

The UHG has set a timescale of:

- Evidence gathering to support our application Q1 and Q2 of 2026/7
- Completion of application form and submission to the UHA September 2026; subject to release of criteria in April 2026 and capacity within WWL and EHU

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	1 April 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. The report contains information relating to the National Staff Survey 2025.

Equality, diversity, and inclusion (EDI) implications
There are no EDI implications in this report. The report contains information about the Trust receiving Bronze Recognition for our Anti-Racist Framework from the North West Black, Asian and Minority Ethnic Assembly.

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.

Official Opening of the Andrew Foster Endoscopy Unit
I begin this Board report by acknowledging the contributions of Andrew Foster, our former Chief Executive and Chair of WWL, who passed away in 2023. It was a privilege to welcome his family for the official opening of the Andrew Foster Endoscopy Unit at the Royal Albert Edward Infirmary site. Andrew made such a significant contribution, not just to WWL, but to the wider Wigan Borough, Greater Manchester and beyond, and his legacy lives on at the Trust to this day. The new endoscopy facilities will provide quicker access to endoscopy procedures, ultimately leading to better outcomes for patients, as well as an improved environment for both patients and staff. This will ensure that patients will be receiving the highest possible standards of care, with improvements in privacy and dignity, increased patient choice, and more timely appointments. Naming this unit after Andrew has been a privilege and was an emotional moment for everybody at the event. He was a boss, a leader, a mentor, a confidant, and a friend, and my only sadness is that wasn't here to see this moment for himself. This new unit is a place that will change lives, honour his legacy and continue the work that he cared so deeply about.

National Staff Survey
In March, we received our 2025 National Staff Survey Results. This was WWL's best ever response, with 48% of staff taking the time to respond - an increase from 35% in 2024 and above the national average. To put that into context, we heard from 1,000 more members of our staff, which is a huge achievement, and means we now have a better understanding of how our staff feel about working at WWL. Creating a safe, engaging and rewarding place to work will always be one of our top priorities, and we had some significant improvements in this years' results. We remain the highest Trust in Greater Manchester for the fifth year running in both Morale and 'We Are Safe and Healthy'. However, we also have room for improvement, as some scores have fallen since last year, with a number of them remaining below the national average. We heard from staff that they are less likely to recommend WWL as a place to work or to receive care. Strengthening staff advocacy is one of our priorities this year, through focusing on clear communication, visible leadership, and ensuring staff members feel valued, listened to, and proud of the care we provide. We are actively working with representatives from across the organisation who are analysing our survey results alongside other feedback and insights, working closely with our divisions to understand what matters most to them, and providing targeted and tailored support to help teams make meaningful and lasting improvements to culture. The voices of our staff remain central to every decision we make, and their honest feedback gives us clear direction on how to celebrate our strengths but also tackle our challenges and keep building a workplace where everyone feels valued, supported and empowered.

Anti-Racist Framework Recognition
We were recently awarded Bronze Recognition for our Anti-Racist Framework from the North West Black, Asian and Minority Ethnic Assembly. This is a real achievement, signifying our time, effort and dedication to making WWL an anti-racist organisation. Anti-racism is not a sub-theme within our wider Equality, Diversity and Inclusion activity - it is a distinct, mission-critical priority which is integral to our Trust Strategy and Corporate Objectives. It reflects our explicit recognition of the structural and institutional racism, and the impact it can have on our staff, our patients, and the wider community. Key milestones include launching our Trust Values and Civility Frameworks, and we have also developed our Anti-Racist Strategy and our Anti-Racism and Zero Tolerance Policy, which are due to be launched soon. I am determined to build an inclusive culture at WWL; to amplify voices, strengthen leadership and accountability, commit to educating people on anti-racism, and improve the experience for our staff and patients. Achieving Bronze Recognition is proof that we are making a difference at WWL, and I am committed to continuing the hard work already underway.

WWL Named Cleanest Hospital in PLACE Assessments
Patient-Led Assessments of the Care Environment (PLACE) continue to provide invaluable insight into how our clinical environment can be enhanced from the perspective of those who use our services. I am pleased to report that WWL has once again been recognised as the cleanest Acute Trust in the country for the third consecutive year, out of 119 Trusts.
Over the past eight years, WWL has consistently ranked within the top ten per cent nationally. In 2025, the Trust achieved joint first place across England and secured first place within the North West for all Acute Trusts. This sustained performance reflects our organisation-wide commitment to maintaining the highest standards of cleanliness and ensuring an environment that supports safe,

high-quality care. These outcomes are a direct result of the dedication and professionalism demonstrated daily by our Estates and Facilities teams. Their efforts underpin the Trust's ability to provide a clean, welcoming, and safe environment for patients, visitors, and staff. I would like to extend my sincere thanks and congratulations to all colleagues involved; their continued hard work represents the very best of WWL.

National Oversight Framework
The NHS National Oversight Framework (NOF) 2025/26 released its third round of results in March, with WWL remaining in Segment 4 and improving its rank to 117 from 119 since Quarter 2. Established in 2025, the NOF serves as the national system for monitoring organisational performance. At WWL, we recognise the areas requiring focused attention and are actively implementing significant transformation programmes, particularly in urgent care and elective recovery. These initiatives are designed to improve our performance and prioritise the needs of our patients, staff, and the residents of Wigan Borough.

Emergency and Urgent Care
March has seen a positive improvement to four-hour performance across the Emergency Department, Paediatric Emergency Department and our Urgent Treatment Centres. Our current performance is just over 77%, reflecting an 11% improvement this month and more than a 5% increase compared to last March. As part of the 'March Sprint' campaign the Urgent and Emergency Care teams have taken a number of actions to support the improvements including increasing the Frailty Same Day Emergency Care area, implementation of an Urgent Treatment Centre co-ordinator and a tracker role in our Emergency Department. We are working to embed these improvements and ensure that they continue to be sustained. To further support this, today we launched the Right Patient Right Ward programme. This initiative targets four critical conditions, heart attack, stroke, acute abdomen, and fracture of the neck of femur, with the aim of enhancing patient outcomes and overall experience.

NHS England Advice to Virtually Eliminate Corridor Care
This month, we received advice from NHS England that, from May 2026, data will be collected in relation to corridor care and published on NHS England's website. As we continue to make steps within WWL to combat having escalated areas in corridors, we are also taking on board some of the actions that were identified at the Corridor Summit for Provider Trusts outlined the additional actions that need to be taken at a national level, including identifying corridor care as an organisation risk, and making reviews of corridor care and incidence data a standing risk at Trust Board. A Getting It Right First Time (GIRFT) guide on Corridor Care Improvement has also been published, which details actions to take to reduce corridor care with clear executive owners and a detailed report on how this will be managed and reported will be brought to the June Trust Board for consideration.

Neighbourhood Health Framework and Population Health Delivery Models
On 17 March 2026, NHS England published the Neighbourhood Health Framework and accompanying guidance on Population Health Delivery Models. Together set out a major shift towards more preventative, integrated and neighbourhood-based care. The Framework strengthens the role of the Integrated Care Board (ICB) as strategic commissioners and introduces new population-based contractual arrangements intended to reduce fragmentation and enable a more consistent, outcomes-focused approach across primary, community, mental health and social care services. The publications provide greater clarity on the "left shift" required nationally and the associated expectations around outcomes, financial flows and local planning. Of particular relevance to WWL is the development of Integrated Neighbourhood Teams with an early focus on frailty, long-term conditions, children and young people, and improved access to general practice. Over the coming weeks we will work with the ICB and wider partners to assess the implications for our neighbourhood development across the Wigan Borough, future integrated care models, and next stages of our organisational redesign.

To:
- Trust chief executive officers and chairs

cc.
- Trust medical directors and directors of nursing
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 March 2026

Dear colleagues

Additional actions to virtually eliminate corridor care

We all know that corridor care is unacceptable; it creates an exceptionally poor experience for patients – particularly older patients – and their loved ones, generates low morale for our staff, and undermines the public's confidence in the ability of the NHS to provide safe care when they need it most.

This year, a number of colleagues have gone to great lengths to eradicate or significantly reduce the incidence of corridor care, and to mitigate its effects where needed. It is evidence that with the right leadership ambition and focus we can do much more to prevent corridor care in the future.

Over the last few weeks, we have worked constructively with the Corridor Care Coalition – representing patients, staff and the public – on this issue, and want to thank them for their leadership and challenge on behalf of both patients and staff.

Responding to their collective constructive challenge, we write to inform you of the following actions we are now taking, in addition to existing work led by GIRFT.

Increasing visibility and transparency

We agree with the Corridor Care Coalition central ask that the starting point needs to be consistent transparency on the extent to which patients are experiencing – and staff are having to deliver – care in non-designated areas.

To that end we have engaged with clinical and professional groups on a single definition of 'corridor care' to be shared across the NHS.

In summary, a patient has experienced corridor care if they have spent at least 45 minutes in a clinically inappropriate area of an emergency department or general and acute ward.

Ambulance handover delays should continue to be reported separately and monitored alongside corridor care to ensure efforts to reduce corridor care do not lead to longer waits in ambulances outside the hospital.

The 45-minute threshold for corridor care aligns with the W45 protocol for ambulances. We aim to revise both down to 30 minutes in 2027/28 once demonstrable progress has been made.

The full definition and worked examples accompany this letter and are on our website. These should be used consistently from now on, both internally to your organisation and in discussions with system, and regional and national colleagues.

Based on this definition, we will begin collecting data on corridor care and will publish it, subject to data quality, each month from May 2026 on NHS England's website.

The newly defined corridor care measures will need to be submitted in the UEC Daily Sitrep collection. New fields to collect these data will be available for completion from 6 March. At the same time, the current fields used to collect Temporary Escalation Spaces will be stood down.

If you have any questions about the definitions, please email england.DailySitRep@nhs.net.

For questions about beds, please email england.bedsanddischarges@nhs.net.

For technical questions about the submission of your data, please email nhsi.SITREPSupportTeam@nhs.net.

Additional national-level actions

In addition to increasing consistency and transparency of what we measure, we will be taking forward the following national actions over the coming months.

1. **Supporting operational and clinical improvement** – we will shortly publish a **Getting It Right First Time improvement guide** on corridor care based on learning from the team's work on the ground with the most challenged organisations. The GIRFT programme's intensive on-the-ground work with the most challenged trusts will also continue.
2. **Increasing public awareness of ED alternatives and preventative actions** – we will review national communications' campaigns and resources for local use on community-based alternatives to Emergency Departments and avoiding hospital admissions, to ensure they are effective.
3. **Clarifying escalation and incident reporting** – our recent Principles for providing patient care in corridors guidance reminds trusts of the importance of internal oversight, escalation and incident reporting. We will refine these further to make it clearer that trust boards should take formal ownership of corridor care as an organisational risk, that any proposed use of corridor care should be approved at executive-level, and that all individual cases meeting the criteria in the definition should be reported as an incident.
4. **Supporting trusts and systems to implement existing guidance on improving urgent and emergency and acute care** – including the Model Emergency Department, Extended emergency medicine ambulatory care operating principles, Model Acute Pathway and the FRAIL strategy, to embed important measures which can make a difference to the timeliness and efficiency of care, including timely assessment by senior doctors, particularly for older people with frailty.

5. **Prioritising the eradication of corridor care as part of wider ongoing work on <u>new</u> care delivery standards** – we are currently developing a new **Urgent and Emergency Care Strategy** through which we will set out priority work to improve the whole pathway. Additionally, as part of other ongoing work across NHS England, we will:
    a) **set expectations of the role of senior clinicians.** As part of the **National Care Delivery Standards –** within the **Quality Strategy** workstream – we will set further expectations on access to consultants and other key professionals to support clinical decision making
    b) **review the Section 136 pathway, including the role of places of safety, and ensuring clear alignment with the development of Mental Health Emergency Departments.** This work aims to improve the experience and care of people in mental health crisis and reduce the need for prolonged stays in Emergency Departments, as part of the wider programme to strengthen the national mental health crisis care model
6. **Supporting the workforce** – as part of ongoing work on the **10 Year Workforce Plan,** we will consider UEC and acute staffing models, and further support for staff who may be required to provide care outside of their normal environment.
7. **Co-produce further actions local leaders can take to reduce corridor care and improve support for staff and patients** – working initially with the 30 trusts facing the biggest challenges, as set out in the following section.

Co-producing further trust-level actions

On 26 February we convened CEOs, chairs, chief operating officers, medical directors, chief nurses and directors of communication from 30 trusts assessed as facing the biggest challenges on corridor care.

The purpose of this summit was to discuss and develop additional actions to support the eradication of corridor care which are more amenable to local ownership rather than national direction.

I want to thank those colleagues who attended for the positive and proactive approach to owning and solving these challenges displayed in the room.

There was a clear consensus in the room on the importance of:

- trust boards owning and treating corridor care as an organisational risk, including making reviews of corridor care and incidence data a standing item at trust board meetings
- trust executives regularly walking the corridors and wards, including out of hours, to speak with patients who have been waiting more than 12 hours, and to staff
- trust chief executives, medical directors and chief nurses regularly chairing hospital discharge meetings to better understand actual system blockages and ensure effective discharge planning

- trusts taking steps to improve the capture of near real-time patient and staff experiences of corridor care to inform action and board oversight – which we will develop a support offer on
- trusts setting and enforcing clear professional standards and expectations on senior clinicians to lead organisational responses to situations where corridor care is being used or is at risk of being used

Each of the 30 trusts is now rapidly developing their own set of commitments for action over the coming months. To support further improvement, we will assess the real-world impact of these actions to inform future guidance for all trusts.

I said at the beginning of this letter that we all know that corridor care is unacceptable. Where colleagues have made the biggest difference this year leadership teams have adopted this as an organisational policy, and acted accordingly.

So while there are many factors at play in corridor care which are beyond the direct control of individual trusts, let's all emulate those colleagues who are showing the way on this, and ensure we are doing everything within our control to eradicate corridor care, and give all our patients the quality, safety and dignity of care they deserve.

Yours sincerely

Sarah-Jane Marsh CBE

National Director of Urgent and Emergency Care and Operations

NHS England

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Partnerships Report
Presented to:	Board of Directors
On:	1st April 2026
Presented by:	Richard Mundon, Director of Strategy and Planning
Prepared by:	Chris Clark, Director of Strategic Transformation
Contact details:	Email: chris.clark@wwl.nhs.uk

Executive summary

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

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

- The NHS England *10 Year Health Plan*, which highlights three radical shifts; from hospital to community; analogue to digital; and sickness (reactive care) to prevention.
- The *Planning Framework for the NHS in England*, which promotes integrated, system-wide planning focused on population health, financial sustainability, and service transformation.
- The *Neighbourhood Health Framework*, which sets out the next steps for the NHS, local government and voluntary, community and social enterprise partners to develop neighbourhood health services.
- *Fit for the Future: Towards Population Health Models* which sets out guidance on three new contractual models to support delivery of population-level delivery models.

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

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

Risks associated with this report and proposed mitigations
No specific risks linked to this report. Risk to partnerships included within the Board Assurance Framework (see PR8)

Financial implications
No financial implications to this report.

Legal implications
No financial implications to this report.

People implications
No financial implications to this report.

Wider implications
None noted.

Equality, Diversity and Inclusion Implications

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

Recommendation
The Board of Directors is requested to note the contents of this report.

Why partnerships matter & national drivers

The latest version of the NHS Foundation Trust Code of Governance (published in April 2023) sets a clear expectation that providers work effectively with system partners on all issues, including those that may be contentious, and that the success of NHS trusts will increasingly be judged not only on organisational performance but on their contribution to the wider objectives of the ICS. This reflects the establishment of Integrated Care Systems on a statutory footing, with Integrated Care Boards (ICBs), Integrated Care Partnerships (ICPs), place-based partnerships (such as the Healthier Wigan Partnership), and provider collaboratives collectively responsible for improving population health and delivering integrated care across localities.

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

Table 1 – Code of Governance Principles

1.1 Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust ***as part of the ICS and wider healthcare system in England***, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public.

1.2 The board of directors should establish the trust's vision, values and strategy, ***ensuring alignment with the ICP's integrated care strategy*** and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture.

1.3 The board of directors should give ***particular attention to the trust's role in reducing health inequalities in access, experience and outcomes***.

1.4 The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the ***trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners***, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions

1.5 For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and ***encourage collaborative working at all levels with system partners.***

1.6 The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.

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

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

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

Core to achieving these shifts, as set out in the 10 Year Health Plan, is development of a truly Neighbourhood Health Service, which is multi-disciplinary, prevention focussed and rooted in

communities. Achievement of this will only come through effective working with our partners across the locality. Further detail on this was set out in two complementary publications on the 17th March 2026: "*Neighbourhood Health Framework*"; and "*Fit for the Future: towards population health delivery model*s".

The *Neighbourhood Health Framework* introduces Integrated Neighbourhood Teams (INTs) as the core delivery model, bringing together primary care, community services, mental health, social care and voluntary sector partners to provide more proactive, preventative and person-centred care within neighbourhoods. It prioritises improved outcomes for people living with frailty, those with multiple long-term conditions, and children and young people, and strengthens expectations around access to general practice. Delivery of neighbourhood health is intended to be locally led, with ICBs and local authorities required to set neighbourhood geographies, develop shared outcomes, and plan services jointly through Health and Wellbeing Boards.

Fit for the Future: Towards Population Health Delivery Models introduces a suite of new contractual approaches designed to deliver outcomes for defined populations. The models — Single Neighbourhood Provider (SNP), Multi-Neighbourhood Provider (MNP) and Integrated Health Organisation (IHO) contracts — aim to align incentives, reduce fragmentation and support providers to take on greater responsibility for resource allocation, pathway redesign and the delivery of population-level outcomes. These arrangements strengthen the strategic commissioning role of ICBs and reinforce the national shift towards prevention, integrated community-based care and outcomes-focused delivery. High-performing providers may, over time, be able to hold outcomes-based, population-level budgets, with effective partnership working across primary, community, mental health, social care and acute services a prerequisite for this.

In September 2025, NHS England also published the *Planning Framework for the NHS in England*, which introduced a rolling five-year planning horizon (2026/27–2030/31) and emphasised integrated, system-wide planning focused on population health, financial sustainability and service transformation. This Framework is a key enabler of the new national direction, reinforcing the need for coordinated planning across the ICS and its localities, and strengthening the importance of effective partnership working in delivering the NHS's strategic ambitions.

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

How this aligns with Our Strategy 2030

As part of developing the Our Strategy 2030, the Trust engaged widely with partners across the Wigan locality alongside considering strategies at a Greater Manchester level. Our Strategy 2030 is focussed on delivery across our "4 Ps", one of which is Partnerships.

Since *Our Strategy 2030* was agreed, the Trust has moved beyond the post-pandemic phase, completed major organisational and leadership changes, and is now operating within a new planning and policy environment shaped by the NHS 10 Year Health Plan (10YHP), Five-year Medium-term Planning Framework, and a stronger emphasis on population health and place-based care. While the core strategic intent of the current strategy remains valid, it no longer fully reflects these changes or the scale of opportunity and challenge facing the Trust. In accordance with the discussion at Trust Board workshop in January, we are going to refresh rather than recreate the strategy, retaining the 3Is and 4Ps framework and overall direction, while sharpening focus, strengthening delivery ambitions, and aligning more clearly with local priorities. A structured programme of engagement with patients, staff and system partners is being developed, which will lead to a refreshed strategy for approval and launch in Summer 2026.

Delivery of the Trust's strategy is then focussed on an annual basis as part of the corporate objective setting and supporting divisional plans. In addition to Our Strategy 2030, several other drivers are considered as part of setting the annual corporate objectives including: changes in national planning guidance and/or expectations; and any new partnership strategies as they emerge. As we head into 2026/27, we have a specific partnership objective: "To strengthen existing and develop new partnerships at place, system and wider network level in response to NHS reforms – supporting our NHS services and research activities". Risks to achievement of this objective are monitored through the Board Assurance Framework (BAF).

Greater Manchester System Working

All Executive Directors play an active role in their relevant sub-group or network across GM as well as the GM wide programme boards, which track system wide actions against priority areas. Several of the Executive Team have key roles within the GM Trust Provider Collaborative including the Chief Executive, who chairs the GM Elective Recovery Board. and the Deputy Chief Executive who has chaired the GM Directors Strategy group for several years (although this has recently been handed over to another colleague in GM). We also continue to be closely involved in the processes to allocate capital funding across the GM ICS, with the Chief Finance Officer part of the GM Capital Resource Allocation Group (CRAG). More recently, we have led on the establishment of a cross-GM group to review opportunities to develop commercial partnerships.

WWL was significantly involved at multiple levels throughout the organisation to ensure that our recently submitted Medium Term Plan submission was consistent with planning assumptions within the GM ICS and that it contributes towards delivery of the GM ICS plan to meet national operational planning requirements. This included active involvement in the GM planning hub meeting, GM Executive meetings (e.g. GM Directors of Strategy and GM Directors of Finance); and the Trust Provider Collaborative (TPC).

Delivery of our plan will require continued close working with partners in GM with the following specific issues having been identified during the planning round:

- Agreement with NHS GM ICB on the specific community services to be commissioned to support admission avoidance and demand management, and transformation of our virtual ward model to focus on step-up pathways; and
- Delivery of the planned improvement in DM01, particularly in 2026/27 is a significant challenge. Commitment from partners across GM has however been given to support achievement of this. Further work is however required including: GM ICB recommissioning of NOUS provision and development of detailed plans with the Trust Provider Collaborative.

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

Pathology We have had a shared pathology for many years with Salford Royal (now part of the Northern Care Alliance). We are committed to building on this to develop a single pathology service for GM, through supporting Manchester Foundation Trust and the Northern Care Alliance to develop a best practice model for pathology.

Procurement We are the strategic lead for developing a single procurement hub for GM, and an early adopter of the new model.

Recruitment We are committed to supporting development of a single recruitment model for GM

With the ICB's role now changing to focus on strategic commissioning, there will be a greater role for the Trust Provide Collaborative (TPC) to drive service change and integration. Whilst further detail on this is to be worked up, the initial areas identified by TPC include: Outpatient Redesign; Cancer Improvement; and development of a GM model for frailty. All three of these areas will support areas that we have already identified as priorities for local transformation, and we will be working with GM partners to maximise the further benefits to be obtained from working across GM where it makes sense to do so.

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

Our participation in GM programmes supports access to capital funding to deliver improvements in our services. Since the last partnerships report to Trust Board, several developments have completed, all of which have been completed through successful bids to specific capital funding programmes and were supported by GM:

- The new endoscopy unit at RAEI has opened. This is a key part to supporting the achievement of JAG accreditation for Wigan. When this accreditation is secured, it will support the delivery of Bowel Cancer Screening lists at Wigan as well as Leigh, increasing accessibility of screening and supporting a reduction in health inequalities given the variation in screening take up across the Borough.
- The new radiology area adjacent to ED. This has included installation of a CT scanner on Level 2 and the replacement of two aging X-ray rooms. The co-location of a CT scanner will significantly reduce the transfer time for patients, supporting compliance with NICE guidelines for Trauma CTs and for stroke patients, leading to improved outcomes.
- The refurbishment of the Discharge Lounge which has included improvements to external access (supporting improved patient and transport flow) and internal refurbishment to ensure compliance with infection control, safeguarding, and accessibility standards.

Work is also currently underway to co-locate the Surgical Admissions Lounge with theatres, improving patient dignity and experience, as well as increasing efficiency, and work will begin shortly to refurbish Theatres 5&6 at RAEI. We are currently awaiting the outcome of bids for further capital funding through the UEC, diagnostics and estates safety capital programmes for 2026/27 onwards.

Collaboration with Bolton NHS Foundation Trust

Our collaborative work with Bolton continues in line with the principles below that have previously been agreed and reported to Trust Board.

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

Whilst there have been several examples of collaboration these have largely focussed on sharing of ideas and expertise across teams and exploration of joint roles where these make sense to do so, rather than significant service changes. The exception to this is the urology shared oncall model which has both strengthened the clinical sustainability of the service, supporting substantive recruitment and reduced agency costs.

With the Medium-Term Plans for both organisations now submitted, it is clear that there are opportunities for more substantive collaboration in support of service sustainability. It is planned to refocus the collaboration with Bolton as we move into 2026/27, with the next Collaboration Board in April to focus on clinical services where there are benefits in working together, including exploring collaborative options for the Virtual Ward service and on how we maximise the use of Leigh Infirmary as a shared facility.

Healthier Wigan Partnership

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

We continue to explore, and implement, new opportunities to deliver services jointly with our locality partners, the most recent example of which is provision of a joint Infection Prevention and Control service with Wigan Council.

As previously reported to Board, our commitment to increasing focus on prevention and reducing health inequalities together is demonstrated by the joint appointment of a Consultant in Public Health with Wigan Council to provide leadership across organisational boundaries - bringing specialist expertise in epidemiology and health improvement into hospital services and supporting targeted action on health inequalities and embedding prevention within clinical pathways. A Health Inequalities and Prevention Plan is being developed which will be overseen by Board through to the Quality & Safety Board Sub-Committee.

A key element of our work to build community wealth—which we recognise as a foundation for strong community health and a core pillar of "Progress with Unity"—is our commitment to the Wigan Education and Skills Partnership (WESP). Created in response to the Wigan Employment and Skills Strategy, WESP aims to raise aspirations from school age through to adulthood, improve access to high-quality learning and technical education, and develop a skilled local workforce aligned to employer needs. WWL plays an active role through the WESP Health and Social Care Subgroup, working with partners across health, education and local government to shape workforce planning, respond to long-term workforce challenges, and create clear entry routes into clinical and non-clinical roles. Strengthening career pathways, apprenticeships and work placements supports the borough's levelling-up ambitions and contributes directly to improved long-term wellbeing.

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

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

The programme is delivering sustained improvements in avoiding unnecessary admissions and reducing length of stay for patients with no criteria to reside. Since the last partnerships report to Trust Board, the focus has been on supporting prompt discharge of patients from hospital and ensuring that we make the most of our reablement and rehabilitation services across the Borough. This will support increases in the number of patients who are able to return to their usual place of residence and reduce those going into long term care. Whilst there is more to do to realise and sustain the full level of benefits expected, this work, combined with internally focussed improvement work within the Emergency Department and inpatient flow, is supporting significant improvement in performance. Our 4-hour A&E performance in March is ~77% which is an 11% improvement in month and an over 5% increase on last March's performance.

Moving forwards, we are seeking to build on our solid foundations of locality partnership working to further develop our approach to neighbourhood care. We will be reviewing the implications of the *Neighbourhood Health Framework* and *Fit for the Future: Towards Population Health Delivery Models* documents for WWL with our partners, ensuring alignment with our organisational redesign, our neighbourhood development work with the ICB, and our broader ambitions around prevention, proactive care and system integration.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	11 March 2026
Chair:	Francine Thorpe

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

ALERT

Sepsis & escalation gaps: There is delayed blood-culture collection within the 'golden hour', despite improvements across other sepsis metrics and declining national early warning score (NEWS2) compliance, posing a risk of missed recognition of deterioration.

Infection prevention & control (IPC): Hospital-acquired infections under national oversight framework (NOF) reporting (C. diff, E. coli, MRSA) remain an area of concern. C. difficile case numbers are rising, moving upwards against the Trust's planned trajectory despite WWL performing better than some Greater Manchester peers. The deep clean programme remains paused due to lack of decant space, increasing environmental-risk exposure.

ASSURE

Corporate objectives: The Committee is assured that the quality-related corporate objectives for 2025/26 are appropriate, and supported by clear operational plans, further work was requested in terms of measurement Quarterly progress reports will return to Q&S.

Lost to follow-up (LTFU): The Lost to Follow Up Group has reduced the risk relating to this issue due to a fall in lost-to-follow-up incidents, strengthened monitoring through learning from patient safety events (LFPSE) and Datix. Retrospective audits continue to be undertaken within services for oversight.

Deteriorating patients: The Committee was assured that:

- sepsis improvement work is delivering results,
- Acute illness management training coverage has increased across acute wards,
- paediatric sepsis and digital monitoring are being strengthened, and
- positive cultural shifts are evident in escalation behaviour.

Patient Experience & Engagement Group: The Committee was assured by improved maternity Picker outcomes, strengthened EDI and interpreter-service work, and effective divisional reporting.

IPC: Assurance was gained that:

- all C. diff, E. coli and MRSA cases continue to receive robust clinical review;
- antibiotic stewardship remains strong (WWL prescribing levels among the lowest in GM);
- the Chief Nurse will raise regional consistency concerns on C. diff reporting at the GM Chief Nurses Group.

A low-level explanatory update on C. difficile and sepsis will be provided to the Board.

ADVISE

Children's audiology – peer review progress: The Committee agreed to advise the Board to the ongoing delay in completion of the 600-case external peer review, which remains outside the Trust's direct control. A "touchpoint" update will be brought to the next meeting and there have been no critical concerns identified to date.

Lost to follow-up (LTFU): delays in implementing the digital outcome form (DOF) continue to present a risk and that technical issues remain outstanding

Corridor care – national directive: A mandatory national directive has been issued requiring immediate actions to eliminate corridor care, with specific expectations for the Board. Guidance and action cards have now been received and an update will be presented to the April Board.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Nothing was noted for escalation to the Board.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	12 November 2025
Chair:	Mary Moore

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

ALERT

Right patient, right ward (corporate objective): further work presented, comparing Professional Body recommendations for timely admission to the right ward. Poor compliance with timely admission to specialist wards for heart attack, stroke, fractured neck of femur, acute abdomen; There is a risks to patient outcomes and mortality if not addressed however our mortality metrics overall do not reflect this at the present time. Realistic targets for the above to be reviewed within the BAF, noting seasonal risk variation. Mitigations to be linked to Better Lives Programme and the use of the escalation policy. Quarterly reporting to Q&S to commence.
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.

ASSURE

Patient story (complex care pathway): Positive outcome, reduced hospital admissions, improved patient alertness, effective MDT working.
Maternity safety standards (Ockenden, CNST) A lengthy report required to come to Board assurance committees. Compliance with training, minimal staffing vacancies, ongoing audit, no Regulation 28, complaints managed on time and litigation by value and cost lowest in GM.
ASPIRE Accreditation (quality improvement): Significant improvement in ward environments, collaborative learning, electronic process, triangulation with other assurance. All scores improving with lowest scoring wards (White) demonstrating improvement. Personal assurance via feedback from clinical staff within the meeting.
Oxygen prescribing: Compliance above target, ongoing monitoring, successful PDSA cycles.

ADVISE

Organisational restructure: Transition to new divisional structures continue on track, further work ongoing progressing clinical models and pathways, staff thanked for adaptability, further update due at January Q&S.
Patient Experience and Engagement Group: Complaints and PALS data notes a predominantly white ethnic group interaction. Further work ongoing to identify underrepresented patient voices within our communities. National Oversight Framework metrics to be included in reporting going forward. action plans in place, improvement trends noted.
Medical engagement (Maternity Safety Champions): Continued slow engagement of medical staff in safety culture work and initial response to SCORE survey, impacted by sickness within the consultancy company undertaking the work.**Sepsis performance:** Slow improvement, blood culture metric stubbornly low, risk of missed timely care due to A&E congestion and HO45 ambulance handover process. New process recently implemented for timely blood culture testing (via canula on admission to A&E) Metrics to be triangulated with HO45 to identify

possible impact.**Flu vaccination update:** Uptake improving, targeted messaging, monitoring ongoing, data not yet linked to staff receiving vaccine outside of the organisation.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
Bed base & patient flow: Lowest bed base in region, ageing population, risk of overcrowding and inability to ring-fence specialist beds. **Sepsis & ED congestion:** Delays in timely care due to ED overcrowding and ambulance handover process, risk to patient outcomes. **IT delays:** SBar tool implementation delayed, risk to communication and patient safety. **Seasonal variation in risks:** Need for dynamic risk assessment in BAF to reflect operational pressures.

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	25 March 2026
Chair:	Julie Gill

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

ALERT

- Regarding the 26/7 plan, the committee noted the increased cost improvement programme (CIP) requirement of £3m to £31.8m and the associated delivery risk arising from the 40/60 H1/H2 phasing, which is more heavily weighted towards the latter part of the year and so creates a risk to achievement, being closer to the winter period.
- Regarding the cash position, although the 26/27 plan forecasts that no additional cash support will be required in 2026/27, the underlying cash burn rate means this remains a material risk and cash balances will be low in months 4 and 6.
- The Stryker IT outage resulted in a suspension of the delivery of essential theatre toga gowns and supply chain issues for bone cement led to unavoidable orthopaedic cancellations, which will negatively affect March performance. Although supply and systems have now stabilised, the Committee agreed this short-term operational impact should be highlighted to the Board. *Stryker is a global medical technology company that manufactures orthopaedic implants, surgical equipment, trauma products, and digital surgical systems used widely across the NHS and experienced a major global cyber-attack in march 2026.*

ASSURE

- Triangulation between the Medium-Term Financial Plan, the corporate objectives and the transformation programmes has been carried out to ensure that they work in tandem.
- The Trust is over delivering against plan in several areas and continues to take the necessary actions to deliver a strong year-end financial position.
- Robust mitigations are in place for the supply and IT issues, with alternative supply routes and replanned theatre lists ensuring minimal impact on elective performance until full supply resumes.

ADVISE

- The board should be advised on the pressure to deliver the CIP for 2026/27 and to generate the required cash balances, given the forecast drop in cash - particularly in the middle of the year - it is therefore imperative that the CIP delivery profile runs to plan.
- Performance highlights included:
  Sustained high demand in UEC with year-on-year growth: A&E attendances and ambulance arrivals increased by **8% compared with the same period last year**, driving significant operational pressure through December–February.
  Marked improvement in performance through March: Despite these pressures, the Trust delivered a **12% uplift in four-hour standard performance**, improving from **65% in February to 77.09% in March**, supported by targeted operational interventions.
  Impact of improvement initiatives becoming embedded:
  Key actions—such as expansion of frailty same-day emergency care, strengthened

Urgent Treatment Centre coordination, enhanced tracking, and the accelerated admissions policy are now showing **sustained, repeatable effects** rather than short-term gains. • The Committee has received a letter received from NHSE detailing how corridor care should be managed, which will be provided at the April Board meeting.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• None.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	17th March 2026
Chair:	Mark Wilkinson

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

ALERT

The Committee wish to alert the Board that:

- Persistent high sickness absence (particularly stress-related) represents an ongoing people risk with operational and financial implications. The sickness absence action plan is in place, and this has been reviewed to ensure a focus on stress related absence management via stress risk assessments.
- A declining advocacy score in the National Staff Survey and confidence in organisational response to concerns may represent a reputational, cultural and workforce risk. Without sustained action, this may undermine engagement, retention and psychological safety. The staff survey action plan seeks to address this.
- A report on the national revisions to nursing job profiles will come to the next meeting of the People Committee, with the financial implications to be highlighted at the Finance and Performance Committee.
- Continued reliance on bank staffing presents a financial and workforce sustainability risk.
- Improved workforce data integration is required to support more targeted intervention and understand the drivers of the reliance.
- Current Board Assurance Framework aggregation may not sufficiently reflect the breadth and complexity of people-related risks. Further disaggregation and risk maturity is required for 2026/27.

ASSURE

The Committee wish to assure the Board that:

- The organisation is managing the FTSU transition from an ICB provided service to a collaboration with Bolton FT in a controlled, transparent and assured manner, with continued Non-Executive oversight.
- The organisation has recognised the risk of unintentional harm that employee relations processes may cause and has an active programme to mitigate it. Staff voices are informing policy and process redesign.
- The organisation is actively responding to staff feedback with a structured, sustained and transparent improvement approach.
- Workforce development and entry-route programmes are well governed and aligned to strategic workforce needs.

ADVISE

The Committee wish to advise the Board that:

- The Committee approved the amended People objectives reflecting the importance of the development of our culture and seeking to improve staff survey advocacy scores.
- The committee would support development of a more mature and granular People risk framework for 2026/27.

RISKS FOR ESCALATION

The following risks were discussed.

- **Working Time Directive compliance risk**, particularly within the medical workforce, linked to additional work outside core hours
- **Risk aggregation within the BAF**, potentially obscuring multiple underlying people risks

Agenda item: 10.3

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	20 January 2026
Chair:	Mr M Wilkinson

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

ALERT

- The committee will alert the board to the high proportion of anonymous freedom to speak up concerns (over half), noting the trust is second only to the Northern Care Alliance on this measure, and that this is now benchmarked against other providers within the local region. Board is advised on further work needed to triangulate freedom to speak up data with staff survey results and other sources to better understand the culture of raising concerns.
- The committee noted a decline in staff advocacy scores for recommending the trust as a place to work or receive treatment, which has deteriorated for the second year running.
- The committee highlighted that appraisal performance is not where it should be, however, an audit is forthcoming which will support improvement in this area.

ASSURE

- Progress has been made on job planning, with 71% completion, and manual checks have increased confidence in the accuracy of this data.
- The committee is assured that the trust is above its workforce plan for starters versus leavers, and agency usage is reducing, with bank usage reflecting escalation and sickness pressures.

ADVISE

- The committee noted that actions are in place to address inclusive recruitment, with data on shortlisting and recruitment outcomes to be included in future reports.
- The committee will review the gender pay gap data over a longer trend period and integrate intersectionality into future equality, diversity and inclusion strategy and reporting.
- It was noted that the 10-point plan for resident doctors needs regular oversight by the committee, including reporting to ensure progress and mitigate industrial action or working environment issues, this would be added to the workplan.
- No outstanding audit actions for the people team were noted.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The Committee Chair will review the board assurance framework (BAF) risk scoring with the incoming Chief People Officer, after she has attended divisional performance reviews and will raise this with members and then the board if there are concerns around any risk rating contained therein.
- The committee was pleased to note no outstanding reports or recommendations in respect of internal audits.

Committee report

Report from:	Research Committee
Date of meeting:	3 March 2026
Chair:	Clare Austin

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

ALERT

- The Committee noted the following around **charitable funds**:
  - A lack of awareness among clinical teams about available funds;
  - Inconsistent understanding of opportunities by divisional fundholders;
- Resulting missed opportunities to support research, equipment, and development activity. The Charity's approach needs to be aligned moving forwards with the organisational re- design.
- Once again members heard that ongoing **clinical pressures continue to limit clinicians' ability to undertake research** (per the surgery divisional research report), even where motivation and expertise exist. This has a material effect on NIHR bid development, leadership capacity, and ability to maintain a pipeline of research active clinicians.
- The Committee highlighted a **reduction in NIHR income** and inability to increase the grants. This remains a strategic risk previously escalated to Board.
- The Committee discussed the need for education to have more prominence at Board level, as aligned to the likely revised University Hospital Association criteria.

ASSURE

- The Committee noted positive work done with Wigan Council, Edge Hill and the community relating to research.
- The Committee noted positive progress against delivery of the Research Strategy.
- Positive NIHR recruitment was noted.

ADVISE

- Work is ongoing to **refresh the Research Strategy -** a bridging work plan would likely be developed and more focus given to health inequalities.
- **CIP for research is challenging** as it is reliant upon external income which is out of the Trusts control and failure to deliver has an impact on other corporate services.
- **WWL and Edge Hill University will refresh their memorandum of understanding**.
- The Trust has **contributed to the development of revised criteria for University Hospital status** and finalised new criteria are expected soon. Activity and achievement relating to the new criteria will be mapped by the trusts University Hospital Association Group with an application anticipated later in the year.
- Despite the alerted challenges relating to time for research, the committee heard from the clinical research lead, surgery that time had been given to support the **development and writing of a research grant.**

- The Committee heard about the development of more standardised models to store data and support the use of data and data accessibility.
- The Committee noted the enthusiasm and support for research for NMAHP Colleagues and the need for similar support for doctors.
- The Committee heard a research story which highlighted the importance of collaboration and discussed the need for more internal dissemination including impact on patients.
- In discussing EDI the committee noted the challenges with data protection and patient demographics.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- None to be escalated to the Board.

Title of report:	National Staff Survey 2025 Results and Engagement Plan
Presented to:	Board of Directors
On:	01/04/2026
Item purpose:	Information
Presented by:	Emma Newton, Interim Chief People Officer
Prepared by:	Angelique Hartwig, Head of Staff Experience Rachel Gleave, Associate Director of Staff Experience
Contact details:	Angelique.hartwig@wwl.nhs.uk

Executive summary

This report provides a summary of the 2025 National Staff Survey (NSS) results and indicative results for the National Quarterly Pulse Survey (NQPS) Q4 and the National Staff Survey (NSS) 2025 Engagement Plan which sets out our approach for the coming year, along with the indicative timelines for delivery. For 2026/27, we are proposing a strengthened One Team approach, grounded in genuine partnership working across the organisation, to ensure that improvements to people experience are shaped directly by staff voice and by the insights emerging from the NSS.

A central focus of this year's engagement activity is improving staff advocacy, measured specifically through the two NSS metrics: whether staff would recommend the organisation as a place to work, and whether they would recommend it as a place to receive care. Our approach is designed to positively influence these measures by targeting four priority drivers known to underpin staff advocacy:

To deliver meaningful and sustained improvement, we also recognise the importance of a fifth element that underpins all four drivers: Continuous Improvement. Embedding continuous improvement principles across divisions and teams ensures that cultural progress is iterative, data-informed and locally owned. This includes supporting leaders and teams to routinely review their insight, test and implement small-scale changes, evaluate impact, and adapt their approach over time. Strengthening improvement capability at team level enables long-term cultural change rather than one-off interventions.

To support this approach, we propose the establishment of a People Experience MDT, bringing together expertise to coordinate delivery, triangulate organisational insight and provide targeted support to divisions, leaders and teams. The MDT will oversee four key engagement workstreams

designed to ensure meaningful activity at every level of the organisation: Executive Listening into Action, Divisional People Promise Plans, Team In Reach support and Leadership Engagement.

A critical enabler of this plan is the development of a Staff Survey Dashboard that provides leaders with team-level NSS results and enables them to translate insight into focused, actionable improvement plans. Without accurate, granular data, leaders cannot take visible, meaningful action on feedback or understand the specific drivers of staff advocacy within their teams. Currently, leaders have never had access to team-level NSS data, which limits their ability to design effective, locally owned improvement plans. Other organisations, including MFT, The Christie and NCA, already use Power BI-based Staff Survey Dashboards offering trust-wide to team-level data, placing WWL at a disadvantage. Alongside creating the dashboard, we will also need to build leaders' confidence in accessing, interpreting and acting on culture data through clear guidance and development support.

To strengthen accountability and ensure consistent monitoring of progress, we recommend establishing Divisional People Committee Groups. These groups will oversee divisional People Promise Plans, track progress against NSS themes and advocacy drivers, and ensure visibility of risks and improvements. Together, strengthened data capability, clear advocacy-focused priorities, continuous improvement, multidisciplinary support and improved divisional governance create a coherent and aligned framework for improving people experience across the organisation.

Link to strategy and corporate objectives
People and Culture Strategy 2025-2028

Risks associated with this report and proposed mitigations
If we are unable to develop a Staff Survey Dashboard, we risk not having meaningful, accessible team-level data to engage our leaders. Without this insight, leaders will be limited in their ability to understand their results, identify priorities, and take effective local action.

Financial implications
N/A

Legal implications
The Trust has statutory duties to promote staff wellbeing, attendance and retention under the NHS Standard Contract, and to meet the Public Sector Equality Duty by eliminating discrimination, advancing equality and fostering good relations. The National Staff Survey supports these obligations by providing essential insight into staff experience, including for those with protected characteristics.

People implications

By listening to and acting on staff feedback, we commit and contribute to the NHS People Plan which supports the national transformation of the workplace culture and staff experience in the NHS and has further implications for the strategic priorities of the Trust. Improvements in organisational culture and staff engagement have a strong impact on staff retention and sickness absence rates, performance, operational delivery, and patient outcomes.

Equality, diversity and inclusion implications
The National Staff Survey includes questions which feed into the Workforce Race and Disability Equality Standards (WRED and WDES) which are one of the main national EDI reporting frameworks focussing on the experience of our staff from Black and Minority ethnic backgrounds and those who are disabled. Progress against WRES and WDES is important to demonstrate that staff have equal opportunities to thrive at WWL regardless of their background or any health condition.

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

- People Committee, 17th March 2026
- Wider Leadership Team, 10th March 2026

Recommendation(s)

The Board is asked to note the content of the report and to:

- Endorse the National Staff Survey engagement strategy 2026/27 and the focus on increasing staff advocacy, measured through NSS recommendation metrics (recommend as a place to work / recommend as a place to receive care).
- Endorse the strengthened people governance through divisional-level Divisional People Committee Groups to provide routine assurance, accountability and visibility of progress against divisional People Promise Plans and NSS improvement activity.

Report

National Staff Survey 2025
The National Staff Survey 2025 took place from 9th September till 28th November and closed with an improved response rate of 48% (compared to 34% in 2024; subject to embargo) which is better than the national sector median response rate (121 comparison Acute and Acute & Community Trusts). The achieved increase in response rate means that nearly 1000 more staff had their say this year demonstrating the impact of the planning and engagement work undertaken by our Communications team, OD team and our staff across the organisation.

The results suggest that most People Promises have remained stable with 'We are safe and healthy' and Morale continuing to perform significantly better than the sector average and 'We are always learning' being worse than the sector (based on IQVIA sector comparison group and comparable to national benchmarking group). 'We are a Team' score has significantly improved since 2024 and is now in line with the sector average.

The highlights and areas of improvement are summarised below:

Areas of strength:

- **'We are a Team'** score has significantly improved (improvement in line management and teamworking including mutual respect, role clarity and shared objectives)
- **Leadership** scores have had biggest significant improvements (including compassionate leadership and line management)
- **Equality**: Small sign. improvements in experiences of discrimination, bullying and abuse
- **Inclusion** score has seen small sign. improvement in value-based behaviour (kindness, respect, feeling valued)
- **Support for work-life balance** has improved since the 2024, both compared to WWL's scores and with comparator organisations.

Areas for improvement:

- **Compassionate Culture** is worse than sector and has had largest sign. decline in **Advocacy** score (perception of patient care and recommendation as a place of care and as a place to work)
- **Raising concerns:** Decline in confidence in organisation to act on concerns and in response to errors, near misses or incidents
- **Health and wellbeing**: Decline in confidence that organisation takes positive action on health and wellbeing
- **We are always Learning** and **Appraisal** scores continue to be lowest scoring People Promise scores and worse than sector

<u>Divisional results</u>
Divisional comparison analysis was undertaken using the IQVIA heatmap reports which compares each division to the organisational average (scores +/-0.3 above or below organisational average). Corporate continues to score higher than organisational average on 5 People Promises, followed by Community with 3 People Promises and Estates and Facilities with 2 People Promises. Medicine scores lower than organisational average on 6 People Promises and Themes, however it is the only division that has seen improvements on all People Promises and Themes and biggest question-level improvements.

<u>Workforce Race Equality Standards and Workforce Disability Equality Standards (WRES and WDES results)</u>

The WRES results included in the NSS data suggest that the People Promise scores for our staff from Black, Ethnic Minority backgrounds are mostly in line with those for white staff and are slightly better for We are always learning and Staff Engagement. There has been a positive reduction in reported cases of bullying, harassment and abuse from staff over the last 12 months (reduced to

23.2% from 31.6% in 2026) as well as discrimination (15.7% from 23.7% in 2024) which demonstrates the impact of the Trust-wide anti-racism agenda on our BME staff's experience working at WWL. There has also been a slight improvement of equal opportunities for career progression by 2% since 2024.

The WDES results suggest that staff with long-term health conditions continue to score lower across all People Promise scores compared to staff without health conditions, however there has been a slight improvement in experience of bullying from managers (13.1% compared to 15.5% in 2024).

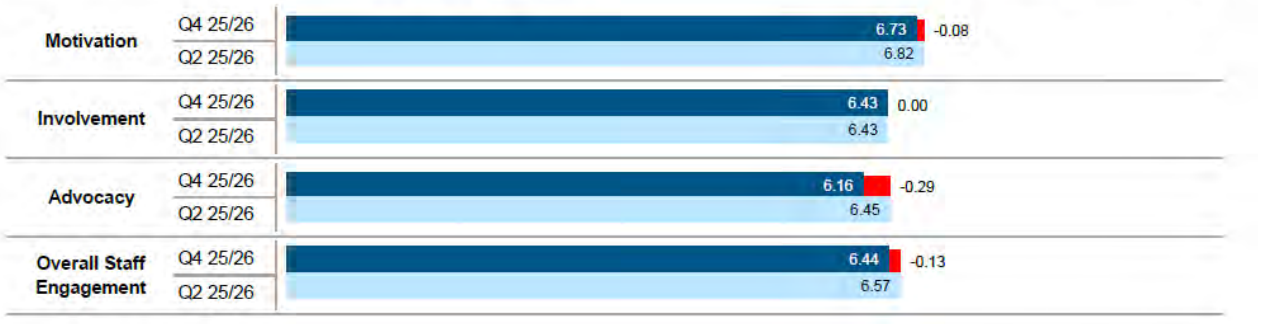
Detailed NSS results including divisional trends, significance testing for comparison with IQVIA sector comparison group as well as key national benchmarking results can be found in the NSS result slide deck. Please note that significance testing is only available for IQVIA sector comparison group. The results are embargoed and cannot be shared outside of the organisation until 12th March.

National Quarterly Pulse Survey Q4

The NQPS is a short survey which compliments the National Survey and measures indicators of staff engagement, including motivation, involvement and advocacy. It takes place three times each year in January, April and July. It is not run in October when the National Staff Survey takes place. This survey is also administered by IQVIA. The Q4 survey took place from 5th January till 31st January and yielded a response rate of 12.9% (955 responses). As with previous quarterly surveys, we included bespoke local questions relating to raising concerns, work-life balance and organisational positive action to support health and wellbeing which provide a temperature check on some of the areas of improvement over the last 12 months.

The Staff Engagement scores for Q4 suggest a decline in motivation, advocacy and overall engagement, which align with the trends seen in the NSS 2025 results. The advocacy score has seen the largest deterioration and may be explained by the organisational restructuring process which has impacted on staff job security, morale and patient care.

Trust Level Staff Engagement	*Q1 25/26*	*Q2 25/26*	*Q4 25/26*
Motivation	6.80	6.82	6.73
Involvement	6.35	6.43	6.43
Advocacy	6.36	6.45	6.16
Overall Staff Engagement	**6.49**	**6.57**	**6.44**



Like the NSS 2025 results, there has been a slight decline in the question relating raising concerns and confidence in the organisation that these will be addressed. We also note that in contrast to NSS 2025 results, there has been a slight decline in support for home and work life and positive action to support health and wellbeing. There may be several reasons for the recent change, including less proactivity to support work-life balance and flexibility regarding working patterns during winter pressures as well as the recent change in staff wellbeing service provision. We will continue to monitor these scores in the next quarter and ensure that the engagement plan will address the key drivers for advocacy and overall engagement.

Divisionally, Estates and Facilities have reported highest level of Advocacy and Staff Engagement overall. Corporate and Medicine have reported the lowest scores for recommending the organisation as a place to work or as a place for treatment.

Staff Engagement	*Community Services Area Q4 25/26*	*Corporate Services Q4 25/26*	*Estates & Facilities Q4 25/26*	*Medicine Q4 25/26*	*Specialist Services Q4 25/26*	*Surgery Q4 25/26*
Motivation	6.93	6.33	7.28	6.35	6.73	6.67
Involvement	6.90	6.54	6.24	5.83	6.63	6.29
Advocacy	6.10	5.73	6.85	5.75	6.16	6.23
Overall Staff Engagement	**6.64**	**6.20**	**6.77**	**5.99**	**6.51**	**6.39**

National Staff Survey 2025 Engagement Plan

Case for change

The National Staff Survey (NSS) results are typically received between December and January to aid action planning and are subject to an embargo period until March. In previous years, the comms and engagement plans were focused on sharing high level results with all staff through Trust communication channels after the embargoed period and engage with divisional leaders to share more detailed results at sub-divisional level to develop divisional People Promise Plans which address priority themes from the NSS data. Whilst this approach is useful to socialise the NSS results widely and start engagement with our leaders who can influence change, there has been less of a focus on turning the survey results into meaningful action and having a consistent approach to action planning across divisions. There has also been no strategic plan to engage with services and teams where we see good practice and where staff experience is consistently low. It is important that we proactively engage with teams which would benefit from bespoke support and enable leaders to bring about positive change in their teams with the help of the expertise of our Corporate support services.

For 2026/27, we will align NSS engagement activity to increase staff advocacy (recommend as a place to work / receive care) and the drivers that most strongly enable advocacy:

1. Voice, Influence & Psychological Safety

(Combines: involvement in decision-making, ability to improve services, psychological safety)
Staff who feel heard, able to influence decisions, make improvements, and speak up safely are consistently more likely to recommend their organisation.

What we will do through NSS engagement:

- Use Executive-Led Listening into Action initiatives such as local walkabouts to surface barriers to speaking up, influence and local improvement, including targeted space for underrepresented groups.
- Enable leaders to run team-level 'review and improve' sessions using their NSS results (via a new Staff Survey Dashboard) and co-design 3 practical improvement objectives with staff as part of their local People Promise Plans and track through Divisional People Committee Groups.
- Triangulate NSS insight with organisational insight (FTSU themes, ER data etc) through the People Experience MDT to identify areas where psychological safety may be compromised.

2. Compassionate & Supportive Leadership

(Combines: leadership behaviours, appreciation, recognition, team climate)
Advocacy rises when leaders are compassionate, supportive, appreciative, and create strong team climates with minimal hierarchy.

What we will do through NSS engagement:

- Build on the We Lead foundations by giving leaders practical tools to translate their NSS themes into compassionate leadership behaviours (recognition, inclusion, fairness, team climate).
- Use People Experience MDT support to identify where leadership capability, team climate and hierarchy are key drivers and provide targeted support (coaching, facilitation, OD support) and track through Divisional People Committee Groups.

3. Wellbeing, Workload & Morale

(Combines: workload/stress, morale, intention to stay)

Staff who experience manageable workloads, feel supported with wellbeing, and have strong morale are markedly more willing to recommend their organisation.

What we will do through NSS engagement:

- Ensure divisional People Promise Plans include an explicit wellbeing/workload element where survey themes indicate risk.
- Use People Experience MDT approach to triangulate data (sickness absence, incidents, complaints, ER data) to identify teams where workload, stress or morale themes require support and track through Divisional People Committee Groups.

4. Visible Action on Staff Feedback

(Combines: belief that feedback leads to improvement)

Advocacy is enhanced when staff see meaningful, visible action in response to their feedback. Without this, confidence in the process can fall, leading to reduced advocacy and engagement.

What we will do through NSS engagement:

- Introduce a consistent Trust-wide "You said, we did / We did, we learned / Next we will…" approach across divisional People Promise Plans and Team In-Reach.
- Use Divisional People Committee Groups to track delivery and ensure actions are visible and communicated locally and organisationally.

Introduction of MDT approach

In previous years, the OD team has led the National Staff Survey engagement strategy and worked with respective divisional leadership teams to develop local action plans. However, because the survey spans multiple domains, it often becomes clear during planning that input from a range of stakeholders is essential to create meaningful actions that improve staff experience and, subsequently, patient care. Given the breadth of factors influencing staff wellbeing and engagement, we propose expanding support to divisional leaders by involving multi-disciplinary partners from Corporate Services who can bring their expertise to triage priorities and provide targeted advice to ensure improvement actions are effective and sustainable.

We propose the formation of a People Experience MDT consisting of representatives from People Services (HR, OD, Occupational Health), Freedom to Speak Up Guardian, Transformation and Quality Improvement teams, and Staff Side who will triangulate the NSS results with organisational insights and support leaders and their teams with their engagement activities at Executive, divisional, leadership and team level as outlined below. The People Experience MDT will draw on a number of data sources to triangulate the NSS results and support divisional leaders in identifying priority themes and services, including sickness absence, Datix data, complaints, FTSU reports and ER cases. A multi-disciplinary approach would bring together expertise from HR, OD, clinical leadership, and transformation teams to help leaders better understand staff needs and address root causes of concerns. This collaborative model promotes shared responsibility for improvement across the organisation and strengthens partnership working.

Turning staff voice into action

Executive Listening into Action Walkabouts: By embracing our Trust value of *Listen and Involve*, we propose that the Executive Team undertake a series of Listening into Action Walkabouts in Q1 2026/27. These walkabouts will be carried out with a clear staff survey lens, focusing on the key advocacy drivers: voice and influence, psychological safety, compassionate leadership, wellbeing and workload, and visible action on feedback. Executive Team members will engage directly with staff in their working environments, creating opportunities for open, real-time conversations about local issues, barriers and ideas for improving the experience of working at WWL. This approach enhances senior visibility, strengthens authentic listening, and allows advocacy themes to be understood within the context of day-to-day work rather than through formal meetings alone.

To ensure transparency and meaningful follow-through, a one-page summary will be produced after each walkabout with those summaries feeding into our "You Said, We Did" process and will be shared through Executive vlogs and broader communications, reinforcing visible organisational accountability and demonstrating how staff feedback directly shapes change at team, divisional and organisational levels.

This approach also amplifies voices that may be less represented in formal forums, including inclusion groups and underrepresented communities, ensuring their experiences inform our cultural and improvement priorities. The Executive Team will be supported by the MDT to plan and align walkabouts with the issues highlighted through survey feedback, ensuring the initiatives contribute directly to improving staff advocacy and overall experience.

Divisional People Promise Plans: To truly put our *People at the Heart*, we will ask divisional leadership teams to develop divisional-level People Promise Plans that respond directly to National Staff Survey feedback. Each plan will focus on three key themes: inclusion and wellbeing, improvement, and a division-specific priority. This approach ensures alignment with the NHS People Promise while allowing flexibility for local needs. Divisional leaders will be supported by the MDT to identify priorities and shape actionable plans. Leaders will also have the option to run their own team-level 'review and improve' sessions to co-create solutions with staff. This empowers local leaders, strengthens ownership, and fosters a culture of collaboration and continuous improvement.

Team In Reach: As part of our commitment to the *One Team* approach, the People Experience MDT will partner with divisional leaders to identify teams and services that require targeted support to embed culture change. Once identified, these teams will be aligned to the most appropriate improvement stream—such as the Culture and Engagement Programme or quality improvement initiatives—ensuring interventions are tailored and impactful. The MDT will triage teams based on their level of need and support will be structured through our tiered OD model, enabling us to match the level of intervention to the needs of the team. For teams with emerging or isolated issues, we will provide light-touch, self-serve resources, including toolkits and guides designed to help leaders create the right conditions for a positive staff experience and healthy team culture. Teams requiring more focused development will be supported through our structured Culture & Engagement Programme, which helps teams explore key cultural drivers, enhance team cohesion, and improve collective performance through facilitated sessions and practical improvement tools.
For teams experiencing more significant cultural challenges, an enhanced team programme, provides deeper diagnostic work and bespoke OD support—to address underlying issues and enable sustainable cultural change. This tiered and structured approach ensures that resources are used effectively, support is targeted where it will have the greatest impact, and teams are equipped to make measurable progress toward a positive, inclusive and high-performing culture across the organisation.

Leadership engagement: Our goal is to enable leaders to drive meaningful, measurable improvements within their areas of responsibility. Building on the foundations laid by the We Lead programme which helps to improve our leaders' capability to lead compassionately and inclusively, we want to enable our leaders to translate staff feedback into tangible actions. Leaders will be equipped to review their team and departmental-level NSS data, identify priority themes and co-design improvement initiatives with their staff. They will have access to clear guidance on interpreting NSS results and practical tools to help turn insight into improvements in staff experience,

engagement and wellbeing. Leaders will also be signposted to resources available through the Culture & Engagement Programme, wellbeing services, and supported by ongoing input from the People Experience MDT. This approach ensures that actions are evidence-based, collaborative and aligned with our strategic aim of fostering a positive, inclusive workplace culture.
The effectiveness of this leadership engagement approach is dependent on leaders having access to accurate, granular data. This can only be achieved through the development of the Staff Survey Dashboard, as committed to during the NSS engagement phase. Team leaders will require access to their own team-level results—subject to the national threshold of 10 or more responses—including People Promise scores, sub-themes and individual question-level insights. Providing leaders with this level of visibility is essential for empowering them to take ownership of their feedback, identify meaningful actions and demonstrate progress to their teams.

National Staff Survey data release

The NSS results were published on 12th March 2026. We propose a phased release of NSS data: NSS sub-divisional and team-level data will be shared with the Executive Team, People Experience MDT and divisional leadership teams at the beginning of March 2026 to enable swift action planning, followed by the release of divisional NSS data to all staff at the end of March 2026.

This year, for the first time, we are able to analyse our staff feedback survey at departmental and team level. Access to data at this granularity enables us to understand staff experience within their actual working teams and to tailor support to the specific needs of each service. Leaders have previously reported difficulty interpreting National Staff Survey results, as earlier datasets often combined responses from staff both within and outside their immediate teams. This year, our aim is to provide leaders with more accurate and meaningful data to inform how they support their teams. With access to hundreds of team-level results, it is essential that this information is made easily accessible to leaders to inform meaningful, locally owned improvement plans. To achieve this, we are designing a simple, user-friendly Staff Survey Dashboard that displays National Staff Survey results by division, sub-division and team. The dashboard will include appropriate access controls to ensure that team-level data is visible only to leaders within their own sub-division. The Staff Survey Dashboard is a critical enabler of improved staff advocacy, including the NSS measures of recommending WWL as a place to work and a place to receive care, as it will allow leaders to identify the local drivers of advocacy, engage their teams in understanding the findings, and co-design actions that respond directly to their feedback.

National Staff Survey Comms Plan

A high-level timeline for the communications and engagement plan is detailed below:

Date	**Activity**
10th March 2026	WLT presentation on NSS results and engagement plan
Mar - Apr 2026	People Experience MDT meetings and divisional people plan discussions between March – April
March 2026	NSS assurance paper to People Committee and Board
March 2026	NSS results and engagement plan presentations at Partnership Forum and LNC
March - Apr 2026	Trust wide NSS results, including global, social media posts, ASTB section, newsletters, highlight good practice stories
May – June 2026	Executive listening events
May 2026	Divisional people plans to be showcased at ASTB/newsletter
April – Sept 2026	NSS engagement activities and divisional people plan updates as standing agenda item on WLT agenda

April – Oct 2026	Bi-annual NSS assurance reports to ETM, People Committee and Board

Governance

The National Staff Survey engagement activities are coordinated and monitored by the People Experience MDT to provide central oversight of the engagement strategy. Progress on all NSS engagement activity will be reviewed at the Wider Leadership Team on a bi-monthly basis, enabling the sharing of good practice and early identification of any support required by divisional leaders.
In addition, biannual assurance reports will be submitted to the People Committee and the Board to provide oversight of progress, risks, and organisational learning.

To strengthen accountability and ensure that cultural improvement work is consistently prioritised within divisions, we recommend establishing divisional-level People Committees (or equivalent people-focused governance forums). These groups will oversee Divisional People Promise Plans, track progress against NSS themes and the key advocacy drivers, and provide a clear route for routine assurance, escalation and organisational learning. The frequency and membership of these committees will be explored further to ensure they are aligned to divisional operating structures and able to provide meaningful oversight.

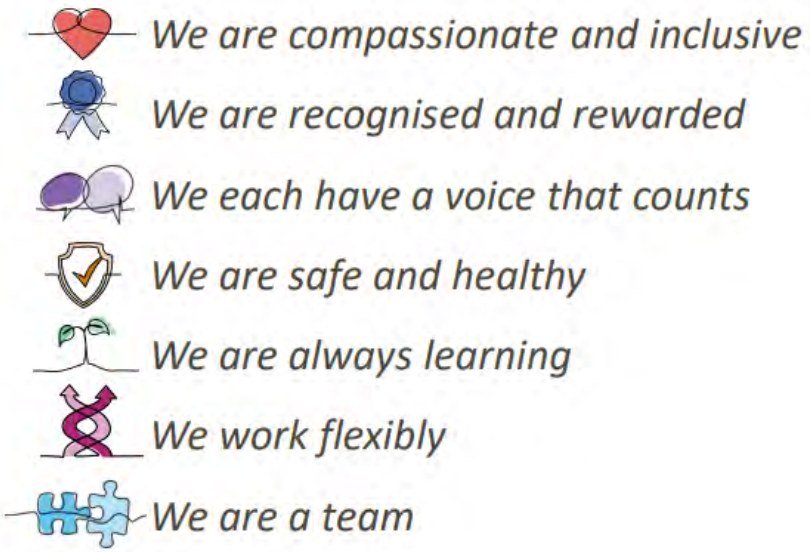
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Staff Survey Results 2025

April 2026

Summary Indicators

The **People Promise summary indicators** provide an overview of staff experience in relation to the seven elements of the People Promise:



Scores are also reported for two Themes ***Staff Engagement*** and ***Morale.***

All scores are out of 10. ***NOTE*** *the data has been tested for significance.*

Survey Engagement

Response Rate

2023: 37%
2024: 35%
2025: 48%

Acute and Acute & Community Hospitals average response rate = 47%

WWL heard from 1000 more staff in 2025 National Staff Survey…

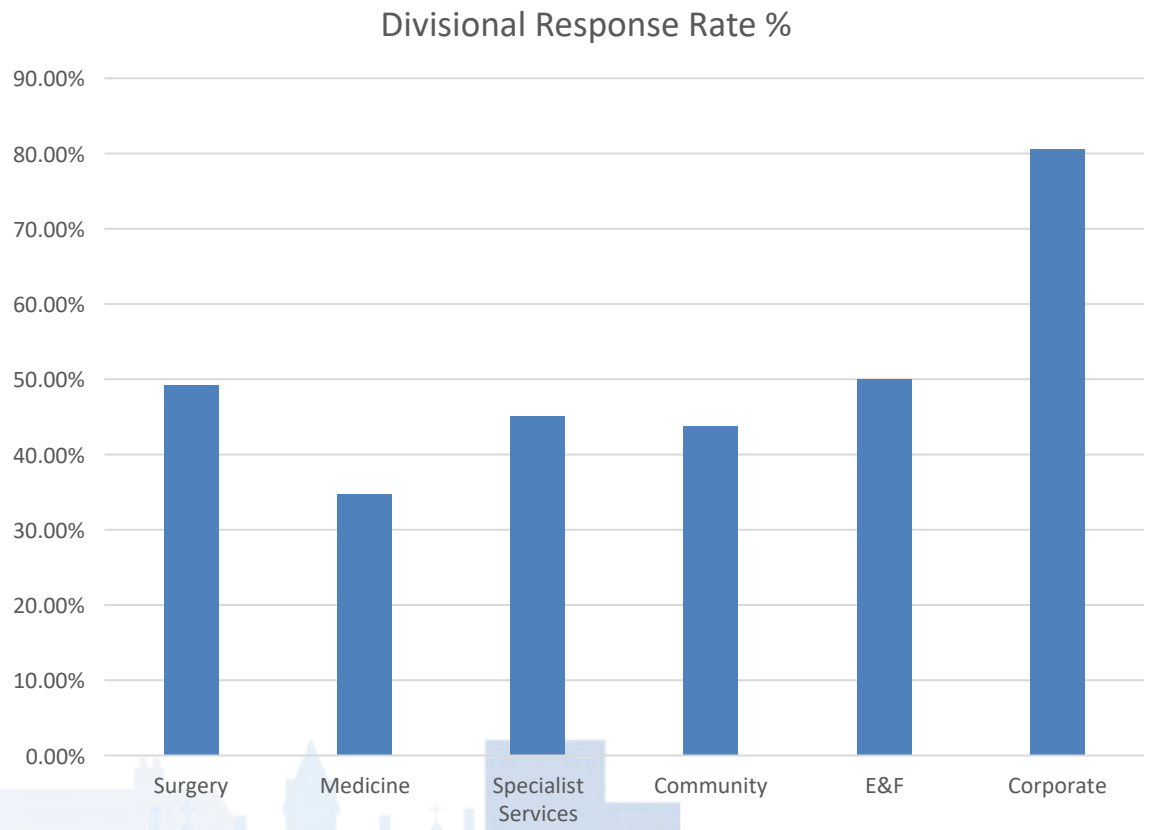
Comms & Engagement Plan

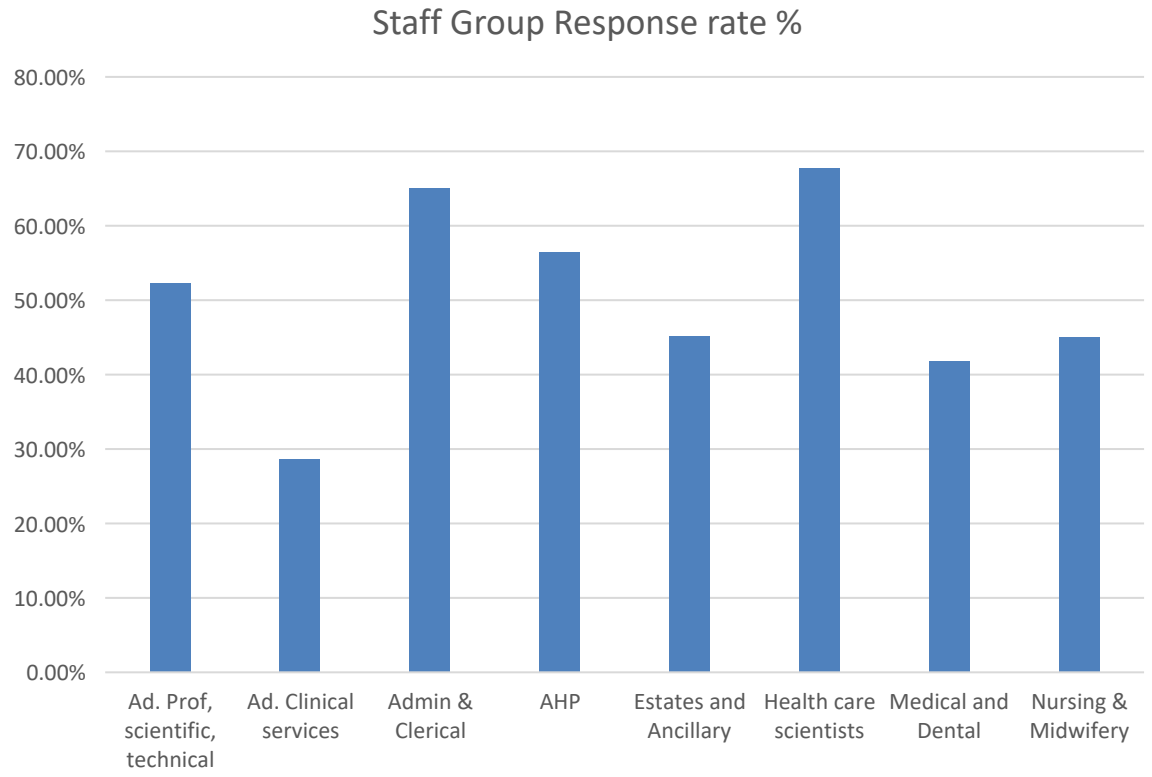
Visible Leadership
Executive sponsorship
Senior Walkabouts
Progress Updates

Targeted Engagement
Trusted staff network meetings
Simple, engaging, visual posters/ graphics
Walkabouts informed by data

Recognition & Motivation
Incentive scheme
Team and organisational recognition

Organisational Participation





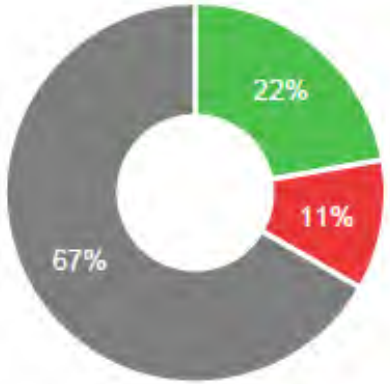
People Promises trend 2024-25

WWL / Local changes: Overview of People Promise and Theme results between WWL's NSS scores for 2024 and 2025.

Note these scores are tested for significance and RAG to show significant improvements or declines.

People Promise & Themes	2024	2025	Change
We are a team	6.24	6.78	0.14
We are compassionate and inclusive	7.25	7.33	0.08
We are always learning	5.27	5.35	0.08
We work flexibly	6.23	6.29	0.06
We are safe and healthy	6.22	6.25	0.03
We are recognised and rewarded	5.89	5.91	0.02
We each have a voice that counts	6.65	6.65	0
Morale	6.05	6.03	-0.02
Staff Engagement	6.77	6.73	-0.04

Comparison to sector



- 2 (22%) People Promise(s) / Theme(s) scored significantly better than the sector average
- 1 (11%) People Promise(s) / Theme(s) scored significantly worse than the sector average
- 6 (67%) People Promise(s) / Theme(s) showed no significant difference in relation to the sector average or comparisons could not be drawn

Significantly Better Scores

People Promise / Theme	Your Org.	Sector	Difference
People Promise 4 We are safe and healthy	6.25	6.09	+0.16
Theme Morale	6.03	5.88	+0.15

Significantly Worse Scores

People Promise / Theme	Your Org.	Sector	Difference
People Promise 5 We are always learning	5.35	5.64	-0.29

Areas of strengths and improvement

What we are proud of:

- **'We are a Team'** score has significantly improved (improvement in line management and teamworking including mutual respect, role clarity and shared objectives)
- **Leadership** scores have had biggest significant improvements (including compassionate leadership and line management)
- **Equality**: Small sign. improvements in experiences of discrimination, bullying and abuse
- **Inclusion** score has seen small sign. improvement in value-based behaviour (kindness, respect, feeling valued)
- **Support for work-life balance** has improved since the 2024, both compared to WWL's scores and with comparator organisations.

What we want to improve:

- **Compassionate Culture** is worse than sector and has had largest sign. decline in **Advocacy** score (perception of patient care and recommendation as a place of care and as a place to work)
- **Raising concerns:** Decline in confidence in organisation to act on concerns and in response to errors, near misses or incidents
- **Health and wellbeing**: Decline in confidence that organisation takes positive action on health and wellbeing
- **We are always Learning** and **Appraisal** scores continue to be lowest scoring People Promise and worse than sector

Top 10 most improved question scores for WWL compared to 2024

Question	Diff Score	2025 Score	2024 Score
10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours (More than 0 hours).	4.8%	30.2%	35.0%
9c My immediate manager asks for my opinion before making decisions that affect my work (Agree/Strongly agree).	4.0%	59.9%	55.9%
31b Has your employer made reasonable adjustment(s) to enable you to carry out your work (Yes).	3.4%	69.2%	65.8%
7d Team members understand each other's roles (Agree/Strongly agree).	3.3%	73.9%	70.6%
16b In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (Yes).	3.2%	6.9%	10.1%
6d I can approach my immediate manager to talk openly about flexible working (Agree/Strongly agree).	2.9%	70.9%	68.0%
7c I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	2.8%	71.9%	69.1%
7a The team I work in has a set of shared objectives (Agree/Strongly agree).	2.7%	73.3%	70.6%
11c During the last 12 months have you felt unwell as a result of work related stress (Yes).	2.4%	39.9%	42.4%
11d In the last three months have you ever come to work despite not feeling well enough to perform your duties (Yes).	2.4%	55.8%	58.2%

Top 10 most declined question scores for WWL compared to 2024

Question	Diff Score	2025 Score	2024 Score
25a Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	-4.1%	68.0%	72.1%
25c I would recommend my organisation as a place to work (Agree/Strongly agree).	-4.0%	55.2%	59.2%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	-3.8%	44.4%	48.3%
11a My organisation takes positive action on health and well-being (Agree/Strongly agree).	-3.8%	50.8%	54.6%
19c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again (Agree/Strongly agree).	-3.2%	65.5%	68.7%
4b The extent to which my organisation values my work (Satisfied/Very satisfied).	-3.1%	39.6%	42.7%
25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	-3.0%	55.7%	58.7%
4c My level of pay (Satisfied/Very satisfied).	-2.7%	33.6%	36.3%
3h I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	-2.4%	58.7%	61.1%
25b My organisation acts on concerns raised by patients / service users (Agree/Strongly agree).	-2.4%	67.0%	69.4%

Question-level comparison to sector

Top 3 question-level scores compared to sector average	WWL	Sector	Difference
Experienced discrimination on grounds of race	46.30%	55.20%	-8.90%
In the last 12months I have personally experienced harassment, bullying or abuse at work from patients/ service users, their relatives or members of the public	20.00%	24.90%	4.90%
I often / always feel worn out at the end of my working day / shift	38.40%	43.10%	-4.70%
Bottom 3 question-level scores compared to sector average	**WWL**	**Sector**	**Difference**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	55.70%	62.20%	-6.50%
The appraisal / review helped me agree clear objectives for my work	31.10%	36.30%	-5.20%
In the last 12 months, I have had an appraisal, annual review, development review or knowledge and skills development review.	81.30%	86.30%	-5.00%

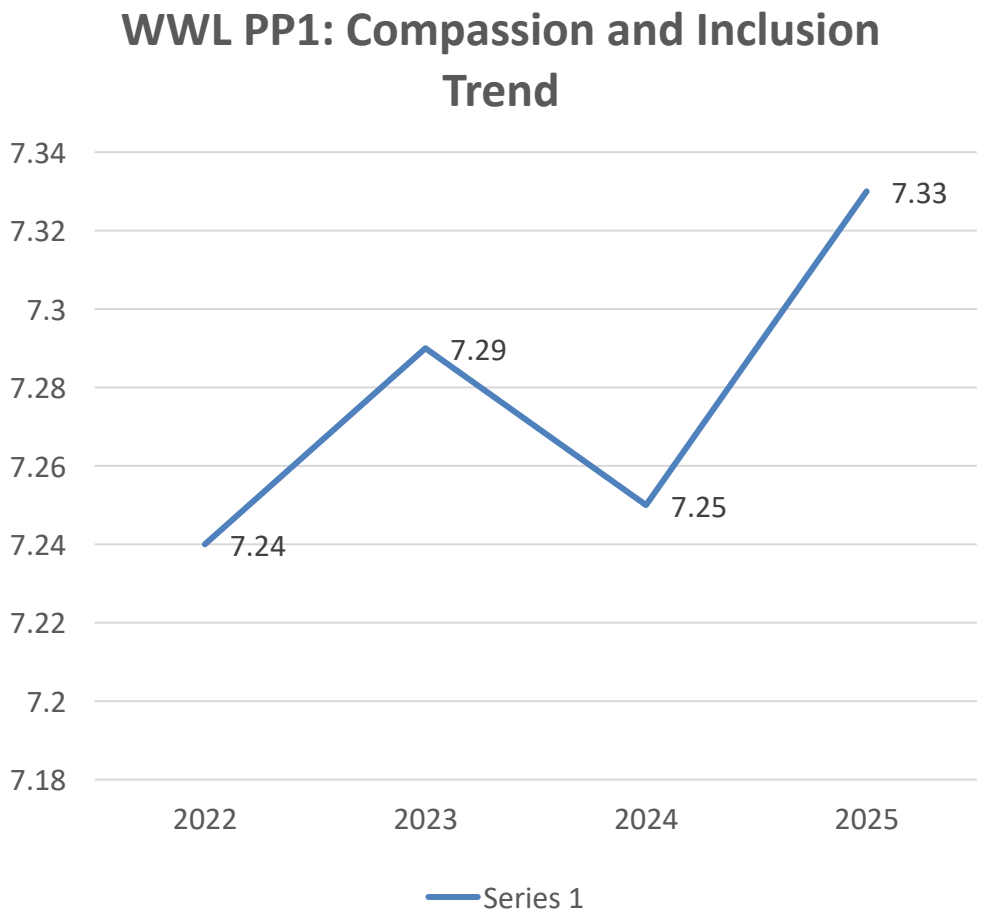
NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

People Promises – Organisational results

We are Compassionate & Inclusive

- Compassionate culture
- Compassionate leadership
- Diversity and equality
- Inclusion

PP1: We are compassionate and inclusive - Highlights



Key Highlights

This is the highest scoring People Promise for WWL this year and slightly above sector average.

Diversity and Equality sub-score has improved and is significantly better than sector

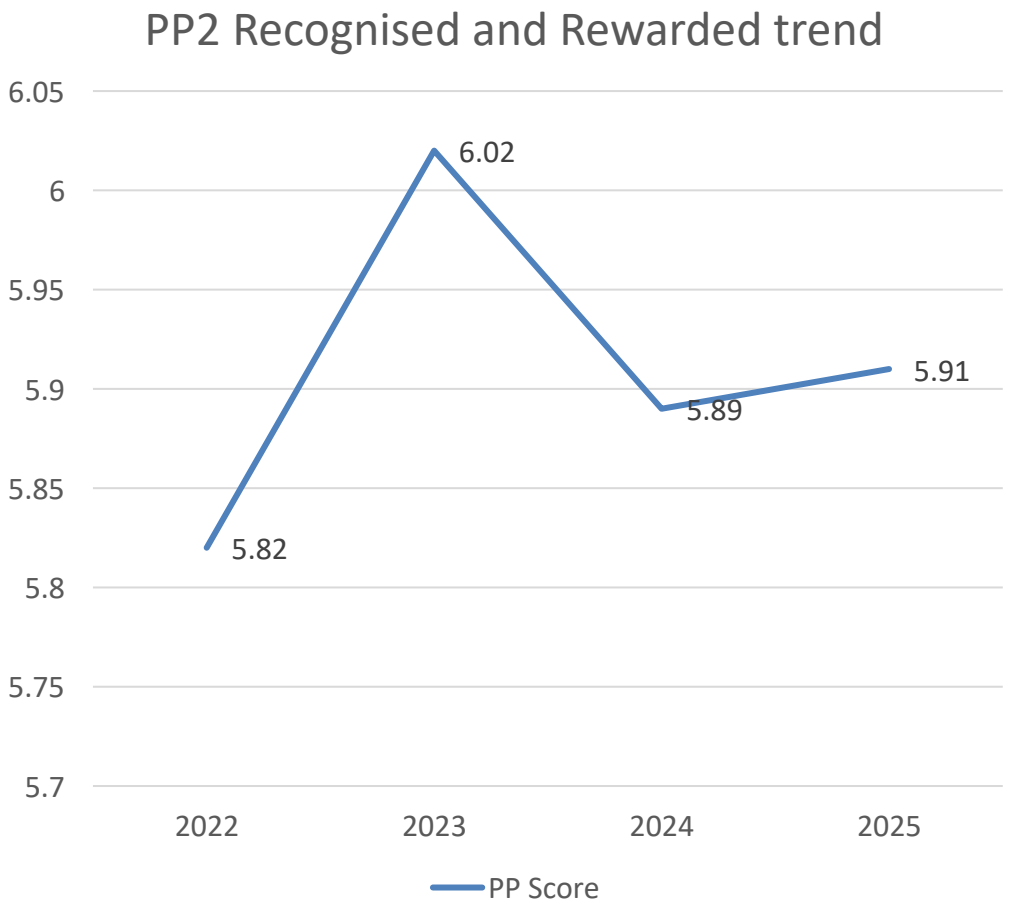
Compassionate Culture is a low score and getting worse, and significantly below sector.

4 of the 10 worst performing questions relate to compassionate culture.

We are Recognised and Rewarded

- Satisfied with recognition, value and pay
- People show appreciation to each other
- Immediate manager values work

PP2: We are recognised and rewarded - Highlights



Key Highlights

This People Promise is scoring in line with sector average and with 2024 scores.

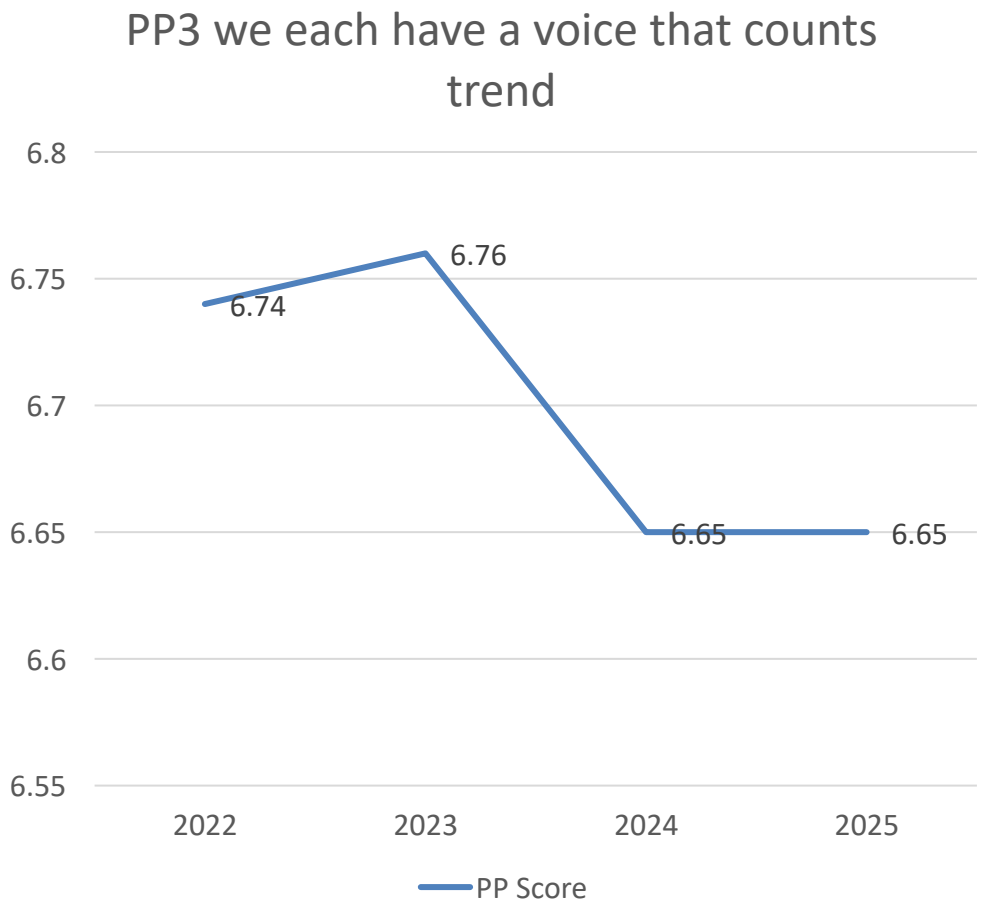
Q. 'I am satisfied with the extent to which my organisation values my work': scores significantly lower than sector average and significantly declined since 2024.

Q. 'I am satisfied with my level of pay': scores significantly declined locally but significantly better than sector.

We each have a voice that counts

- Autonomy and control
- Raising concerns

PP3: We each have a voice that counts - Highlights



Key Highlights

People Promise score in line with 2024 score

Autonomy and Control is significantly better than sector.

Raising concerns is in line with sector

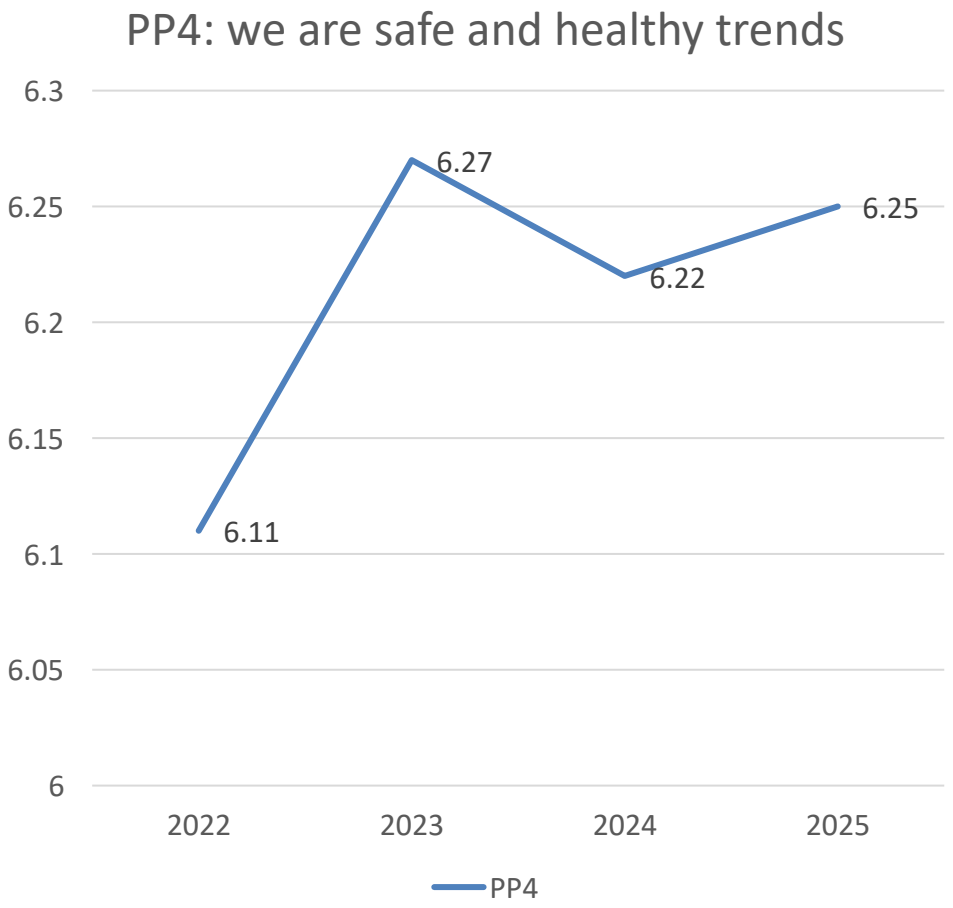
Feeling safe to speak up question score is significantly lower than sector.

Question on staff confidence that WWL would address their concern has significantly declined and is lower than sector. This is the third most declined score in the survey results.

We are Safe and Healthy

- Negative experiences
- Health & Safety climate
- Burnout

PP4: We are safe and healthy - Highlights



Key Highlights

This People Promise is significantly better than sector (including all 3 sub scores

Negative experiences including experience of bullying, harassment or abuse from colleagues have significantly improved since 2024

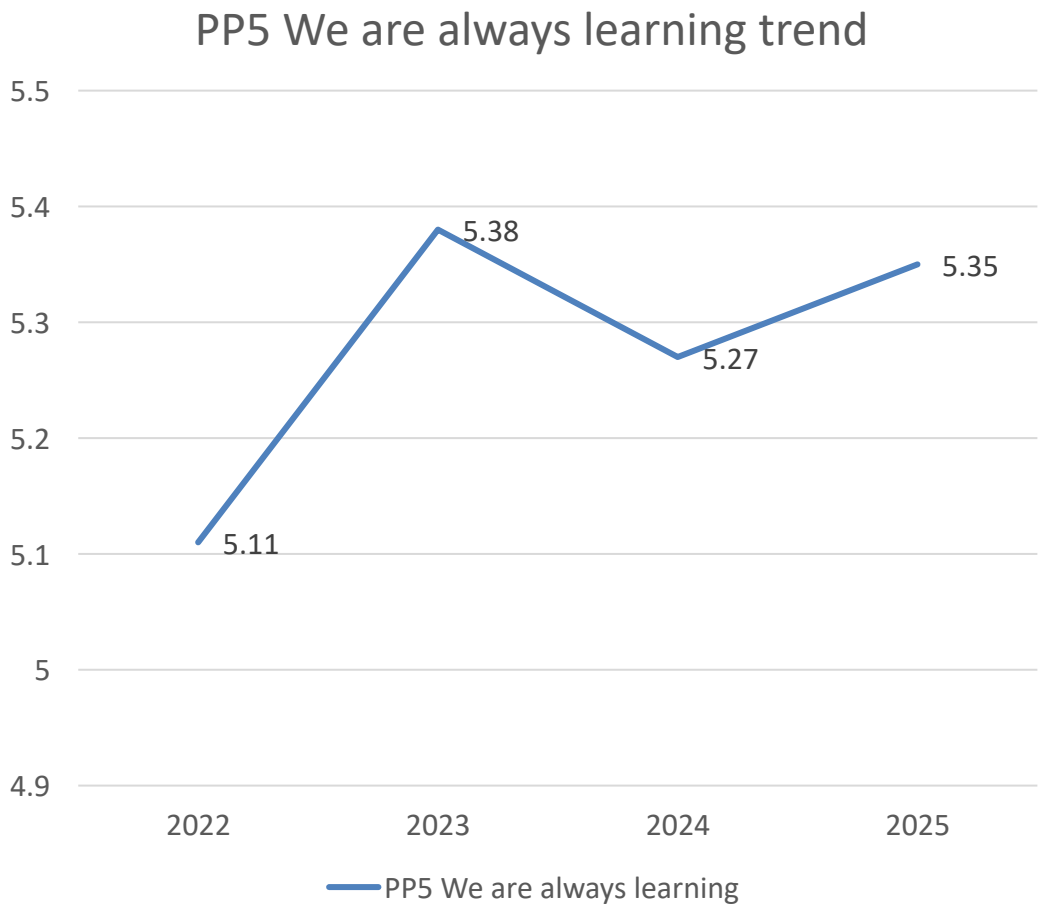
Q ‘My organisation takes positive action on health and wellbeing’ is significantly lower than sector and has significantly declined from 2024.

5 out of 7 questions relating to *Burnout* score significantly better than sector. 2 questions have improved locally compared to 2024 - However, note the scores are relatively low.

We are always learning

- Development
- Appraisals

PP5: We are always learning - Highlights



Key Highlights

This People Promise is in line with 2024 scores and continues to be significantly below sector average.

Development in line with sector and 2024 results

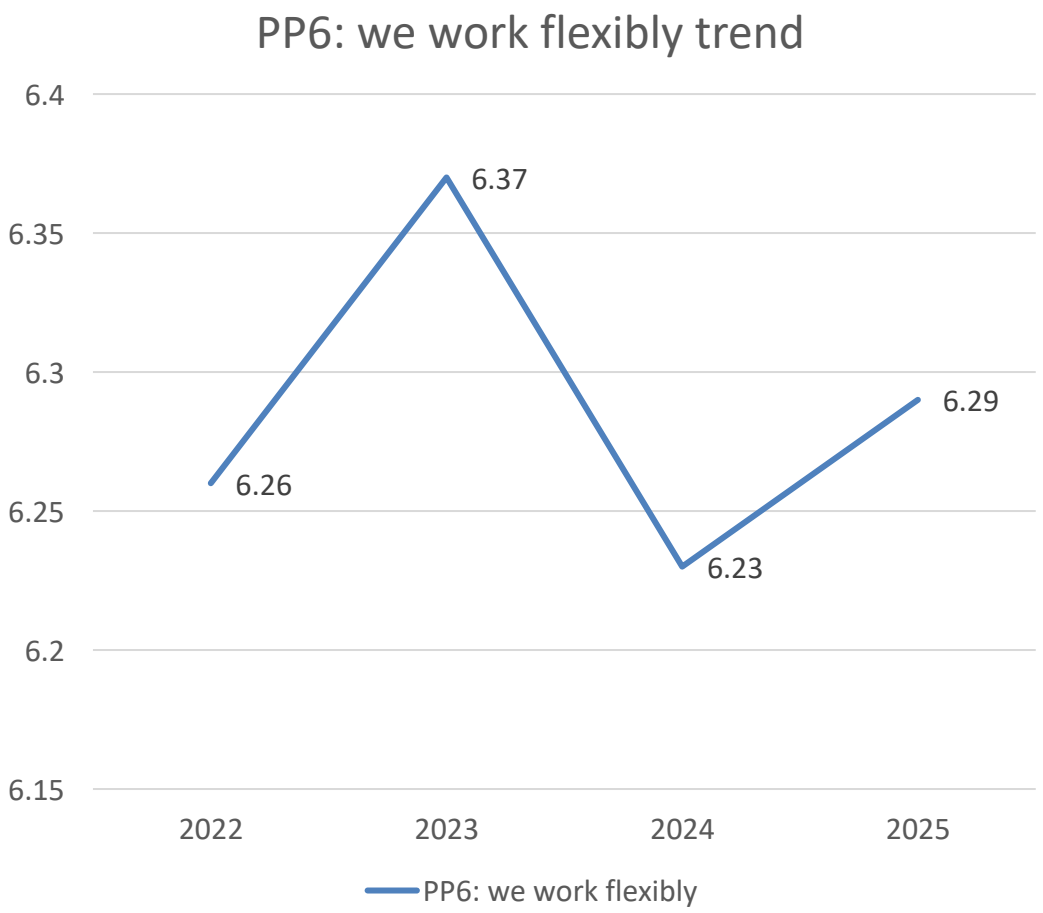
Appraisals is significantly lower than sector and in line with 2024 results

Opportunities to develop career in organisation score significantly worse than sector but slight improvement of development opportunities for BME colleagues since 2024

We work flexibly

- Support for work-life balance
- Flexible working

PP6: We work flexibly - Highlights



Key Highlights

This People Promise is in line with sector and 2024 scores.

Support for work life balance is significantly better than sector.

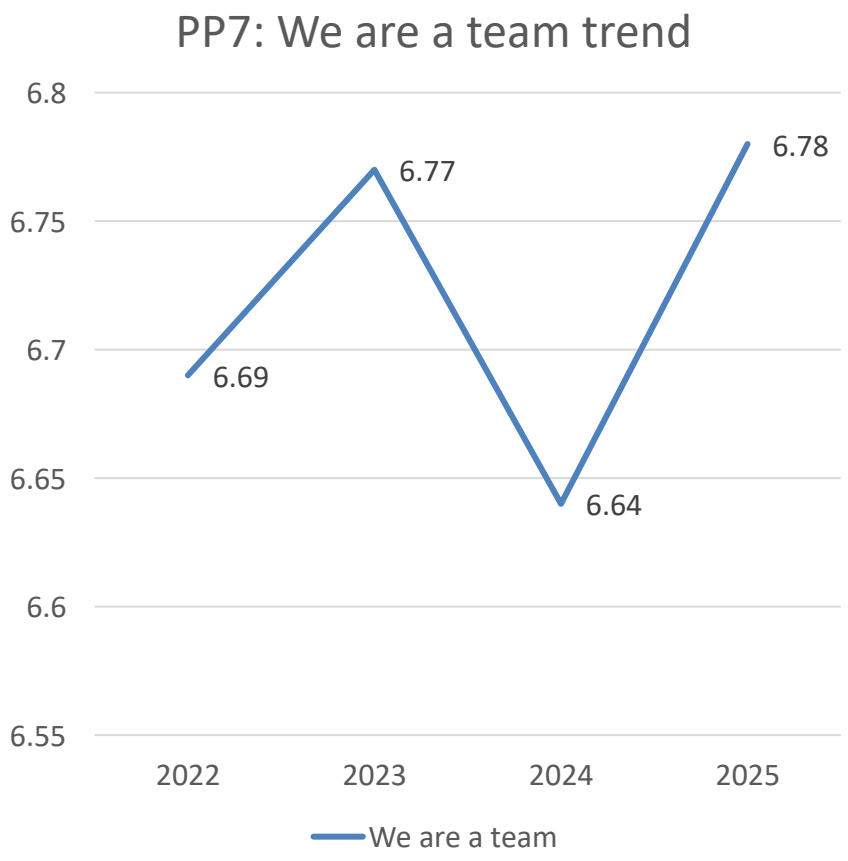
'I can approach my immediate manager to talk openly about flexible working' question has significantly improved since 2024.

'I achieve a good balance between my work life and my home life' question is significantly better than sector

We are a team

- Team working
- Line management

PP7: We are a team - Highlights



Key Highlights

This is the most improved People Promise score and in line with sector after the decline in 23-24.

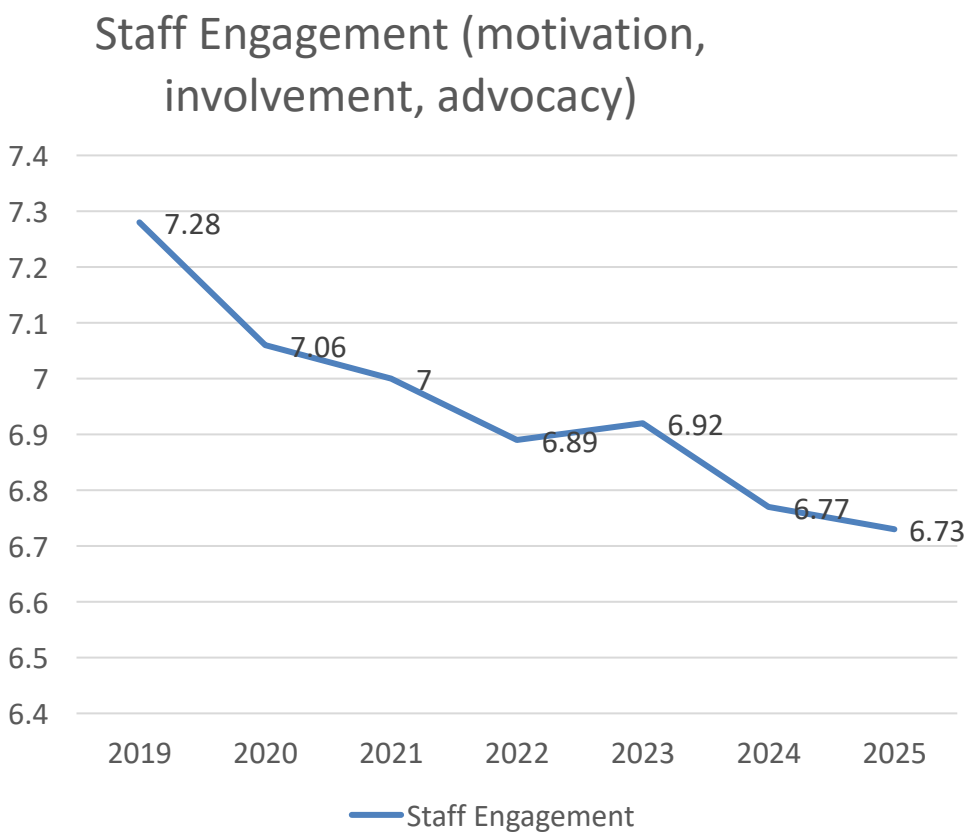
Team-working is in line with 2024 scores and sector.
Line management has had largest significant improvement locally and in line with sector.

3 questions relating to this People Promise are in the top 10 most improved, and have all significantly improved since 2024 including role clarity, mutual respect and shared team objectives

Staff Engagement

- Motivation
- Involvement
- Advocacy

Theme: Staff Engagement - Highlights



Key Highlights

Overall Staff Engagement is in line with sector and with 2024 scores.

Motivation and Involvement scores are in line with WWL's 2024 scores, and *Involvement* scores significantly better than sector.

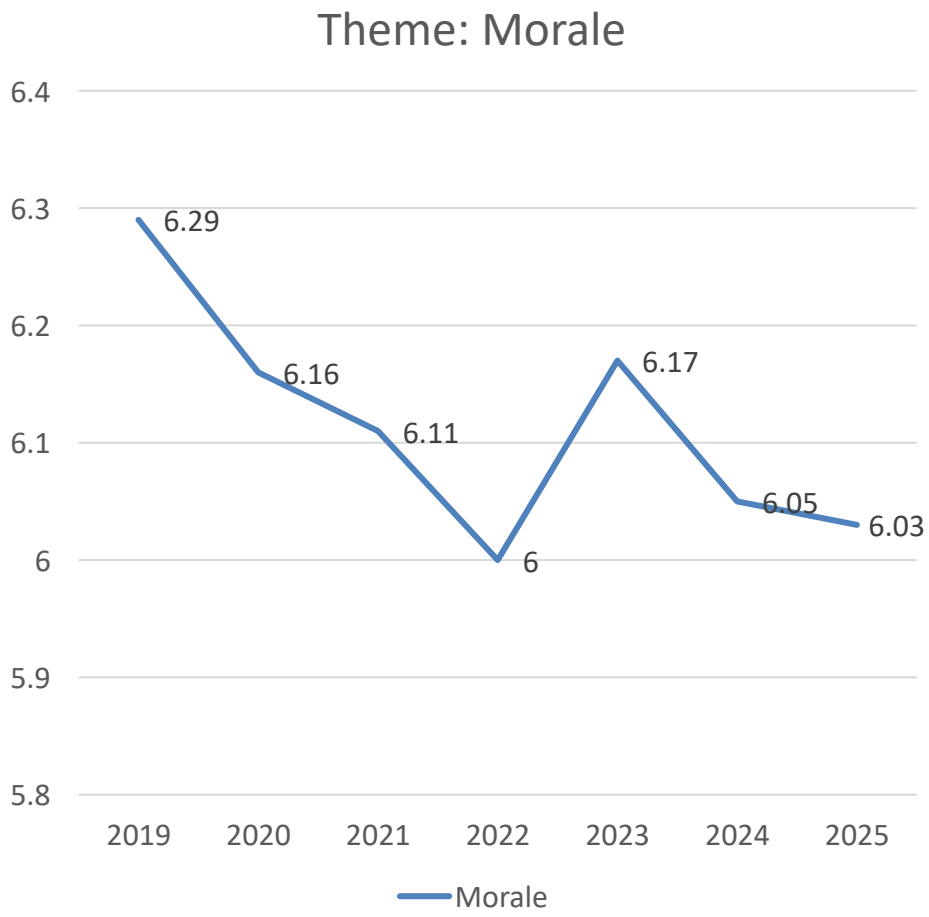
Enthusiastic about my job' (**motivation)** scores significantly better than sector.

Advocacy scores have seen biggest significantly decline locally and are significantly lower than sector; includes perception of care of patients being organisation's top priority; recommend as a place to be treated and as a place to work.

Morale

- Thinking about leaving
- Work pressure
- Stressors (HSE index)

Theme: Morale - Highlights



Key Highlights

Morale is significantly better compared to sector (top 20%) but is in line with 2024 results.

Work pressure and *Stressors* are significantly better than sector.

Thinking about leaving is in line with sector and 2024 scores.

Q. I receive the respect I deserve from my colleagues at work has significantly improved since 2024

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Divisional results

People Promise and Themes 2025 scores - Divisions

People Promises and Themes	Comparator	WWL Trust Average	Community	Corporate	Estates & Facilities	Medicine	Specialist Services	Surgery
We are compassionate and inclusive	7.28	7.33	7.67	7.52	7.17	7.00	7.41	7.23
We are recognised and rewarded	5.88	5.91	6.15	6.53	5.87	5.49	5.84	5.68
We each have a voice that counts	6.62	6.64	6.90	6.80	6.47	6.41	6.73	6.55
We are safe and healthy	6.09	6.30	6.22	6.67	6.85	5.74	6.28	6.13
We are always learning	5.64	5.31	5.57	5.69	4.93	5.02	5.38	5.23
We work flexibly	6.23	6.32	6.82	7.15	5.96	5.82	6.40	5.92
We are a team	6.75	6.78	7.19	7.24	6.44	6.39	6.86	6.60
Staff engagement	6.75	6.72	6.90	6.83	6.65	6.55	6.73	6.67
Morale	5.88	6.05	6.04	6.26	6.42	5.62	6.07	5.95

Community

Survey Coordination Centre

Community Services Area

NHS

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.67	6.15	6.90	6.22	5.57	6.82	7.19	6.90	6.04
Your org	7.33	5.91	6.64	6.30	5.31	6.32	6.78	6.72	6.05
Responses	529	529	526	528	507	528	528	529	529

6

Surgery

Survey Coordination Centre

Surgery

NHS

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.23	5.68	6.55	6.13	5.23	5.92	6.60	6.67	5.95
Your org	7.33	5.91	6.64	6.30	5.31	6.32	6.78	6.72	6.05
Responses	786	787	780	780	740	784	786	788	787

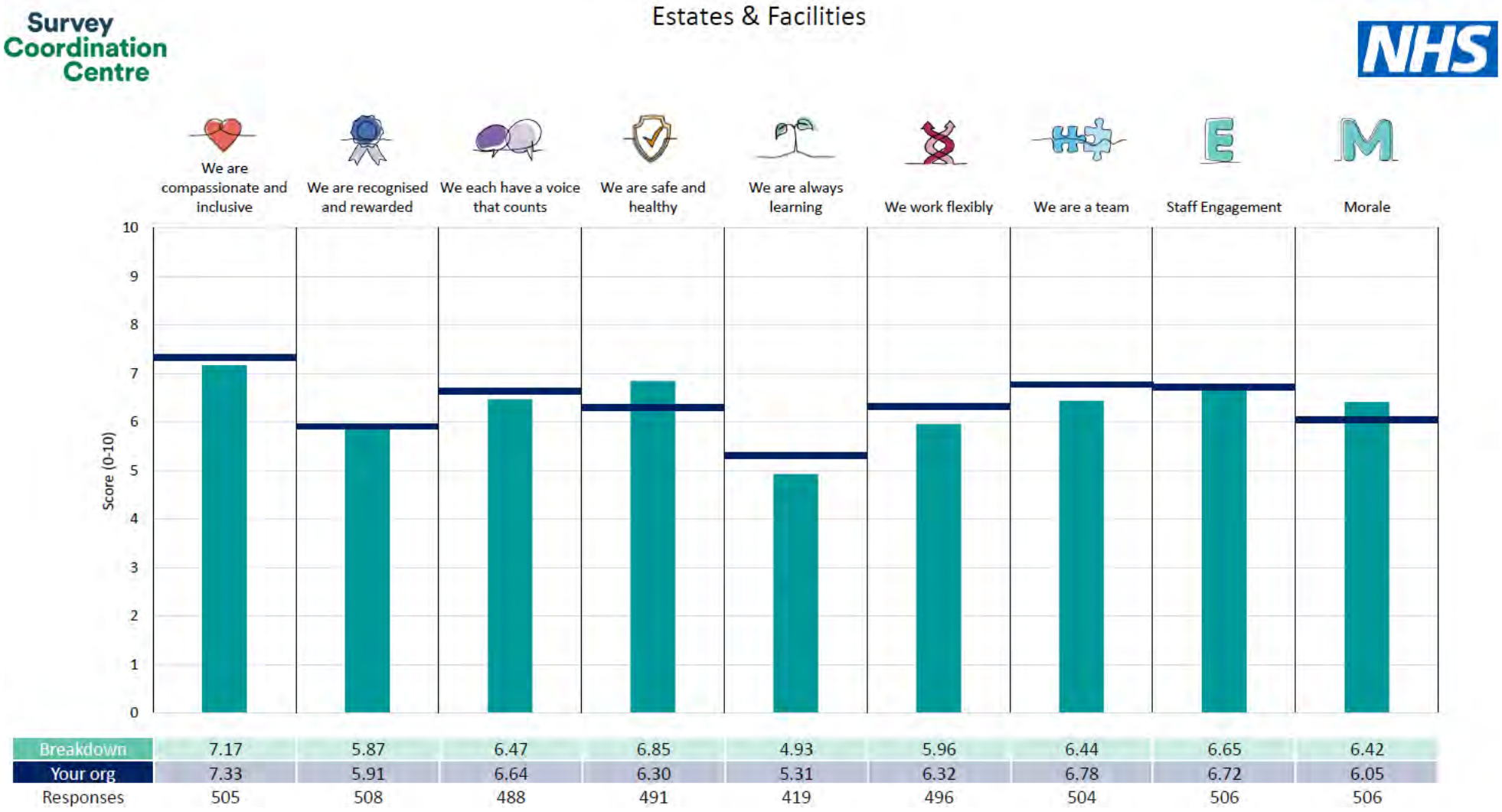
Specialist Services

Survey Coordination Centre

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.41	5.84	6.73	6.28	5.38	6.40	6.86	6.73	6.07
Your org	7.33	5.91	6.64	6.30	5.31	6.32	6.78	6.72	6.05
Responses	606	606	597	605	575	605	606	606	606

Estates & Facilities

Survey Coordination Centre



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.17	5.87	6.47	6.85	4.93	5.96	6.44	6.65	6.42
Your org	7.33	5.91	6.64	6.30	5.31	6.32	6.78	6.72	6.05
Responses	505	508	488	491	419	496	504	506	506

Corporate

Survey Coordination Centre

Corporate Services

NHS

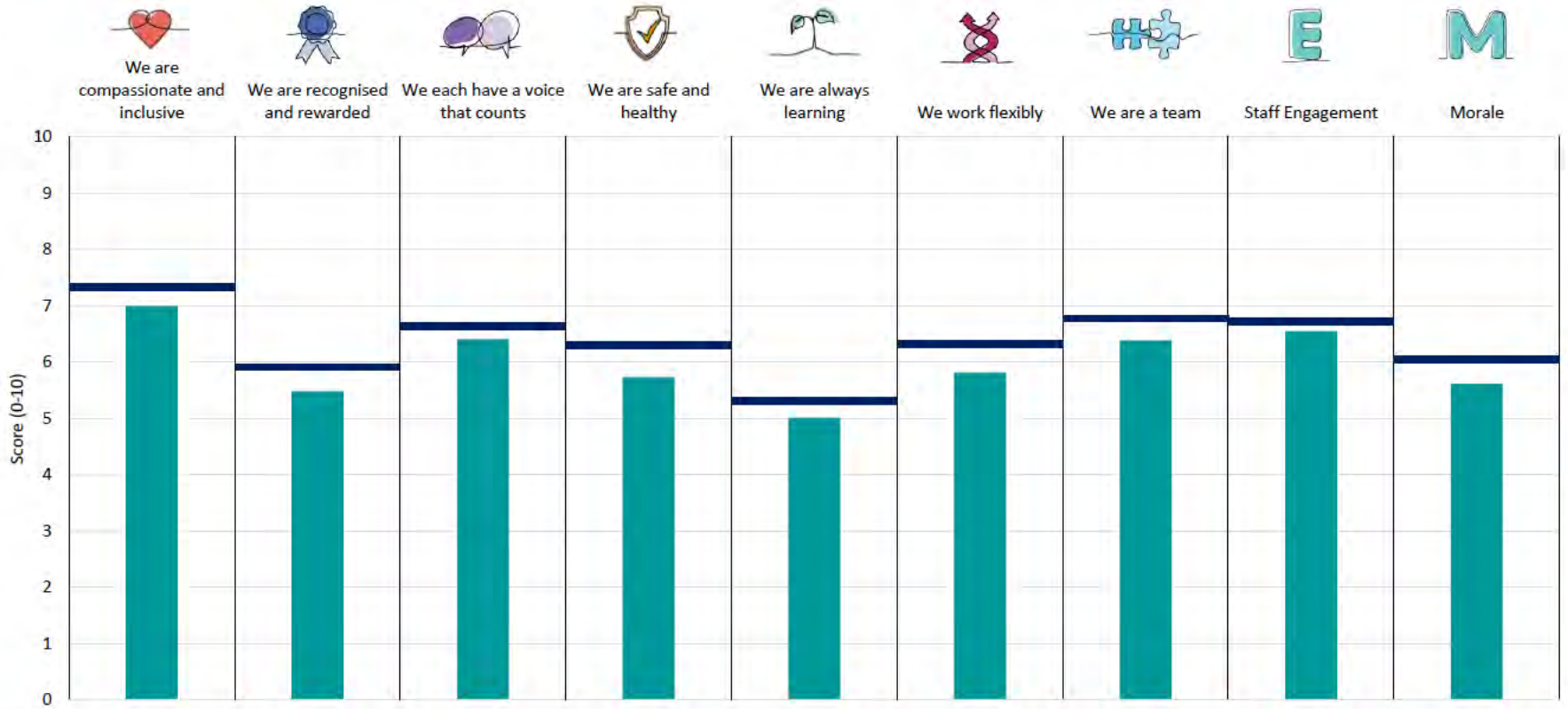
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.52	6.53	6.80	6.67	5.69	7.15	7.24	6.83	6.26
Your org	7.33	5.91	6.64	6.30	5.31	6.32	6.78	6.72	6.05
Responses	558	558	555	554	535	552	558	558	558

Medicine

Survey Coordination Centre

Medicine

NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.00	5.49	6.41	5.74	5.02	5.82	6.39	6.55	5.62
Your org	7.33	5.91	6.64	6.30	5.31	6.32	6.78	6.72	6.05
Responses	532	531	526	528	492	524	531	531	532

Medicine

PP	WWL 2025 scores	Medicine 2025 scores	Medicine 2024 score	Medicine difference
PP1 we are compassionate and inclusive	7.33	7	6.53	0.47
PP2 we are recognised and rewarded	5.91	5.49	5.04	0.45
PP3 we each have a voice that counts	6.65	6.41	6.03	0.38
PP4 we are safe and healthy	6.62	5.74	5.47	0.27
PP5 we are always learning	5.35	5.02	4.5	0.52
PP6 we work flexibly	6.29	5.82	5.42	0.4
PP7 we are a team	6.78	6.39	5.78	0.61
staff engagement	6.73	6.55	6.17	0.38
morale	6.03	5.62	5.28	0.34

Colour Key – score change of +/- 0.2 indicated in green or red.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Results by Ethnicity and Disability

Results by Ethnicity

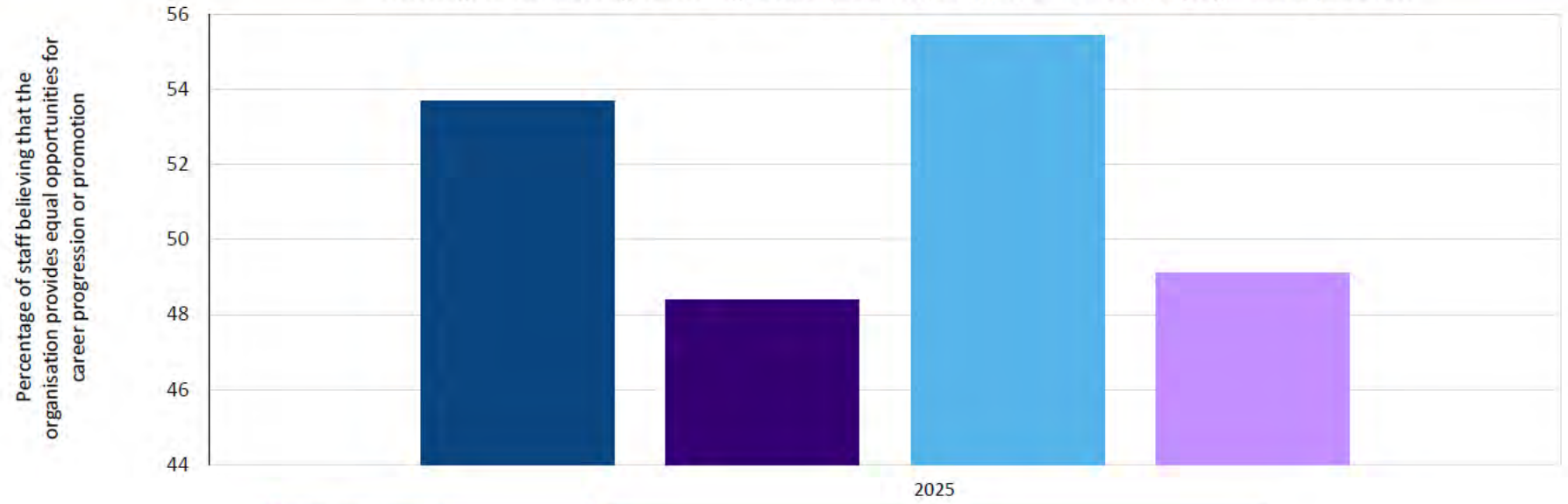
	Metric	Sector	Organisation	White	BME	Not Available
PP1	We are compassionate and inclusive	7.20	7.24	7.25	7.20	6.72
PP2	We are recognised and rewarded	5.88	5.91	5.89	6.08	5.73
PP3	We each have a voice that counts	6.62	6.64	6.64	6.70	6.20
PP4	We are safe and healthy	6.01	6.23	6.22	6.29	6.18
PP5	We are always learning	5.64	5.31	5.20	6.05	4.80
PP6	We work flexibly	6.23	6.32	6.33	6.31	5.82
PP7	We are a team	6.75	6.78	6.78	6.85	6.25
E	Staff engagement	6.75	6.72	6.66	7.07	6.52
M	Morale	5.88	6.05	6.03	6.20	6.00

WRES Highlights

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

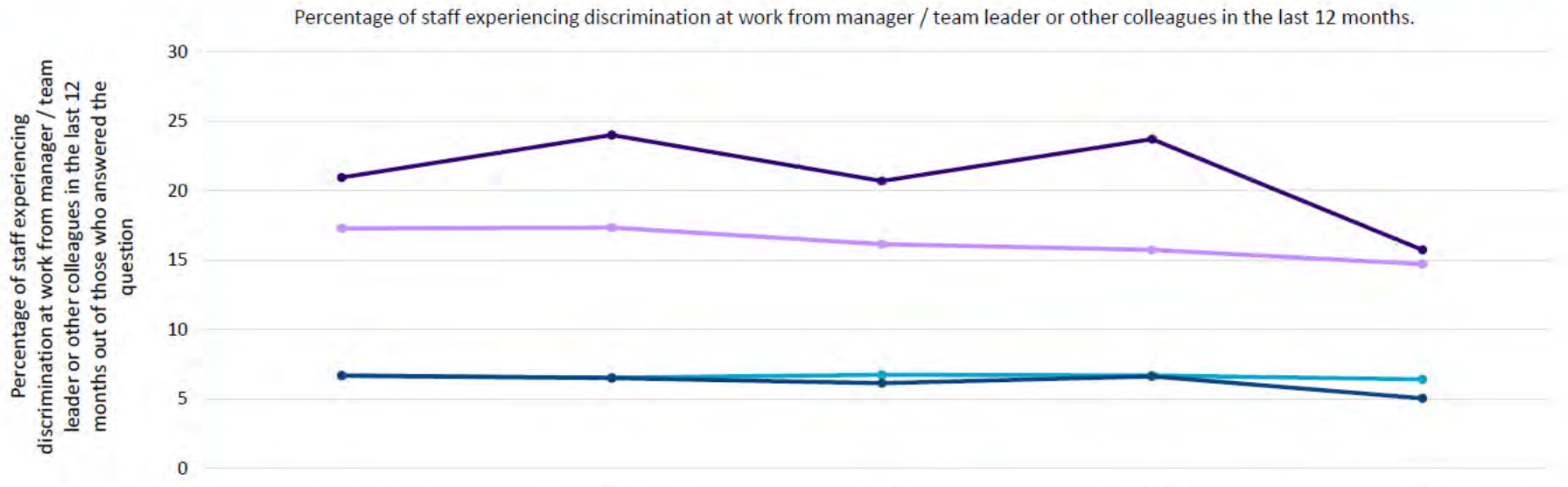


White staff: Your org	53.69%
All other ethnic groups*: Your org	48.41%
White staff: Average	55.46%
All other ethnic groups*: Average	49.11%
White staff: Responses	2928
All other ethnic groups*: Responses	502

WRES Highlights

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS



	2021	2022	2023	2024	2025
White staff: Your org	6.68%	6.50%	6.14%	6.63%	5.04%
All other ethnic groups*: Your org	20.94%	24.00%	20.68%	23.69%	15.73%
White staff: Average	6.67%	6.52%	6.73%	6.69%	6.40%
All other ethnic groups*: Average	17.28%	17.33%	16.14%	15.72%	14.70%
White staff: Responses	1736	2107	2265	2187	2936
All other ethnic groups*: Responses	191	250	324	287	496

WRES Highlights

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

	2021	2022	2023	2024	2025
White staff: Your org	24.02%	21.78%	19.20%	18.90%	18.10%
All other ethnic groups*: Your org	28.42%	27.27%	28.13%	31.60%	23.20%
White staff: Average	23.65%	23.25%	22.12%	21.53%	20.48%
All other ethnic groups*: Average	28.53%	28.81%	25.16%	24.78%	24.06%
White staff: Responses	1736	2121	2276	2201	2950
All other ethnic groups*: Responses	190	253	327	288	500

*Staff from all other ethnic groups combined

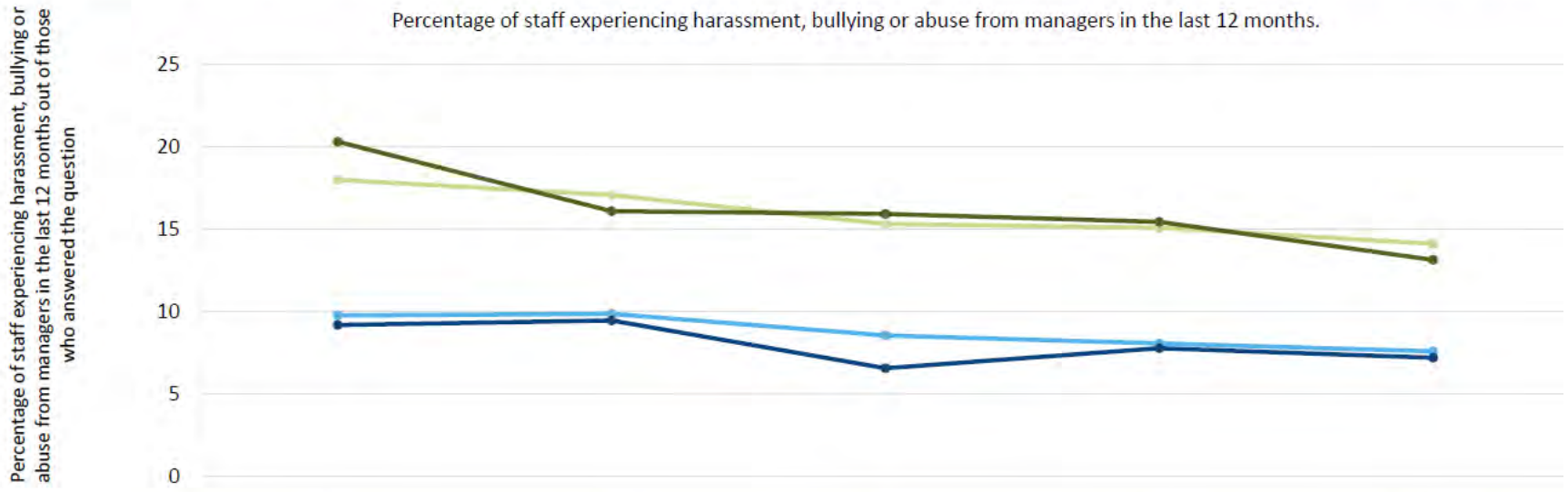
Results by Disability/Long-Term Condition

Metric		Sector	Organisation	Yes	No	Not Available
PP1	We are compassionate and inclusive	7.20	7.24	6.88	7.35	7.15
PP2	We are recognised and rewarded	5.88	5.91	5.43	6.06	6.00
PP3	We each have a voice that counts	6.62	6.64	6.23	6.78	6.49
PP4	We are safe and healthy	6.01	6.23	5.64	6.42	6.40
PP5	We are always learning	5.64	5.31	4.77	5.48	5.51
PP6	We work flexibly	6.23	6.32	5.93	6.45	6.36
PP7	We are a team	6.75	6.78	6.39	6.91	6.71
E	Staff engagement	6.75	6.72	6.31	6.86	6.60
M	Morale	5.88	6.05	5.57	6.20	6.30

WDES Highlights

Workforce Disability Equality Standards

Survey Coordination Centre NHS



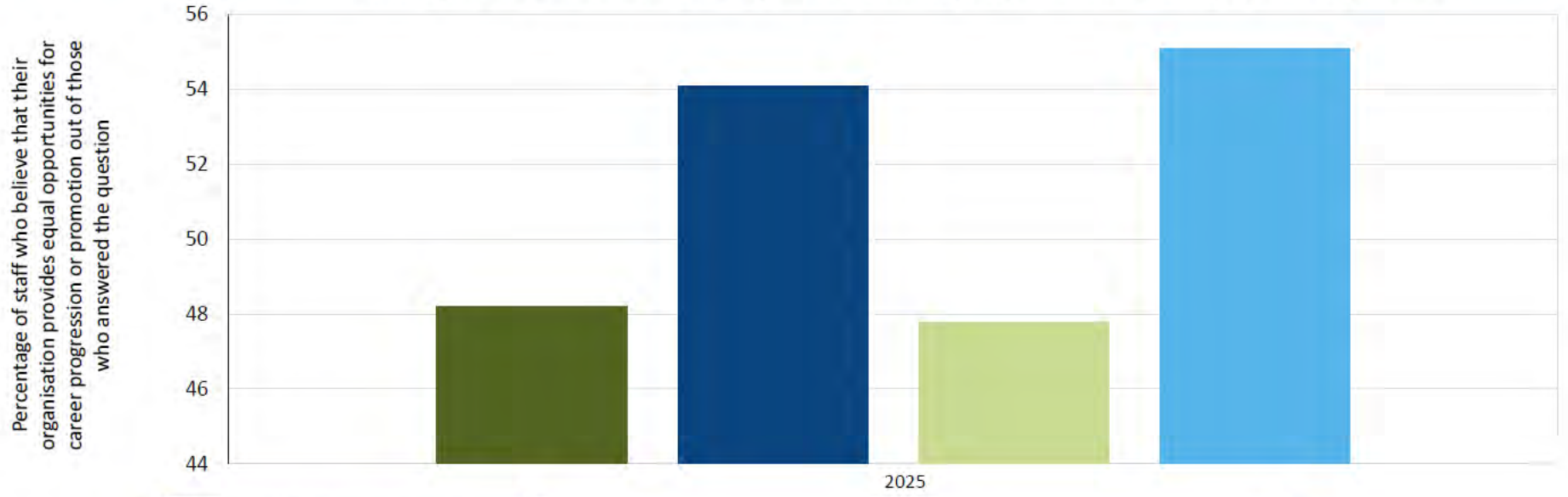
	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	20.32%	16.11%	15.94%	15.45%	13.15%
Staff without a LTC or illness: Your org	9.20%	9.47%	6.57%	7.79%	7.21%
Staff with a LTC or illness: Average	18.00%	17.09%	15.33%	15.10%	14.12%
Staff without a LTC or illness: Average	9.77%	9.88%	8.56%	8.08%	7.60%
Staff with a LTC or illness: Responses	438	565	621	602	829
Staff without a LTC or illness: Responses	1467	1784	1962	1862	2566

WDES Highlights

Workforce Disability Equality Standards

Survey Coordination Centre NHS

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.



Staff with a LTC or illness: Your org	48.19%
Staff without a LTC or illness: Your org	54.07%
Staff with a LTC or illness: Average	47.79%
Staff without a LTC or illness: Average	55.09%
Staff with a LTC or illness: Responses	830
Staff without a LTC or illness: Responses	2565

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Staff Survey Engagement Plan 2026

Staff Survey Engagement Plan

A central focus of this year's engagement activity is improving staff advocacy, measured specifically through the two NSS metrics:

- staff recommending the organisation as a place to work, and
- staff recommending it as a place to receive care.

National Staff Survey 2025 Engagement plan will focus on improving key enablers of staff advocacy:

Staff Survey Engagement Plan

National Staff Survey 2025 Engagement Plan

Introduction of People Experience MDT, bringing together expertise from People Services and Quality Improvement to oversee four key engagement workstreams and provide targeted support to divisions, leaders and teams:

Listening Into Action Walkabouts	Executive Team will undertake a series of Listening into Action Walkabouts in Q1 2026/27. These walkabouts will be carried out with a clear staff survey lens, focusing on the key advocacy drivers.
Divisional People Promise Plan	Divisional leadership teams will develop divisional-level People Promise Plans that respond directly to National Staff Survey feedback. Each plan will focus on three key themes: inclusion and wellbeing, improvement, and a division-specific priority.
Team In Reach support	People Experience MDT will partner with divisional leaders to identify teams and services that require targeted support to embed culture change. Once identified, these teams will be aligned to the most appropriate improvement stream ensuring interventions are tailored and impactful.
Leadership Engagement	Using a new data dashboard, leaders will be equipped to review their team and service-level data, identify priority themes and co-design improvement initiatives with their staff. They will have access to clear guidance on interpreting NSS results and practical tools to help turn insight into improvements in staff experience, engagement and wellbeing.

Staff Survey Engagement Plan

Governance and Quality assurance

- Central oversight of the engagement strategy and activities by the People Experience MDT
- Progress on all NSS engagement activity will be reviewed at the Wider Leadership Team on a bi monthly basis
- Recommend establishing divisional level People Strategy groups (or equivalent people focused governance forums) to oversee Divisional People Promise Plans, track progress against NSS themes and the key advocacy drivers
- Biannual assurance reports to go to the People Committee and the Board to provide oversight of progress, risks, and organisational learning

Staff Survey Engagement Plan

Date	Activity
10th March 2026	WLT presentation on NSS results and engagement plan
Mar - Apr 2026	People Experience MDT meetings and divisional people plan discussions between March – April
March 2026	NSS assurance paper to People Committee and Board
March 2026	NSS results and engagement plan presentations at Partnership Forum and LNC
March - Apr 2026	Trust wide NSS results, including global, social media posts, ASTB section, newsletters, highlight good practice stories
May – June 2026	Executive listening events
May 2026	Divisional people plans to be showcased at ASTB/newsletter
April – Sept 2026	NSS engagement activities and divisional people plan updates as standing agenda item on WLT agenda
April – Oct 2026	Bi-annual NSS assurance reports to ETM, People Committee and Board

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Medium Term Planning: Final Plan Resubmission
Presented to:	Board of Directors
On:	1st April 2026
Item purpose:	Information
Presented by:	Richard Mundon, Deputy Chief Executive
Prepared by:	Chris Clark, Director of Strategic Transformation Heather Shelton, Deputy Director of Operational Finance
Contact details:	E: chris.clark@wwl.nhs.uk heather.shelton@wwl.nhs.uk

Executive summary

The Trust submitted its Medium-Term Plan submission on the 18th March 2026, in accordance with the Medium-Term Planning Framework published by NHS England, covering the period 2026/27 – 2028/29.

This report provides the Board with an update on the submission, in particular covering: the strategic context for the planning framework; the national requirements of the Medium-Term Plan submission; and our compliance with against these requirements within the final plan submitted to NHS England on the 18 March 2026.

Link to strategy

Our operational plans are a key delivery mechanism for *Our Strategy 2030*.

Risks associated with this report and proposed mitigations

- **Delivery risk:** Achieving multi-year improvements in performance and financial sustainability depends on sustained improvement capability, leadership capacity, and pathway redesign. *Mitigations include:* established governance, improvement methodology, organisational redesign and clear prioritisation.
- **System dependency risk:** Several trajectories require joint delivery with Wigan partners and Greater Manchester system colleagues. *Mitigation:* established governance under the Healthier Wigan Partnership and active participation in the GM Trust Provider Collaborative.
- **Workforce risk:** Workforce redesign, productivity improvements and digital change require strong engagement. *Mitigation:* aligned workforce strategy, engagement based on staff survey results, and move from short-term vacancy management to long-term redesign.

Financial implications
Cited within relevant sections of the report.

Legal implications
None identified.

People implications
None identified.

Equality, diversity and inclusion implications
The Equality Impact Assessment (EIA) accompanying the plan highlights the importance of maintaining equitable access as performance recovers and services are redesigned – any proposed specific service changes during the plan period will be subject to an Equality Impact Assessment.

Which other groups have reviewed this report prior to its submission to the committee/board?
The development of the Trust's plan has been overseen by the Trust Board.

Recommendations
Members of the Board are asked to note the final plan resubmission to NHS England on the 18th March.

Report

1.0 Context and background: the Medium-Term Planning Framework

On 24 October 2025 NHS England (NHSE) and the Department of Health and Social Care (DHSC) jointly published a Medium-Term Planning Framework covering the financial years 2026/27 to 2028/29. The Framework aligns with the ambitions of the Ten-Year Health Plan and emphasises performance recovery, improved access, prevention, and financial sustainability.

Underpinning an ambition to return to delivery of the constitutional standards are the three strategic shifts set out in the 10 Year Health Plan:

- **From hospital to community:** Shift care out of hospitals and into community settings, focusing on prevention, early intervention, and care closer to home.
- **From analogue to digital:** Use digital tools, data, and technology to improve access, productivity, and patient experience.
- **From sickness to prevention:** Prioritise preventing ill health and reducing inequalities rather than only treating illness once it occurs.

These national expectations align strongly with the Trust's Our Strategy 2030, and our strategic delivery priorities of Improve, Integrate and Innovate. We are intending to refresh Our Strategy 2030, recognising the progress that has been made against it since its publication in 2021, whilst refining our strategic delivery priorities for the next 5 years.

The Framework marks a shift away from short-termism, and unlike most recent planning guidance covering only one year, this planning framework covers three years, following the three-year revenue and four-year capital spending review settlements published in the summer. It also returns to some of the basics that have taken a back seat over the last decade incorporating expectations around patient and staff feedback and aims to support delivery of the ambitions in the Ten-Year Health Plan (10YHP). The Framework also expresses an ambition to return to constitutional standards by 2028/29 (see section 3.0 below).

2.0 Requirements of the Medium-Term Plan Submission

The national planning process requires providers to submit integrated plans including:

- Activity and performance
- Workforce
- Finance (including multi-year revenue and capital planning)
- Narrative plans describing delivery, risks, and system alignment

Provider Boards hold accountability for ensuring plans are credible, affordable and deliverable, supported by Board Assurance Statements. While Trust Boards are responsible for approving these plans, final acceptance and assurance must come from the NHSE regional team. Our final plan submission was made on the 18th March 2026. At the time of writing this report it is still subject to formal review by the NHS England Regional team.

3.0 Performance Compliance

The Trust's final plan reflects significant work undertaken with the GM Integrated Care Board and NHSE regional colleagues to ensure compliance across key performance and financial standards.

We have set an ambitious plan to deliver year on year improvements against all the constitutional standard metrics and are aiming to meet the national targets in each year of the plan. The details of these metrics are set out in table 1 below.

Achievement of the plan will require a cohesive partnership approach – both across our place, in Wigan, and with partners across Greater Manchester. In Wigan, there is an established governance framework under the Healthier Wigan Partnership and the subgroups that sit underneath this where partners are developing a mature approach to solving challenging issues together and taking opportunities to work together to utilise the collective financial resources to provide the best care for patients and residents, and we will continue to build on this in support of delivery of this plan. We also continue to play an active role within the Greater Manchester Trust Provider Collaborative committee, in support of delivering improvements in services for our residents.

Table 1: Forecasted performance against headline national targets

In summary, we are forecasting to deliver against all key targets in each of the three years of the plan.

Area	Metric	Targets			Forecast Position		
		26/27	27/28	28/29	26/27	27/28	28/29
RTT	18-week treatment	65% (or 7% improvement vs. 25/26, whichever is greater	N/A	92%	67%	79.5%	92%
Cancer	28-day Faster Diagnosis Standard	80% (maintained)			80%	80%	80%
	31-day	94% (by March 2027)	96% (by March 2028)	96% (maintained)	94%	96%	96%
	62-day	80% (by March 2027)	82.5% by March 2028)	85% (maintained)	80%	82.5%	85%
Diagnostics	DM01	Minimum 3% improvement or performance of 20% or better, whichever is greater	N/A	<1% of patients waiting over 6 weeks for a test	4.3%	1.5%	1%
A&E	4-hour	82% (by March 2027) (every Trust)	Average 83% across year (national average target)	Average 85% across the year (national target)	82%	83%	85%
	12-hour	Improve vs. 25/26	Improve vs. 26/27	Improve vs. 27/28	14.3%	11.4%	8.6%
Community	18 weeks	Minimum 78% of community health service activity occurring within 18 weeks (maintained)	N/A	Minimum 80% of community health service activity occurring within	78%	79%	80%

Area	Metric	Targets			Forecast Position		
		26/27	27/28	28/29	26/27	27/28	28/29
				18 weeks (maintained)			

3.0 Financial Compliance

The medium-term revenue plan covering 2026/27 to 2028/29 is breakeven each year, aligning with the NHSE control total. Although the plan has not yet received formal approval, achieving the control total is the minimum requirement for acceptance.

The Trust has made significant progress in reducing the underlying deficit over the last two years as part of our financial sustainability plan. Our Medium-Term plan that we have submitted projects attainment of underlying financial sustainability by the conclusion of 2027/28.

4.0 Delivery

Delivery is structured around the Trust's strategic framework of Patients, People, Performance and Partnerships, underpinned by our improvement methodology, governance and analytical capability

The organisational redesign into two clinical divisions aligned to pathways will support better patient flow, integration, and productivity.

Our transformation and improvement priorities focus on where there is the potential greatest impact on constitutional standards, patient experience, productivity and financial sustainability, with particular focus on Urgent and Emergency Care, Outpatient Redesign, and Cancer.

Digital, data and technology are central to delivery of the plan. Building on a mature electronic patient record and strong digital foundations, the Trust will accelerate the adoption of digital self-service, automation and real-time analytics to release staff time, improve reliability, and support better decision making across pathways. Workforce strategy is fully aligned to service transformation and affordability, with a deliberate shift from short term vacancy management to long term role redesign, productivity improvement and prevention-based wellbeing models.

4.0 Summary

The Trust's Medium-Term Plan has undergone substantial refinement since the December and February updates. The final submission on 18 March is now compliant across all national standards, supported by strengthened trajectories, financial recovery plans and clear system dependencies.

Agenda item: [XX]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Financial reporting month 11 – Trust Finance Report
Presented to:	Board of Directors
On:	1 April 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

We've delivered a stronger position in month 11, and it's essential that we maintain this momentum into month 12 to achieve our agreed breakeven revenue plan. Our focus for the final month remains firm: tight control of variable pay, restraint on discretionary non-pay, maximising elective activity delivery, and securing cash-releasing CIP. The month 11 position was £0.4m favourable to plan, improving our trajectory and reducing the YTD deficit to £1.9m adverse to plan.

CIP delivery in-month is £3.7m, outperforming the £3.4m plan by £0.3m. However, recurrent CIP under-delivery continues to drive our adverse variance, with £5.3m of slippage year-to-date. We are now targeting £18.0m recurrent delivery in-year and £23.0m on a fully recurrent basis. To genuinely support financial recovery, CIP must translate into a sustained reduction in the expenditure run rate.

February was a strong month for divisional elective API activity, and we are above plan by £0.4m in month and £0.3m YTD. This includes the additional activity stepped up for the Q4 performance sprint. In month, Specialist Services is on plan, Medicine is £0.3m favourable and Surgery is £0.2m favourable.

The cash balance at the end of February was £16.3m, improving operating cash days to 10. Cash increased by £9.3m compared to last month, mainly due to the timing of nationally funded capital schemes. The cash position is expected to strengthen further in March before declining from April, reflecting the phasing of capital expenditure. The current underlying run rate would indicate we will require external cash support in Q1 2026/27.
We are beginning to see a reduction in our substantive workforce. In February, the total workforce decreased to 6,854 WTE, a reduction of 57 WTE compared to last month. Despite this improvement, we remain 105 WTE above the workforce plan of 6,749 WTE. Pay expenditure for the month was £34.2m, which is £1.3m above plan. The main drivers of this overspend were CIP underperformance, medical staffing pressure, escalation costs and redundancy costs.

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 5 March 2026. The full finance report was reviewed at the Financial Improvement Group on 23 March 2026 and the Finance and Performance Committee on 25 March 2026.

Wider implications

There are no wider implications of this report.

Recommendation(s)

The Board is asked to note the month 11 financial position.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

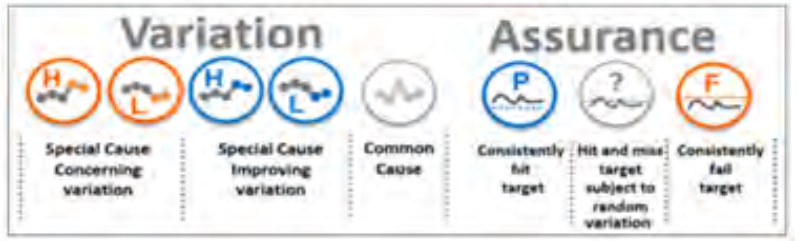
Trust Finance Report - Board

Month 11 – February 2026

Contents

Main report

Statistical Process Chart (SPC) Key



Key Financial Messages

We've delivered a stronger position in month 11, and it's essential that we maintain this momentum into month 12 to achieve our agreed breakeven revenue plan. Our focus for the final month remains firm: tight control of variable pay, restraint on discretionary non-pay, maximising elective activity delivery, and securing cash-releasing CIP. The month 11 position was £0.4m favourable to plan, improving our trajectory and reducing the YTD deficit to £1.9m adverse to plan.

CIP delivery in-month is £3.7m, outperforming the £3.4m plan by £0.3m. However, recurrent CIP under-delivery continues to drive our adverse variance, with £5.3m of slippage year-to-date. We are now targeting £18.0m recurrent delivery in-year and £23.0m on a fully recurrent basis. To genuinely support financial recovery, CIP must translate into a sustained reduction in the expenditure run rate.

February was a strong month for divisional elective API activity, and we are above plan by £0.4m in month and £0.3m YTD. This includes the additional activity stepped up for the Q4 performance sprint. In month, Specialist Services is on plan, Medicine is £0.3m favourable and Surgery is £0.2m favourable.

The cash balance at the end of February was £16.3m, improving operating cash days to 10. Cash increased by £9.3m compared to last month, mainly due to the timing of nationally funded capital schemes. The cash position is expected to strengthen further in March before declining from April, reflecting the phasing of capital expenditure. The current underlying run rate would indicate we will require external cash support in Q1 2026/27.

We are beginning to see a reduction in our substantive workforce. In February, the total workforce decreased to 6,854 WTE, a reduction of 57 WTE compared to last month. Despite this improvement, we remain 105 WTE above the workforce plan of 6,749 WTE. Pay expenditure for the month was £34.2m, which is £1.3m above plan. The main drivers of this overspend were CIP underperformance, medical staffing pressure, escalation costs and redundancy costs.

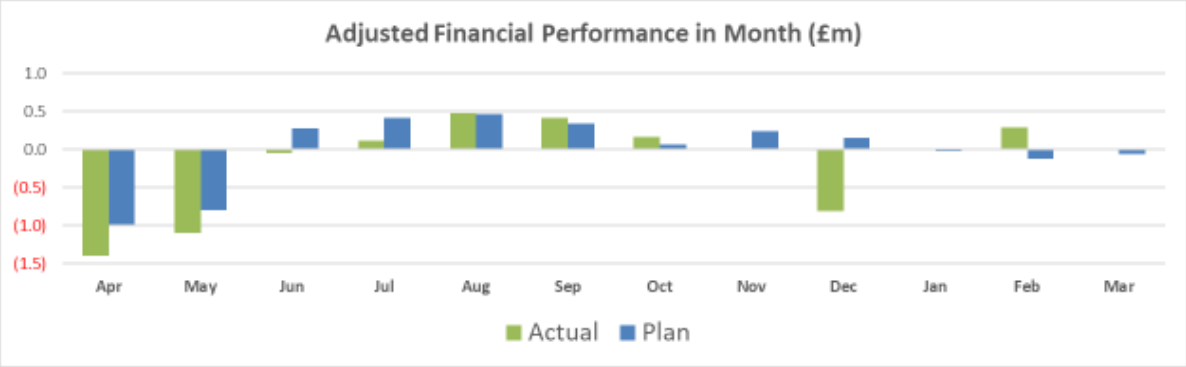
Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Amber		We've delivered a stronger position in month 11, and it's essential that we maintain this momentum into month 12 to achieve our agreed breakeven revenue plan. Our focus for the final month remains firm: tight control of variable pay, restraint on discretionary non-pay, maximising elective activity delivery, and securing cash-releasing CIP. The month 11 position was £0.4m favourable to plan, improving our trajectory and reducing the YTD deficit to £1.9m adverse to plan.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		The cash balance at the end of February was £16.3m, improving operating cash days to 10. Cash increased by £9.3m compared to last month, mainly due to the timing of nationally funded capital schemes. The cash position is expected to strengthen further in March before declining from April, reflecting the phasing of capital expenditure. The current underlying run rate would indicate we will require external cash support in Q1 2026/27.
API Income	Achieve the elective activity plan for 2025/26.	Green		February was a strong month for divisional elective API activity, and we are above plan by £0.4m in month and £0.3m YTD. This includes the additional activity stepped up for the Q4 performance sprint. In month, Specialist Services is on plan, Medicine is £0.3m favourable and Surgery is £0.2m favourable.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Red		CIP delivery in-month is £3.7m, outperforming the £3.4m plan by £0.3m. However, recurrent CIP under-delivery continues to drive our adverse variance, with £5.3m of slippage year-to-date. We are now targeting £18.0m recurrent delivery in-year and £23.0m on a fully recurrent basis. To genuinely support financial recovery, CIP must translate into a sustained reduction in the expenditure run rate.
	Deliver Recurrent CIP of £23.0m	Red		
Agency expenditure	30% reduction in agency spend.	Amber		Agency spend is showing a cumulative 9% 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 14% 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 11 is £4.5m which is £3.4m above 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 96.4% by volume and 95.8% by value. YTD performance was 93.1% by volume and 96.5% by value.

Financial Performance

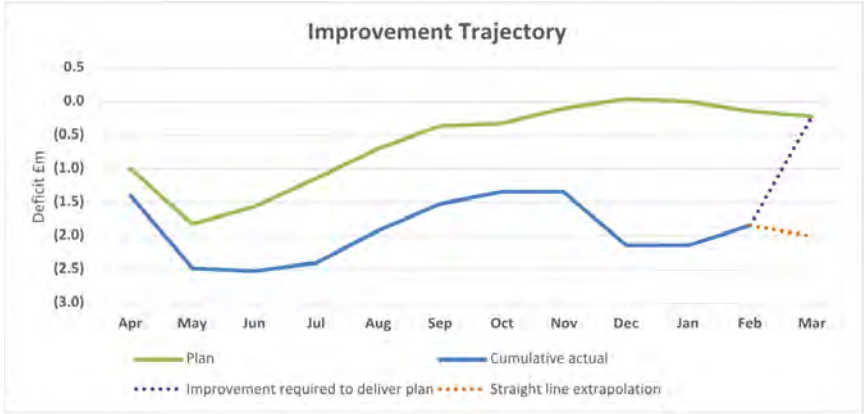
Headlines

- We have seen an improvement in month 11 which needs to be sustained in month 12 to ensure we deliver our agreed breakeven revenue plan.
- The focus for the final month remains on grip and control of variable pay, discretionary non pay, delivery of elective activity and cash releasing CIP.
- In month 11, our position is **£0.4m favourable to plan**, reducing the YTD variance to **£1.9m adverse to plan**.
- Income was above plan in month by £1.2m, with elective income above plan in month by £0.4m and YTD by £0.3m. This includes the Q4 performance sprint.
- There was improvement in Medicine and Surgery, with both divisions on plan in month.
- Actual CIP delivery in month is £3.7m, which is £0.3m favourable to plan.
- We are **£1.2m behind** our best-case trajectory, which was shared with NHSE in Q3 to deliver our plan.
- The National Oversight Framework (NOF) metric for variance YTD to financial is at segment 3 (Q1 segment 3, Q2 segment 2).
- A settlement in full has been agreed with Specialist Commissioners for the bespoke prosthesis limb salvage for 2025/26 non-recurrently.



Improvement Trajectory to Deliver Revenue Plan

Based on the current run rate there needs to be a **£2.1m improvement in** March 2026 to deliver the 2025/26 plan.



Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	49,043	47,847	1,196	535,309	525,096	10,214	572,943
Pay	(34,151)	(32,860)	(1,291)	(376,622)	(362,436)	(14,186)	(395,279)
Non Pay	(14,164)	(14,570)	406	(155,785)	(156,728)	944	(171,256)
Financing / Technical	(428)	(552)	124	(4,863)	(6,069)	1,206	(6,621)
Surplus / Deficit	300	(135)	435	(1,961)	(138)	(1,823)	(213)
Adjusted Financial Performance (AFP)	298	(117)	415	(1,841)	59	(1,900)	0
Memo							
Deficit support funding	(741)	(741)	0	(8,152)	(8,152)	0	(8,893)
AFP excluding deficit support funding	(443)	(117)	(326)	(9,993)	59	(10,052)	(8,893)

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

Income

Division	In Month (£000)			Year to Date (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	986	415	571	6,036	4,555	1,481
Surgery	509	217	293	2,976	2,379	596
Specialist Services	1,559	1,600	(41)	17,929	17,574	354
Community Services	783	676	108	7,159	7,420	(261)
Non Divisional Income	43,879	43,932	(54)	488,020	482,161	5,859
Finance	17	17	(1)	167	176	(9)
People Services	110	71	38	987	782	205
Dir Of Strat & Planning	155	136	19	1,933	1,494	440
Chief Operating Officer	0	0	0	0	0	0
Medical Director	178	74	104	1,095	810	285
Estates & Facilities	472	404	67	4,948	4,402	546
Nurse Director	114	83	32	1,128	1,009	119
Trust Executive	0	(33)	33	0	(319)	319
Corporate	104	67	37	1,003	735	269
Digital Services	3	7	(4)	44	81	(37)
GTEC	174	181	(7)	1,884	1,836	47
Total	**49,043**	**47,847**	**1,196**	**535,309**	**525,096**	**10,214**

Headline

- Income is **£1.2m favourable** in month and £10.2m favourable YTD.

Clinical divisions

- **Medicine**: Income is **£0.6m favourable** in month. Elective API income is £0.3m favourable in month and unbundled drugs and devices income is £0.2m favourable in month including drugs gainshare.
- **Surgery**: Income is **£0.3m favourable** in month. This is predominantly due to Elective API income which is £0.2m favourable in month.
- **Specialist Services**: Income is **£41k adverse** in month. Elective API income is on plan in month; unbundled drugs and devices is £0.1m favourable offset by under performance in private patient income and CDC income which are both £0.1m adverse in month.

Other

- **Non-Divisional income**: **£0.1m adverse** in month, driven by lower CRU income, partially offset by the Bespoke Limb Salvage recharge. The additional YTD Bespoke Limb salvage income attributed to NHSE totals £2.3m; this has been agreed at a meeting on 6 March as a non-recurrent settlement for 2025/26. Collaborative discussion will continue in respect of 2026/27 and a sustainable arrangement.
- **Community Services: £0.1m favourable** in month due to £0.2m over performance on Education funding offset with by under performance on private patient of £0.1m as the SOS feeding service has not yet commenced.
- **Medical Director**: Income is **£0.1m favourable** in month due to over performance on Education income.

Divisional Elective API Activity and Income v Internal Plan

Division	POD	In Month Activity			In Month (£000)			Year to Date Activity			Year to Date (£000)		
		Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,730	1,528	202	1,137	1,013	124	16,662	17,652	(990)	11,125	11,695	(570)
Medicine	Electives	211	39	172	237	53	183	1,100	452	648	1,442	616	826
Medicine	OP Proc New	83	142	(59)	26	52	(26)	972	1,639	(667)	298	604	(307)
Medicine	OP Proc FUP	638	591	47	128	111	17	7,869	6,823	1,046	1,627	1,283	345
Medicine	OPA New	2,319	2,554	(235)	597	669	(72)	27,082	29,494	(2,412)	7,001	7,727	(726)
Medicine	A&G	398	276	122	86	60	26	5,432	3,031	2,401	1,177	656	521
Medicine Total		**5,379**	**5,129**	**250**	**2,211**	**1,958**	**253**	**59,117**	**59,091**	**26**	**22,670**	**22,582**	**88**
Specialist Services	Day Cases	818	784	34	1,345	1,408	(64)	8,881	8,573	308	14,832	15,249	(417)
Specialist Services	Electives	356	385	(29)	2,685	2,882	(197)	4,012	4,159	(147)	30,684	31,123	(439)
Specialist Services	OP Proc New	1,020	871	149	169	147	22	11,229	10,058	1,171	1,890	1,692	198
Specialist Services	OP Proc FUP	2,045	1,283	762	325	181	144	18,977	14,819	4,158	2,751	2,094	657
Specialist Services	OPA New	3,588	3,110	478	742	658	84	37,317	35,926	1,391	7,848	7,601	247
Specialist Services	A&G	238	171	67	52	37	15	3,533	1,884	1,649	765	408	357
Specialist Services Total		**8,065**	**6,605**	**1,461**	**5,317**	**5,314**	**4**	**83,949**	**75,418**	**8,531**	**58,770**	**58,167**	**602**
Surgery	Day Cases	1,015	1,043	(28)	1,455	1,453	2	11,277	11,446	(169)	14,738	15,702	(963)
Surgery	Electives	167	175	(8)	598	495	102	1,630	2,018	(388)	5,867	5,722	145
Surgery	OP Proc New	1,639	1,920	(281)	358	420	(62)	19,103	22,112	(3,009)	4,271	4,825	(554)
Surgery	OP Proc FUP	3,931	3,004	927	804	616	187	41,094	34,696	6,398	8,635	7,120	1,514
Surgery	OPA New	3,644	4,125	(481)	749	840	(91)	42,481	46,595	(4,114)	8,765	9,530	(765)
Surgery	A&G	283	107	176	61	23	38	2,467	1,180	1,288	534	255	279
Surgery Total		**10,679**	**10,374**	**305**	**4,025**	**3,847**	**178**	**118,052**	**118,048**	**5**	**42,811**	**43,154**	**(344)**
Divisional ERF Totals		**24,124**	**22,109**	**2,015**	**11,554**	**11,119**	**435**	**261,118**	**252,557**	**8,561**	**124,250**	**123,903**	**347**

Above the core plan by £0.3m YTD

- Medicine £0.3m
- Specialist Services breakeven
- Surgery £0.2m

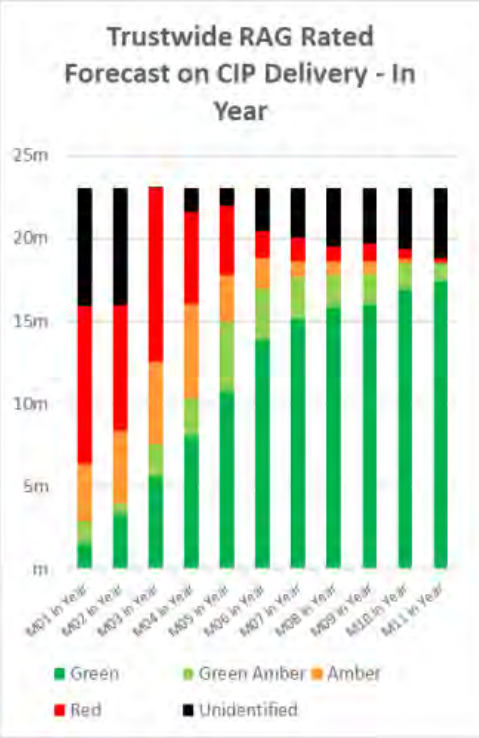
Elective API Performance

- In month 11, we have over performed against the elective API plan by £0.4m.
- **Medicine** are £0.3m favourable to plan in month predominantly due to General Medicine £0.2m.
- **Specialist Services** are breakeven in month overall. T&O are £0.3m behind plan in month and Dermatology, Rheumatology and Plastics have over performed by £0.1m. An accrual has been included for Physio Activity of £0.2m as they are currently missing a month's activity since the move to System One. T&O lost 32 elective cases and circa £0.3m due to the surgical cement supply issue.
- **Surgery** are £0.2m above plan in month, mainly relating to Colorectal Surgery.
- Advice and guidance income of £0.2m has been included in month. YTD A&G is £1.2m above plan of which £0.5m relates to GM.

Trust Wide CIP Delivery 2025/26

2025/26 CIP Delivery

- Total CIP delivered in Month 11 is £3.9m, which is £0.5m above plan: £2.16m is recurrent (55%) and £1.05m is non-recurrent (45%).
- The full value of recurrent CIP transacted or categorised as low risk has decreased by £0.02m to £18.47m, however the recurrent delivery in the year to date position has reduced by £0.1m to £5.3m behind plan.
- At Month 11, £4.2m 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.



Feb 2026 Reported Position (Rec)

RAG	Value £'000
	4,204
	303
	42
	18,471
CIP Total	23,020

Jan 2026 Reported Position (Rec)

RAG	Value £'000
	3,665
	631
	230
	18,493
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 £14.13m.

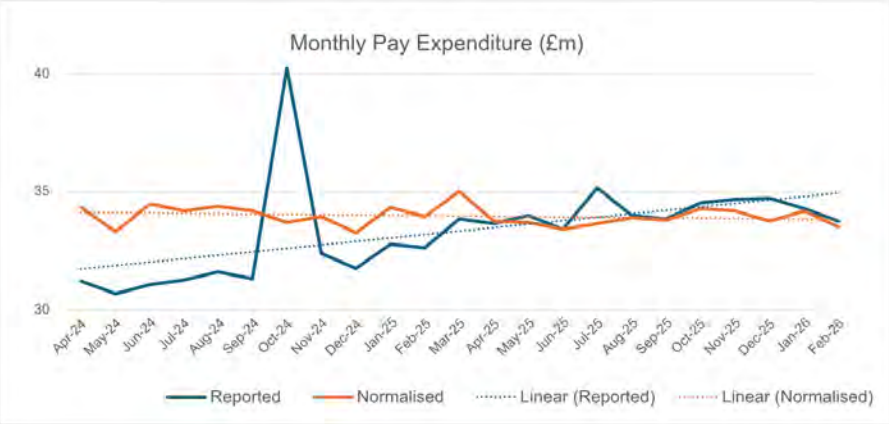
In total we have transacted £17.42m recurrent CIP in year with a full year impact of £22.54m.

	In Year		Full Year Impact	
Recurrent CIP	Included in scenarios (£m)	Reported at M11 Actual (£m)	Target (£m)	Transacted at M11 (£m)
All Recurrent	18.00	17.42	23.00	22.54
Cash Releasing	17.18	14.13	20.00	19.19

Workforce

Pay expenditure

- The in-month pay expenditure is £34.2m which is £1.3m above plan in month. This is due to CIP underperformance £0.2m, medical staffing £0.3m, escalation costs £0.3m, redundancy costs £0.3m.
- The normalised pay expenditure has been rebased in line with 2025/26 rates and remains within the range seen since from Q4. The January/February normalised pay average is £33.9m compared to the 2024/25 Q4 monthly average of £34.5m. This is a reduction of £0.6m



Pay £1.3m above plan in month

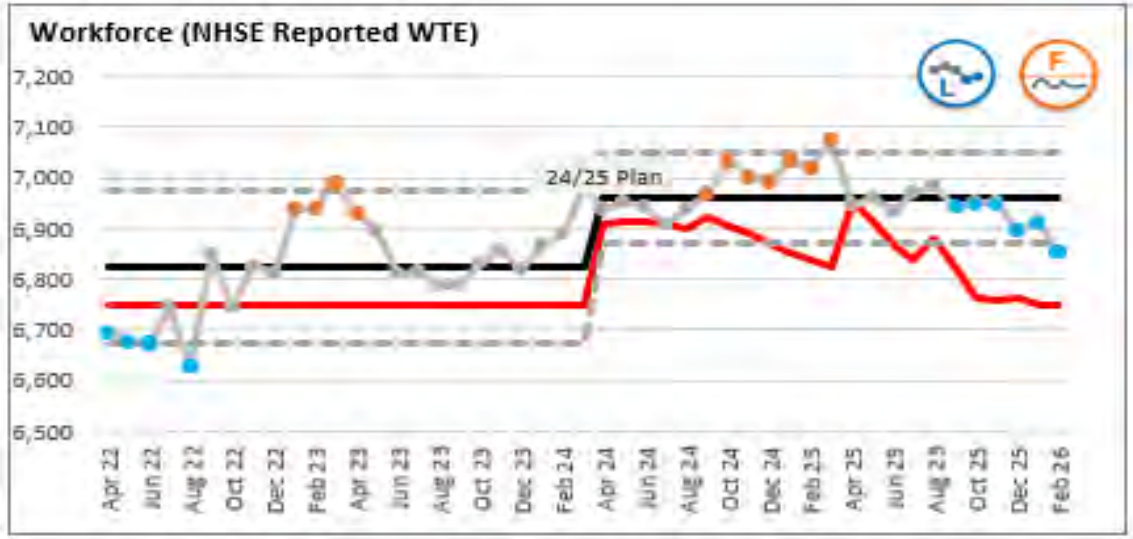
Normalised pay is reducing c£33.9m

Normalised quarterly average

Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Jan/Feb 25/26
£33.7m	£34.5m	£33.7m	£33.8m	£34.1m	£33.9m

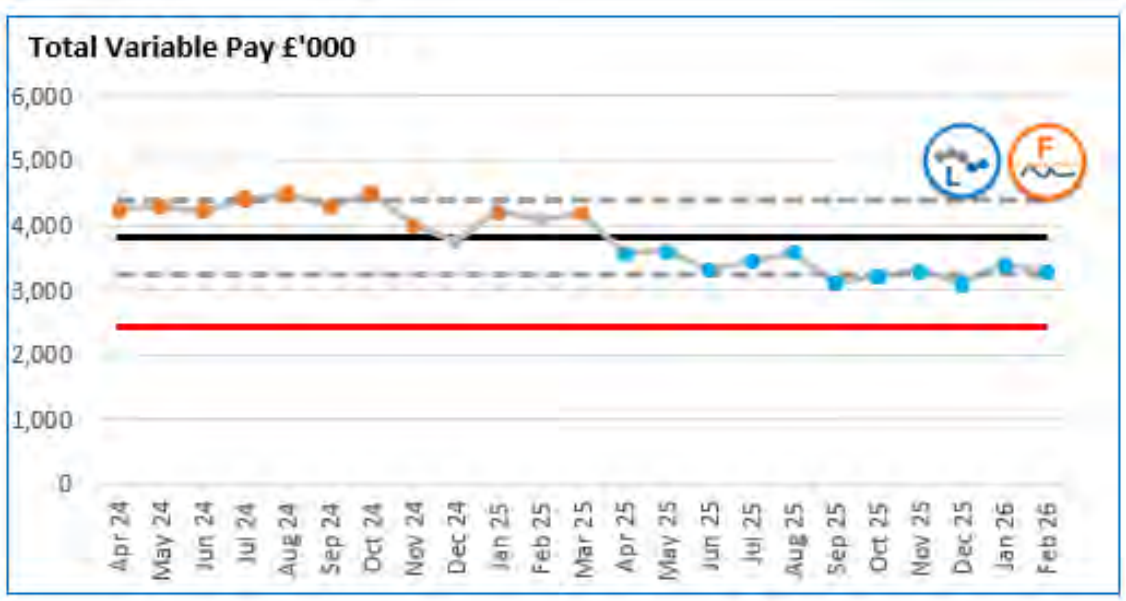
Workforce (WTE)

- Actual workforce 6,854 WTE in February. This is a reduction of 57 WTE from last month and is 105 WTE above the workforce plan of 6,749 WTE.
  - Substantive staffing has decreased by 38 WTE.
  - Bank staffing has decreased by 9 WTE.
  - Agency has decreased by 10 WTE compared to last month.
- The graph is now showing special cause improving variation with WTE reducing by 94 WTE from 6,948 WTE in April to 6,854 WTE in February.



WTE above plan by 105 WTE (at an average WTE cost this equates to £0.4m in month)

Variable Pay



Key messages

- Overall, SPC trend is positive and shows total variable pay reducing.
- There is an immediate focus on actions to reduce variable pay to support delivery of the 2025/26 position, whilst recognising there are also longer-term areas of opportunity.
- Total variable pay is £3.3m in month, £37.0m YTD; an average of £3.4m per month.
- February saw a £0.1m decrease from the prior month, predominantly in agency £0.1m. We are expecting a further reduction in March due to the focused actions associated with the recovery plan.
- The spend split by staffing group is Medical £17.6m, Nursing £17.3m and Corporate £2.0m.
- 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

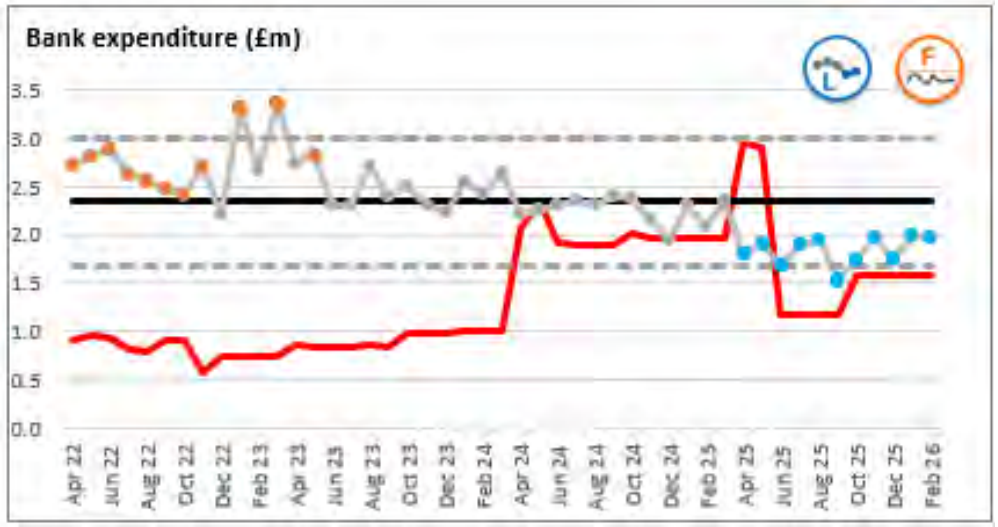
Bank & Agency Staffing

Bank expenditure

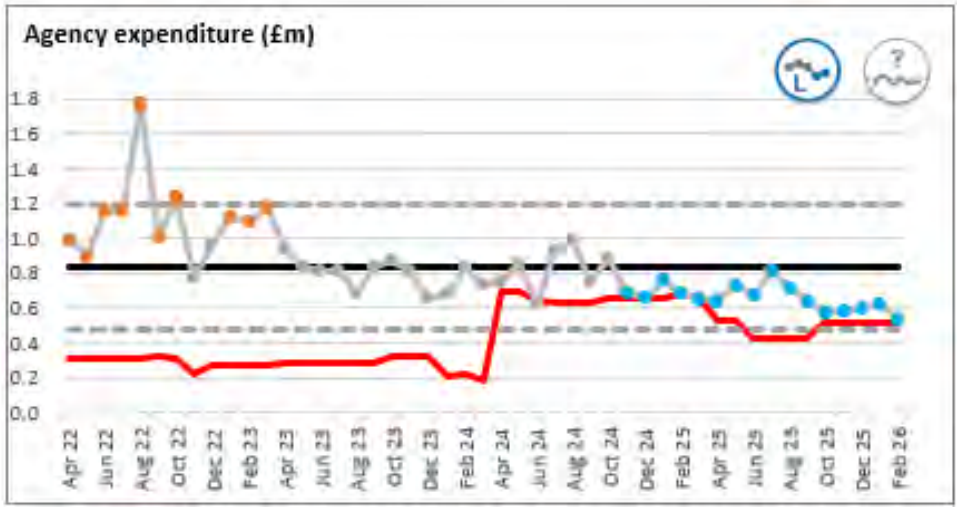
- Bank costs were £2.0m in February, the same as last month.
- The chart is showing a special cause improving variation.
- In February, Medicine (£1.1m) and Surgery (£0.4m) continue to be the biggest users.
- Bank WTE decreased by 9 WTE.
- Bank spend is showing a cumulative 14% reduction relative to 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.

Agency expenditure

- Agency spend in month is £0.5m, with a £0.1m reduction on last month. The trend is still showing common cause improving variation.
- Agency WTE decreased by 10 WTE.
- 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 9% 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.



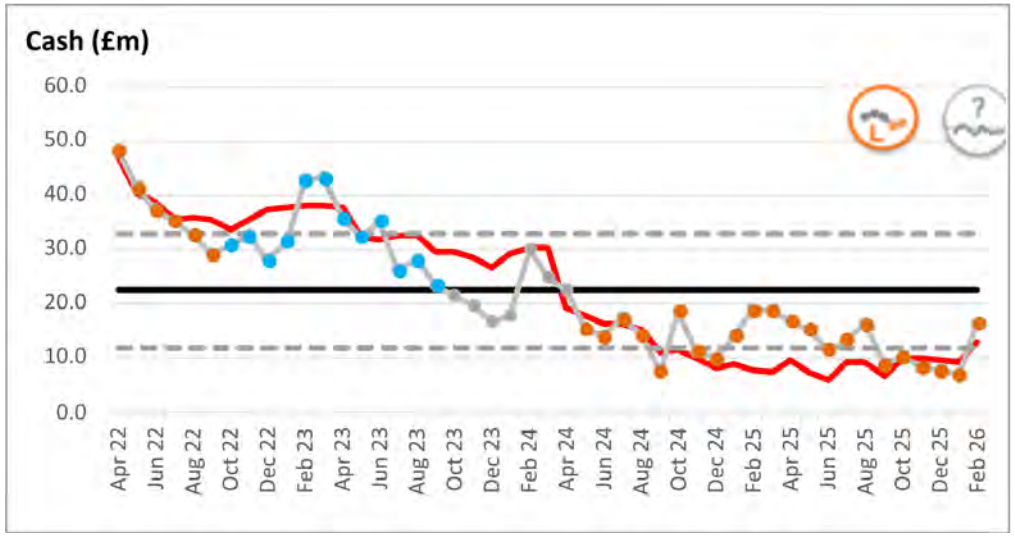
Bank expenditure stabilised in month.

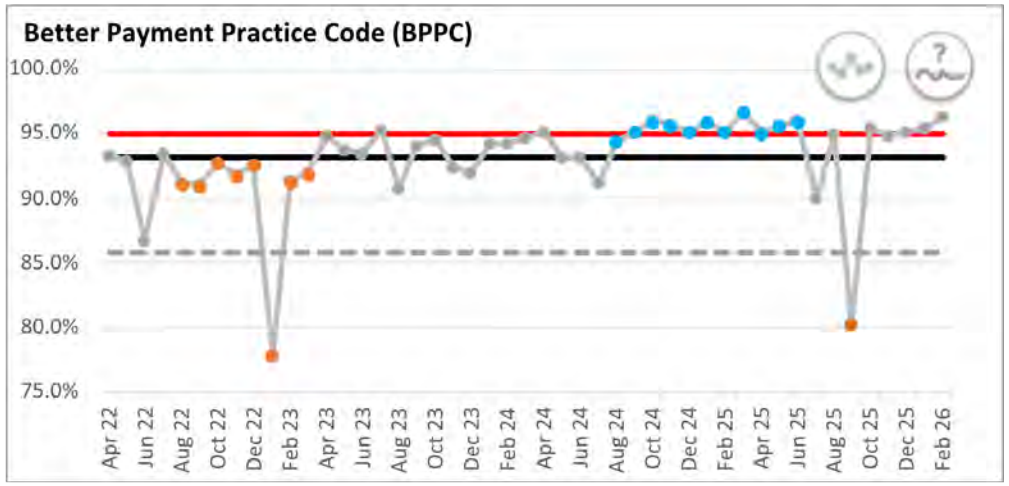


Agency expenditure reducing compared to last month

Scrutiny remains high on agency spend

Cash and BPPC





Current cash position

- Closing cash at the end of February was £16.3m, an increase of £9.3m from January. This is £8.6m above the plan submitted to NHSE. As anticipated, this was due to receipt of PDC capital funding £4.1m and the quarterly receipt of education funding £2.4m both of which provide a temporary benefit ahead of corresponding cashflows, in addition, the receipt of £1.5m for Industrial Action costs was received.
- Operating cash days at the end of February increased to 10 days.

Cash forecast

- The cash plan assumes delivery of the revenue, efficiency and capital plans in full. Based on the current run rate and cash management mitigations, the forecast indicates there will be sufficient cash balances for the remainder of the financial year because of receiving capital PDC receipts in advance of cash payments.
- The monthly PFRs have been updated to reflect the cash forecast for the remaining months of 2025/26 to flag any cash requirements to NHSE ahead of any cash support requests, if required.

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 96.4% by volume and 95.8% by value.
- The YTD performance was 93.1% by volume and 96.5% by value

Capital

Scheme	In Month (£000) Actual	Plan	Var	Year to Date (£000) Actual	Plan	Var	Full Year (£000) Plan	YTD Actual of Full Year Plan (%)
Operational capital programme	1,195	377	(818)	12,257	13,827	1,570	15,150	81%
Over programming and over allocation							(672)	0%
Operational capital (CDEL)	**1,195**	**377**	**(818)**	**12,257**	**13,827**	**1,570**	**14,478**	**85%**
National funding (PDC)								
Solar Panels	620	215	(405)	1,153	1,933	781	2,148	54%
Diagnostics prioritisation	0	0	0	134	239	105	359	37%
UEC - Discharge Lounge capacity	11	0	(11)	702	572	(130)	635	111%
Elective prioritisation - Theatres 5&6	331	131	(200)	840	919	79	1,050	80%
Estates Safety bids (Backlog Maintainance)	368	159	(209)	2,842	2,611	(231)	2,744	104%
Estates Safety bids (Backlog Maintainance) Phase 2	57	0	(57)	172	0	(172)	595	29%
UEC (A&E Diagnostics)	(35)	0	35	3,712	3,747	35	3,747	99%
UEC SDEC	630	224	(407)	1,073	1,118	45	1,341	80%
CDC Pathway - Gynaecology	102	0	(102)	102	0	(102)	109	93%
Sound Treatment Rooms (audiology)	0	0	(0)	66	0	(66)	120	55%
RAAC - Leigh infirmary	7	0	(7)	359	0	(359)	391	92%
EV Chargers	32	0	(32)	32	12	(20)	31	104%
CDC Pathway - Urology	304	0	(304)	314	0	(314)	540	58%
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	839	0	(839)	1,846	0	(1,846)	2,764	67%
ENT Bundle	62	0	(62)	62	0	(62)	206	30%
Maternity & Bereavement Suite	0	0	0	0	0	0	206	0%
Community Paeds and Audiology	0	0	0	0	0	0	17	0%
Radiology	0	0	0	0	0	0	118	0%
Breast Screening Equipment	0	0	0	0	0	0	26	0%
Sub total national funding	**3,329**	**729**	**(2,600)**	**13,739**	**11,151**	**(2,588)**	**17,573**	**78%**
Total capital programme	**4,524**	**1,106**	**(3,419)**	**25,996**	**24,978**	**(1,018)**	**32,051**	**81%**

Month 11 Headlines

- Total capital expenditure in month 11 is £4.5m which is £3.4m above plan.
- Year to date, total capital expenditure of £26.0m is £1.0 above plan.
- There is £6.0m to be spent in month 12 to deliver our agreed capital programme for 2025/26.

Operational CDEL

- Operational capital expenditure in month 11 of £1.2m is £0.8m above plan.
- The YTD expenditure of £12.3m is £1.6m behind plan, the pharmacy robot (£1.0m) has slipped to 2026/27, deferral of 2 equipment leases to 26/27 (£0.3m) and underspends on leases.
- Underspends have been reallocated as recommended by CSG and expect to deliver in Q4 and slippage principles agreed with CSG.
- The over programming and over allocation associated with the planning tolerance has been fully mitigated within the capital programme.

PDC funded schemes

- Expenditure on PDC funded schemes is £3.3m in month, £2.6m ahead of plan and £13.7m year to date which is £2.6m ahead the plan of £11.2m. There is a mix of under and overspends across the schemes.
- The solar panel scheme, Theatre 5&6 and SDEC have all commenced in January as planned.
- All MoUs are in place and £13.5m of cash funding has been drawn with the remaining balance scheduled for receipt on 9th March.

Full Year Scenarios

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

Straight line forecast -£2.0m	Remove non-recurrent items and phasing adjustments -£0.5m	Key assumptions +£1.2m	Mid-case scenario: £1.3m deficit	Best-case scenario: Breakeven
• Extrapolated from £1.8m YTD deficit.	• Non recurrent items, extrapolated impact -£0.5m (includes one-off benefits £6.8m across month 3 to 11). • Upside of national funding for industrial action.	• CIP run rate improvement +£0.9m. • Elective activity contribution +£0.4m. • Risk adjusted recovery plan +£0.6m • Other smaller items -£0.7m.	• The current mid-case scenario indicates risk of £1.3m. • All other pressures to be mitigated within existing plan.	• Requires improvement in month 11 run rate to be sustained for month 12. • Focus on immediate actions to reduce expenditure with a focus on variable pay.

Key actions to achieve plan

- CIP delivery as per M11 risk adjusted divisional tracker.
- Deliver elective activity plan.
- Deliver recovery plan.
- Monthly run rate improvement of £2.1m required in month 12.

High level scenarios for full year forecast

Worst Case	Mid Case	Best Case
£2.9m deficit (£2.9m adverse to plan)	£1.3m deficit (£1.3m adverse to plan). There remains a risk to delivery of our control total, but this has reduced since last month (Month 11 mid case £3.0m deficit)	Breakeven (on plan)

All scenarios assume no clawback of DSF.

Risk Management and Mitigation

Revenue position

Recovery plan: We need the improvement in the run rate position seen in February to be sustained for the remainder of the year.

Recurrent CIP delivery: Recurrent CIP slippage remains a contributing factor of our adverse variance, with the month 11 position now £5.3m behind the recurrent plan of £20.9m. We are on track to deliver £23.0m full year effect.

API activity: This is above plan YTD when including the benefit of the Q4 performance sprint. This performance needs to be sustained to the end of the financial year to support delivery of our control total.

Exit run rate: Failing to achieve our planned exit run rate of £11.9m deficit, through higher reliance on non-recurrent measures, would mean carrying a higher underlying cost base into 2026/27, limiting our ability to deliver a balanced plan. This increases the risk of a deeper underlying deficit and reduces our financial resilience going into the new year.

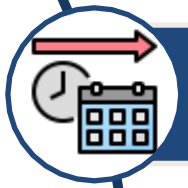
Other

Cashflow: Cash days at month 11 remain low and whilst cash is expected to improve in March due to capital receipts in advance of expenditure, this is a temporary reprieve. The current underlying run rate would indicate we will require external cash support in Q1 2026/27.

Capital programme: There is a delivery risk in the remaining month with £6.0m (19%) of expenditure required before 31st March. Oversight is provided via the Operational Capital Group and Capital Strategy Group.

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 £2.1mimprovement needed in our current run rate required in March. Oversight continues via the divisional performance reviews, Financial Improvement Group and Executive Team Meeting, with fortnightly updates on the recovery plan.



We are due to make a resubmission of the medium-term plan on 18 March 2026. Operational plans are required for 3 years to cover finance, activity, performance and workforce. We have 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 at pace ahead of the planned go-live on 1 April 2026. Following the formal go-live decision on 23 February, system build and cutover activity is now well underway. A comprehensive training and communications plan is in place to support end users and ensure a smooth transition.

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. The transition date was due to be 1 April 2026; however, this has been extended to provide assurance all the necessary due diligence has been completed.

The Government has confirmed a 3.3% consolidated uplift for all staff covered by the Agenda for Change (AfC) framework for 2026/27, following full acceptance of the NHS Pay Review Body recommendation. The increase will be applied in April 2026 payroll, and further funded pay structure reforms are expected following discussions with trade unions and employers.

NHS Oversight Framework

Quarter 3 Summary Review

18TH March 2026

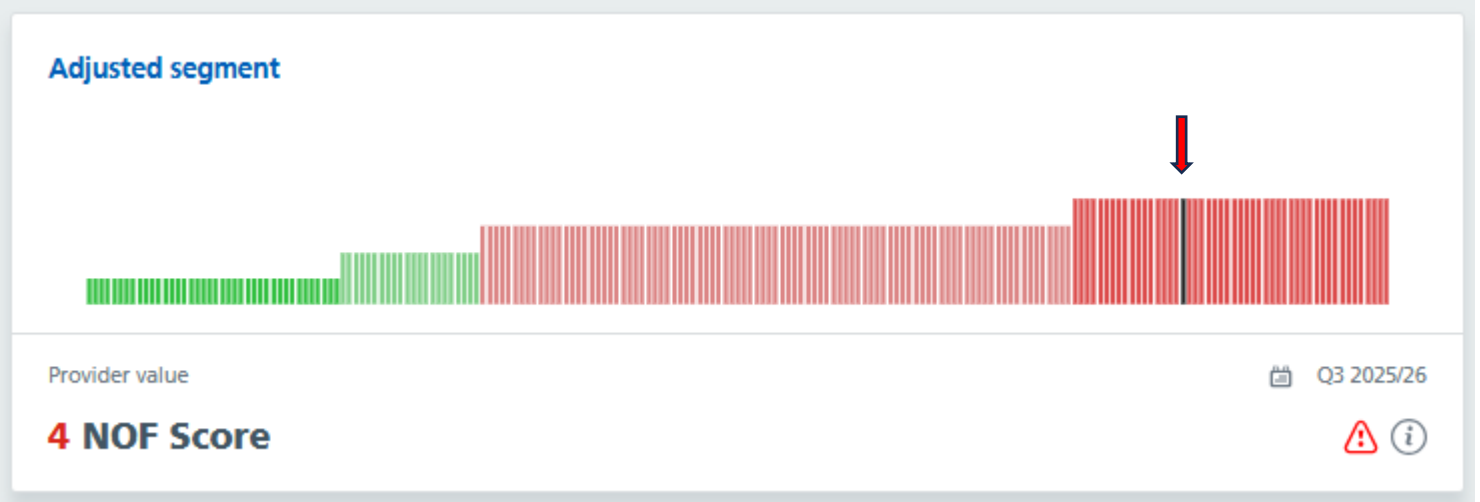
01 April 2026

Overview Quarter 3

NOF Segment 4

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

WWL's average metric score of **2.89** puts WWL in **segment 4**.
Against Acute providers this ranks
WWL **117** out of **134**



Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment	Q3 2025/26	4	NOF Score		Provider value	
Average metric score	Q3 2025/26	2.89	NOF Score		Provider value	
Unadjusted segment	Q3 2025/26	4	NOF Score		Provider value	
Financial override	Q3 2025/26	Yes	Yes	Yes	Provider median	

NHS Oversight Framework

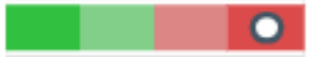
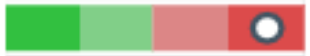
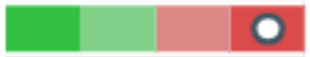
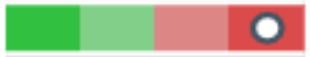
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

5 Domain Segments	Q1	Q2	Q3
1. Access to services domain segment	3	3	4
2. Effectiveness and experience of care domain segment	2	4	4
3. Patient safety domain segment	3	3	3
4. People and workforce domain segment	4	4	4
5. Finance and productivity domain segment	4	4	4

5 Domains, 21 KPI's (applicable to WWL) Quarter 3

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Segmentation scores are shown below for each of the domains. Important to note that only each indicators segment score is used to form the overall average NOF score - used for segmentation and ranking. Each domain and indicator is broken down further in the following slides.

Domain Scores	Data period	Provider value	Chart
Access to services domain segment	Q3 2025/26	4 NOF Score	
Effectiveness and experience of care domain segment	Q3 2025/26	4 NOF Score	
Patient safety domain segment	Q3 2025/26	3 NOF Score	
People and workforce domain segment	Q3 2025/26	4 NOF Score	
Finance and productivity domain segment	Q3 2025/26	4 NOF Score	

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	M11 25/26 Integrated Performance Report
Presented to:	Board of Directors
On:	1st April 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. National Benchmarking of NHS Access Standards report has been added as an Appendix.

The Integrated Performance Report for Month 11 reflects a Trust that has been operating under sustained and exceptional pressure through the winter period, while continuing to demonstrate resilience, strong clinical leadership and early signs of recovery as we move into March.

The period from December through February was characterised by very high demand, particularly across Urgent and Emergency Care, driven by increased attendances, acuity, constrained bed capacity, norovirus outbreaks and workforce pressures. These conditions inevitably impacted patient flow, experience and performance against a number of operational standards. At times, the organisation was required to operate in escalation, making difficult decisions to maintain patient safety.

Against this backdrop, there are important areas of assurance for the Board. Mortality performance remains a clear strength, with both SHMI and HSMR within expected ranges and HSMR performing significantly better than national benchmarks. Mortality governance remains robust. One Never Event was reported during the month and has been appropriately escalated and managed in line with national guidance.

There remain quality risks that require continued focus. Category 2 and above pressure ulcers and healthcare associated infections continue to be areas of concern, alongside a sustained increase in complaints, largely reflecting pressures within Emergency Care. It is encouraging to see

strengthened oversight arrangements, new dashboards and the commissioning of enhanced nurse led safety assurance frameworks to improve grip and learning.

Our workforce continues to operate under considerable pressure. Sickness absence and turnover remain challenges, though there are early signs of stabilisation, including the lowest monthly sickness rate since September. Mandatory training and appraisal compliance remain below target and require ongoing executive and divisional focus. Reliance on bank staffing, driven by winter pressures, continues to have both financial and quality implications.

From a performance perspective, elective recovery continues to progress, with reductions in the RTT waiting list and only a small number of very long waiters remaining, albeit with vascular and cancer pathways presenting ongoing risks. Diagnostic performance has improved significantly in several areas. Cancer performance remains below national standards, particularly in breast and lower GI pathways, but there are early signs of improvement through the Faster Diagnosis Standard and established transformation programmes.

Urgent and Emergency Care performance deteriorated through February, reflecting system wide pressures, but early March data shows meaningful recovery, with improvements in four-hour performance, reduced corridor care and stabilising flow. The Board should note the impact of focused improvement initiatives, including the four-hour sprint, Accelerated Admissions and frailty pathways.

Financially, the Trust's position has improved in Month 11, supported by strong elective activity delivery and better than planned CIP performance. However, underlying risks remain, particularly around recurrent savings delivery and variable pay, and maintaining momentum into Month 12 is essential.

In summary, Month 11 presents a Trust that has been severely tested but has maintained patient safety, delivered improvement in key areas and is now showing early signs of recovery. Risks remain real and material, but there is clear evidence of grip, learning and action. The Board's continued focus on flow, quality assurance, workforce sustainability and financial discipline will be critical as we move into the new financial year.

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 16.3.26, ETM 19.3.26, ETM 26.3.26.

Recommendation(s)

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

Report

Please see the attached M11 25/26 IPR report.

Appendices
Please see the attached M11 National Benchmarking of NHS Access Standards report.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

25/26 Integrated Performance Report

Meeting presented to:

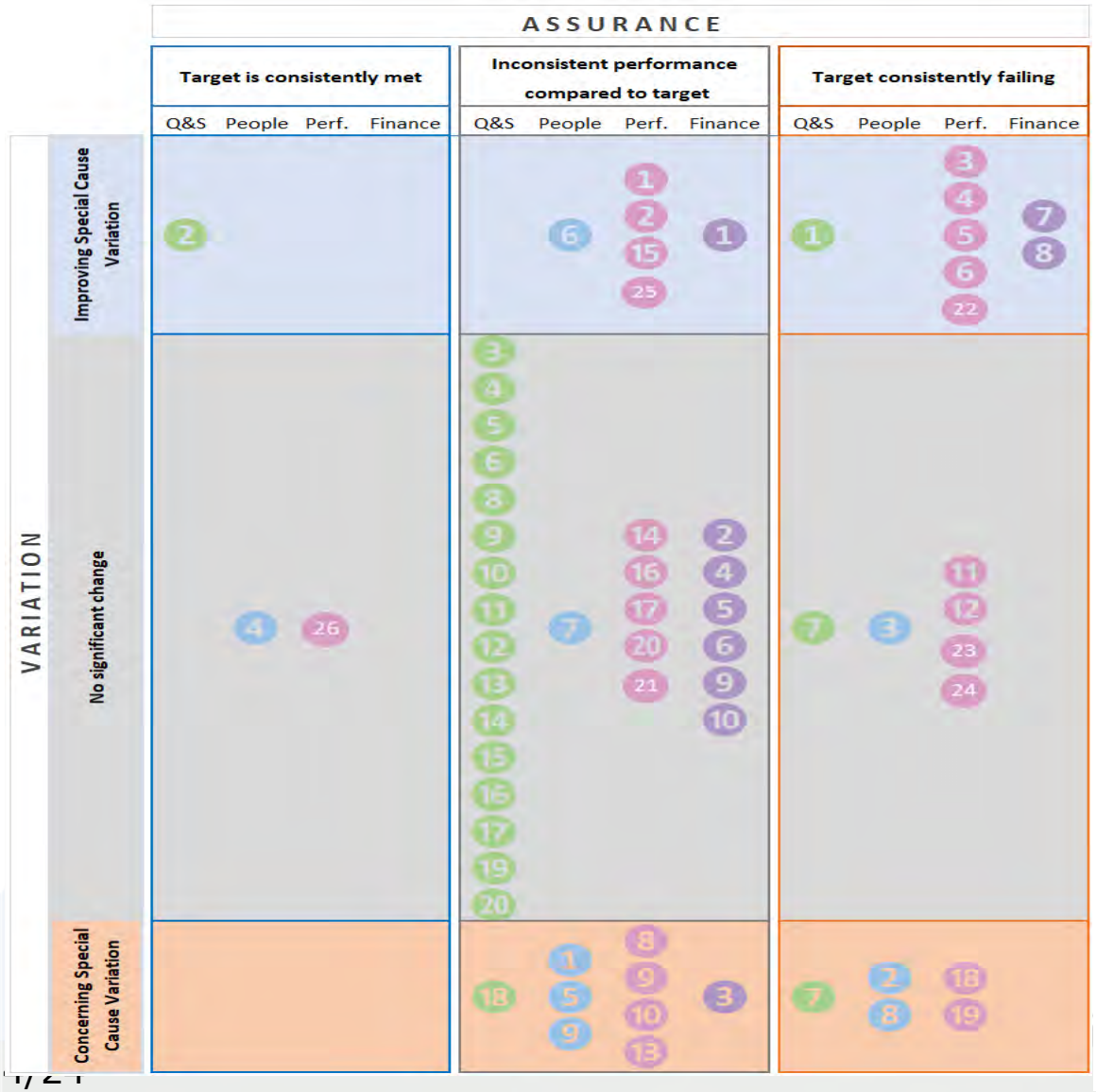
Board of Directors : 1/4/26

Contents

Trust Matrix : M11 25/26

VARIATION	ASSURANCE: Target is consistently met	ASSURANCE: Inconsistent performance compared to target	ASSURANCE: Target consistently failing
Improving Special Cause Variation	HSMR Rolling 12 Months	Vacancy Rate Total Patients Waiting for First Attendance RTT Waiting List Elective Recovery Plan : Inpatient Activity Performance Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days Variance Year-to-Date to Financial Plan (NOF %)	SHMI Rolling 12 Months Percentage of Patients Waiting Over 52 Weeks for Elective Treatment Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under Total Patients Waiting Over 65 Weeks Percentage of cases where a patient is waiting 18 weeks or less for elective treatment Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days Agency Expenditure (£m) Bank Expenditure (£m)
No significant change	Price Cap Compliance - Non Medical Urgent Community Response (UCR) - 2-Hour Performance	Never Events Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation How Many Incidents Triggered a Patient Safety Review No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care 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 Number of Whole Time Equivalent Posts Elective Recovery Plan : Day Case Activity Performance Percentage of Patients Waiting Over 52 Weeks for Community Services Average Time to Ambulance Handover Overnight Total General and Acute Beds and the Number of Which are Occupied Virtual Ward Occupancy Adjusted Financial Performance (£m) - Variance to Plan API Income (£m) - Variance to Plan Total Cost Improvement Programme (CIP) (£m) - Variance to Plan Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan Capital Expenditure (£m) - Variance to Plan Better Payment Practice Code (BPPC)	Reduction in Category 2 and DTI HAPU and CAPU Overall Price Cap Compliance - Medical Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test Outpatient New : Follow-up Ratio 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 Cancer 31 Day Treatment Standard Performance Percentage of Patients Treated for Cancer Within 62 Days of Referral Elective Theatre Utilisation - Capped Touchtime Cash (£m)	Appraisal Sickness - Percentage Time Lost (%) - Rolling 12 months Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department

Trust Matrix : M11 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

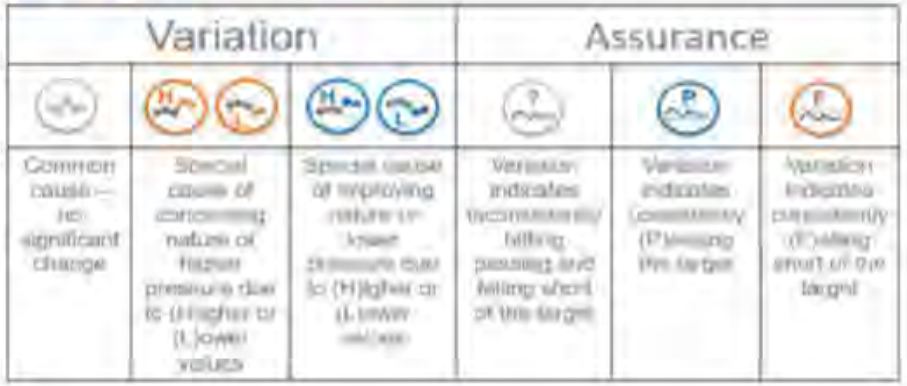
Statistical Process Control (SPC) is a method for viewing data over time to highlight variation. This methodology has long been associated with Quality Improvement and enables us to understand where variation is normal and also where variation is different and requires further actions. This is known 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 : M11 25/26

The Integrated Performance Report for Month 11 reflects a Trust that has been operating under sustained and exceptional pressure through the winter period, while continuing to demonstrate resilience, strong clinical leadership and early signs of recovery as we move into March.

The period from December through February was characterised by very high demand, particularly across Urgent and Emergency Care, driven by increased attendances, acuity, constrained bed capacity, norovirus outbreaks and workforce pressures. These conditions inevitably impacted patient flow, experience and performance against a number of operational standards. At times, the organisation was required to operate in escalation, making difficult decisions to maintain patient safety.

Against this backdrop, there are important areas of assurance for the Board. Mortality performance remains a clear strength, with both SHMI and HSMR within expected ranges and HSMR performing significantly better than national benchmarks. Mortality governance remains robust. One Never Event was reported during the month and has been appropriately escalated and managed in line with national guidance.

There remain quality risks that require continued focus. Category 2 and above pressure ulcers and healthcare associated infections continue to be areas of concern, alongside a sustained increase in complaints, largely reflecting pressures within Emergency Care. It is encouraging to see strengthened oversight arrangements, new dashboards and the commissioning of enhanced nurse led safety assurance frameworks to improve grip and learning.

Our workforce continues to operate under considerable pressure. Sickness absence and turnover remain challenges, though there are early signs of stabilisation, including the lowest monthly sickness rate since September. Mandatory training and appraisal compliance remain below target and require ongoing executive and divisional focus. Reliance on bank staffing, driven by winter pressures, continues to have both financial and quality implications.

From a performance perspective, elective recovery continues to progress, with reductions in the RTT waiting list and only a small number of very long waiters remaining, albeit with vascular and cancer pathways presenting ongoing risks. Diagnostic performance has improved significantly in several areas. Cancer performance remains below national standards, particularly in breast and lower GI pathways, but there are early signs of improvement through the Faster Diagnosis Standard and established transformation programmes.

Urgent and Emergency Care performance deteriorated through February, reflecting system wide pressures, but early March data shows meaningful recovery, with improvements in four-hour performance, reduced corridor care and stabilising flow. The Board should note the impact of focused improvement initiatives, including the four-hour sprint, Accelerated Admissions and frailty pathways.

Financially, the Trust’s position has improved in Month 11, supported by strong elective activity delivery and better than planned CIP performance. However, underlying risks remain, particularly around recurrent savings delivery and variable pay, and maintaining momentum into Month 12 is essential.

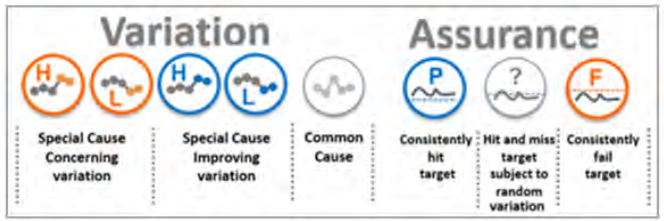
In summary, Month 11 presents a Trust that has been severely tested but has maintained patient safety, delivered improvement in key areas and is now showing early signs of recovery. Risks remain real and material, but there is clear evidence of grip, learning and action. The Board’s continued focus on flow, quality assurance, workforce sustainability and financial discipline will be critical as we move into the new financial year.

Quality & Safety Overview 1 of 2: M11 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	Oct 25	Yes	100.65	100			103.81	102.47	105.14	S	T	P
2	HSMR Rolling 12 Months	Dec 25	No	89.17	100			91.91	89.48	94.33	S	T	P
3	Never Events	Feb 26	No	1	0			0	0	2	S	T	P
4	Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation	Feb 26	No	4	4			2	0	7	S	T	P
5	How Many Incidents Triggered a Patient Safety Review	Feb 26	No	10	33			25	4	47	S	T	P
6	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care	Feb 26	No	0	0			2	0	7	S	T	P
7	Reduction in Category 2 and DTI HAPU and CAPU Overall	Feb 26	No	70	46			78	54	102	S	T	P
8	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care	Feb 26	No	0	1			1	0	4	S	T	P
9	To Reduce the Total Number of Falls per 1000 Bed-days	Feb 26	No	7.5	6.1			7.0	4.4	9.7	S	T	P

*Please note : NOF denotes the National Oversight Framework

Summary icons key:



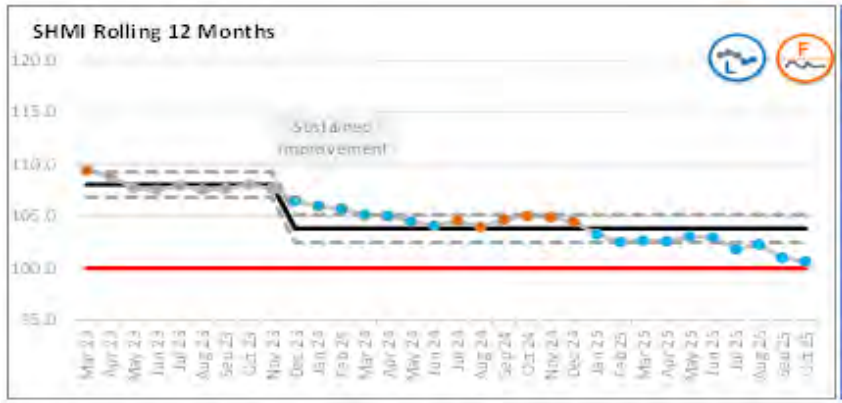
Quality & Safety Overview 2 of 2: M11 25/26

	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)	Feb 26	Yes	0	0			0	0	0	S	T	P
11	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Feb 26	No	0	0			1	0	5	S	T	P
12	WWL Clostridium Difficile (CDT)	Feb 26	Rate	11	5			6	0	15	S	T	P
13	Escherichia Coli (E.coli)	Feb 26	Rate	0	3			4	0	10	S	T	P
14	Klebsiella Species	Feb 26	No	1	1			1	0	4	S	T	P
15	Pseudomonas Aeruginosa	Feb 26	No	1	0			0	0	2	S	T	P
16	Reduction in the Number of Patients who Transfer Between Wards More Than 5 Times	Feb 26	No	8	8			7	1	13	S	T	P
17	Mixed Sex Accomodation Breaches - Non Clinically Justified	Feb 26	No	16	19			19	5	33	S	T	P
18	Reduction in the Number of Complaints	Feb 26	No	84	40	H		47	23	72	S	T	P
19	Complaints Responses	Feb 26	No	69.5%	90.0%			71.6%	50.4%	92.8%	S	T	P
20	Patient Experience (FFT) - Patients who Would Recommend the Service	Feb 26	No	90.6%	90.0%			87.7%	81.8%	93.7%	S	T	P

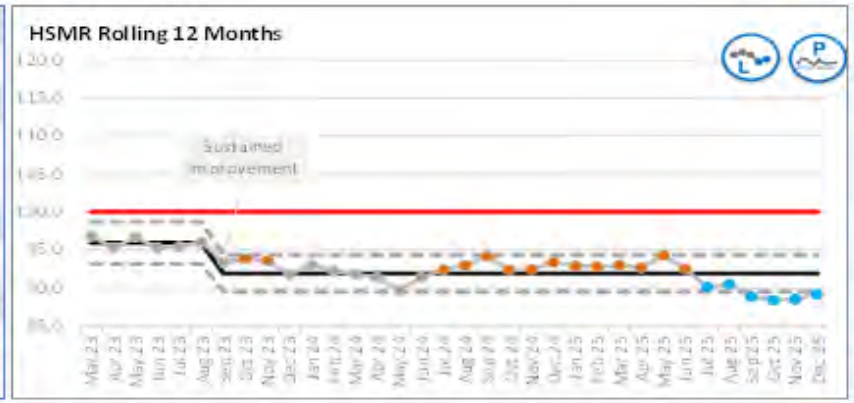
Summary icons key:

*Please note : NOF denotes the National Oversight Framework

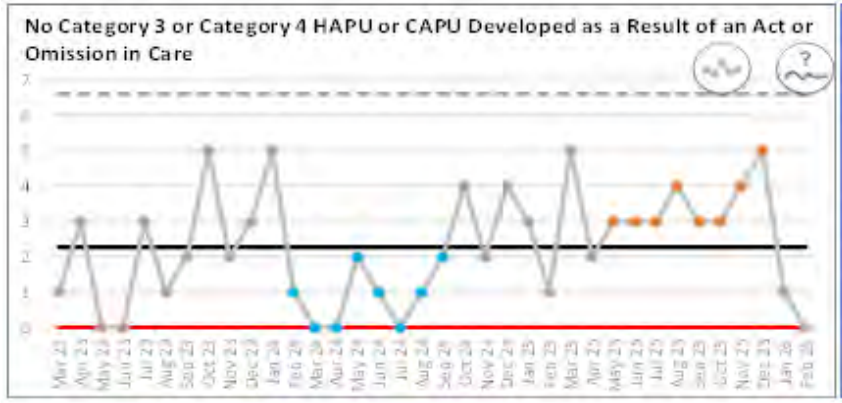
Quality & Safety Insight Report 1 of 2: M11 25/26



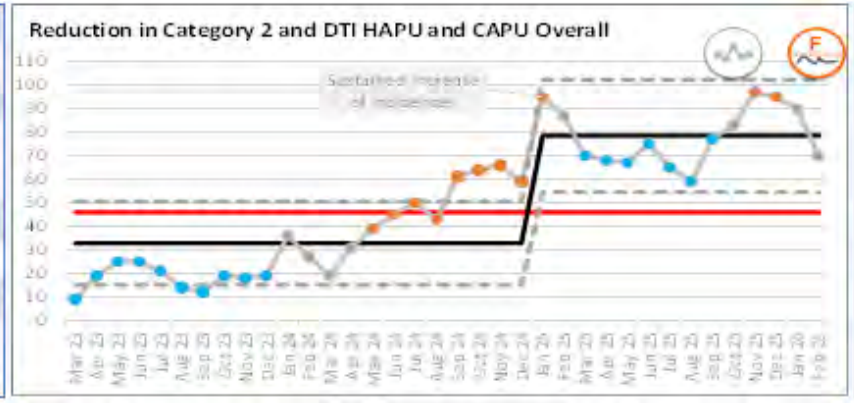
Oct-25
100.65
Variance Type
Special cause improving variation points
Threshold
100
Target achievement
Metric is consistantly missing the target/ threshold



Dec-25
89.17
Variance Type
Special cause improving variation points
Threshold
100
Target achievement
Metric is consistantly achieving the target/ threshold



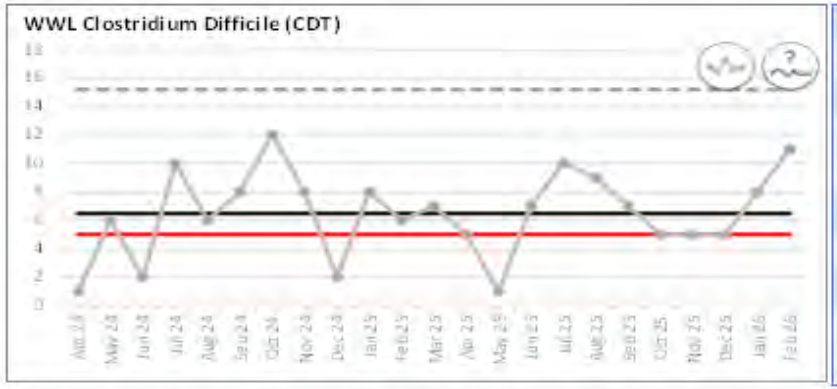
Feb-26
0
Variance Type
Common Cause Variation
Threshold
0
Target achievement
Inconsistent performance compared to threshold/ target



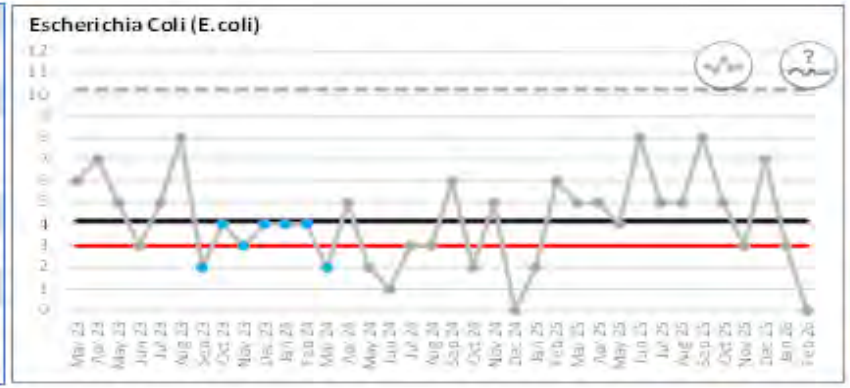
Feb-26
70
Variance Type
Common Cause Variation
Threshold
46
Target achievement
Metric is consistantly missing the target/ threshold

Summary:	Actions:	Assurance:
1 . SHMI & 2. HSMR : Monthly and quarterly mortality review groups continue to review any areas of SHMI that are alerting and seek assurances that these are being managed appropriately. We remain well within the expected range for SHMI and better than the expected range for HSMR. **3. Pressure Ulcers – category 3 and above:** In month 11 we have reported 0 incidents. However, this may change with real time refresh as the pressure ulcer review process is followed. **4. Pressure Ulcers – category 2 and above:** The Clinical Divisions continue to review all cases of Category 2 pressure ulcers, and these are reported via their Divisional governance architecture. The Trust are still observing a significant number of Category 2 Pressure ulcers.	**1. SHMI & 2. HSMR:** Continue improvement plans to ensure that patients are appropriately managed. Continue to work with system partners to ensure appropriate discharge placements for patients **3. Pressure Ulcers – category 3 and above:** A pressure ulcer dashboard has been developed to provide more visibility of incidents **4. Pressure Ulcers – category 2 and above:** Divisions are asked to embed learning from the thematic reviews which have been completed.	**1. SHMI & 2. HSMR :** SHMI is currently within national expected range and has been so for many months. SHMI continues to improve and is consistently better than some other similar sized GM Trusts **3. Pressure Ulcers – category 3 and above:** The pressure ulcer dashboard requires embedding to streamline the pressure ulcer review process to give a more timely opportunity for learning and board reporting assurance. **4. Pressure Ulcers – category 2 and above:** The Chief Nurse has commissioned a new framework for reporting on performance related harms, including pressure ulcers which will be implemented through a review of the Patient Safety Group from M1 26/27.

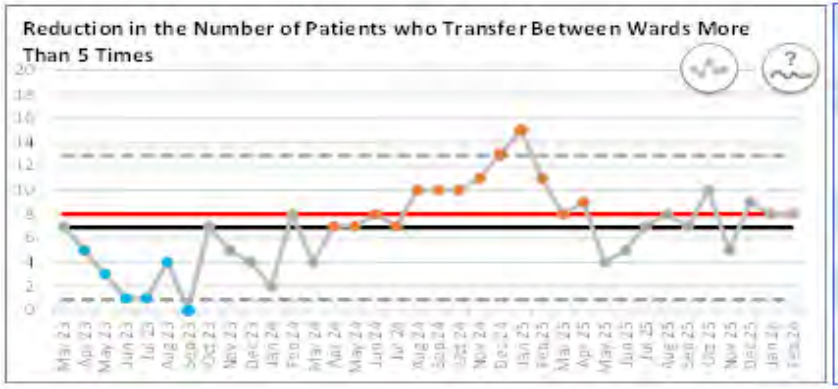
Quality & Safety Insight Report 2 of 2: M11 25/26



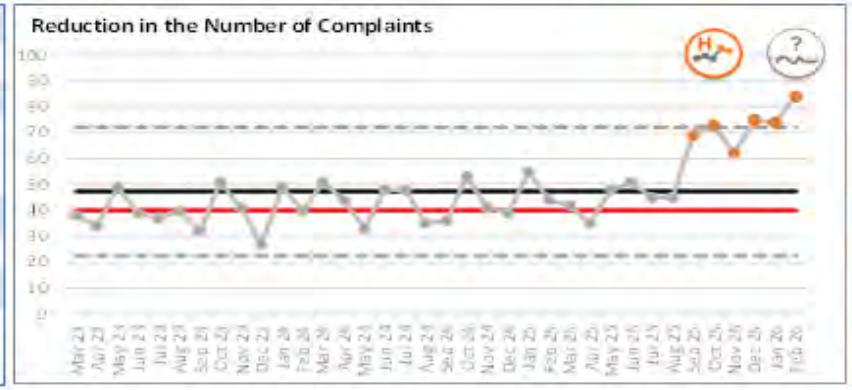
Feb-26
11
Variance Type
Common cause variation
Threshold
5
Target achievement
Inconsistent performance compared to threshold/ target



Feb-26
0
Variance Type
Common cause variation
Threshold
3
Target achievement
Inconsistent performance compared to threshold/ target



Feb-26
8
Variance Type
Common cause variation
Threshold
8
Target achievement
Inconsistent performance compared to threshold/ target



Feb-26
84
Variance Type
Special cause concerning variation
Threshold
40
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. Clostridium Difficile (CDT): The number of cases increased in month from eight in January 2026 to eleven cases in February 2026. **2. E-Coli: The** E.coli count reduced in month from three cases in January 2026 to Zero cases in February 2026. **3. Ward Transfers:** We have had two consistent months where the threshold has been met. **4.Complaints:** The Trust has continued to see a sustained increase in the number of complaints it receives.	**1. Clostridium Difficile (CDT):** The CDI 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. Ward Transfers:** The number of ward transfer metric will be revised to more than two moves in line with the Internal Professional Standards. **4.Complaints:** The complaints response time has deteriorated as a consequence of the increase in complaints. The divisions will develop improvement plans to demonstrate that associated learning from the commissioned report in February is being translated into practice.	**1. Clostridium Difficile (CDT):** CDT Reviews are completed to Case 65 (11.03.2026), with remaining cases in process **2. E-Coli:** Reporting and surveillance continues for all Mandatory reportable HCAI organisms. **3. Ward Transfers:** The number of ward moves is overseen the Internal Professional Standards workstreams and the Escalation Patient Safety Assurance Group. **4.Complaints:** Learning and performance of complaints will be reported into the new Safety, Quality and Governance Group which has been commissioned by the Chief Nurse and will be implemented from M1 26/27.

Quality & Safety Narrative: M11 25/26

Operationally at the beginning of M.11 the RAEI site remained under significant pressure. This impacted the delivery and quality of care; patient safety remained the priority. Although attendances have decreased in month, they are higher in comparison to this time last year. Peaks in seasonal presentations (Respiratory and gastroenterology) for example Norovirus saw low discharges from core wards which impacted on the continued reliance of the utilisation of escalation capacity. 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.

On 16th February we implemented the pilot SOP Accelerated Admissions using Safer Placement Spaces as Temporary Escalated Spaces to provide a continuous flow model to mitigate the need to redeploy staff from core wards to support escalated corridor care and other escalated areas. White board huddles were also introduced on 4 pilot wards as part of the Inpatient Flow project to support further mitigation in response to site pressures.

As a Trust, we use two methods to report mortality figures: Summary Hospital-level Mortality Indicator (SHMI) developed by NHS England and Hospital Standardised Mortality Ratio (HSMR) developed by Dr Foster. SHMI monitors in hospital deaths and patients who die out of hospital within 30 days of discharge, includes some adjustment for patient comorbidities, but does not adjust for deprivation or frailty. HSMR monitors in hospital deaths only, adjusts for deprivation and frailty and has a more refined comorbidity model.
The latest Dr Foster model which has resulted in an improved latest rolling 12-month HSMR position of 87.85, significantly below the 100 threshold and much better than many similar sized GM hospitals. The latest 12-month SHMI standardised position has improved again to 100.65 for the latest rolling 12 months to November 25, which is within the expected range. We continue to closely scrutinise our mortality figures through monthly mortality meetings and audit any alerting areas to ensure pathways are managed appropriately. Our latest 12 months in-hospital SHMI, for in hospital deaths, is 98.42; our out of-hospital SHMI, for out of hospital deaths within 30 days of discharge, is 110.75.

Within M11 the Trust escalated 4 incidents for a Patient Safety Incident Investigation, 1 of these was classified as a Never Event. This related to an incident involving a patient who attended for a right carpal tunnel release. The patient had been appropriately consented, and the correct limb was clearly marked; however, the specific incision site itself had not been marked. The surgeon identified anatomical landmarks and crease patterns, with the most prominent crease appearing slightly more lateral than expected and proceeded to make the initial incision. When the supervising Consultant returned to theatre, having not been present at the start of the procedure, it was identified that the incision was not in the correct position and a second incision was made at the correct site. As the patient required two incisions, and in line with NHS England's definition of wrong-site surgery ("an invasive procedure where a patient's anatomy begins to be permanently altered, such as when the first incision is made"), this incident meets the criteria for a Never Event

Health Care Associated Infections have remained variable in month. CDT count increased to 11 cases in February 2026 from 8 cases in January 2026. The CDI Review Process continues to identify learning, good practice and areas for action. E.coli count reduced to 0 cases in February 2026 from 3 cases in January 2026.Surveillance of E.coli continues, with identification and analysis of themes and trends, with an aim to develop a robust post infection review process. Surveillance of Klebsiella and Pseudomonas continues (aligned with the E.coli process). MRSA remained at 0 cases in February 2026. Reporting and surveillance continues for all Mandatory reportable HCAI organisms.

Although there has been a decrease of the category 3 and above hospital acquired pressure ulcers due to an omission of care in February, it should be noted thathis may change with real time refresh as the pressure ulcer review process is followed. The Chief Nursing Officer has commissioned a new group in which nurse specific safety indicators (for example pressure ulcer prevention) will be monitored and assurance will be sought. This group will commence in Quarter 1 26/27. In addition, the Data Analytics and Assurance team have developed a pressure ulcer oversight dashboard which enables key metrics to be reviewed to improve triangulation of data; this now needs to be embedded at operational level.

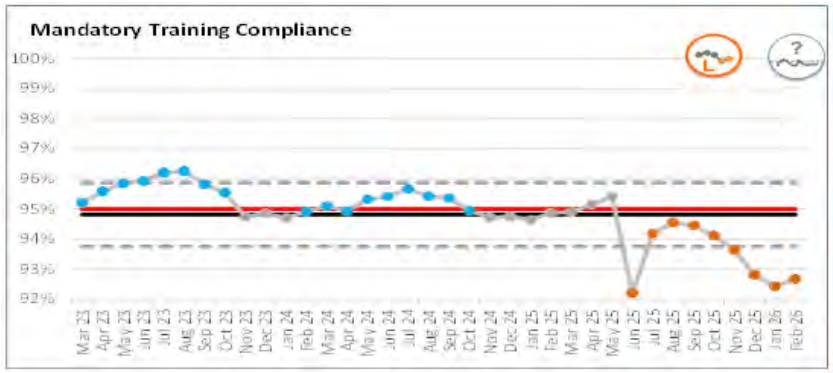
Our People Overview : M11 25/26

	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	Feb 26	No	92.7%	95.0%	L	?	94.8%	93.8%	95.9%	S	T	P
2	Appraisal	Feb 26	No	81.1%	90.0%	L	F	81.8%	80.5%	83.2%	S	T	P
3	Price Cap Compliance - Medical	Feb 26	No	0.0%	60.0%		F	0.6%	-0.7%	1.9%	S	T	P
4	Price Cap Compliance - Non Medical	Feb 26	No	96.3%	80.0%		P	97.3%	88.6%	106.0%	S	T	P
5	% Turnover Rate	Feb 26	No	9.7%	8.5%	H	?	8.8%	8.5%	9.2%	S	T	P
6	Vacancy Rate - Variance to plan	Feb 26	No	5.2%	5.0%	L	?	5.6%	4.4%	6.7%	S	T	P
7	Number of Whole Time Equivalent Posts	Feb 26	No	-104.86	0.00		?	-105.50	-227.04	16.05	S	T	P
8	Sickness - Percentage Time Lost (%) - Rolling 12 months	Feb 26	Yes	6.2%	5.0%	H	F	5.6%	5.4%	5.8%	S	T	P
9	Time to Hire	Feb 26	No	60.1	65.0	H	?	59.3	48.3	70.3	S	T	P

Summary icons key:

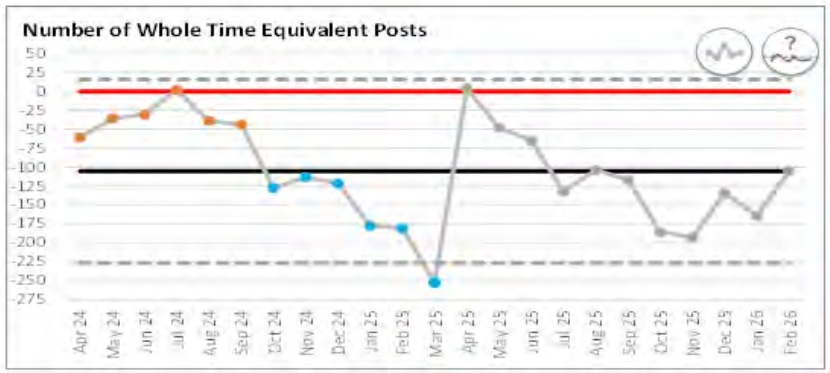
*Please note : NOF denotes the National Oversight Framework

Our People Insight Report : M11 Month Year



Feb-26
92.7%
Variance Type
Special cause concerning variation
Target
95%
Target achievement
Inconsistent performance compared to threshold/ target

Feb-26
9.7%
Variance Type
Special cause concerning variation
Target
9%
Target achievement
Inconsistent performance compared to threshold/ target



Feb-26
-104.86
Variance Type
Common cause variation
Target
0
Target achievement
Inconsistent performance compared to threshold/ target

Feb-26
6.2%
Variance Type
Special cause improving variation
Target
5.0%
Target achievement
Metric is consistently missing the threshold/ target

Summary:	Actions:	Assurance:
1. Mandatory Training Compliance: Increased slightly to 92.7% just below the 95% target **2. Turnover:** remains stable at 9.7%, relocation, work life balance, promotion and retirement were the top leaving reason. **3. Whole Time Equivalent Posts:** continues to decrease, whilst the total workforce is above plan by 104.9WTE, this is mainly driven by Bank (103.1 WTE above plan). **4. Sickness:** The 12-month rolling sickness absence rate remained stable at 6.16%, whilst in month has reduced to 6.17%, our lowest sickness rate since September 25.	**1. Mandatory Training Compliance:** 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. Turnover:** Whilst turnover is not of major concern, the Trust continues with delivery of the WWL People & Culture Strategy to support retention of staff. **3. Whole Time Equivalent Posts:** 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. Sickness:** 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. Mandatory Training Compliance:** Monthly data circulated; Divisional Assurance Packs; local compliance can be access via the Learning Hub. **2. Turnover:** People Dashboard presented to Wider Leadership Team and discussed further at People Committee **3. Whole Time Equivalent Posts: D**rivers review commenced with interim CPO **4. Sickness:** A 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 : M11 25/26

Appraisals –appraisal compliance remains stable at 81.1%, which is below the Trust's 90% target. All divisions remain under close scrutiny through Divisional Performance Reviews, with progress monitored against local action plans.

Vacancy Rate – The Trust-wide vacancy rate remains stable at 5.2%, which slightly above 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.

Turnover- The Trust turnover increased slightly to 9.7% . Over the last few months WWL Executive Team have undertaken a high volume of listening events with staff to understand experience have enacted change as a result. Several areas are expected to impact positively on staff experience - new leadership programme (We Lead); new Fundamentals of Care Strategy; Innovate Together; Wellness to Work plans to support implementation of reasonable adjustments.

WTE –Actual total workforce 6,854.2 WTE in February. This is a decrease of 57.4 WTE from last month and is 104.9 WTE above the total workforce plan of 6,749.3 WTE.

- Actual substantive workforce saw a decrease of -38.2 WTE and is now getting closer to the substantive workforce plan (+10.5 WTE).
- Bank staffing also decreased by 9 WTE, and remains above plan by 103.1 WTE
- Agency also decreased by 10.2WTE compared to last month, this is in line below the plan by 8.7 WTE

Medical Price cap –compliance remains a concern whilst **non-medical** continues to exceed the target and performs well.

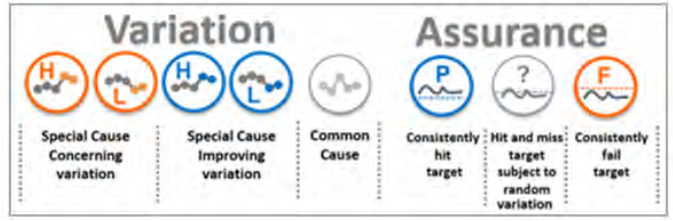
Our Performance Overview – Elective Care : M11 25/26

	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	Total Patients Waiting for First Attendance	Feb 26	No	25684	27903			31886	27700	36072			
2	RTT Waiting List	Feb 26	No	44410	51455			49170	47480	50860			
3	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment	Feb 26	Yes	2.1%	2.3%			3.1%	2.7%	3.6%			
4	Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under	Feb 26	No	0.3%	0.3%			0.5%	0.3%	0.6%			
5	Total Patients Waiting Over 65 Weeks	Feb 26	No	23	0			85	33	136			
6	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Feb 26	Yes	59.0%	60.0%			57.1%	54.9%	59.4%			
7	Difference between planned and actual 18 week performance score	Feb 26	Yes	-0.33%	1.00%			1.44%					
8	Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks	Jan 26	Yes	72.8%	80.0%			79.6%	73.1%	86.1%			
9	Cancer 31 Day Treatment Standard Performance	Jan 26	No	75.8%	96.0%			90.8%	82.2%	99.3%			
10	Percentage of Patients Treated for Cancer Within 62 Days of Referral	Jan 26	Yes	61.3%	75.0%			75.8%	64.3%	87.3%			
11	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test	Feb 26	No	19.2%	5.0%			24.5%	15.3%	33.6%			
12	Outpatient New : Follow-up Ratio	Feb 26	No	2.07	2.00			2.22	2.04	2.40			
13	Elective Theatre Utilisation - Capped Touchtime **	Feb 26	No	72.0%	85.0%			81.6%	77.6%	85.7%			
14	Elective Recovery Plan : Day Case Activity Performance	Feb 26	No	102.5%	100.0%			97.3%	85.3%	109.2%			
15	Elective Recovery Plan : Inpatient Activity Performance	Feb 26	No	120.5%	100.0%			102.6%	84.0%	121.2%			
16	Percentage of Patients Waiting Over 52 Weeks for Community Services	Feb 26	Yes	0.0%	0.0%			0.1%	0.0%	0.2%			

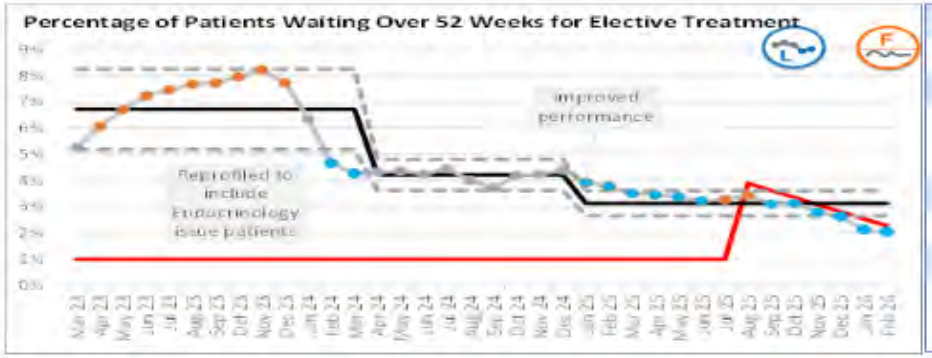
*Please note : NOF denotes the National Oversight Framework

**Elective Theatre Utilisation Capped Touchtime– please note that there are significant data quality issues with touchtime metrics, driven by non availability of sessions data following the implementation of Surgical Care. Digital Services are currently working with Altera, the system supplier, to resolve these issues.

Summary icons key:



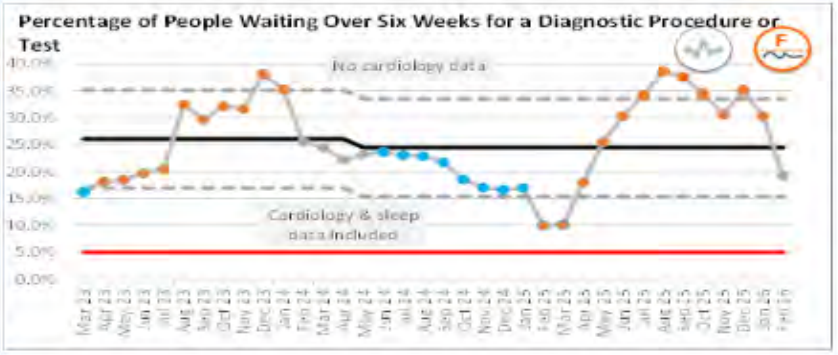
Our Performance Insight Report : Elective Care M11 25/26



Feb-26
2.05%
Variance Type
No target/ threshold
Target
2.3%
Target achievement
Metric is consistently missing the threshold/ target

Feb-26
59.00%
Variance Type
Special cause improving variation
Target
60.0%
Target achievement
Inconsistent performance compared to threshold/ target

Jan-26
75.80%
Variance Type
Special cause concerning variation point
Target
96%
Target achievement
Inconsistent performance compared to threshold/ target



Feb-26
19.23%
Variance Type
Special cause concerning variation
Target
5%
Target achievement
Metric is consistently missing the threshold/ target

Summary:	Actions:	Assurance:
1. RTT 52WW: Waiting list size has continued to decrease through validation. Metric is showing improving special cause variation trend and is currently achieving target. **2. 18-week RTT performance:** **3. Cancer 31 Day:** Deterioration due to lack of treatment capacity due to reduced numbers of breast surgeons and theatre allocation for breast and lower GI specialties. **4. Diagnostic Waits:** Performance has returned to expected levels but continues to fail the target, driven by a reduction in in 6-week breaches due to continued reduction in MR and NOUS breaches. Ongoing breaches in echocardiography.	**1. RTT 52WW:** 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. 18 week RTT performance:** **3. Cancer 31 Day:** Review of surgical model and best practice exemplars. Action to increase staffing levels by recruitment to vacancy, locum and WLI activity. Planning for Theatre 5&6 refurbishment. **4. Diagnostic Waits:** Recovery planning for echocardiography which includes insourcing solutions.	**1. RTT 52WW:** Weekly PTL/ long waits week meeting with Deputy COO to review and track 65/52/18-week waits **2. 18-week RTT performance:** **3. Cancer 31 Day:** Potential for deterioration if actions to improve early diagnosis in breast and LGI pathways creates a temporal increase in surgical treatments and theatre demand. **4. Diagnostic Waits:** Confidence that MR and NOUS will return to compliance with the 5% threshold in Q1 26/27.

Our Performance Elective Care Narrative : M11 25/26

RTT Waiting List: The overall RTT waiting list continues to decrease, In February the trust reported 23 patients in breach of the RTT (Referral to Treatment) Waiting List for patients waiting over 65 weeks, . There was a movement to zero breaches in plastics and dermatology in month which is exceptionally pleasing to note. The small number of breaches are across a number of specialties however vascular now remains the most challenged. Arrangements are being sought to improve the capacity issue.

Cancer: Cancer performance is still an ongoing challenge with continued failure to follow the national performance standards. The Faster Diagnosis Standard has started to prove a marginal improvement due to some of the changes implemented to support the lower GI and breast pathways due to improved access to diagnostics and intensive management of PTLs. It is expected that improving performance of the FDS with has a positive impact on the 62-day performance in later months. There is an elevated level of confidence that the improvement of access to endoscopy and restoration of expected service levels for straight-to-test diagnostics will improve FDS and 62-day performance. The breast cancer pathway stays the primary concern with an inability to undertake surgical treatments within the pathway milestones which is resulting in a high number of breaches. Surgical and radiology clinical teams have agreed to align clinic and one-stop capacity which will improve performance against the FDS and return the service to best practice compliance. Theatre capacity stays a constraint due to insufficient operating sessions rather than a lack of physical theatre space. Operational models to explore undertaking breast surgery at Wrightington are being reviewed to understand if this will reduce demand and lead times upon the Wigan theatre lists. Cancer performance and associated recovery actions are being intensively managed to avoid breaches. A cancer transformation program has been set up to deliver long term improvements to cancer care and compliance with national performance standards

Radiology: Radiology has demonstrated strong improvement in performance with significant reduction in 6-week diagnostic breaches in NOUS and MR. DEXA stays with DM01 compliance. CT is reporting over 200 breaches exclusively due to lack of capacity for CTCA(CT coronary angiogram). Plans are in place to increase capacity with radiographer supervised lists from April 2026. There are discussions with colleagues in Cardiology to revise the job planned sessions to increase supervised lists from 3 to 5 per week. MR has rapidly recovered its performance position following a protracted equipment breakdown at Leigh CDC. Mutual aid for patients with cardiac pacemakers and MR guided breast biopsy is being re-opened to GM providers to reduce health inequity within the system. NOUS backlog position has significantly reduced with a corresponding reduction in risks associated with delivery of the service. There continues to be notable clinical risks with delivery of obstetric ultrasound, but the service is running following expected standards of care.

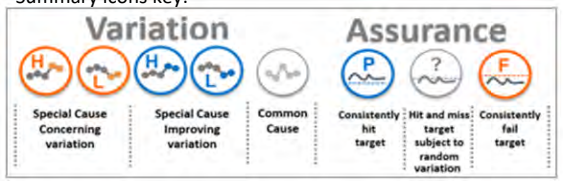
Our Performance Overview – Urgent & Emergency Care: M11 25/26

	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	Feb 26	No	00:32:37	00:35:00		?	00:29:19	00:20:58	00:37:40	S	T	P
18	Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours	Feb 26	Yes	65.1%	76.0%	L	F	70.1%	66.0%	74.2%	S	T	P
19	Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department	Feb 26	Yes	24.7%	10.0%	H	F	18.7%	14.3%	23.0%	S	T	P
20	Overnight Total General and Acute Beds and the Number of Which are Occupied	Feb 26	No	92.7%	96.0%		?	93.0%	88.6%	97.4%	S	T	P
21	Virtual Ward Occupancy	Feb 26	No	72.9%	80.0%		?	74.7%	50.0%	99.5%	S	T	P
22	Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days	Feb 26	No	1548	1439	L	F	1899	1615	2183	S	T	P
23	Average Number of Days Between Planned and Actual Discharge Date (Includes patients discharged on discharge ready date)	Feb 26	Yes	0.7	0.5		F	0.9	0.6	1.2	S	T	P
24	Percentage of Patients who do not Meet the Criteria to Reside	Feb 26	No	22.6%	12.5%		F	23.5%	20.7%	26.2%	S	T	P
25	Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days	Feb 26	No	1001	1560	L	?	1366	991	1741	S	T	P
26	Urgent Community Response (UCR) - 2-Hour Performance	Jan 26	Yes	82.8%	70.0%		P	83.0%	74.3%	91.6%	S	T	P

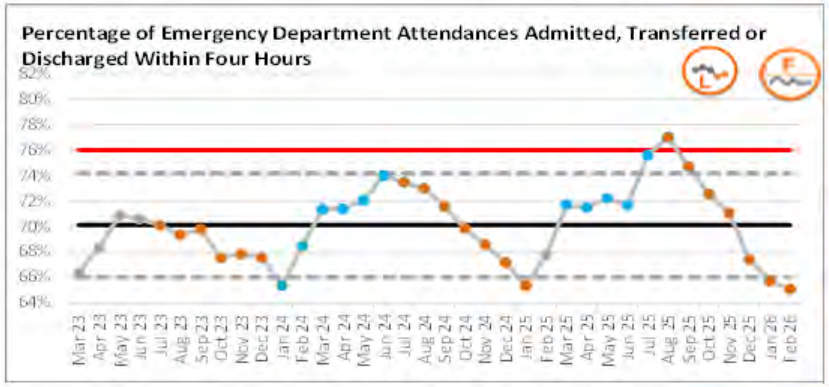
*Please note : NOF denotes the National Oversight Framework

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

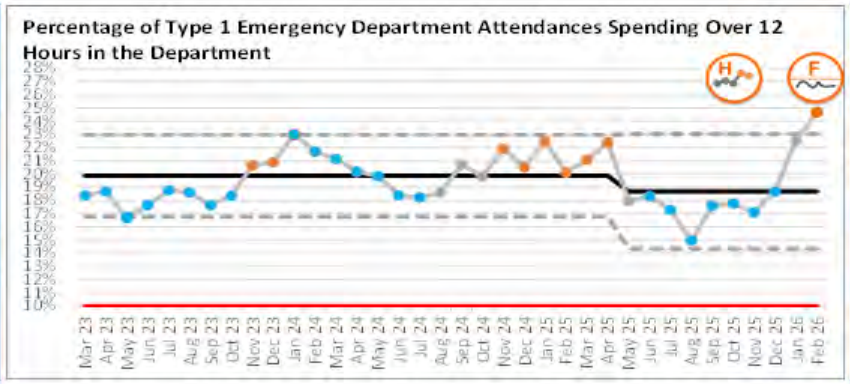
Summary icons key:



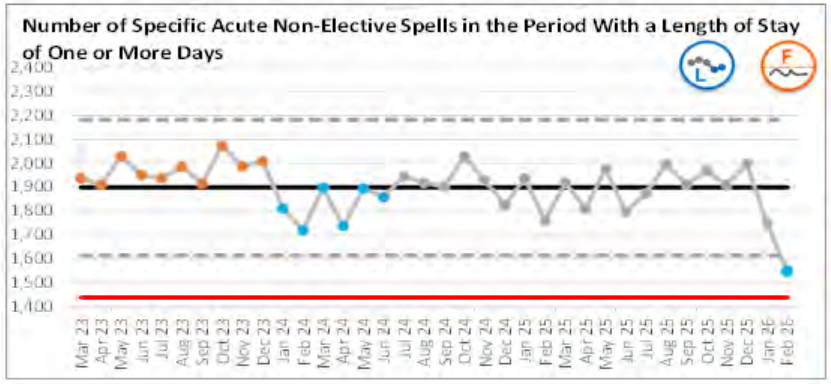
Our Performance Insight Report : Urgent & Emergency Care M11 25/26



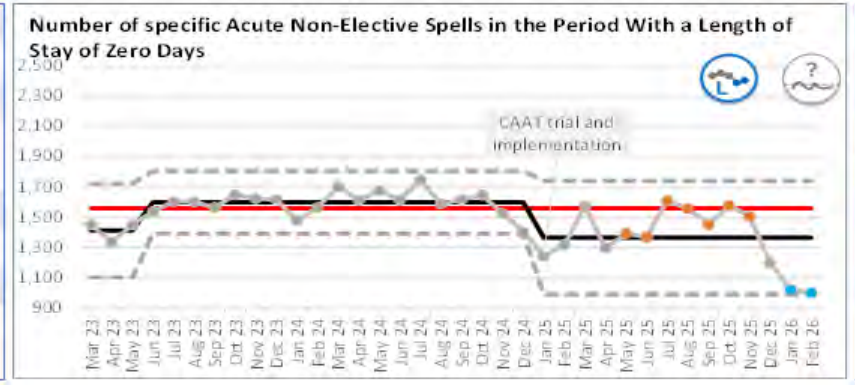
Feb-26
65.1%
Variance Type
Special cause concerning variation
Target
76.0%
Target achievement
Metric is consistently missing the threshold/ target



Feb-26
24.67%
Variance Type
Special cause concerning variation
Target
10.0%
Target achievement
Metric is consistently missing the threshold/ target



Feb-26
1548
Variance Type
Special cause improving variation
Target
1439
Target achievement
Metric is consistently missing the threshold/ target



Feb-26
1001
Variance Type
Special cause improving variation
Target
1560
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. A&E 4 Hour Waits: There has been further deterioration in the four-hour performance target which is linked to increased ED attendances, acuity and a congested Emergency Department. **2. A&E 12 Hour Waits:** This is again reflected in the 12-hour performance, which in February increased to 24.67% 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 have increased the amount of time patients wait for a bed. **3. No of Non-Elective Stays 1+ Days:** LoS in February is driven by patients who have not yet been discharged **4. No of Non-Elective Stays 0 Days:** CDW was repurposed in November as an assessment area for ED waiting room patients. Furthermore, AAA was being used as a multi-specialty cohorting area for surgical patients – this ceased in January when it was converted to bedded escalation.	**1. A&E 4 Hour Waits:** Significant operational and transformational improvements underway as part of the 4-hour sprint and BetterLives programme including UTC Coordinator, ED Navigator, Improved grip and control measures, zero tolerance approach to non-admitted breaches and paediatric breaches. **2. A&E 12 Hour Waits:** Significant operational and transformational improvements underway as part of the 4-hour sprint and BetterLives programme including expansion of the Frailty SDEC model and conversion of cubicles 17-26 into an Acute Medical Receiving Unit **3. No of Non-Elective Stays 1+ Days:** DAA review is scheduled to understand drivers for the drop in patients with 1+ day LoS **4. No of Non-Elective Stays 0 Days:** CDW has been re-established in March 2026 in support of the 4-hour Sprint so 0 day LOS admissions will begin to recover	**1. A&E 4 Hour Waits:** As of 12th March 4-hour performance is 77.09% - a 12% improvement on February. **2. A&E 12 Hour Waits:** As of 12th March 12-hour ED performance is 19.69% - a 5% improvement on February. **3. No of Non-Elective Stays 1+ Days:** LoS is being addressed as part of the Inpatient Flow Programme as part of Better Lives, including Board Round processes and long length of stay reviews **4. No of Non-Elective Stays 0 Days:** Re-establishment of CDW in ED in March will increase 0-day LoS admissions. This is further supported by an expansion in the Frailty SDEC model which should deliver a further increase in 0 day admissions.

Our Performance Urgent & Emergency Care Narrative: M11 25/26

The Emergency Department experienced sustained and significant operational pressure throughout December to February, driven by high attendances, ambulance arrivals, acuity, and constrained medical bed capacity. In line with this pressure, performance against the 4-hour and 12-hour standards deteriorated, primarily due to overcrowding in the Emergency department as a result of low admissions from ED. A business continuity incident was declared in January in addition to a critical incident following the loss of IT systems enabling access to patient records.

In order to respond to the ongoing pressure and maintain capacity for incoming acute admissions, escalation capacity has been sustained through much of January and February with use of Bryn Ward North, Discharge Lounge, AAA, CAU chairs and Safer Placement Beds. Furthermore, to ensure continued capacity to offload incoming ambulances, patients have been escalated within the Emergency Department onto the corridor and into waiting room 3. During the extremely cold and inclement weather, escalated patients in ISAT were becoming cold and consequently were transferred into the main ED in spaces around the nurses station. Extensive use of escalation capacity throughout January has put pressure on nursing staff to maintain safety through redeployment with many wards dropping to or below minimum numbers.

This position was further exacerbated in February with norovirus outbreaks across the hospital resulting a large number of “trapped” empty beds on closed bays. The associated short-term sickness also had an impact on the organisation's ability to maintain safe staffing of escalation capacity.

Targeted improvement actions implemented from late February have begun to stabilise UEC performance. March 4-hour performance has improved to 77.09% as of 12 March, representing a 12% improvement compared with February, and corridor care has not been used during March to date. Key enablers of this improvement include the 4-hour sprint, de-escalation of the Discharge Lounge, implementation of the Accelerated Admissions Policy and expansion of Frailty SDEC. Furthermore, there are plans in March to convert cubicles 17-26 to an Acute Medical Receiving Unit to support the Acute Medical Model.

Ambulance handover performance recovered in February, returning to below the 30-minute target, supported by strengthened operational oversight when ISAT becomes escalated.

Community and admission-avoidance services continue to perform strongly, including the Virtual Hub, CAAT Front Door, and Call Before Convey pathways, providing critical mitigation to front-door demand.

While pressure remains high, early March data indicates that flow and performance are beginning to recover, with continued focus required on the 4-hour sprint and the Better Lives transformation programme.

Our Finance Performance Overview : M11 25/26

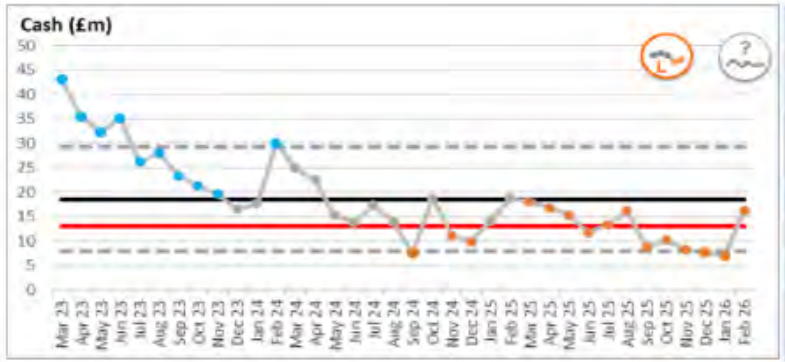
	KPI	Latest month	Metric included in NOF *	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Timely & Complete	Process & System
1	Variance Year-to-Date to Financial Plan (NOF %)	Feb 26	Yes	-0.41%	0.00%			-0.91%	-1.98%	0.17%			
2	Adjusted Financial Performance (£m) - Variance to Plan	Feb 26	No	0.4	0.0			0.0	-3.0	3.1			
3	Cash (£m)	Feb 26	No	16.3	9.2			18.5	7.9	29.2			
4	API Income (£m) - Variance to Plan	Feb 26	No	0.4	0.0			-0.2	-1.6	1.2			
5	Total Cost Improvement Programme (CIP) (£m) - Variance to Plan	Feb 26	No	0.5	0.0			0.0	-1.2	1.1			
6	Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan	Feb 26	No	0.01	0.00			-0.62	-1.70	0.46			
7	Agency Expenditure (£m)	Feb 26	No	0.5	0.4			0.8	0.5	1.0			
8	Bank Expenditure (£m)	Feb 26	No	2.0	1.2			2.2	1.6	2.8			
9	Capital Expenditure (£m) - Variance to Plan	Feb 26	No	3.4	0.0			1.0	-3.0	5.0			
10	Better Payment Practice Code (BPPC)	Feb 26	No	0.96	0.95			0.94	0.88	1.00			

Summary icons key:

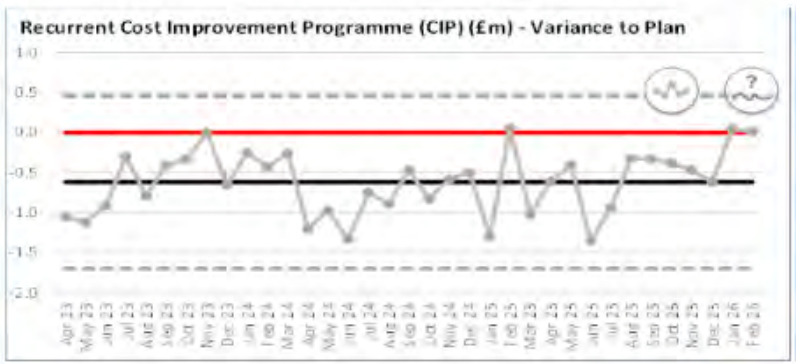
*Please note : NOF denotes the National Oversight Framework

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

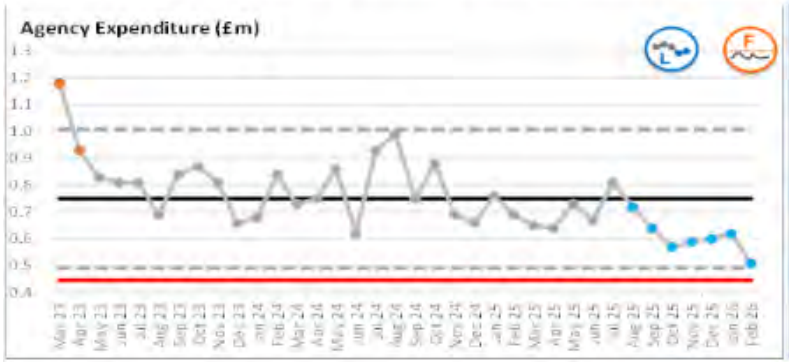
Our Finance Performance Insight Report : M11 25/26



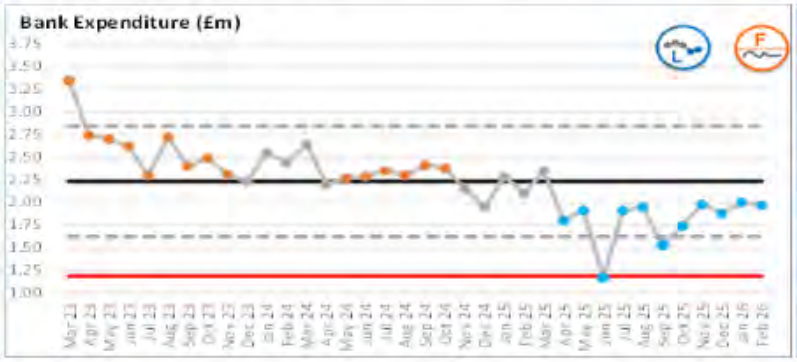
Feb-26
16.27
Variance Type
Special cause concerning variation
Target
13.0
Target achievement
Inconsistent performance compared to threshold/ target



Feb-26
0.01
Variance Type
Common cause variation
Target
0.0
Target achievement
Inconsistent performance compared to threshold/ target



Feb-26
0.5
Variance Type
Special cause improving variation
Target
0.4
Target achievement
Metric is consistently missing the threshold/ target



Feb-26
2.0
Variance Type
Special cause improving variation
Target
1.2
Target achievement
Metric is consistently missing the threshold/ target

Summary:	Actions:	Assurance:
1. Cash: The cash balance at the end of February was £16.3m, improving operating cash days to 10. Cash increased by £9.3m compared to last month, mainly due to the timing of nationally funded capital schemes. The cash position is expected to strengthen further in March before declining from April, reflecting the phasing of capital expenditure. The current underlying run rate would indicate we will require external cash support in Q1 2026/27. **2. Recurrent CIP**: Total CIP delivered in Month 11 is £3.9m, which is £0.5m ahead of plan: £2.2m is recurrent (55%) and £1.7m is non-recurrent (45%). The recurrent delivery year to date is £5.3m behind plan **3. Agency:** Agency spend is showing a cumulative 9% 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 **4. Bank:** Bank spend is showing a cumulative 14% 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. Cash**: This continues to be closely monitored. A temporary increase is expected to be sustained in March due to timing of nationally funded capital projects therefore cash support is not required in Q4. **2. 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. **3. Agency**: Reducing variable pay is being targeted critical to plan delivery. This is being led by the CFO with executive scrutiny at ETM. Agency spend reduction links to CIP, recovery plan and control total delivery. **4. Bank**: Reducing variable pay is being targeted critical to plan delivery. This is being led by the CFO with executive scrutiny at ETM. Bank spend reduction links to CIP, recovery plan and control total delivery.	**1. Cash**: Operational Cash Management Group, Finance and Performance Committee, recent internal audit review of cashflow forecast processes with substantial assurance. **2. 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. **3. Agency:** Executive Pay Control Group, Divisional Performance Reviews, Finance Improvement Group, Finance and Performance Committee, ETM **4. Bank**: Executive Pay Control Group, Divisional Performance Reviews, Finance Improvement Group, Finance and Performance Committee, ETM

Our Finance Performance Narrative : M11 25/26

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Amber		We've delivered a stronger position in month 11, and it's essential that we maintain this momentum into month 12 to achieve our agreed breakeven revenue plan. Our focus for the final month remains firm: tight control of variable pay, restraint on discretionary non-pay, maximising elective activity delivery, and securing cash-releasing CIP. The month 11 position was £0.4m favourable to plan, improving our trajectory and reducing the YTD deficit to £1.9m adverse to plan.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		The cash balance at the end of February was £16.3m, improving operating cash days to 10. Cash increased by £9.3m compared to last month, mainly due to the timing of nationally funded capital schemes. The cash position is expected to strengthen further in March before declining from April, reflecting the phasing of capital expenditure. The current underlying run rate would indicate we will require external cash support in Q1 2026/27.
API Income	Achieve the elective activity plan for 2025/26	Green		February was a strong month for divisional elective API activity, and we are above plan by £0.4m in month and £0.3m YTD. This includes the additional activity stepped up for the Q4 performance sprint. In month, Specialist Services is on plan, Medicine is £0.3m favourable and Surgery is £0.2m favourable.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Red		CIP delivery in-month is £3.7m, outperforming the £3.4m plan by £0.3m. However, recurrent CIP under-delivery continues to drive our adverse variance, with £5.3m of slippage year-to-date. We are now targeting £18.0m recurrent delivery in-year and £23.0m on a fully recurrent basis. To genuinely support financial recovery, CIP must translate into a sustained reduction in the expenditure run rate.
	Deliver Recurrent CIP of £23.0m	Red		
Agency expenditure	30% reduction in agency spend.	Amber		Agency spend is showing a cumulative 9% 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 14% 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 11 is £4.5m which is £3.4m above 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 96.4% by volume and 95.8% by value. YTD performance was 93.1% by volume and 96.5% by value.

National Benchmarking of NHS Access Standards

Based on data published by NHSE

NHS
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	Jan-26	58.00%	0.50	0.30	91/130	57.5%	61.1%	65.7%
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Jan-26	2.4%%	-0.40	-1.10	101/130	2.3%	1.2%	0.9%
Percentage of patients waiting over 52-weeks for community services	Jan-26	0.00%	0.00	-0.30	1/77	8.5%	1.0%	0.0%
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	Jan-26	30.40%	-4.80	-4.20	99/133	31.9%	20.0%	8.9%
Cancer Care								
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Jan-26	72.8%	-3.60	-0.80	75/118	69.4%	74.8%	78.9%
Percentage of patients treated for cancer within 31 days	Jan-26	75.8%	-6.70	-12.10	115/118	88.0%	93.3%	96.5%
Percentage of patients treated for cancer within 62 days of referral	Jan-26	61.30%	-6.50	-10.10	97/118	63.1%	68.5%	75.7%
Urgent and Emergency Care								
Percentage of emergency department attendances admitted, transferred or discharged within 4 hours (All Types)	Feb-26	65.00%	-0.70	-5.80	97/123	66.2%	72.0%	76.7%
Percentage of emergency department attendances spending over 12 hours in the department (Type 1 & 2)	Feb-26	25.00%	2.60	8.10	119/123	15.0%	11.9%	6.6%
Average ambulance handover time (minutes)	Feb-26	32.2	-1.90	2.00	83/123	36.50	24.60	18.80

- 62-day Cancer has deteriorated. Based on the publicly available data, Lower Gastro-intestinal and Breast are ranked lowest compared to other tumour groups (includes private providers)
- NOUS is the leading modality reducing WWL's performance and national ranking, followed by Echocardiography.
- WWL's AE Performance has reduced in recent months and in relation to national.

1.10
-4.00

Red represents deterioration in performance, also indicted by arrow.
Green represents improved performance, also indicated 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.

Source: Nationally published data surfaced by Healthcare Base

RTT by Speciality : January 26

Breakdown of benchmarked speciality performance for RTT supports understanding of service pressures. Ranked out of 130 Trusts. Other Medical – Endocrinology.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Specialty	Wait List		18 Week Standard		52 Week Standard	
	Total ↓		Total		Total	
All Specialties	45,540	(67 / 130)	58%	(91 / 130)	2.4%	(101 / 130)
Trauma & Orthopaedic	8,746	(102 / 120)	59.6%	(38 / 120)	1.8%	(49 / 120)
Ear Nose & Throat	4,830	(65 / 114)	45.9%	(93 / 114)	3.7%	(84 / 114)
Gastroenterology	4,673	(102 / 119)	54.2%	(99 / 119)	2%	(101 / 119)
Other - Surgical	4,443	(70 / 115)	53.5%	(96 / 115)	3.8%	(102 / 115)
Dermatology	2,930	(53 / 104)	57.2%	(67 / 104)	0.9%	(70 / 104)
Gynaecology	2,738	(28 / 118)	57.9%	(54 / 118)	2.6%	(72 / 118)
Other - Paediatric	2,673	(84 / 117)	63.4%	(72 / 117)	1.8%	(98 / 117)
Cardiology	2,622	(63 / 121)	69%	(47 / 121)	0.3%	(66 / 121)
General Surgery	1,947	(50 / 117)	49.9%	(92 / 117)	5%	(105 / 117)
Respiratory Medicine	1,902	(91 / 119)	64.9%	(88 / 119)	0.7%	(94 / 119)
Urology	1,527	(12 / 115)	72.2%	(27 / 115)	3%	(94 / 115)
Oral Surgery	1,461	(27 / 107)	58.2%	(41 / 107)	1.4%	(48 / 107)
Other - Medical	1,398	(21 / 122)	51.8%	(119 / 122)	5.3%	(120 / 122)
Ophthalmology	1,307	(8 / 110)	82.7%	(10 / 110)	0.3%	(49 / 110)
Plastic Surgery	1,024	(45 / 80)	41.7%	(70 / 80)	9.1%	(78 / 80)
Rheumatology	750	(51 / 115)	78.7%	(48 / 115)	0.1%	(68 / 115)
Elderly Medicine	384	(101 / 116)	47.4%	(114 / 116)	0%	(1 / 116)
General Internal Medicine	152	(64 / 99)	86.2%	(48 / 99)	0%	(1 / 99)
Cardiothoracic Surgery	23	(17 / 45)	47.8%	(42 / 45)	0%	(1 / 45)
Neurosurgical	9	(2 / 29)	55.6%	(19 / 29)	11.1%	(29 / 29)
Other - Other	1	(1 / 114)	100%	(1 / 114)	0%	(1 / 114)

Source: Nationally published data surfaced by Healthcare Base

62-day cancer benchmark by tumour site: January 26
Ranked out of 118

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

January 26

Cancer	Treatments ↓		62 Day Standard	
All Cancers	165.5	(77 / 118)	61.3%	**(97 / 118)**
Breast Cancer	56	(19 / 117)	42.9%	(105 / 117)
Urological - Prostate Cancer	31.5	(67 / 118)	93.7%	(15 / 118)
Skin Cancer	13.5	(96 / 110)	70.4%	(90 / 110)
Urological - Other (a) Cancer	13.5	(51 / 117)	85.2%	(19 / 117)
Lower Gastrointestinal Cancer	11.5	(99 / 118)	34.8%	(110 / 118)
Upper Gastrointestinal - Oesop...	10	(30 / 117)	80%	(38 / 117)
Upper Gastrointestinal - Hepato...	8	(66 / 118)	56.3%	(102 / 118)
Head & Neck Cancer	5	(68 / 110)	20%	(104 / 110)
Haemotological - Other (a)	4.5	(77 / 113)	55.6%	(101 / 113)
Lung Cancer	4	(117 / 118)	50%	(77 / 118)
Haemotological - Lymphoma	3	(94 / 117)	66.7%	(58 / 117)
Gynaecological Cancer	2.5	(104 / 117)	20%	(111 / 117)
Other (a) Cancer	2.5	(80 / 114)	100%	(1 / 114)

Source: Nationally published data surfaced by Healthcare Base

Diagnostics: January 26
Breakdown of benchmarked modality. Ranked out of 133

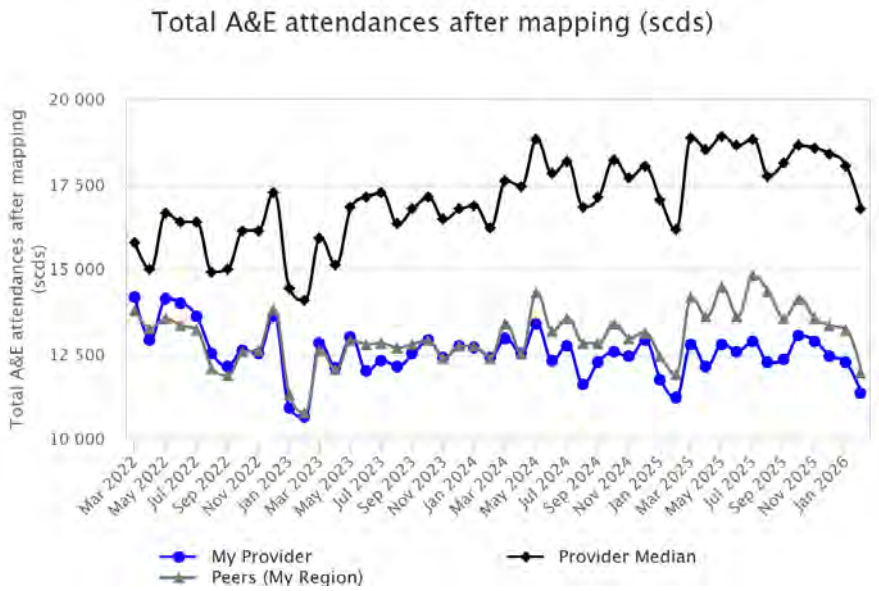
NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

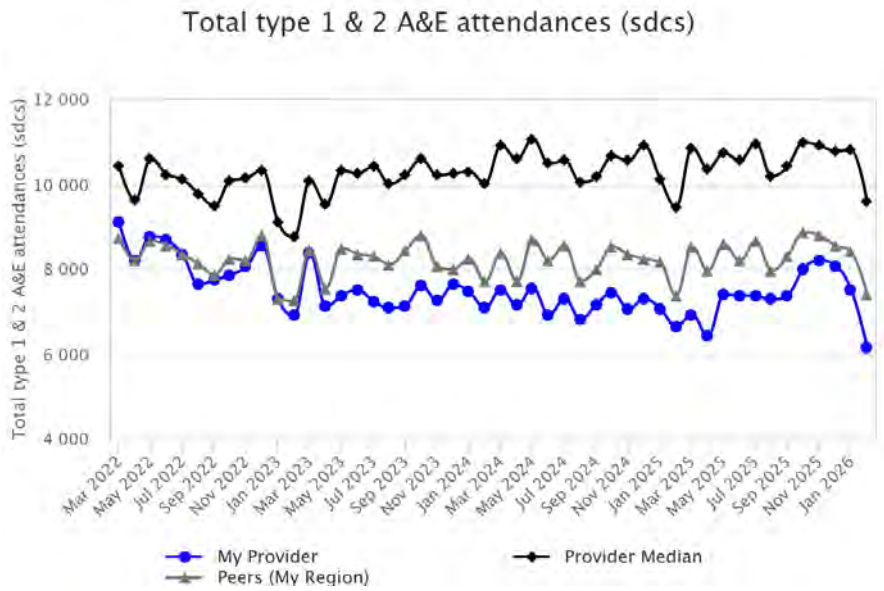
Test	Wait List ↓		6 Week Standard	
Diagnostics	**12,136**	**(74 / 133)**	**30.4%**	**(99 / 133)**
Non-obstetric Ultrasound	4,343	(81 / 133)	28.8%	(100 / 132)
MRI Scans	2,717	(84 / 133)	24.5%	(93 / 132)
Echocardiography	1,997	(116 / 133)	49.8%	(109 / 125)
CT Scan	1,235	(68 / 133)	19.8%	(117 / 132)
Audiology	766	(92 / 133)	50.8%	(80 / 112)
Dexa Scan	301	(61 / 133)	0.7%	(51 / 115)
Gastroscopy	229	(28 / 133)	21%	(71 / 123)
Colonoscopy	201	(26 / 133)	11.9%	(51 / 122)
Flexi Sigmoidoscopy	117	(64 / 133)	39.3%	(90 / 120)
Cystoscopy	97	(42 / 133)	14.4%	(53 / 121)
Peripheral Neurophysiology	57	(53 / 133)	10.5%	(38 / 93)
Sleep Studies	35	(40 / 133)	0%	(1 / 105)
Barium Enema	31	(95 / 133)	0%	(1 / 54)
Urodynamics	10	(30 / 133)	10%	(28 / 111)

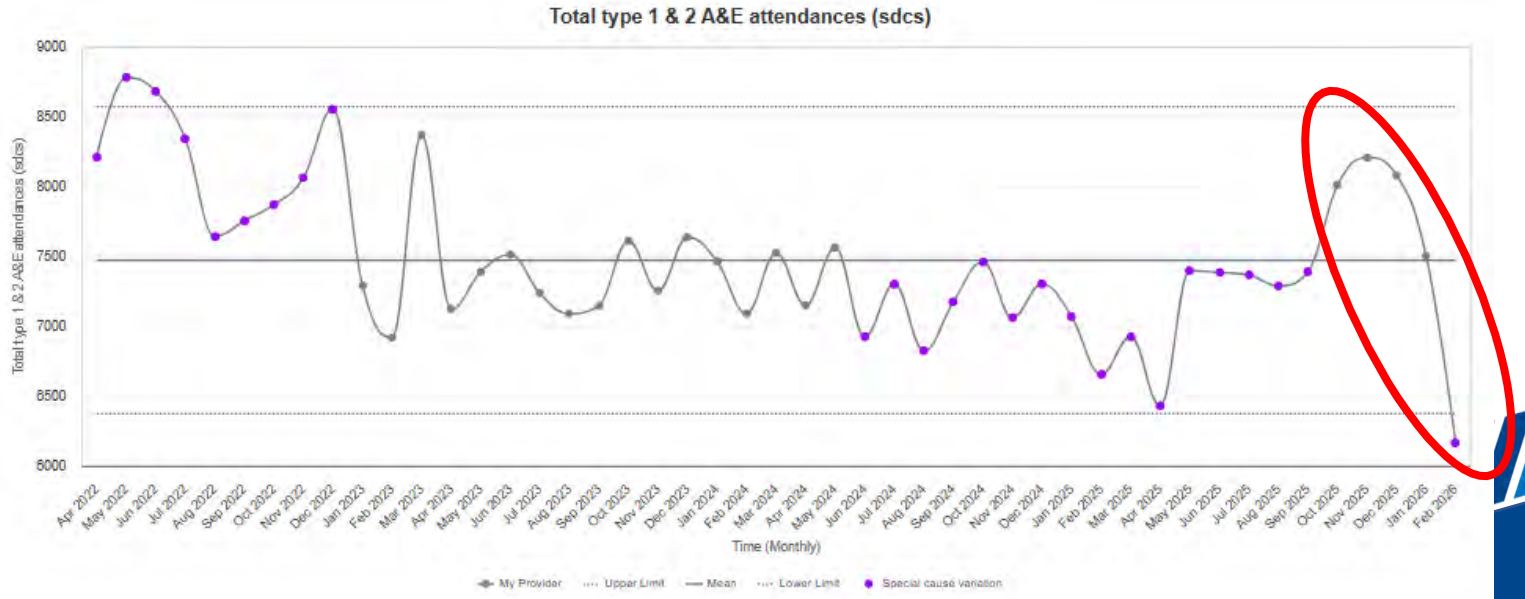
Source: Nationally published data surfaced by Healthcare Base

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. Following the peak in Nov/Dec 2025 there has been a reduction in attendances at a greater rate than national.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust







Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Board Assurance Framework (BAF) 2025/26 Closing Report
Presented to:	Board of Directors
On:	1 April 2026
Item purpose:	Approval
Presented by:	Director of Corporate Governance
Prepared by:	Head of Risk Director of Corporate Governance
Contact details:	E: julie.dawes@wwl.nhs.uk

Executive summary

The closing report of the trust's key strategic risks to the achievement of the annual corporate objectives 2025/26 is presented here for approval by the Board.

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?
F&P, Q&S, People, ETM.

Recommendation(s)

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

1. Introduction

1.1 Our Board Assurance Framework (BAF) provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy 2030 and the annual corporate objectives. This is the closing report for the 2025/26 BAF.

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

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

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

2. BAF Review

2.1 The closing report of the trust's key strategic risks for 2025/26 is presented here for approval. The BAF is included in this report with detailed drill-down reports into all individual risks. It is recommended that the risks on the 2025/26 BAF are closed down with new risks drafted via the Sub Committees for approval at the next Board meeting in June 2026. It is recommended that any residual risk remaining from the 2025/26 BAF, which does not align with the 2026/27 strategic objectives, is transferred to the corporate risk register for ongoing management and oversight.

2.2 **Patients:** Current risks have been reviewed and updated in line with the 2025/26 corporate objectives prior to the Quality and Safety Committee Meeting on 11 March 2026. There are currently three patient focussed strategic risks.

2.3 **People:** The current risk has been being reviewed and updated in line with the 2025/26 corporate objectives prior to the People Committee Meeting on 17 March 2026. There is currently one people focussed strategic risk.

2.4 **Finance and Performance:** Current risks were reviewed and updated in line with the 2025/26 corporate objectives at the F&P Committee meeting on 25 March 2026. There are currently three finance and performance focussed strategic risks.

2.5 **Partnership:** The current risk has been reviewed and updated in line with the 2025/26 corporate objectives prior to the Board meeting on 1 April 2026. There is currently one partnership focussed strategic risk.

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

4.1 The BAF is reviewed bi-monthly by the Board. The next review is scheduled for June 2026 and will include the new 2026/27 BAF risks, aligned to the 2026/27 risk appetite statement and corporate objectives.

5. Recommendations

5.1 The Board are asked to:

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

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:

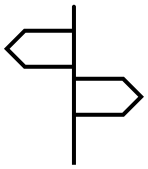
Board of Directors	February 2025
Quality and Safety Committee:	March 2026
Finance and Performance Committee:	March 2026
People Committee:	March 2026
Executive Team:	March 2026

“ **assurance** (/əˈʃɔːrəns/) *noun*

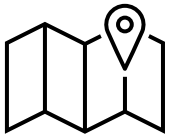
The process by which a board of directors gains confidence in the organisation's governance, risk management, and internal control frameworks. It involves evaluating the effectiveness of these frameworks and identifying areas that need improvement to ensure the organisation achieves its objectives. ”

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

How the Board Assurance Framework fits in

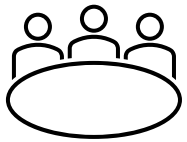


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

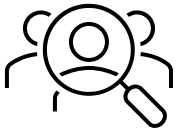


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

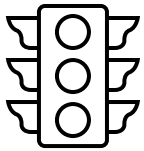
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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

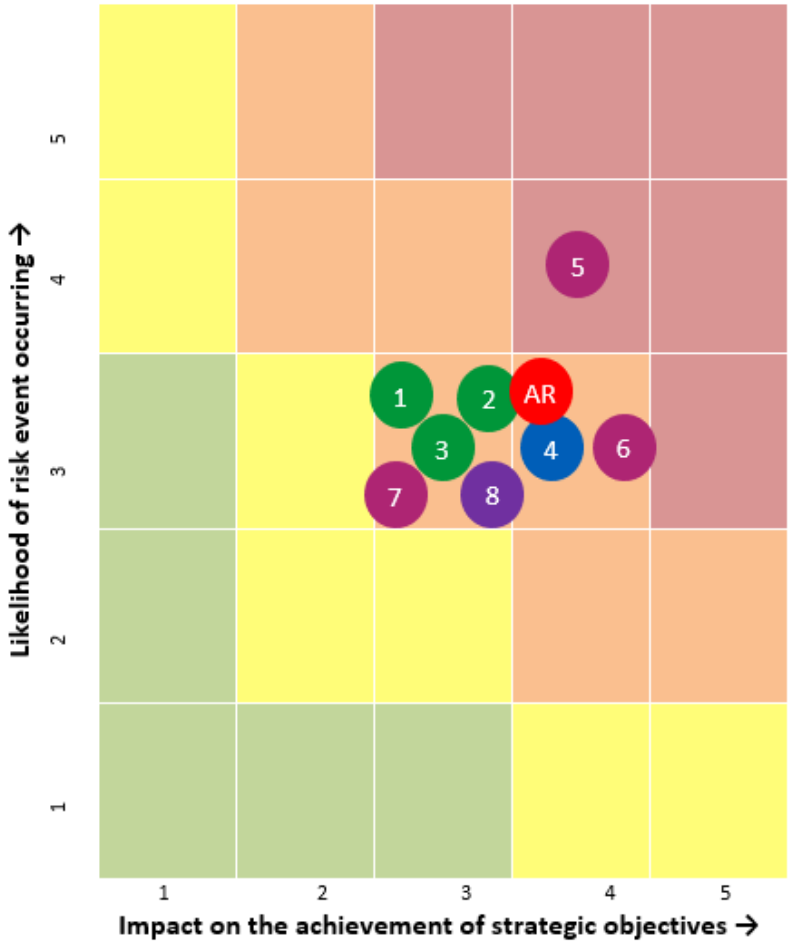
To further strengthen existing partnerships and develop new ones to complement and support our NHS services and research activities

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

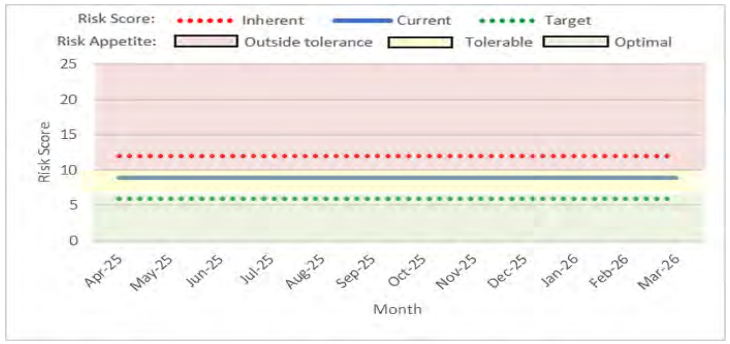
The following corporate objectives are aligned to the **patients** strategic priority:

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	9	6	6-10
	3x3	3x3	3x3	3x3	3x3	2x3	
	LxC	LxC	LxC	LxC	LxC	LxC	
Risk Appetite	Within	Within	Within	Within	Within	Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q4 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 Q1: Deteriorating
Stable
Improving

Rationale: Stable
Risk score remains stable at 9.

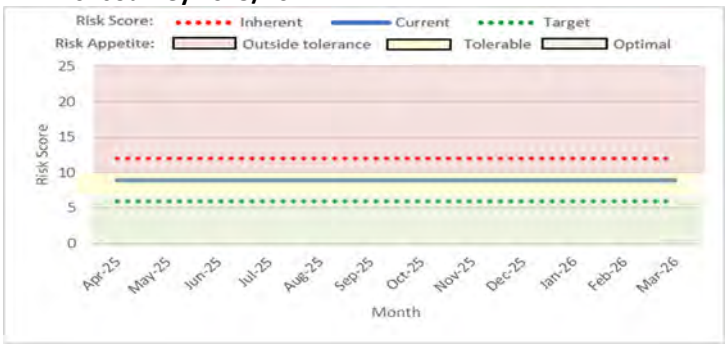
CONTROLS →	ASSURANCES →	EVIDENCE
• **Right Patient, right ward:** Further work presented, comparing Professional Body recommendations for timely admission to the right ward.	• 2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – Mar 2026
• **ASPIRE Accreditation (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 – Mar 2026
• **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 – Mar 2026

• **Oxygen prescribing**: Compliance above target, ongoing monitoring, successful PDSA cycles.	•2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – Mar 2026
• **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 – Mar 2026
• **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	9	6	6-10
	3x3	3x3	3x3	3x3	3x3	2x3	
	LxC	LxC	LxC	LxC	LxC	LxC	
Risk Appetite	Within	Within	Within	Within	Within	Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q4 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 Q1: Deteriorating
Stable
Improving

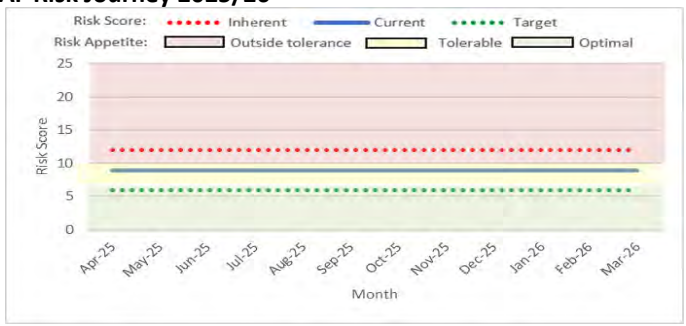
Rationale: Stable
Risk score remains stable at 9.

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 – March 2026
• **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	9	6	6-10
	3x3	3x3	3x3	3x3	3x3	2x3	
	LxC	LxC	LxC	LxC	LxC	LxC	
Risk Appetite	Within	Within	Within	Within	Within	Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q4 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 Q1: Deteriorating
Stable
Improving

Rationale: Stable
The risk score has not changed from Q1 to Q4. 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:

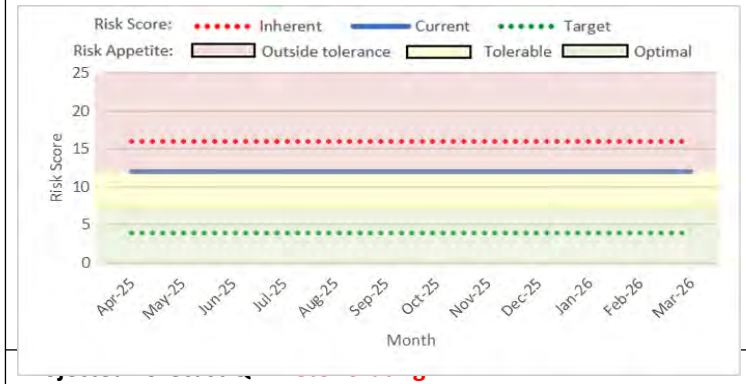
BOARD ASSURANCE FRAMEWORK 2025/26

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



Stable
Improving

BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	12	12	12	12	12	4	8-12
	3x4	3x4	3x4	3x4	3x4	2x2	
	LxC	LxC	LxC	LxC	LxC	LxC	
Risk Appetite	Within	Within	Within	Within	Within	Within	Within

RATIONALE FOR CURRENT RISK SCORE:

The risk score at Q4 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.

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. 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 Run MAR Scheme to support acceleration of workforce movement	CPO CPO CPO	31.03.26 31.03.26 31.03.26	Divisional Performance Reviews ETM/WLT People Committee	Meeting held with Divisions and Executive Team 25/11/25 to accelerate discussions. On track 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 Increased monitoring of bank usage Increased scrutiny of medical agency usage Refer to actions within Trust Sickness Absence improvement plan	CPO/CNO CPO/CNO CPO/CMO CPO	Complete 31.03.26 31.03.26 31.03.26	Finance Improvement Group Wider Leadership Team 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

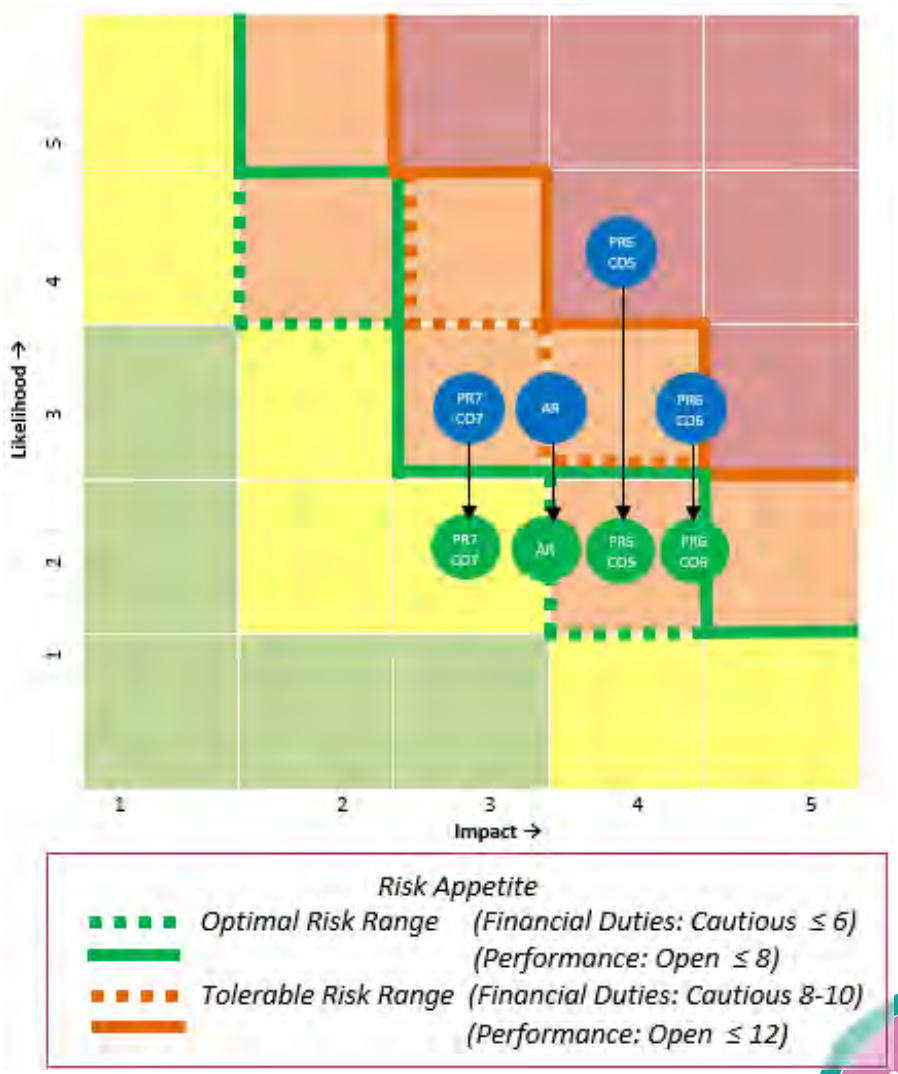
To consistently deliver efficient, effective and equitable patient care

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:



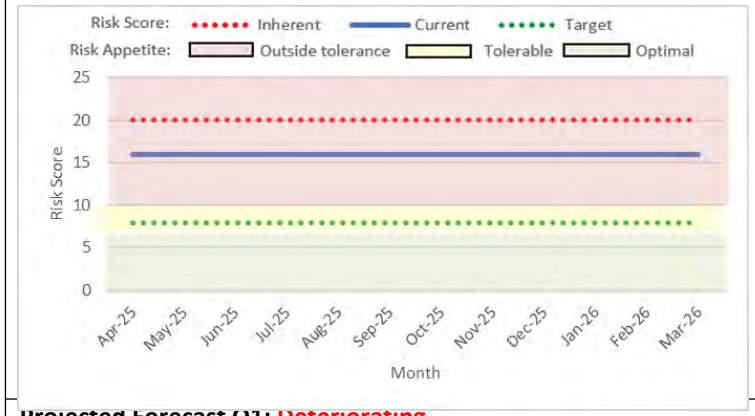
BOARD ASSURANCE FRAMEWORK 2025/26

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	16	8	6-10
	4x4	4x4	4x4	4x4	4x4	2x4	
	LxC	LxC	LxC	LxC	LxC	LxC	
Risk Appetite	Outside	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, excluding temporary benefit in Q4 due to timing of national capital schemes. Likely cash support requirement in Q1 of 26/27 based on current run rate.

CIP is behind plan YT but expect to deliver FYE. Improvement in underlying position compared to 2024/25 exit run rate. Implied productivity taken at month 11 shows a deterioration vs 24/25.

Projected Forecast Q1: 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	• 1st Line - Monthly Performance Review meetings for all clinical divisions and Finance Improvement Group (FIG) • 2nd Line - Finance & Performance Committee March 2026 • External - Monthly Provider Oversight Meeting with GM ICB (Ext)	F&P Performance Report

• Discretionary non-pay controls ongoing for specific categories of spend. • Stringent business case criteria remains to ensure only business critical investments are approved. • 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 • Deficit Support Funding (DSF) confirmed for Q3-Q4. This would not be subject to clawback in year; if the control total was not met in year it would be repayable in future years as per NHSE business rules. • Divisional control totals issued for Q4 to support delivery of improvement required associated with the recovery plan, elective activity and CIP delivery impacting run rate. • Board confirmed to NHSE our intention to deliver our revenue control total for 2025/26 on 4 Feb.		
• 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, now included as a standing agenda through Wigan System Finance Group chaired by WWL CFO.	• 1st Line - Monthly Divisional Performance Review meetings and monthly finance improvement group (FIG) • 2nd Line - Finance & Performance Committee March 2026 • External - Monthly Provider Oversight Meeting with GM ICB (Ext)	F&P Performance Report

• Finance Improvement Group meeting monthly with agreed workplan • Established QIA process led by Chief Nurse and Medical Director • Cross divisional CIP group ongoing, chaired by COO from January 26 • 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 (Oct-Dec 25) • 98% of CIP schemes categorised as implemented or fully developed • CIP WTE reduction on track to deliver • CIP minimum standard is included in the Divisional Control Totals to support 2025/26 delivery of the financial plan		
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 • All drawdown requests for nationally funded schemes submitted to NHSE in advance of deadline • Operational Capital Group frequency increased to weekly for March to support delivery of the 2025/26 capital allocation	• 1st Line - Monthly Capital Strategy Group • 2nd Line - Finance & Performance Committee March 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. • 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; this will be a virtual reference group • Cash forward look presented to FIG in 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)	• 1st Line – Cash management group • 2nd Line - Finance & Performance Committee March 2026.	

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
• 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
• 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

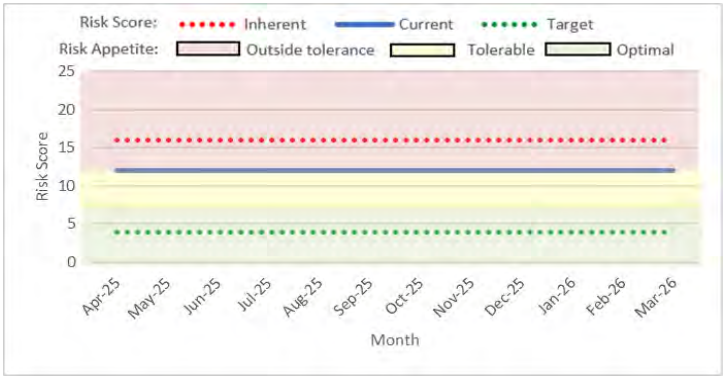
BOARD ASSURANCE FRAMEWORK 2025/26

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	12	4	8-12
	3x4	3x4	3x4	3x4	3x4	2x2	
	LxC	LxC	LxC	LxC	LxC	LxC	
Risk Appetite	Within	Within	Within	Within	Within	Outside	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 Q1: Deteriorating
Stable
Improving

Rationale: Stable

The risk score has not changed from Q1 to Q4. 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 – March 2026	Finance and Performance Committee AAA Report
• Digital strategy delivery is strong, with key programmes on track and compliance with statutory targets noted.	• 2nd line – Finance & Performance Committee – March 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 – March 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	Throughout 2025/26	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.	DCOO	Throughout 2025/26		
• 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.	DCOO	Throughout 2025/26		

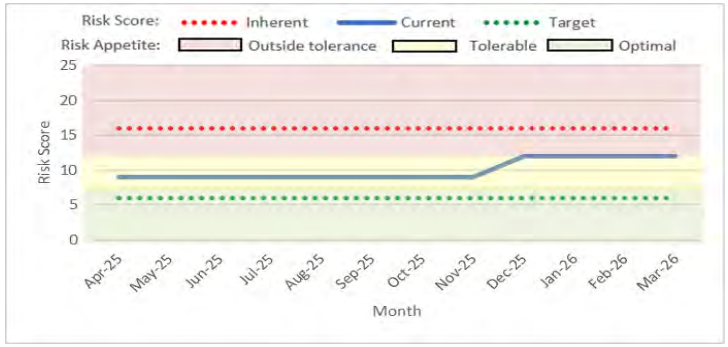
BOARD ASSURANCE FRAMEWORK 2025/26

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	12	6	8-12
	3x3	3x3	4x3	4x3	4x3	2x3	
	LxC	LxC	LxC	LxC	LxC	LxC	
Risk Appetite	Within	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 Q1: Deteriorating
Stable
Improving

Rationale: Stable

The risk score remains at 12 in Q4, having increased from 9 to 12 in quarter 3. 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
• The UEC March Sprint is underway. The aim to achieve a 78% 4-hour performance.	2nd line – Finance & Performance Committee – March 2026	Finance and Performance Committee AAA Report
• Trauma and orthopaedics recovery plan is in place.	2nd line – Finance & Performance Committee – March 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 – March 2026	Finance and Performance Committee AAA Report
• Gastro business case approved.	2nd line – Finance & Performance Committee – March 2026	Finance and Performance Committee AAA Report

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	Throughout 2025/26	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	Throughout 2025/26	F&P Committee	Action underway

Partnerships

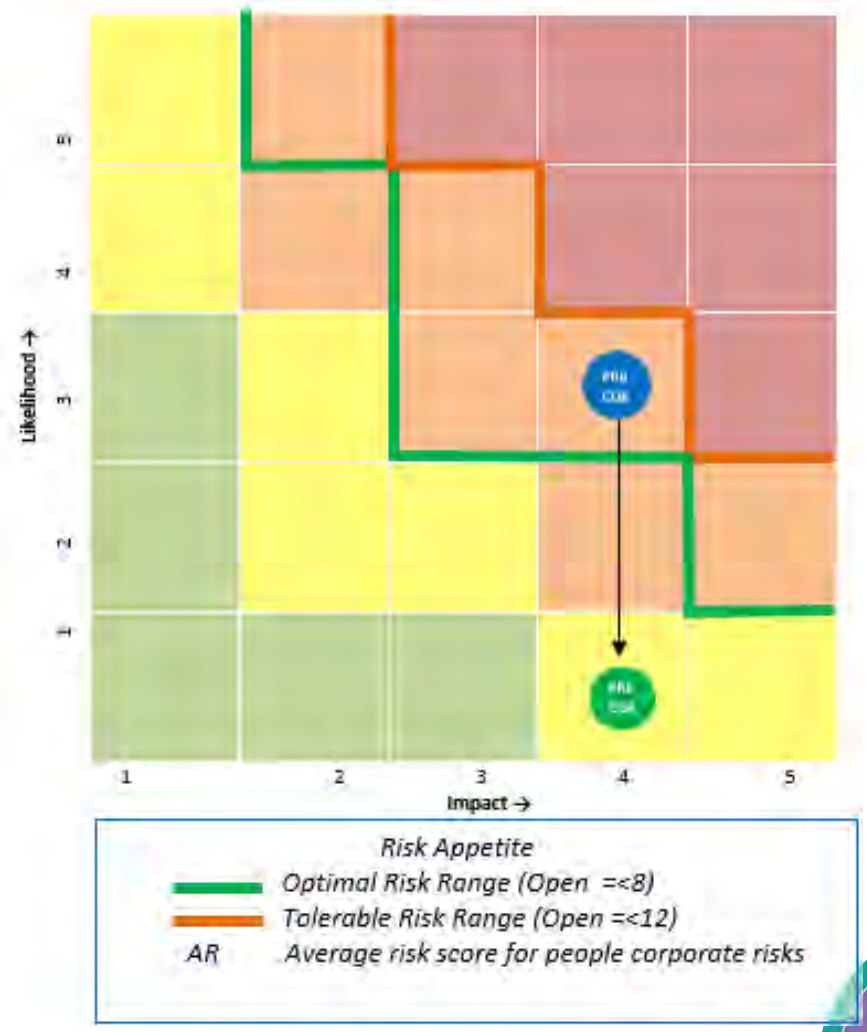
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

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:



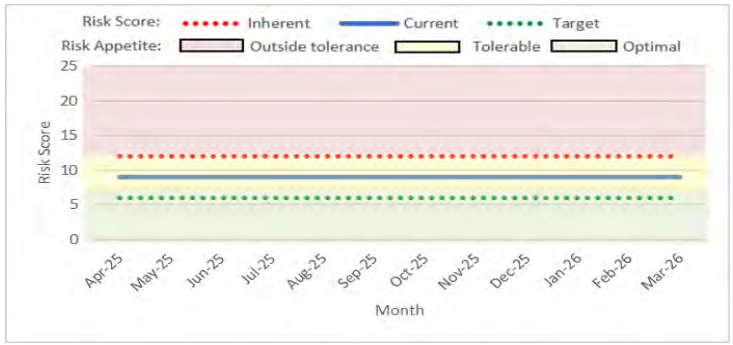
BOARD ASSURANCE FRAMEWORK 2025/26

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	9	4	8-12
	3x3	3x3	3x3	3x3	3x3	2x2	
	LxC	LxC	LxC	LxC	LxC	LxC	
Risk Appetite	Within	Within	Within	Within	Within	Within	Within

RATIONALE FOR CURRENT RISK SCORE:

The risk score at Q4 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 Q1: 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:	Corporate Objectives
Presented to:	Board of Directors
On:	1st April 2026
Item purpose:	Discussion and Approval
Presented by:	Richard Mundon, Deputy Chief Executive
Prepared by:	John Humphreys, Head of Business Planning
Contact details:	E: john.humphreys@wwl.nhs.uk

Executive summary

The Corporate Objectives provide a focus for the whole organisation, setting the direction and defining 'what' we are seeking to deliver over the coming year, aligned to the requirements of national planning frameworks, *Our Strategy 2030,* and local system priorities.

Executive Leads have proposed eight finalised Corporate Objectives for 26/27, which have been iterated via engagement in several forums since development was initiated in November. As with previous years, the objectives are grounded in the Trust's 4Ps and reflect our ambition to deliver safe, personalised and compassionate care, leading to excellent outcomes and patient experience. They represent a key mechanism for translating strategic intent into measurable delivery.

Since the proposed Corporate Objectives were last discussed at Trust Board on 21st January, they have been further developed at WLT (10th Feb) and, where possible, refined with subject matter experts at existing sub-committees. The reviewing sub-committees have been:

- Quality & Safety Committee (Patients)
- People Committee (People)
- Finance & Performance Committee (Performance)
- Research Committee (for research elements of Partnerships)

Summary of recent changes influenced by sub-committees:

- **Patients:** no changes
- **People:** strengthened scope and focus for learning and development opportunities in CO4
- **Performance:** added reference in CO5 to 'increased non-NHS core income' to detail of how objective will be achieved
- **Partnerships:** focus and scope of CO8 amended to (1) add that objective should have a positive impact on local health inequalities; and (2) reference the Neighbourhood Health

Framework, which has been published since development of our 26/27 Corporate Objectives started.

The full set of proposed Corporate Objectives for 26/27 is provided as Appendix 1.

Link to strategy
The 2026/27 Corporate Objectives articulate the Trust's priorities for the year ahead, aligned to *Our Strategy 2030* and the Medium-Term Planning Framework.

Risks associated with this report and proposed mitigations
The Corporate Objectives themselves do not introduce new risks, however there are inherent delivery risks associated with the performance related corporate objectives for 2026/27. Risks identified will be mitigated through existing management and governance mechanisms, with clear executive ownership and oversight.

Financial implications
There are no specific additional financial implications arising directly from this report. Delivery of the objectives for 2026/27 will be supported through existing resources and aligned transformation and improvement programmes, where appropriate.

Legal implications
There are no specific legal implications arising from this report.

People implications
There are no direct people implications arising from this report. However, delivery of the objectives relies on staff engagement, capability, and a positive safety culture.

Equality, diversity and inclusion implications
There are no specific equality, diversity and inclusion implications arising from this report.

Which other groups have reviewed this report prior to its submission to the committee/board?
Executive Team Meeting, Wider Leadership Team, Trust Board Workshop, and sub-committees most closely associated to each of the 4Ps.

Recommendation(s)
Trust Board is requested to review the corporate objectives proposed within Appendix 1 and endorse them for implementation in 26/27, enabling a full-year cycle to achieve their delivery and work to being immediately to establish the internal dashboard to measure their success.

Corporate objectives 2026/27: timeline and development to date

Timeline

w/c 13/10	→	27/11	3/12	→	15/1	21/1	10/2	→	1/4
Engagement with Exec colleagues	Objective development	ETM	Review of draft objectives at Board	Iteration of Objectives	ETM	Review of draft objectives at Board	Review at WLT	Finalise via sub-committees	Endorse final version at Trust Board

Development has considered

- Progress against 2025/26 objectives; do any objectives need to be rolled over?
- *Our Strategy 2030*
- NOF requirements and metrics
- National planning guidance
- Local priorities
- Subject matter expertise within sub-committees

Patients

Exec Lead: Sanjay

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

CO1	To improve the quality of care for our patients and residents.	• To reduce harm through application of Internal Professional Standards - ensuring we get the right patients to the right ward/speciality, within the right time for patients presenting with heart attack, acute abdomen, stroke or fractured neck of femur.	• Increase in % of patients being admitted to right ward for disease specific conditions within the target time
			  • heart attack from 40% to 75% (within 12 hours)
			  • acute abdomen from 51% to 75% (within 4 hours)
			  • stroke from 1% to 25% (within 12 hours)
			  • fractured neck of femur from 1.34% to 25% (within 4 hours)
				Medical Director	Q&S Committee	✓	✓	

		• To improve outcomes and experience, by strengthening frailty-focused care in hospital, and working with partners to develop neighbourhood plans which embed care for our frail elderly residents in the most appropriate setting – building on the Better Lives Programme.	• Improved quality and coordination of inpatient care demonstrated through :
			  - increase in proportion of patients aged 65+ receiving a comprehensive geriatric or frailty assessment within 72 hours of admission
			  - Reduction in average length of stay for patients aged 65+ with frailty
			• Neighbourhood plans developed with partners which embed holistic care for our frail residents, with the aim of reducing inappropriate admissions for frail patients aged 65+					

Patients

	Patients	Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
	Purpose of the Objective	**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
CO2	To ensure that our residents and patients have the best possible experience of our care	•Putting patients and residents at the heart of decision making; about their care and about the design of services •Developing a culture among our teams which empower our patients and their families •Support patients to manage their own care, particularly making use of digital approaches (e.g. patient initiated follow ups, digital apps, self-booking) •Improving our communication with patients and residents of the Borough, ensuring it is inclusive of population needs •Review our estates through the eyes of our patients, staff including volunteers 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 will be evident in our decision making and service improvement •Increase in the % of patients who would recommend WWL as a place to be treated, achieving a minimum of segment 2 in the NOF for CQC inpatient score •Increase in compliments / decrease in complaints	Chief Nurse	Q&S Committee	✓		

Patients

Exec Lead: Kev

	Patients	Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
	Purpose of the Objective	**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
CO3	To promote early detection and intervention, preventing avoidable ill-health.	• Endorse the development of the Health Inequalities and Prevention Plan, recognising it as a strategic priority for the Trust and a key enabler of equitable care and improved population health. • Support the establishment of a Health Inequalities and Prevention Group, with appropriate reporting lines and senior leadership chairing arrangements, to provide oversight and assurance on delivery. • Endorse and enable activity against each of the priority areas outlined • Ensure alignment with statutory duties and system-wide priorities, and advocate for the integration of health equity principles across Trust strategies and programmes	• Embed a health inequalities metric in reporting and assurance processes and operational groups. • Programmes of work to improve data quality, specifically ethnicity and violent assault data. • Support the creation of a Wigan wide health inequalities and prevention community of practice for healthcare professionals and the production of a workforce development plan. • Promote and enable staff participation in training opportunities and Community of Practice. • Endorse a pilot for opportunistic patient vaccinations. • Advance health literacy across the organisation to become a health literate organisation • Support engagement, and leadership, in population health research, including a local child health cohort study in partnership with Edge Hill University and Wigan Council.	Chief Nurse	Q&S Committee Wigan borough Integrated Delivery Board Wigan Borough HWP System Board	✓	✓	

Exec Lead: Emma

People

	People	To ensure wellbeing and motivation at work and to minimise workplace stress.						
	Purpose of the Objective	**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
CO4	Make WWL a great and inclusive place to work, ensuring that our staff feel safe, engaged, empowered and valued	• Well developed compassionate and brilliant leaders, who are visible, listen to feedback and act upon it • Ensure leaders support the wellbeing of our staff to ensure staff remain well and in work • 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 from the local community into employment • Prioritise recruitment into hard to fill roles • Support our staff to feel safe to speak up and ensure that, when they do, we listen and follow up • Ensure equality, diversity and inclusion exists for all and raise the voice of minority groups, eliminate discrimination and become an Anti-Racist Organisation • Develop and implement a zero tolerance approach to violence and aggression towards our workforce • Improve the experience of our Resident Doctor workforce • Develop a financially sustainable workforce plan that meets the transformation needs both relevant to WWL and that of the NHS 10 Year Plan. • Enhance learning and development opportunities for staff by investing in accessible, flexible training solutions, fostering partnerships with local organisations, and continually refining our training offer to meet evolving service needs.	• Improved staff engagement and advocacy measured through the national staff survey • Improve workplace inclusivity by reducing reported discrimination among staff, measured through the national staff survey • Reduced sickness absence • Continued low turnover • Essential bank use only and no agency • Increased response rate to the Staff Survey and Pulse Surveys • Improved Staff Survey results • Improved WRES/WDES/Gender Pay • Increased representation across Bands 8 and above • Reduction in incidents of violence and aggression towards staff • Increased satisfaction reported from student workforce in education and training experience at the Trust	Chief People Officer	People Committee	✓		

Exec Leads: Tabitha / Richard

Performance

	Performance	Our ambition is to consistently deliver efficient, effective and equitable patient care						
	Purpose of the Objective	**Scope and focus of the objective**	**How will we know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
CO5	Foster a sustainable, efficient and productive financial environment	• Ensure regulatory compliance and delivery of our financial statutory duties • Transform and innovate to achieve sustainable improvement and to manage within our resources • Develop robust planning to ensure priority areas are being addressed for capital, digital, workforce and finance	• Meeting NHSE financial performance metrics for revenue, capital and cash • Increased non-NHS core income alongside delivery of cash releasing CIP including planned reductions in our workforce • Underlying financial position improving as per the 3-year financial sustainability plan	Chief Finance Officer Director of Strategy	Finance and Performance Committee Divisional Assurance Meetings Provider Oversight Meetings	✓		✓

Exec Leads: Sarah / Tabitha

Performance

	Performance	Our ambition is to consistently deliver efficient, effective and equitable patient care						
	Purpose of the Objective	**Scope and focus of the objective**	**How will we know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
CO6	Drive improvements in our overall performance, placing patients at the centre of everything we do.	• 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	• To improve our 4-hour A&E performance to 82% by March 2027 • To achieve 12-hour A&E performance of over 90% of patients admitted, discharged and transferred from ED within 12 hours • To reduce ambulance hand over times to below 30 minutes • To maintain over 80% for urgent community response 2-hour performance	Chief Operating Officer	Finance and Performance Committee	✓		
		• Ensure that patients receive care in a timely way both in the community and a hospital setting • Ensure that patients experience a timely outcome when they are referred for suspected cancers and they are treated in a timely way if they receive a cancer diagnosis • Ensure that diagnostics are available to patients in a timely way	• Address long waiting times for community health services so that at least 78% of community health service activity occurring within 18 weeks • Improve the percentage of patients waiting no longer than 18 weeks for treatment to 7% higher than or a minimum of 65%, whichever is greater (to deliver national performance target of 70%) • Improve performance against cancer constitutional standards by maintaining performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80% and delivering 94% performance for 31-day and 80% performance for 62-day standards by March 2027 • Improve performance against the DM01 diagnostics 6-week wait standard (delivering a minimum 3% improvement on 2025/26 performance or performance of 20% or better, whichever level of improvement is greater (to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test)					

Exec Leads: Sarah / Tabitha

Performance

	Performance	Our ambition is to consistently deliver efficient, effective and equitable patient care						
	Purpose of the Objective	**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
CO7	• Optimise delivery of our elective and non-elective services	• Maximise the utilisation and efficiency of our Elective Hubs to support recovery at both Trust and Greater Manchester level, recognising their role as GM system assets. • Improve productivity across elective and non-elective services through the implementation of best practice (including GIRFT and clinical standardisation), • Transform our outpatient services by working with partners, enabled by digital technology to reduce unnecessary referrals, maximise our capacity and expand alternative methods of delivery.	• Higher utilisation of elective hub sites – minimal fallow theatre lists • Increasing number / range of procedures identified as 'suitable for surgical hub' • Demonstrable improvements in key productivity metrics (to be agreed in Q4) • Reduction in unnecessary referrals to agreed specialties • Increased utilisation of outpatient clinics	Chief Operating Officer Chief Finance Officer/ Chief Operating Officer	Finance and Performance Committee Divisional Assurance Meetings	✓	✓	✓

Exec Lead: Richard

Partnerships

	Partnerships	To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester						
	Purpose of the Objective	**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
CO8	To strengthen existing and develop new partnerships at **place, system and wider network level** in response to NHS reforms – supporting our NHS services and research activities	**System and place-based** • Working with or partners to positively impact health inequalities across the Wigan Borough • Shared ownership across organisations in Wigan to solve tricky system issues, aligned to the recently published Neighbourhood Health Framework • 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) • Active participation and leadership within provider collaboratives, place-based partnerships and GM-wide programmes, mitigating any unintended consequences of organisational or NOF-driven silo working **Research, innovation and academic** • Embedding research and innovation as a core component of partnership working, including stronger collaboration with academic, NIHR, industry and system partners **Commercial** • Development of Commercial partnerships in line with our values, which support increased income through private patients and corporate opportunities, while maintaining our primary commitment to NHS patient care.	**System and place-based** • Clear patient pathways across organisations • Joint Work programmes and clear visibility of funding for key issues • Joint approach to risk management across the system • Shared approach to communication on handling change or tackling challenges • Locality teams and members • A survey of our GPs, partner organisations and key stakeholders **Research, innovation, academic and commercial** • Increase in commercial and research income • Increase in the number and diversity of colleagues participating in research • A further increase in the surplus position for commercial income that positively supports the Trust's overall financial position.	Deputy Chief Executive / Executive Director of Comms	Six monthly report to Trust Board	✓	✓	✓

Corporate objectives 2026/27: NOF requirements and metrics

Access domain	Effectiveness and experience of care domain	Patient safety domain	People and workforce domain	Finance and productivity domain
COO	CNO, MD	CNO	CPO	CFO
%age of emergency department attendances admitted, transferred or discharged within 4 hours	Summary Hospital Level Mortality Indicator (MD)	NHS staff survey – raising concerns sub-score	Sickness absence rate	Planned surplus / deficit
%age of emergency department attendances spending over 12 hours in the department	Re-admission rate band (MD)	CQC safe inspection score	NHS staff survey engagement theme score	Variance year-to-date to financial plan
%age of patients waiting less than 18 weeks	CQC inpatient survey satisfaction rate (CNO)	Rates of HCAI	NHS staff survey education and training theme score	Implied productivity level
%age of patients waiting over 52 weeks	National maternity service score (CNO)	Percentage of inpatients acquiring a new pressure ulcer	National Education and Training Survey overall satisfaction score	
Cancer: %age of urgent referrals to receive a definitive diagnosis within 4 weeks				
%age of patient treated for cancer within 62 days of referral				
%age of patients waiting over 52 weeks for community services				
Urgent community response 2-hour performance				

Corporate objectives: key planning targets for 26/27

Consistent with the 25/26 planning guidance, the Medium-Term Planning Framework mandates a small cohort of performance targets but sets an expectation around ambitious incremental improvements in performance each year.

Success measure	25/26 planning guidance target (if applicable)	26/27 target	28/29 target
Improve the percentage of patients waiting no longer than 18 weeks for treatment	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%)	Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment
Improve performance against cancer constitutional standards	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	
	Improve performance against the headline 62-day cancer standard to 75% by March 2026	Every trust delivering 94% performance for 31-day and 80% performance for 62-day standards by March 2027	Maintain performance against the 31-day standard at 96% and 62-day standard at 85%
Improve performance against the DM01 diagnostics 6-week wait standard	N/A	Every system delivering a minimum 3% improvement in performance or performance of 20% or better, whichever level of improvement is greater (to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test)	Achieving the standard that no more than 1% of patients are waiting over 6 weeks for a test
4-hour A&E performance	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	Every trust to maintain or improve to 82% by March 2027	National target of 85% as the average for the year
12-hour A&E performance		Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours
Category 2 response times	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	Improve upon 2025/26 standard to reach an average response time of 25 minutes	Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90% of calls responded to within 40 minutes
Address long waiting times for community health services	N/A	At least 78% of community health service activity occurring within 18 weeks	At least 80% of community health service activity occurring within 18 weeks
Reduce use of bank and agency staffing		Trusts to reduce agency and bank use in-line with individual trust limits, as set out in planning templates, working towards zero spend on agency by 2029/30 Annual limits will be set individually for trusts, based on a national target of a 30% reduction in agency use in 2026/27, and a 10% year-on-year reduction in spend on bank staffing	

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Risk Appetite 2026/27 Review
Presented to:	Board of Directors
On:	01 April 2026
Item purpose:	Approval
Presented by:	Director of Corporate Governance
Prepared by:	Head of Risk Director of Corporate Governance
Contact details:	E: julie.dawes@wwl.nhs.uk

Executive summary

This paper proposes our risk appetite statement for 2026/27 and recommends that we focus on five key risk types which align with our four principal objectives. The risk appetite statement was reviewed at the Board Workshop in March 2026 and it has been updated to reflect that the Trust will have to be more cautious of finance and performance risks to achieve the national targets and financial requirements being set for it. The WWL risk appetite statement has been cross referenced with the NHS GM risk appetite statement, which will aid the escalation of risks from WWL to the Wigan locality and NHS GM risk registers where required.

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

Risk appetite statements may influence the amount of risk which the trust is willing to pursue and tolerate when considering the trust's risks.

Financial implications

This report recommends the risk appetite for managing risks relating to financial duties.

Legal implications

This report recommends the risk appetite for managing risks relating to how we are perceived by our regulators.

People implications

This report recommends the risk appetite for managing risks relating to people management.

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? Executive Team Meeting, Board Workshop.

Recommendation(s)

The Board are asked to approve the trust's risk appetite statement for 2026/27.

1. Background

1.1 NHS well led guidance (2017) requires the trust to have clear and effective processes for managing risks, issues and performance including a clear understanding of the Board's risk appetite and tolerance, which is reviewed regularly (at least annually) and appropriately communicated to staff.

1.2 In addition, we are required to describe the key elements of our risk management strategy as part of the annual report, including a narrative on how risk appetites are determined.

2. Definitions

Within the WWL Risk Management Framework, we refer to optimal and tolerable risk appetite positions using the following definitions:

Optimal risk position: the level of risk with which the trust aims to operate. This is informed by the trust's strategic objectives.

Tolerable risk position: the level of risk with the trust is willing to operate, given current constraints.

3. Risk Appetite

3.1 Our proposed risk appetite position for 2026/27 is summarised in the following table:

Risk category and link to principal objective	Threat		Opportunity	
	Optimal	Tolerable	Optimal	Tolerable
Quality and Safety How will we deliver safe services?	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
People How will organise our workforce?	**≤ 8 Open**	**≤ 12 Open**	**≤ 15 Eager**	**≤ 16 Eager**
Financial How will we use our resources?	**≤ 6 Cautious**	**8 – 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
Performance How will we be perceived by regulators?	**≤ 6 Cautious**	**8 – 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
Reputational How will we be perceived by the public and our partners?	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**

3.2 The risk appetite statement for 2026/27 has been reviewed and updated with reference to GGI Board Guidance on Risk Appetite (2020) and Gov: The Orange Book Risk Appetite Guidance Note (2021). The number of risk categories has been reduced to five key risk types to improve alignment with our four principal objectives. A risk appetite has been set based on whether the risk poses a threat or an opportunity. Detail on the optimal and

tolerable risk scores is also provided to guide risk leads in their decision-making, see appendices 1 and 2.

3.3 In line with recommended practice, a one-word description of our risk appetite levels has been devised into five categories on a scale from least risk to most risk. NHS GM use a similar scale, but have a sixth category named 'Mature', which is incorporated into the 'Eager' category within the WWL risk appetite scale.

Least risk		← →		**Most risk**
Adverse	Minimal	Cautious	Open	Eager

3.4 This paper was presented and reviewed at the Board Workshop in March 2026. The risk appetite statement has been updated to reflect that the Trust will have to be more cautious of finance and performance risks to achieve the national targets and financial requirements being set for it. The number of risk types has been reduced from sixteen to five key risk types which align with our four principal objectives.

4.0 Recommendations for risk appetite scoring

4.1 The Board are asked to approve the trust's risk appetite statement for 2026/27.

Appendix 1: Risk Appetite Statements 2026/27

Patients	Our ambition is to be widely recognised for delivering safe, personalised, and compassionate care, leading to excellent outcomes and patient experience				
Risk Appetite / Risk Category	**Adverse**	**Minimal**	**Cautious** Threat	**Open** Opportunity	**Eager**
Quality and Safety How will we deliver safe services?	We will avoid anything that may impact on quality outcomes unless essential. Defensive approach to operational delivery – aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Innovations largely avoided unless essential. Decision making authority held by senior management.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer term rewards. Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators.	We will pursue innovation wherever appropriate, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	We seek to lead the way and will prioritize new innovations, even in emerging fields. Desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control.
People	To ensure wellbeing and motivation at work and to minimise workplace stress.				
Risk Appetite / Risk Category	**Adverse**	**Minimal**	**Cautious**	**Open** Threat	**Eager** Opportunity
People How will organise our workforce?	We will avoid all risk relating to our workforce unless essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards our workforce. Where attempting to innovate, we would seek to understand where similar action had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result of from innovation as long as there is the potential for improved recruitment and retention, and development opportunities for staff.	We will pursue workforce innovation. We are willing to take risk which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.

Performance

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

Risk Appetite / Risk Category	Adverse	Minimal	Cautious (Threat)	Open (Opportunity)	Eager
Financial Duties How will we use our resources?	We are only willing to accept the possibility of limited financial risk. Avoidance of any financial impact or loss, is a key objective.	We are only willing to accept the possibility of limited financial risk if essential to delivery.	We are prepared to accept the possibility of some financial risk as long as appropriate controls are in place. Seek safe delivery options with little residual financial loss only if it could yield upside opportunities.	We will invest for the best possible return and accept the possibility of increased financial risk. We will minimise the possibility of financial loss by managing the risks to tolerable levels.	We will consistently invest for best possible benefit and accept possibility of financial loss (controls must be in place).
Performance How will we be perceived by our regulator?	We will avoid any decisions that may result in heightened regulatory challenge unless essential. Play safe and avoid anything which could be challenged, even unsuccessfully.	We are prepared to accept the possibility of limited regulatory challenge. Want to be very sure we would win any challenge.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably sure we would win any challenge.	We are willing to take decisions that will likely result in regulatory intervention if we are likely to win, and the gain will outweigh the adverse impact.	We are comfortable challenging regulatory practice. Chances of losing are high but exceptional benefits could be realised.

Partnerships

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

Risk Appetite / Risk Category	Adverse	Minimal	Cautious (Threat)	Open (Opportunity)	Eager
Reputational How will we be perceived by the public and our partners?	We have zero appetite for any decisions with high chance of repercussion for trust's reputation.	We have an appetite for risk taking limited to those events where there is no chance of any significant repercussion for the trust.	We have an appetite for risk taking limited to those events where there is little chance of any significant repercussion for the trust.	We have an appetite to take decisions with potential to expose the trust to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	We have an appetite to take decisions which are likely to bring additional scrutiny only where potential benefits outweigh risks.

Appendix 2: Risk Appetite Statement 2026/27				
Principal Objective	**Risk Appetite** **A**dverse, **M**inimal, **C**autious, **O**pen, **E**ager 	**Risk Statement**	**Optimal Risk Position**	**Tolerable Risk Position**
Patient		We have an **OPEN** appetite for risks that present an opportunity relating to safety, quality of services and patient experience.	**= < 8 Open**	**= < 12 Open**
		We have a **CAUTIOUS** appetite for risks that present a threat to safety, quality of services and patient experience.	**= < 6 Moderate**	**8 - 10 High**
People		We have an **EAGER** appetite for risks that present an opportunity relating to staff capacity and capability, experience and wellbeing.	**= < 15 Significant**	**= < 16 Significant**
		We have an **OPEN** appetite for risks that present a threat to staff capacity and capability, experience and wellbeing.	**= < 8 Open**	**= < 12 Open**
Performance		We have an **OPEN** appetite for risks that present an opportunity relating to financial duties.	**= < 8 Open**	**= < 12 Open**
		We have an **OPEN** appetite for risks that present an opportunity relating to performance targets.	**= < 8 Open**	**= < 12 Open**
		We have a **CAUTIOUS** appetite for risks that present a threat to financial duties.	**= < 6 Moderate**	**8 - 10 High**
		We have a **CAUTIOUS** appetite for risks that present a threat to performance targets.	**= < 6 Moderate**	**8 - 10 High**
Partnerships		We have an **OPEN** appetite for risks that present an opportunity relating to reputation.	**= < 8 Open**	**= < 12 Open**
		We have a **CAUTIOUS** appetite for risks that present a threat relating to potential adverse publicity.	**= < 6 Moderate**	**8 - 10 High**

Title of report:	Gender Pay Gap Report 2025
Presented to:	Board of Directors
On:	1 April 2026
Item purpose:	Information
Presented by:	Prof Sanjay Arya, Medical Director
Prepared by:	Sarah Berry, Assistant HR Business Partner Angelique Hartwig, Head of Staff Experience
Contact details:	Sarah.berry@wwl.nhs.uk; angelique.hartwig@wwl.nhs.uk

Executive summary

This report provides an analysis of the Trust`s Gender Pay Gap information as at 31st March 2025 and is the eighth round of annual mandatory reporting the Trust has undertaken.

The data highlights that as at 31st March 2025 the Trust has a **27.69% mean average gender pay gap** with females earning **£7.29 an hour less** than males. This position comparable to the 2024 figure of 26.82%. As at March 2025 the Trust has a **13.57% median hourly rate gender pay gap** with females earning **£2.68 an hour less** than males. This position has deteriorated since 2024 when it was 11.14%.

A key factor underpinning the Trust`s gender pay gap is due to a significant proportion of male staff being constituted within the Medical & Dental staff group which is within the higher earning quartiles. If we exclude Medical & Dental staff from the Trust wide gender pay gap figures the Trust`s mean gender pay gap is **2.72%** which equates to females earning **£0.52 less than male staff per hour**. Last year the Trust wide gender pay gap figure excluding medical and dental was 2.40% which equates to females earning £0.43 less than male staff per hour. Section 2.2 of the report provides granular analysis of the pay gap at staff group level.

As at 31st March 2025 male staff proportionately continue to be heavily constituted within the highest earning quartile (quartile 4) accounting for **33.33%** of quartile 4 when male staff represent 20% of the overall Trust workforce. A key factor is due to the Medical & Dental workforce being predominantly male at 65% and this staff group are predominantly constituted within the highest earning quartile. Compared to the previous year in 2024 there were a similar percentage of males in the highest earning quartile at **29.9%**.

As at 31st March 2025 female staff proportionately continue to have lower representation in the highest earning quartile at **66.67%** compared with their overall representation of 80% of the workforce. Compared to the previous year in 2024, there has been a decrease in the percentage of females in the highest earning quartile when it was **70.1%.**

The data highlights that the average bonus pay gap for females as at March 2025 is 74.35% and the median pay gap is 57.95%. This is a deterioration compared to the previous year where the figures were 57.93% average bonus pay and 0.00% median bonus pay gap. In previous years the local clinical excellence award (LCEA) was available however as part of a government reform the funding for LCEA's was redirected into remuneration, ending annual award access from 1st April 2024. In previous years the amount was equally split which would have had a positive impact on the pay gap figures.

The Trust's Gender Pay Gap action plan is currently led by the Medical Director, supported the Deputy Chief People Officer, as part of the pay equality workstream and progress is reviewed regularly through the EDI Strategy Group. The actions in place are summarised in this report.

The report and Gender Pay data for 2025 has been discussed through Wider Leadership Team, Equality & Diversity Steering Group and People Committee, where it was noted that we must go further to address our Gender Pay Gap. A commitment has been made to produce the 2026 Gender Pay data in May 26, which is earlier that the legal requirement, which will enable further, more detailed analysis of more up to date data to be undertaken and to enable additional actions to be developed.

The updated Gender Pay data for March 26 will also reflect the changes in the profile of medical leadership roles which has taken place in the recent organisation redesign. One of the two Divisional Medical Director roles are now held by a female (50%), previously there were none. One of the 4 new Deputy Divisional Medical Director roles is held by a female (25%). 10 of the 33 Clinical Director roles are now held by females (30%), comprising 36% of CDs in Live Well & Urgent Care, and 26% in Start Well & Planned Care. Female Consultants represent c.27% of the Consultant workforce, which demonstrates progress in ensuring that female Consultants are taking up and represented in medical leadership roles, which should help to address the Gender Pay Gap.

Link to strategy and corporate objectives

- People Strategy
- NHS EDI Improvement plan High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps.

Risks associated with this report and proposed mitigations

Risks are set out below.

Financial implications

There are possible risks of employment tribunal claims relating to discrimination arising from the gender pay gap which would have financial implications in terms of legal and compensation costs. However, to date no claims of this nature have arisen within the Trust.

Legal implications

Since 2018, it is mandatory for public sector employers with more than 250 employees to measure and publish their gender pay gap information. There is also a legal obligation under the Equality Act to ensure "equal pay" and to remain compliant as an organisation.

People implications

Gender Pay Gap is a complex issue and there are many contributing factors including external societal factors and internal workforce factors. The people issues which arise from the gender pay

gap are wide ranging and at the heart of this issue is fairness and equality of opportunity for staff within the organisation.

Equality, diversity and inclusion implications
This annual report is an integral part of our commitment to ensuring equality in pay for our workforce and breaking down barriers to inclusion and equal access to lower/middle and high paid roles.

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

This report has been shared at Wider Leadership Team, the EDI Strategy Group and People Committee.

Recommendation(s)

The Board is recommended to receive the report and approve the Gender Pay Gap report for national reporting.

Report

Statutory Gender Pay Gap Reporting

1. Background

In 2018, it became mandatory for public sector organisations with more than 250 employees to report annually on their gender pay gap.

The gender pay gap differs from equal pay and the two terms are not interchangeable. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the differences in the **average pay** between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of reasons for inequality such as access to career progression, recruitment bias etc. The individual calculations may help to identify what those issues are.

The Trust is obliged to publish the following information on our public-facing website and report to government by the 31st March 2026:

- The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the mean gender pay gap');
- The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the median gender pay gap');
- The difference between the mean bonus pay paid to male relevant employees and that of female relevant employees ('the mean gender bonus gap');
- The difference between the median bonus pay paid to male relevant employees and that of female relevant employees ('the median gender bonus gap')
- The proportions of male and female relevant employees paid bonus pay ('the proportions of men and women getting a bonus'); and
- The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay band ('the proportion of men and women in each of four pay quartiles').

2 Gender Pay Gap Reporting Key points

Appendix 1 includes a full copy of the Trust`s Gender Pay Gap information which has been obtained from the Electronic Staff Record (ESR) standard reports. The ESR standard reports are nationally produced to ensure the NHS meet their gender pay gap reporting requirements and the reporting period for the gender pay gap data is as at 31st March 2025.

2.1 Key Points to note are:

- The Trust workforce is **80% female and 20% 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.
- As at March 2025 the Trust has a has a **27.69% mean average** gender pay gap with females earning **£7.29 an hour less** than males. The figure is comparable to March 2024 when females earned **£6.54 an hour** less than males with a 26.82% mean average gender pay gap.
- As at March 2025 the Trust has a **13.57% median hourly rate** gender pay gap with females earning **£2.68 an hour less** than males. The median hourly rate gender pay gap has deteriorated compared to March 2024 when females earned **£2.02 an hour less** than males with a **11.14%** median gender pay gap.
- As at 31st March 2025 male staff proportionately continue to be heavily constituted within the highest earning quartile at 33.33% within quartile 4 compared to male staff representing 20% of the overall workforce. A key factor is due to the Medical & Dental workforce being predominantly male at 65% and this staff group are predominantly constituted within the highest earning quartile.
- As at 31st March 2025 female staff proportionately continue to have lower representation in the highest earning quartile at 66.67% compared with female staff representing 80% of the overall workforce. Compared to the previous year in March 2024 there was a higher percentage of females in the highest earning quartile at 70.1%.
- The data highlights that the average bonus pay gap for females as at March 2025 is 74.35% and the median pay gap is 57.95%. This is a deterioration compared to the previous year when the figures were 57.93% average bonus pay and 0.00% median bonus pay gap. Typical male consultants received much higher bonus pay than typical female consultants, with the middle point also being much higher for male consultants compared to female consultants.

In previous years Local Clinical Excellence Awards (LCEA's) have been available but the last award round for this took place during 2023/24 and funding is now redirected into remuneration. In previous years when the LCEA scheme was available the amount was equally split which would have had a positive impact on the pay gap figures. The changes to LCEA's have impacted a broad group of women, not just outliers. Additionally, as males were more likely to have an LCEA they will now have higher consolidated pay so this will impact wider on the gender pay gap figures.

2.2 Gender Pay Gap Granular reporting

In response to the gender pay gap reporting the Trust has undertaken a granular analysis of the gender pay gap data by staff group to identify any hot spot areas. Medical & Dental and Administrative & Clerical staff groups continue to be areas where gender pay is a particular concern.

Medical and dental staff group

The medical & dental staff group has a **20.79%** mean gender pay gap with female medical & dental staff earning **£9.85 per hour less** than male medical & dental staff. The figure has remained relatively static compared to the previous year where there was a 20.59% average pay gap with female medical and dental staff earning £9.85 an hour less than male medical and dental staff. Female medical & dental staff are overrepresented within this staff group`s lower pay quartiles (quartile 2 & 3).

If we exclude Medical & Dental staff from the Trust wide gender pay gap figures the Trust`s mean gender pay gap is **2.72%** which equates to females earning **£0.52** less than male staff per hour. Last year the Trust wide gender pay gap figure excluding medical and dental was 2.40% which equates to females earning £0.43 less than male staff per hour.

Administrative and clerical staff group

An analysis of the gender pay gap for the Administrative & Clerical staff group highlights this staff group has a **22.38%** average pay gap with female staff earning £**4.75 an hour less** than male staff. This is a comparable position compared to the previous year where there was a 21.54% average pay gap with female administrative & clerical staff earning £4.27 an hour less than male administrative & clerical staff in 2024. Males within this staff group continue to remain significantly constituted within the highest pay quartile at 43% male in quartile 4 which is not comparable to the overall demographic of the staffing group. Comparing these figures to the previous year, the percentage of males in the highest quartile has increased from 39%.

Additional Professional Scientific and Technical staff group

An analysis of the gender pay gap for the Additional Professional Scientific and Technical staff group highlights this staff group has an 6.83% average pay gap with female staff earning £1.59 an hour less than male staff. This is an improved position compared to the previous year where there was an 8.39% average pay gap with female staff earning £1.88 an hour less than male staff in 2024. Representation in the higher quartiles are proportionate to the overall demographic of the Additional Professional Scientific and Technical staff group: quartile 4 male representation was 26% and quartile 3 male representation was 18%. Comparing these figures to the previous year the percentage of males in the quarter 4 has remained comparable.

Other Staffing Groups

In previous years the Trust figures have shown negative pay gaps, i.e. when females earn more than males within the Healthcare Scientists, Nursing and Midwifery registered and Allied Health Professionals staffing groups.

As at 31st March 2025 the only staffing group with a negative pay gap is the Healthcare Scientists where females were earning £0.90 more than males (-4.12%). The percentage has improved compared to March 2024 when it was 5.59% in March 2024.

Although this gap is much smaller compared to the pay gaps in which males earn more than females e.g. Admin & Clerical and Medical & Dental.

Other staffing groups that have historically had negative pay gaps report figures of:

- As at 31st March 2025 the Nursing and Midwifery registered staff group had a **0.72% pay gap (males earn £0.16 more than females per hour)**. The gap has evened out compared to last year where there was a -3.21% pay gap (females earn £0.64 more than male staff per hour).

- As at 31st March 2025 the Allied Health Professionals staff group had a **1.93% pay gap (males earn £0.44 more than females per hour).** This is compared to last year where there was a -1.31% pay gap (females earn £0.28 more than male staff per hour).

3 Actions to reduce Gender Pay Gap

The Mend the Gap Report, an independent review into gender pay gaps in medicine in England, and the Trust's gender pay gap data highlight that the medical and dental staff group is a key area that needs to be focussed on to have a positive impact on the Gender Pay Gap.

A Gender Pay Equality Group has been established at WWL, chaired by our Executive Medical Director, with representation from a number of female Consultants, supported by the Deputy Chief People Officer. The group has been in existence since 17th March 2025, meets on a monthly basis, and reports to the EDI Steering Group.

The group has collaboratively developed an action plan to address some of the issues influencing the gender pay gap. The actions include:

- Encouraging female doctors to apply for National Clinical Impact Assessment Awards (NCIAs) in writing from the Medical Director, offering of support with applications and sharing case studies of women who have been awarded NCIAs. Support will be further enhanced over the coming months for the forthcoming round of NCIA awards.

- Reducing the number of meetings that take place out of normal working hours. Where these cannot be avoided, ensuring sufficient notice is given and offering options for joining remotely place.

- Female Medical Consultants developing a Women's Community of Inclusion, which has met and is developing a list of priority areas of focus.

- Ensuring that health and wellbeing plans/strategies include a focus on supporting women's health e.g. menopause support/policies.

- Promoting flexible working though case studies of female medical staff. Ensuring all adverts promote flexible working approach including LTFT and state a commitment to discuss flexible working, and ensuring flexible working guidance/training for managers is in place.

- Targeted recruitment campaigns where there is known underrepresentation of female medical staff.

- Ensuring female medical staff have equal access to undertake additional shifts or be appointed to roles which attract additional PAs/responsibilities.

- Analysing information such as flexible working requests that have been declined.

- Removal of the ability to negotiate starting salaries, and proactively checking experience of female M&D appointments to ensure previous relevant service is counted towards starting salaries.

As the group was only established in March 2025, with ongoing implementation of the actions, the impact of any improvements will not have been evident in the data in this report (which is taken as at 31st March 2025). Reducing the gender pay can take time, as there may be some individuals who have retained local clinical excellence awards, or have other long standing awards, which have increased their pay for a significant period. The group will continue to meet and ensure the actions are fully embedded.

Changes in the profile of medical leadership roles has taken place in the recent organisation redesign, with one of the two Divisional Medical Director roles now being held by a female (50%), previously there were none. One of the 4 new Deputy Divisional Medical Director roles is held by a female (25%). 10 of the 33 Clinical Director roles are now held by females (30%), comprising 36% of CDs in Live Well & Urgent Care, and 26% in Start Well & Planned Care. Female Consultants represent c.27% of the Consultant workforce, which demonstrates progress in ensuring that female Consultants are represented in medical leadership roles. The changes will be reflected in the data for the 2026 Gender Pay Gap reporting.

Further exploration of other non-medical gender pay gaps will be undertaken e.g. admin & clerical, along with exploration of the ethnicity pay gap.

There is a requirement to publish Gender Pay data by 31st March for the position as at 31st March the previous year. A commitment has been made to produce the Gender Pay data in May 2026 (for March 2026), therefore at a much earlier point, which will enable more detailed analysis of more up to date data to be undertaken, and translated into further targeted actions to address the Gender Pay Gap.

Recommendations

Board is requested to note the contents of the report and the Gender Pay data for 2025, and approve for national reporting, in accordance with our statutory requirements.

Oversight of the reduction of the Gender Pay Gap will continue through the EDI Steering Group and People Committee.

Appendices

Appendix 1

Gender Pay Gap Report summary data as at 31st March 2025

2.1 Table 1- Average & Median Hourly rate

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	26.32	19.72
Female	19.03	17.05
Difference	7.29	2.68
Pay Gap %	27.69	13.57

2.1.1 Average Hourly rate

As at March 2025 the Trust has a has a 27.69% mean average gender pay gap with females earning £7.29 an hour less than males. The figure is comparable to March 2024 when females earned £6.54 an hour less than males with a 26.82% mean average gender pay gap.

2.1.2 Median Hourly rate

As at March 2025 the Trust has a 13.57% median hourly rate gender pay gap with females earning £2.68 an hour less than males. This position has deteriorated since 2024 where it was 11.14%.

2.2 Table 2- % male and female employees in each pay quartile

Quartile	Female	Male	Female %	Male %
1	1466.00	285.00	83.72	16.28
2	1479.00	314.00	82.49	17.51
3	1503.00	270.00	84.77	15.23
4	1182.00	591.00	66.67	33.33

This calculation requires an employer to show the proportions of male and female full-pay relevant employees in four quartile pay bands with quartile 1 being the lowest paid and quartile 4 being the highest paid. All employees are placed into the cumulative order according to their pay which is undertaken by dividing the workforce into 4 equal parts.

Compared with quartiles 1-3 males are more highly constituted within quarter 4 at 33.33% compared with an average of between 15.23% - 17.51% within the other quartiles. Comparatively the reverse is true for females and they constitute 66.67% of quartile 4 compared with an average of between 82.49%- 84.77% within the other quartiles.

The information compares % within the individual quartiles. However, if we review the broader picture comparing the overall workforce constitution there are 1460 male employees and of these 591 are within quartile 4 which represents 40% of all male employees. Comparatively of 5630 female employees only 1182 females are constituted within quartile 4 which represents only 21% of all female employees.

2.3 Bonus information

Table 3

Gender	Avg. Pay	Median Pay
Male	16,313.63	9,048.00
Female	4,185.12	3,804.26
Difference	12,128.51	5,243.75
Pay Gap %	74.35	57.95

Table 4

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	10.00	6001.00	0.17
Male	60.00	1498.00	4.01

The data in tables 3 & 4 relates to National Clinical Impact Awards (NCIAs) for medical staff as this is the only payment identified within the ESR standard report which falls within the set definition of 'bonus pay'. NCIA's aim to reward the consultants who contribute most to the delivery of safe and high-quality care and the improvement of NHS services. In previous years Local Clinical Excellence awards (LCEAs) have been available but the last award round for this took place during 2023/24.

The data highlights that the average bonus pay gap for females as at March 2025 is 74.35% and the median pay gap is 57.95%. This is a deterioration compared to the previous year where the figures were 57.93% average bonus pay and 0.00% median bonus pay gap. In previous years where the LCEAs were available the amount was equally split which would have had a positive impact on the pay gap figures.

As at 31st March 2025 0.17% of female staff received a bonus payment in comparison with 4.01% of male staff. All consultants with a minimum of 12-months service are eligible to submit an application for NCIAs so when reviewing these figures consideration should be given to the overall consultant workforce profile which is predominately male at 72.5%, and this should provide some context as to the disparity of the number of male applications compared to the number of female applications. Consideration should also be given to the number of consultants excluding locums and the proportion of these receiving a bonus. There were 236 consultants excluding locums, 4% of female consultants were paid a bonus and 25% of male consultants were paid a bonus. Last year the proportion of female consultant and male consultants receiving a bonus were far more comparable (83% female and 86% male).

Agenda item: [21]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Standing Financial Instructions
Presented to:	Board of Directors
On:	1st April 2026
Item purpose:	Approval
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Shirley Martland, Associate Director of Financial Services and Payroll
Contact details:	E: shirley.martland@wwl.nhs.uk

Executive summary

The purpose of this paper is to seek adoption of the changes made to the Trust's Standing Financial Instructions (SFIs) and Budgetary Control and Delegation Arrangements by the Board of Directors. These changes were endorsed by the Audit Committee on 23rd February 2026.

Each year a review of the SFI's is undertaken to ensure that the policy accurately reflects current policies, procedures, and practice. There have been no fundamental changes to the SFIs other than some minor amendments which are detailed within this report.

Link to strategy and corporate objectives

None.

Risks associated with this report and proposed mitigations

None.

Financial implications

None.

Legal implications

None.

People implications

None.

Equality, diversity and inclusion implications

None.

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

Senior Finance Team, Audit Committee

Recommendation(s)

It is recommended that the Board of Directors adopt the changes made to the Trust's Standing Financial Instructions (SFIs) and Budgetary Control and Delegation Arrangements as recommended by Audit Committee on 23rd February.

Report

Background

The SFIs detail the financial responsibilities, policies, and procedures to be adopted by the Trust and are designed to ensure that its financial transactions are carried out in accordance with the law and government policy to achieve probity, accuracy, economy, efficiency, and effectiveness.

Each year a review of the SFI's is undertaken to ensure that the policy accurately reflects current policies, procedures, and practice.

Key changes

There have been no fundamental changes to the SFIs. Minor amendments have been made, including updated references to legislation and revisions to banking procedures to reflect that the Trust no longer uses cheques. These changes are detailed in Appendix 1.

Future amendments

The Trust Provider Collaborative (TPC) has formally agreed on eight strategic priorities for 2025/26 and the Trust Finance team is currently leading on two key initiatives that are central to enabling transformation across the Greater Manchester (GM) footprint:

Implementation of a shared general ledger and the Formation of the Greater Manchester Procurement Collaborative.

A dedicated workstream has been established to review the amendments required to the (SFIs) arising from the transition to the Greater Manchester Procurement Collaborative which are expected to be contract awards approval process, procurement activity thresholds and waiver approval thresholds. The implementation date is anticipated to be during 2026/27.

Any further changes to the SFI's following completion of the above initiatives will be brought back to Audit Committee for approval.

Recommendation

It is recommended that the Board of Directors approve the changes made and to recommend these changes for adoption.

Appendix 1

Amendments

Addition of reference to the Economic Crime and Transparency Act 2023 (*SFI 2.22 Page 12)*

Amended SFI 3.6 page 13

From: Budget holders, with divisional responsibility, will electronically sign off their allocated income and expenditure plans at the commencement of each financial year via the Trust's devolved financial management system, the Finance Hub app via Qlik.

To: Budget holders with divisional responsibility will formally approve their allocated income and expenditure plans at the commencement of each financial year, in accordance with the Trust's financial management processes.

Removal of reference to cheques under banking procedures *(SFI 5.5 page 17)*

Amended SFI 6.18 page 19

From: The opening of incoming post shall be undertaken by two officers except were authorised in writing by the Chief Finance Officer. All cash, cheques, postal orders and other forms of payment received shall be entered in an approved form of remittance register. All cheques and postal orders shall be crossed "Not Negotiable Account Payee Only – Wrightington, Wigan and Leigh NHS Foundation Trust". The remittance register should be passed to the cashier from whom a signature should be obtained

To: All incoming correspondence containing financial instruments or payment notifications shall be handled in accordance with approved security procedures. Where physical payments (e.g., cash or cheques) are received, they must be recorded promptly in the approved financial system and secured until banking. Cheques should be crossed "Account Payee Only – Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust." Access to incoming post or electronic remittance advice must be restricted to authorised staff, and appropriate segregation of duties maintained.

Removed the following sentence on the basis that cheques and GBS orders are no longer used:

All unused cheques and GBS orders will be held as controlled stationery and issued in accordance with controlled stationery procedures.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

Approved by the Audit Committee: 23rd February 2026
Review date: September 2025

The WWL Way

FOREWORD

Within the Terms of Authorisation issued by the sector regulator, NHS foundation trusts are required to demonstrate the existence of comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2003.

The standard requires boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to all staff and those representing the Trust. Additionally, the Board has drawn up locally generated rules and instructions, including delegation arrangements and financial procedural notes, for use within the Trust. Collectively these comprehensively cover all aspects of (financial) management and control. They set the business rules which directors, employees and the Council of Governors (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

SFIs are mandatory for all directors, employees including temporary, fixed term and contract staff and members of the Council of Governors.

CONTENTS

Further references and financial procedures are retained in the Finance Department section of the intranet.

The following policies are specifically referenced.

- Intellectual Property Policy
- Commercial Representatives Policy
- Counter Fraud, Corruption and Bribery Policy and Response Plan
- Conflicts of Interest Policy
- Disciplinary Policy
- Code of Conduct Policy
- The Charity's Income and Expenditure Guidance documents.
- Temporary Staffing Policy

The Trust's Constitution, Standing Orders and the Schedule of Matters Reserved are also referenced.

SFI 1. INTRODUCTION

Purpose and scope

SFI 1.1 These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

SFI 1.2 These SFIs also detail the delegation by the Board of powers and approval limits to officers of the Trust, and as such, contain the Trust's Scheme of Delegation.

SFI 1.3 The Trust's Schedule of Matters broadly outlines those decisions and duties specifically reserved to the Board of Directors. These matters are not delegated, and as such, the Schedule of Matters represents the Trust's Scheme of Reservation. It is therefore recommended that the Schedule of Matters is read in conjunction with these SFIs and the Scheme of Delegation contained herein.

SFI 1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer must be sought before acting.

SFI 1.5 Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of Fraud reported to the Local Counter Fraud Specialist.

SFI 1.6 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible. Please refer to Appendix A for further details on compliance.

SFI 1.7 Where failure to comply with this document constitutes a criminal offence it may result in a criminal investigation and criminal sanctions being applied.

SFI 1.8 These Instructions are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

Terminology

SFI 1.9 Any expression to which a meaning is given in the National Health Service Act 2006, National Health Service and Community Care Act 1990 and other acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Financial Instructions, and in addition:

(a) **"Trust"** means **Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.**

(b) "**Accounting Officer"** means the officer responsible to Parliament for the resources under their control. They are responsible for ensuring the proper stewardship of public funds and assets. The National Health Service Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer. The definition of duties and responsibilities of the Accounting Officer are set out within the NHS Foundation Trust Accounting Officer Memorandum.

(c) **"Board"** means the Chairman, Executive Directors and Non-Executive Directors of the Trust collectively as a body.

(d) **"Council of Governors"** means the Council of Governors as constituted within the Constitution.

(e) **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

(f) **"Budget holder"** means the director or employee with delegated authority from the Accounting Officer to manage finances (income and expenditure) for a specific area of the organisation.

(g) **"Budget manager**" means an employee directly responsible to a budget holder.

(h) **"Budget operator**" has delegated power from a budget manager to control a particular budget(s). Such delegation of powers shall be within defined parameters and shall be recorded in writing.

(i) **"NHS England"** means the office of the Regulator of Health Services of England.

(j) **"Chairman of the Board (or Trust)"** is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

(k) **"Chief Executive"** means the Chief Officer (and the Chief Accounting Officer) of the Trust.

(l) **"Chief Finance Officer"** means the Chief Financial Officer of the Trust.

(m) **"Executive Director"** means a Director of the Trust who may also be an officer.

(n) **"Non-Executive Director"** means a member of the Board of Directors who does not hold an executive office of the Trust.

(o) **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

(p) **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and guidance from NHS England and the Department of Health and Social Care.

(q) **"Committee"** means a committee or sub-committee created and appointed by the Trust.

(r) **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

(s) **"Charitable funds"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under s90 of the NHS Act 1977 and the NHS and Community Care Act 1990, as amended.

(t) **"SFIs"** means Standing Financial Instructions.

(u) **"SOs"** means Standing Orders, which are contained within the Trust's Constitution.

SFI 1.10 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

SFI 1.11 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

Responsibilities and delegation

SFI 1.12 **The Board of Directors** exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on members of the Board and employees as indicated within these Instructions.

SFI 1.13 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees as the Trust has established. These provisions are set out in the Trust's Schedule of Matters.

SFI 1.14 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control. Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

SFI 1.15 The Chairman and Chief Executive must ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.

SFI 1.16 It is a duty of the Chief Executive to ensure that members of the Board, employees, and all new appointees are notified of, and put in a position to understand their responsibilities within, these Instructions.

SFI 1.17 In line with the requirements of the NHS Act (2006) the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with NHS Counter Fraud Authority standards for Providers for Fraud, Bribery and Corruption, in accordance with the NHS Standard Contract.

SFI 1.18 The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(a) the provision of financial advice to the Trust, Directors and employees;

(b) the design, implementation and supervision of systems of internal financial control; and

(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

SFI 1.19 All Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, the Schedule of Matters, Standing Financial Instructions (including Schemes of Delegation) and financial procedures.

SFI 1.20 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure, or who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

SFI 1.21 For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

SFI 2. AUDIT, FRAUD, CORRUPTION, BRIBERY AND SECURITY

Audit Committee

SFI 2.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook and in accordance with the Audit Code for NHS Foundation Trusts issued by NHS Improvement, which will provide an independent and objective view of internal control by:

(a) ensuring that there is an effective internal audit function established by management, that meets mandatory Public Sector Internal Audit Standards;

(b) reviewing the work and findings of the external auditors;

(c) reviewing financial and information systems, monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements;

(d) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(e) monitoring compliance with Standing Orders and Standing Financial Instructions;

(f) reviewing schedules of losses and special payments, making recommendations to the Board; and

(g) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

SFI 2.2 Where the Audit Committee considers there is evidence of ultra vires transactions or improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board.

SFI 2.3 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

Chief Finance Officer

SFI 2.4 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS foundation trust audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud, corruption or bribery;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(e) a clear opinion on the effectiveness of internal control in accordance with the current Risk assessment framework issued by NHS England including, for example, compliance with control criteria and standards;

(f) major internal financial control weaknesses discovered;

(g) progress on the implementation of internal audit recommendations;

(h) progress against plan over the previous year;

(i) a strategic audit plan covering the coming three years; and

(j) a detailed plan for the next year.

SFI 2.5 The Chief Finance Officer or designated auditors are entitled, without necessarily giving prior notice, to require or receive:

SFI 2.6 access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

SFI 2.7 access at all reasonable times to any land, premises, members of the Board and Council of Governors or employees of the Trust;

SFI 2.8 the production of any cash, stores or other property of the Trust under a member of the Board or employee's control; and

SFI 2.9 explanations concerning any matter under investigation.

Role of internal audit

SFI 2.10 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data; and

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, or inefficient administration; or

(iii) poor value for money or other causes.

SFI 2.11 Whenever any audit matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

SFI 2.12 The Director of Internal Audit/Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

SFI 2.13 The Director of Internal Audit/Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Director of Internal Audit in the form of an Internal Audit Charter. The Charter will comply with guidance on reporting contained in the Public Sector Internal Audit Standards. The Charter will be reviewed at least every three years.

External audit

SFI 2.14 The external auditor is appointed, through a formal process, by the Council of Governors following recommendation from the Audit Committee which should ensure that a cost efficient service is being provided. Where a problem arises in the provision of this service it should be raised with the external auditor and referred on to NHS England if the issue cannot be resolved.

SFI 2.15 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors, based on recommendations from the Audit Committee. The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by NHS England within the Audit Code for NHS Foundation Trusts, at the date of appointment and on an on-going basis throughout the term of their appointment.

Fraud, corruption and bribery

SFI 2.16 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate counter fraud arrangements. In line with their responsibilities, the Trust Chief Executive and Chief Finance Officer shall monitor and ensure compliance on fraud, corruption and bribery as set out in NHS Counter Fraud Authority Standards for providers.

SFI 2.17 The Trust shall nominate a suitable person to carry out the duties of the Local Counter-Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Manual and guidance.

SFI 2.18 The Local Counter Fraud Specialist shall report to the Chief Finance Officer and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Counter-Fraud Manual.

SFI 2.19 The Local Counter Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. In addition, a Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

SFI 2.20 The Bribery Act (2010) came into force on 1st July 2011. Under the Bribery Act it is a criminal offence for organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

SFI 2.21 The Act:

(a) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) makes it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

SFI 2.22 The Economic Crime and Corporate Transparency Act 2023 (‘ECCTA)’

The Economic Crime and Corporate Transparency Act 2023 (‘ECCTA’) has introduced a new offence of failure to prevent fraud (1st September 2025) by persons associated with a business. NHS bodies now face a potentially unlimited fine where:

(a) An associate of the organisation commits a specified fraud offence; and
(b) the fraud is intended to benefit the organisation, directly or indirectly, or a person to whom services are provided on behalf of the organisation.

The definition of ‘associate’ casts the net very wide and includes employees, suppliers, subsidiaries, and anyone performing a service for or on behalf of the Trust.

The failure to prevent fraud offence is a strict liability offence where the organisation will be liable. A statutory defence is available if the Trust has in place reasonable procedures to prevent fraud. The Trust will ensure that it meets the six guiding principles in which counts as “reasonable procedures” for fraud prevention under ECCTA (Economic Crime and Corporate Transparency Act).

All individuals involved will also be personally liable and may be prosecuted for their role in any offence.

Security management

SFI 2.23 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their

responsibilities, the Trust Chief Executive will monitor and ensure compliance on NHS security management.

SFI 2.24 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management. The Chief Executive has overall responsibility for controlling and coordinating security.

SFI 3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

Preparation and approval of plans and budgets

SFI 3.1 The appropriate Executive Director will compile and submit to the Board a Business Plan, which considers national and system planning guidance, capacity and demand, and workforce, estates and financial targets. The annual business plan will represent the target operating model for the financial year, operationalising the requirements and focus for the coming year to support the Trust's longer term strategic objectives. The Business Plan will contain:

(a) a statement of the significant assumptions on which the plan is based; and

(b) details of major changes in workload, delivery of services, or resources required to achieve the plan.

The Business Plan will be submitted to the Greater Manchester Integrated Care Board and NHS England in line with their deadlines, guidance, and requirements.

SFI 3.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit income and expenditure plans for approval by the Board. Such plans will:

(a) be in accordance with the aims and objectives set out in the Business Plan;

(b) triangulate with workforce, activity and efficiency plans

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

SFI 3.3 The Trust shall submit information in respect of its financial plans to the Greater Manchester Integrated Care Board and NHS England, once approved by the Board of Directors.

SFI 3.4 The Chief Finance Officer will monitor actual financial performance against plan and report variances and risks to the Board.

SFI 3.5 All budget holders must provide information as required by the Chief Finance Officer to enable income and expenditure plans to be compiled.

SFI 3.6 Budget holders with divisional responsibility will formally approve their allocated income and expenditure plans at the commencement of each financial year, in accordance with the Trust's financial management processes.

SFI 3.7 with divisional responsibility, will electronically sign off their allocated income and expenditure plans at the commencement of each financial year via the Trust's devolved financial management system, the Finance Hub app via Qlik.

SFI 3.8 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders, to help them manage their delegated financial performance successfully.

Budgetary delegation

SFI 3.9 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the value of the delegated budget;

(b) the purpose(s) of each budget heading;

(c) whole time equivalents (WTEs) in respect of pay budgets;

(d) individual and group responsibilities;

(e) authority to exercise virement;

(f) achievement of planned levels of service; and

(g) the provision of regular reports.

SFI 3.10 The Chief Executive, Executive Directors, Clinical Directors and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

SFI 3.11 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

SFI 3.12 Non-recurring budgets shall not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

Budgetary control and reporting

SFI 3.13 The Chief Finance Officer will devise and maintain systems of budgetary control and reporting. These will include the following:

(a) Bi-monthly financial reports to Finance and Performance Committee and Board, including:

(i) Key performance indicators via the Integrated Performance Report;

(ii) income and expenditure to date showing trends and forecast year-end position;

(iii) income and expenditure

(iv) movements in working capital;

(v) movements in cash and capital;

(vi) capital project expenditure and projected outturn against plan;

(vii) explanations of any material variances from plan; and

(viii) details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation.

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

(c) Investigation and reporting of variances from financial, activity and manpower budgets.

(d) Monitoring of management action to address variances.

(e) Arrangements for the authorisation of budget transfers.

(f) Advice to the Chief Executive and the Board on the consequences and economic and financial impact on future plans and projects of a change in policy, pay awards and other events and trends affecting budgets.

SFI 3.14 Each budget holder is responsible for ensuring that:

(a) they remain within their budget allocation;

(b) any planned reduction in income or overspending on expenditure, which cannot be addressed by virement, are reported to the Board of Directors;

(c) the amount provided in an approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

(d) all recruitment of fixed term or permanent employees must be approved via the Trust's current recruitment policy. Approval must be gained prior to engaging services of any and all agency workers;

(e) they remain within their funded establishment;

(f) they identify and implement cost improvements and income generation initiatives in accordance with the requirements of the approved budget; and

(g) any proposal to increase revenue spending has an appropriate funding stream identified and that this has been agreed by the Chief Executive. Proposals to increase revenue spending should also be signed off by the Chief Finance Officer. This applies to all revenue developments whether part of Annual Business Plan discussions or separate business case initiatives, however funded.

SFI 3.15 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Business Plan.

Budget transfer - virement

SFI 3.16 The facility of virement is available between budget holders/managers of different budgets. Virement can involve the following different types of transfers:

(a) Transfers between non-pay budgets;

(b) Transfers between staff budgets; and

(c) Transfers from staff to non-pay budgets. NB: Transfers from non-pay to staff budgets are not allowable unless agreed and documented, by the Executive Team or as part of the business planning process.

SFI 3.17 There is no financial ceiling limiting the amount of any one virement transfer. In all cases, the Divisional Finance Manager shall be consulted. It is paramount that virement changes do not undermine the integrity of the budgets.

SFI 3.18 To proceed with budget virements the agreement of both parties should be sought by the Divisional Finance Manager.

Capital expenditure

SFI 3.19 The general rules applying to delegation and reporting shall also apply to capital expenditure.

Monitoring of performance

SFI 3.20 The Chief Executive is responsible for ensuring that

(a) the appropriate monitoring returns are submitted to NHS England;

(b) financial performance measures have been defined and are monitored and reasonable targets have been identified for these measures;

(c) a robust system in in place for managing performance against the targets; and

(d) reporting lines are in place to ensure all performance is managed and arrangements are in place to manage/respond to adverse performance.

Emergency expenditure

SFI 3.21 In instances which are deemed as critical the Chief Executive can approve unbudgeted revenue expenditure up to a value of £10,000 (per instance) and with the additional agreement of the Chairman up to £20,000 (per instance). Applications for such an approval must be submitted to the 'Associate Director of Financial Services and Payroll' who will then forward to the Chief Finance Officer for final submission to the CEO and Chairman**.**

SFI 4. ANNUAL ACCOUNTS AND REPORTS

SFI 4.1 The Chief Finance Officer, on behalf of the Trust, will

(a) keep accounts, and in respect of each financial year;

(b) prepare annual accounts, in such form as NHS England and Department of Health and Social Care may, with the approval of the Treasury, direct;

(c) ensure that, in preparing annual accounts, the Trust complies with any directions given by NHS England and Department of Health and Social Care with the approval of the Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared; and

(ii) the information to be given in the accounts.

(d) ensure that a copy of the annual accounts, and any report of the External Auditor on them, are laid before Parliament and that copies of these documents are sent to NHS Improvement; and

(e) submit financial returns to NHS England for each financial year in accordance with NHS Improvement's timetable.

SFI 4.2 The Trust's audited annual accounts must be presented to the Board for approval and received by the Council of Governors at a public meeting.

SFI 4.3 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented at a public meeting and made available to the public.

SFI 4.4 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health and Social Care Group Accounting Manual.

SFI 5. BANK AND GBS ACCOUNTS

General

SFI 5.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

SFI 5.2 The Chief Finance Officer is responsible for negotiating the Trust's banking contracts, establishing any associated mandates and naming personnel to be signatories for banking transactions.

SFI 5.3 No employee may open or hold a bank account in the name and/or address of the Trust or of its constituent hospitals/departments. Any employee aware of the existence of such an account shall report the matter to the Chief Finance Officer.

Bank and GBS accounts

SFI 5.4 The Chief Finance Officer is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's charitable funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board of any external borrowing requirements; and

(e) ensuring that procedures are maintained that document all transaction processing relating to Trust bank accounts.

Banking procedures

SFI 5.5 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to draw on the Trust's accounts.

SFI 5.6 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

Banking tendering and review

SFI 5.7 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

SFI 5.8 Competitive tenders should be sought at least every five years, unless the Board determines otherwise. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

SFI 6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

Income systems

SFI 6.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

SFI 6.2 Credit note authorisation will be determined for each manager depending on their role/responsibility and a list of managers who are set up to undertake such approvals is maintained within Oracle.

SFI 6.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

Fees and charges

SFI 6.4 The Trust shall follow NHS Improvement's guidance in setting prices for NHS Service contracts, where services are not covered by a mandatory National Tariff. The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS England (such as Payment by Results National Tariffs), HM Treasury or by statute. Independent professional advice on matters of valuation shall be taken as necessary.

SFI 6.5 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the NHS Commissioning Board – Standards of Business Conduct shall be followed.

SFI 6.6 All employees must ensure that an appropriate Service Level Agreement is in place in respect of all transactions which they may initiate or deal with that results in an income stream for the Trust. This will include but is not limited to contracts, leases, tenancy agreements, private patient undertakings. Employees must also ensure that an appropriate mechanism is in place for raising timely invoices to recover income due on such transactions.

Debt recovery

SFI 6.7 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

SFI 6.8 Income which is deemed due, but possibly uncollectable, should be dealt with in accordance with debt recovery procedures, and reported as a write-off loss (SFI 15.5) where appropriate.

SFI 6.9 Overpayments should be detected (or preferably prevented) and recovery initiated.

Security of cash, cheques and other negotiable instruments

SFI 6.10 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

SFI 6.11 Trust cash shall not under any circumstances be used for private transactions such as the encashment of private cheques, bank to bank transfers or temporary loans.

SFI 6.12 Trust accounts should not be used for ad hoc temporary banking of employee funds or other monies unrelated to Trust business and income, except patients' monies held in trust.

SFI 6.13 Trust credit cards should not be used for personal expenditure, even if there is an intention to reimburse the Trust.

SFI 6.14 Trust credit cards should not be used to pay employee expenses without prior approval, as these should be reimbursed via Payroll.

SFI 6.15 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

SFI 6.16 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

SFI 6.17 During the absence (whether sickness or annual leave etc.) of the authorised safe key holder, the officer who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be a written discharge of the safe and/or cash box contents on the transfer of responsibilities, with the discharge document authorised by the relevant senior officer and retained for audit inspection.

SFI 6.18 All incoming correspondence containing financial instruments or payment notifications shall be handled in accordance with approved security procedures. Where physical payments (e.g., cash or cheques) are received, they must be recorded promptly in the approved financial system and secured until banking. Cheques should be crossed "Account Payee Only – Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust." Access to incoming post or electronic remittance advice must be restricted to authorised staff, and appropriate segregation of duties maintained.

SFI 6.19 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately. Where there is prima facie evidence of fraud, corruption and bribery it will be necessary to follow the Trust's Counter Fraud Corruption and Bribery Policy and Response Plan. Where there is no evidence of fraud and corruption the loss shall be reported in line with losses procedures.

SFI 7. TENDERING AND CONTRACTING PROCEDURE

General

SFI 7.1 The procedure for making all contracts by, or on behalf of, the Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions.

SFI 7.2 The approval of business cases prior to the procurement process is covered in SFI 24.

SFI 7.3 **In all instances, the intended expenditure should be reflective of the total life cycle costs of provision of the goods and / or services.**

Procurement

Competitive quotations

SFI 7.4 Competitive quotations are required where the intended expenditure or income is equal to, or is reasonably expected to exceed £10,000 but not exceed £50,000 ex VAT.

(a) Quotations should be obtained from at least three suppliers based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(b) Quotations should be submitted by email or via electronic sourcing software, as deemed appropriate by the Procurement Department.

(c) All quotations should be treated as confidential and should be retained for inspection.

(d) The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation (if payment is to be made by the Trust), or not the highest (if payment is to be received by the Trust), then the choice made and the reasons why should be recorded in a permanent record.

SFI 7.5 Contract and tendering procedures within these SFIs should be applied to quotations as best practice.

Competitive tendering

SFI 7.6 Competitive tenders are required where the intended expenditure or income is equal to or is reasonably expected to exceed £50,000, but not exceed the relevant Procurement Legislation threshold ex VAT.

SFI 7.7 The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) disposals of Trust property or goods (unless specified in **Error! Reference source not found.**).

SFI 7.8 Formal tendering procedures need not be applied where:

(a) the estimated expenditure or income does not, or is not reasonably expected to exceed £50,000 excluding VAT;

(b) the supply is proposed under special arrangements negotiated by the DH, in which event the said special arrangements must be complied with;

(c) the Trust is disposing of Trust assets, as set out in SFI 7.69

(d) the requirement is covered by an existing contract (this includes contracts let by external agencies on behalf of the NHS e.g. NHS Supply Chain); or

(e) there is a national or regional sole supplier agreement in place.

Non–competitive waivers

SFI 7.9 In exceptional instances where competitive quotations and tenders are not deemed possible, Trust officers should seek the approval of the Trust to waive these requirements.

SFI 7.10 Requirements of a statutory nature, and/or services provided by other public sector organisations that are sole suppliers are excluded from these tendering procedures and will not require a non-competitive waiver.

SFI 7.11 Continued professional development and/or training courses that are either sole supplier, provided by another public sector organisation or selected on the basis of geographical location will not require a non-competitive waiver.

SFI 7.12 Contracts for the purchase or rental of land, existing buildings or other immovable property or concerning rights on such property are excluded from the Public Contract Regulations and as such will not require a non-competitive waiver

SFI 7.13 A waiver is not required where a repair is needed to equipment that is covered by an existing approved framework maintenance agreement, and the value of the repair is below £20,000 (ex VAT).

SFI 7.14 Quotation and tendering procedures may only be waived in the following circumstances:

(a) very exceptionally, where the Chief Executive decides that formal tendering procedures would not be appropriate, however in such instances the benefits and rationale must be clearly demonstrated;

(b) timescales - where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(c) sole supplier - where specialist expertise is required and is available from only one source;

(d) maintaining continuity – when there is a clear benefit to be gained from maintaining continuity with an earlier project and/or engaging a different supplier for the new task would be inappropriate. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering (financial evidence must be provided in support); or

(e) standardisation where the requirement is an addition to a previously tendered range of goods and services and clearly supports the Trust policy for standardisation.

SFI 7.15 The waiving of competitive quotation or tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

SFI 7.16 Where it is decided that a competitive quotation/ tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

Authorisation of waivers

SFI 7.17 Where competitive tendering or a competitive quotation process is to be waived, the authorisation limits stipulated are as follows.

Amount	Authorisation
Less than £10,000 ex VAT	No waiver required
£10,001k - £50,000 ex VAT	Deputy Director of Operational Finance or Programme Director – Financial Transformation
£50,001 - £100,000 ex VAT	Director of Operational Finance
£100,001 to legislative threshold ex VAT	Chief Finance Officer
Up to and over legislative threshold ex VAT	Chief Executive (or Deputy)

SFI 7.18 Expenditure exceeding the relevant legislative threshold may not be waived, unless specified in the Procurement legislation. The Trust Procurement Department will advise in these circumstances.

Frameworks and approved supplier lists

SFI 7.19 The Trust shall use framework operators and their associated framework contracts, as approved by NHSE Central Commercial function. If the Trust does not use frameworks as mentioned in SFI 7.19, and where tenders or quotations are not required because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

SFI 7.20 The Trust shall ensure that the suppliers invited to tender for estates-related contracts (and where appropriate, quote) are among those on approved lists such as, ProCure22 or the latest DHSC framework providing design and construction services or those outlined in SFI 7.19.

SFI 7.21 All firms who have applied for permission to tender must satisfy the Trust as to their technical and financial competence. All suppliers must adhere, where appropriate, to the standard NHS Terms and Conditions.

Exceptions to using approved contractors

SFI 7.22 If, in the opinion of the Chief Executive and either the Chief Finance Officer or the Director with lead responsibility for clinical governance, it is impractical to use a potential contractor from the list of approved suppliers (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

Contracting/tendering procedure

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

SFI 7.24 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders, and no tender will be considered for acceptance unless submitted through the e-tender system, as instructed within the tender documentation.

SFI 7.25 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

SFI 7.26 Every tender for goods and services shall embody the NHS Terms and Conditions and, as appropriate, the contract form required for the specific goods and services.

SFI 7.27 Where the Trust is tendering to undertake the provision of goods/services for another organisation then a full financial appraisal must be undertaken and approved by Executive Team Meeting (ETM) prior to any invitation to tender being submitted. Where approval has been granted a full business case must be completed and approved in accordance with the business case approval process during the period in which the contract is being agreed.

Receipt and safe custody of tenders

SFI 7.28 All tenders must be issued and managed via the Trust’s, or other approved, electronic tendering systems. No hard copy tenders will be accepted.

SFI 7.29 Electronic tenders will be held and locked electronically until the allocated time and date for opening.

Opening tenders

SFI 7.30 The electronic tendering system is a fully automated, auditable system which seals bids until the response deadline has passed. Therefore, the originating Contract Manager will be deemed authorised to access the electronic tenders and release them once the sealed date and time has passed.

SFI 7.31 A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

Admissibility of tenders

SFI 7.32 In considering which tender to accept, if any, the designated officer(s) shall have regard to whether value for money will be obtained and whether the number of tenders received provides adequate competition.

SFI 7.33 Tenders received after the due time and date may be considered only if the tenders received on the due date have not been opened and the designated officer(s) decide that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, being satisfied that there is no reason to doubt the bona fides of the tenders concerned.

SFI 7.34 The Chief Executive or the Chief Finance Officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition.

SFI 7.35 Technically late tenders (i.e. those dispatched in good time but delayed through no fault of the tenderer) will be regarded as having arrived in due time.

SFI 7.36 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon their own

initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

SFI 7.37 Where examination of tenders reveals errors, which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

SFI 7.38 Necessary discussions with a tenderer regarding the contents of their tender, in order to elucidate before the award of a contract, need not disqualify the tender.

SFI 7.39 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

SFI 7.40 Where only one tender/quotation is received, the designated officer(s) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

SFI 7.41 A tender other than the most economically advantageous tender shall not be accepted unless for good and sufficient reason and a record of that reason be created and approved by the Chief Executive and held with the appropriate tender documentation.

SFI 7.42 Where the form of contract includes a fluctuation clause, all applications for price variations must be submitted in writing by the tenderer and shall be approved by either the Chief Executive or the Chief Finance Officer.

SFI 7.43 All Tenders should be treated as confidential and should be retained for inspection.

Acceptance of tenders

SFI 7.44 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

SFI 7.45 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless the Chief Executive determines that there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

SFI 7.46 It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach; and

(d) ability to complete the project on time.

SFI 7.47 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

SFI 7.48 Post tender negotiations on price shall not be entered into without the specific prior approval of the Chief Finance Officer in writing and must be in accordance with UK and Procurement legislation. Such approvals shall not be given without prior consultation with the Chairman of the Audit Committee or the Chairman of the Finance & Performance Committee. Such negotiations are to be carried out by a senior manager specifically designated by the Chief

Finance Officer, witnessed by a second manager, and approved by the Chief Executive. The range and scope of the negotiations are to be determined by the Chief Finance Officer on each and every occasion.

SFI 7.49 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions, except with the authorisation of the Chief Executive.

SFI 7.50 The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate/price current at the time the contract was awarded, and that best value for money was achieved.

SFI 7.51 All tenders should be treated as confidential and should be retained for inspection.

Signing of contracts

SFI 7.52 In all instances, the Trust's Procurement Team must be engaged in the tender procurement process prior to an official order being raised.

SFI 7.53 SFI 7.52 to SFI 7.56 refers specifically to circumstances where a contract needs to be signed (see DHSC guidance document available on the www.gov.uk website).

SFI 7.54 Contracts should be approved as follows:

Amount	Authorisation
Less than £10,000 ex VAT	Trust Procurement Manager
£10,001k - £25,000 ex VAT	Deputy Director of Operational Finance or Programme Director – Financial Transformation
Up to £50,000 ex VAT	Director of Operational Finance
Up to legislative threshold ex VAT	Chief Finance Officer
Over legislative threshold ex VAT	Chief Executive (or Deputy)

Tender reports to the Board of Directors

SFI 7.55 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

Fair and adequate competition

SFI 7.56 The Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and, unless not practicable, in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

Expenditure to be within financial limits

SFI 7.57 No tender or quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

Reverse e-auctions

SFI 7.58 Where appropriate, the Trust will use e-auctions, and partner organisations to conduct e-auctions on its behalf and will determine throughout the year the most appropriate product areas that will achieve the best value by being managed through an e-auction.

SFI 7.59 The results of the e-auction will be made available for scrutiny and ratification using a similar process to that of electronic tenders, and a record will be kept of the submissions in full.

Health care services

SFI 7.60 Where the Trust elects to invite tenders for the supply of health care services, these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

Items which subsequently breach thresholds after original approval

SFI 7.61 Items estimated to be below the limits set in these Standing Financial Instructions for which formal tendering procedures are not used, which subsequently prove to have a value above such limits, shall be reported to the Audit Committee on a quarterly basis and be recorded in an appropriate Trust record.

Authorisation of tenders and competitive quotations

SFI 7.62 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided in line with SFI 7.52.

SFI 7.63 In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

Private finance for capital procurement

SFI 7.64 When considering PFI funding the Trust should normally market-test. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) a business case must be referred to the Department of Health and Social Care, NHS Improvement, or as per current guidelines.

(c) the proposal must be specifically agreed by the Board of the Trust; and

(d) the selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Compliance requirements for all contracts

SFI 7.65 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) the Trust's Standing Orders and Standing Financial Instructions;

(b) Procurement legislation and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Health Building Note 00-08: Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable; and

(e) appropriate NHS guidance regarding the form of contracts with foundation trusts.

SFI 7.66 Where appropriate, contracts shall be in, or embody, the same terms and conditions of contract as the basis on which tenders or quotations were invited.

SFI 7.67 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all available systems in place.

SFI 7.68 Commercial negotiations and the establishment of a contract management framework may only be undertaken by members of the Procurement Department, unless otherwise authorised by the Chief Executive or Chief Finance Officer.

Disposals

SFI 7.69 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the relevant disposal policy of the Trust;

(c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

(d) land or buildings subject to compliance with DH guidance.

In-house services and benchmarking

SFI 7.70 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering. This will be undertaken adopting a two-stage process.

SFI 7.71 The process for undertaking the Best Value Review is set out below.

(a) Establish a cross-functional project team, to include senior representatives from the department which is the focus of the exercise, Finance, Procurement, staff-side and HR, with project management responsibility residing with the Associate Director of Procurement.

(b) The project team will be responsible for the scope and specifics of the departmental review. This should include quality targets and innovations, as well as cost analysis. Specific metrics would include the range of services offered, head count, and comparison of KPI data, with the aim of providing the Trust with a holistic view of the value received from the existing in-house service provider. For benchmarking, at least one comparator must be an external provider.

(c) The project team are responsible for the production of a report in which improvements/opportunities are identified. The department or service in question is then given a period of 3 months to make any necessary improvements to the in-house service provision, to align itself to the ‘best in class’ targets. Where improvements are not achieved, escalation to a full ‘market testing’ exercise is an executive decision.

SFI 7.72 On the basis of the outcome of the benchmarking exercise, the Trust may determine that in-house services should be market tested by competitive tendering.

SFI 7.73 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) specification group, comprising the Chief Executive or nominated officer(s) and specialist;

(b) in-house tender group, comprising a nominee of the Chief Executive and technical support; and

(c) evaluation team, comprising normally a specialist officer, a Procurement officer and a representative of the Chief Finance Officer.

SFI 7.74 All groups should work independently of each other, and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

SFI 7.75 The evaluation team shall make recommendations to the Board.

SFI 7.76 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

Applicability of SFIs on tendering and contracting to funds held in trust

SFI 7.77 These Instructions shall equally apply to expenditure from charitable funds.

SFI 8. NON-PAY EXPENDITURE

Delegation of authority

SFI 8.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

SFI 8.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

SFI 8.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

Authorisation levels for approval of purchase orders

SFI 8.4 The below table details the internal approval levels and limits applicable for the procurement of goods and services through the Trust's procurement order processing system.

SFI 9.

Approval Level	Approval Level - Posts	Approval Limit
1	Chief Executive/Deputy Chief Executive/Chief Finance Officer	£1,000,000
2	Director of Operational Finance	£300,000
3	Executive Director	£250,000
4	Associate Director / Deputy Director	£150,000

5	Head of Department or Service	£20,000
6	Deputy Head of Department/Head of Service	£10,000
7	Senior Department/Service Manager	£5,000
8	Department/Service Manager	£2,500
9	Department/Service Approver	£1,000
10	Requestor Only	N/A

SFI 9.1 In cases where expenditure is over £1,000,000, the Chief Executive's limit will be increased to allow electronic authorisation in instances where the business case has been approved by the Board and evidence can be shown of this.

SFI 9.2 The table below details the internal approval limits applicable within the Procurement Department for the approval of purchase orders once authorisation has been given to expenditure.

Position	PO Approval Limit
Procurement Manager	£6,000,000
Contracts Managers	£250,000
Contracts Officer (Capital)	£100,000
eProcurement Manager/ /Assistant Contracts Manager	£100,000
Contracts/eProcurement Officer/Assistant	£50,000

SFI 9.3 The procurement process for goods, services or works depends upon whether expenditure is incurred from capital or revenue budgets, and refers to expenditure not already covered by existing NHS national or local contracts.

SFI 9.4 The limits below refer to whole life cost of the contract

SFI 9.4.1. Revenue expenditure

1. Below £10,000 Purchase order
2. £10,001 to £49,999 Quotation
3. £50,000 to legislative threshold for goods/services Local tender exercise
4. Over current legislative threshold for goods/services Tender exercise

SFI 9.4.2. Capital

1. Below £10,000 Purchase order
2. £10,001 to £49,999 Official quotations
3. £50,000 to legislative threshold for goods/services Local tender exercise
4. Over current legislative threshold for goods/services tTender exercise

Choice, requisitioning, ordering, receipt and payment for goods and services

SFI 9.5 *Requisitioning:* To ensure best value for money all purchases of goods and services must be made utilising the advice and services of the Trust's Procurement Department. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted. All requisitions shall be priced and include the relevant financial code.

SFI 9.6 *System of payment and payment verification:* The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

SFI 9.7 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds should be incorporated in these SFIs and regularly reviewed;

(b) prepare procedural instructions or guidance within these SFIs on the procurement of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, with the only exceptions set out in SFI 9.8 below; and

(e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for the following:

(i) A list of Directors/employees authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

SFI 9.8 *Prepayments:* Prepayments are only permitted where exceptional circumstances apply.

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.

(b) The appropriate authorised staff member must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is, at some time during the course of the prepayment agreement, unable to meet their commitments.

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Procurement legislation rules where the contract is above a stipulated financial threshold).

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

SFI 9.9 *Official orders:* Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Finance Officer;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

They may be transmitted by a system of Electronic Data Interchange (EDI) approved by the Chief Finance Officer.

SFI 9.10 *Duties of managers and staff:* Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and the relevant staff must ensure that:

(a) all contracts (except as otherwise provided for in these SFIs), leases, tenancy agreements and other commitments which may result in a liability are notified to the Procurement Department in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with Procurement legislations;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) all intellectual property (IP) benefits, such as copyright, patents, design rights, trademarks and confidentiality are protected and applied in all cases via the Trust's authorised representatives, (as established in the Trust's Intellectual Property Policy);

(e) discussions with suppliers in respect of commercial terms must not be undertaken other than by members of the Procurement Department;

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(g) all goods, services, or works are ordered on an official order except purchases from petty cash and purchases from suppliers identified on the agreed list of non-PO suppliers/services maintained by Financial Services and Procurement.

(h) verbal orders must only be issued very exceptionally and be accompanied by a purchase order number - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) requisitions/orders/petty cash requests are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(m) petty cash records are maintained in a form as determined by the Chief Finance Officer; and

(n) the Conflicts of Interest Policy (incorporating) Gifts and Hospitality Policy must be adhered to at all times, with no orders issued to or business transacted contrary to this policy.

SFI 9.11 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current guidance.

SFI 9.12 In the case of contracts for building or emergency works which require payment made on account during progress of the works, the Chief Finance Officer shall make payment upon receipt of a certificate from the appropriate technical consultant or works officer appointed to a particular building or engineering contract.

SFI 10. STORES AND RECEIPT OF GOODS

General position

SFI 10.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take; and

(c) valued at the lower of cost and net realisable value, or a weighted average in the case of Pharmacy.

Control of stores, stocktaking, condemnations and disposal

SFI 10.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of any fuel oil and coal shall be the responsibility of a designated estates manager.

SFI 10.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as Trust property.

SFI 10.4 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

(a) All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note should be obtained from the supplier at the time of delivery/service and signed by the staff member receiving the goods/service.

(b) Particulars of all goods/services received shall be registered on the day of receipt, with unsatisfactory goods returned to the supplier within the set timescales.

(c) Stock shall only be issued/released upon receipt of an authorised requisition.

SFI 10.5 All stock records shall be in such form and shall comply with such systems of control as the Chief Finance Officer may require.

SFI 10.6 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

SFI 10.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

SFI 10.8 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 15 Disposals and condemnations, losses and special payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

Goods supplied by NHS Supply Chain

SFI 10.9 For goods supplied via the NHS Supply Chain regional stores, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note ('priced advice note') before forwarding this to the Chief Finance Officer/Director of Operational Finance, depending on value, who shall satisfy him/herself that the goods have been received before accepting the recharge.

SFI 11. CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

Commissioner-related contracts

SFI 11.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Finance Officer regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

SFI 11.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices should comply with NHS Improvement's and NHS England's National Tariff Guidance.

SFI 11.3 The Chief Finance Officer shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

Non commissioner-related contracts

SFI 11.4 Where the Trust enters into a relationship with a non-NHS body or another NHS organisation for the supply or receipt of other services, either clinical or non-clinical, or collaborative arrangements and non-financial contracts, the responsible contracting officer should ensure that an appropriate Service Level Agreement (SLA) or other appropriate contract/collaboration agreement (e.g. in the context of research) is in place and has been signed by both parties. SLAs and other Research Contracts/Collaboration Agreements must be signed off as follows:

(a) For corporate SLAs, the Lead Executive (or nominated deputy)

(b) For divisional SLAs, the Divisional Director of Operations.

(c) For research contracts/collaboration agreements, the Chief Executive (or nominated deputy: Executive Director for Strategy and Planning or Clinical Director for Research

Plus, in all circumstances:

(d) Director of Operations and Performance (or nominated deputy)

(e) Chief Finance Officer (or nominated deputy)

(f) Either: Chief Nurse, or Medical Director (or nominated deputies)

SFI 11.5 This contract should incorporate:

(a) a description of the service and indicative activity levels;

(b) the term of the agreement including termination arrangements;

(c) the value of the agreement;

(d) the operational lead;

(e) performance and dispute resolution procedures; and

(f) risk management and clinical governance arrangements.

SFI 11.6 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

SFI 11.7 Copies of signed SLAs should be retained on file by the contracting officer and, where the contract specifies financial information, a copy should be issued to the appropriate Divisional Management Accountant within Finance.

SFI 11.8 Electronic copies of the SLA and sign off schedule should be submitted to the Head of Legal Services with summary details of the SLA expiry date and any review dates which occur during the term of the SLA.

SFI 11.9 All research contracts/agreements must be expedited and managed by the Research and Development Department in accordance with the National Institute for Health and Care Research (NIHR) standardised contract templates and in compliance with Department of Health and Social Care standard terms and conditions. The Research & Development Department manages all research costings and associated research income and expenditure with Divisional Financial Management oversight. This is performed in accordance with the Trust's Research and Development Policy and national research costing templates and guidelines. Bi-annual financial reports are provided to the Research Committee for review and assurance to the Board.

SFI 12. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EXECUTIVE COMMITTEE AND EMPLOYEES

Remuneration and terms of service

SFI 12.1 The Board shall establish a Remuneration Committee comprised of non-executive directors. Such Committee shall have clearly defined terms of reference which specify which posts fall under its remit as well as its composition and the arrangements for reporting.

SFI 12.2 The Committee will undertake the following:

(a) Decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors and any other senior employees under its remit, including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) payable expenses and compensation payments; and

(iv) arrangements for termination of employment and other contractual terms.

(b) monitor and evaluate the performance of the executive directors and any other senior employees under its remit; and

(c) oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

SFI 12.3 When deciding the remuneration, allowances and the other terms of service of the executive directors and any other senior employees under its remit, the Committee shall ensure that they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

SFI 12.4 The allowances paid to the non-executive directors shall be determined by the Council of Governors**.**

Funded establishment

SFI 12.5 The manpower plans incorporated within the annual budget will form the funded establishment.

SFI 12.6 The funded establishment of any department may not be varied without the approval of the Chief Executive unless in accordance with an establishment control procedure approved by the Board.

SFI 12.7 All budget holders must remain within their funded establishment unless prior consent has been granted by the Board.

Staff appointments

SFI 12.8 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; or

(b) unless the changes are within the limit of their approved budget and funded establishment; or

(c) the change is temporary and within the delegated powers of Pay Control Group.

SFI 12.9 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

Processing payroll

SFI 12.10 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

SFI 12.11 The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the current Data Protection Legislation;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payments to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) segregation of duties in preparing records and handling cash; and

(m) a system to ensure the recovery of sums of money and property, from those leaving the employment of the Trust, due by them to the Trust.

SFI 12.12 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

SFI 12.13 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

SFI 12.14 Advances of pay may only be given to staff to ensure timely remuneration of pay earned or reimbursement of legitimate expenses incurred in advance of normal pay processing. Loans may not be made to staff even if against potential future earnings.

SFI 12.15 Expenses should only be reimbursed via payroll. There should be no reimbursement for Trust purchases via payroll.

Contracts of employment

SFI 12.16 The Board shall delegate responsibility to the Chief People Officer for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment. Local pay variations require the written approval of the Chief People Officer.

SFI 12.17 The Chief Finance Officer will be responsible for maintaining up-to-date procedures, to ensure that assurance can be obtained from off-payroll workers to determine that the correct tax and NI contributions are being paid to HMRC.

SFI 13. EXTERNAL BORROWING AND INVESTMENTS

Public Dividend Capital

SFI 13.1 On authorisation as a foundation trust, the public dividend capital (PDC) held immediately prior to authorisation continues to be held on the same conditions.

SFI 13.2 Additional public dividend capital may be made available on such terms the Secretary of State for Health (with the consent of HM Treasury) decides.

SFI 13.3 Draw down of additional public dividend capital will be authorised by the Chief Executive or Deputy Chief Executive, and by the Chief Finance Officer or the Director of Operational Finance.

SFI 13.4 The Trust shall be required to pay annually to the Department of Health and Social Care a dividend on its public dividend capital at a rate to be determined from time to time, by the Secretary of State.

Commercial borrowing and investment

SFI 13.5 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay interest on, or repay principal on, borrowings held, and will advise the Board on any proposed new borrowing. The Chief Finance Officer is responsible for reporting periodically to the Board concerning all loans and overdrafts.

SFI 13.6 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Finance Officer.

SFI 13.7 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI 13.8 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

SFI 13.9 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Finance Officer.

SFI 13.10 All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Board of Directors.

Investments

SFI 13.11 Temporary cash surpluses must be held only in such public or private sector investments as approved and authorised by the Board in line with the Trust's Treasury Management Policy.

SFI 13.12 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

SFI 13.13 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

SFI 14. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

Capital investment

SFI 14.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

SFI 14.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements; and

(b) that the Chief Finance Officer has certified professionally the costs and revenue consequences detailed in the business case.

SFI 14.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Health Building Note 00-08: Estatecode.

SFI 14.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

SFI 14.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall delegate to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender; and

(c) approval to accept a successful tender.

SFI 14.6 The Chief Finance Officer shall issue procedures for the regular reporting of capital expenditure and commitment against authorised capital expenditure.

Asset registers

SFI 14.7 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a rolling programme of physical checks of assets against the asset register.

SFI 14.8 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Department of Health and Social Care Group Accounting Manual and IFRS accounting standards.

SFI 14.9 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

SFI 14.10 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

SFI 14.11 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

SFI 14.12 The value of each asset shall be depreciated using methods and rates as specified in the Department of Health and Social Care Group Accounting Manual.

SFI 14.13 The Chief Finance Officer shall calculate and pay public dividend capital charges as specified in the Department of Health Group and Social Care Accounting Manual.

Security of assets

SFI 14.14 The overall control of fixed assets is the responsibility of the Chief Executive.

SFI 14.15 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

SFI 14.16 The up-to-date maintenance and checking of asset records shall be the responsibility of designated budget holders for all items for which the initial purchase or replacement is within their service area. All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Chief Finance Officer.

SFI 14.17 Whilst each employee has a responsibility for the security of Trust property, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

SFI 14.18 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

SFI 14.19 The Chief Finance Officer shall be the authorised officer to be responsible for the disposal of assets surplus to requirements.

SFI 14.20 Where practical, assets should be marked as Trust property and have a tag correlating to the record held on the asset register.

SFI 15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

Disposals and condemnations

SFI 15.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

SFI 15.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will notify the Chief Finance Officer to determine the asset's current valuation and the impact the disposal may have on the Trust's finances. Advice will be given as to the disposal procedure and obtaining the estimated market value of the item, taking account of professional advice where appropriate.

SFI 15.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and

(b) recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

SFI 15.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

Losses and special payments

SFI 15.5 The Chief Finance Officer must prepare procedural instructions on the recording of, and accounting for, condemnations, losses, and special payments, with regard to HM Treasury's Managing Public Money, and NHS-specific guidance and directions.

SFI 15.6 Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery, must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer, or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then inform the Chief Finance Officer and/or Chief Executive.

SFI 15.7 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved.

SFI 15.8 Where property loss/damage is suspected, including theft of or criminal damage (including burglary, arson, and vandalism) to staff, patient or NHS property or equipment, the Chief Finance Officer must immediately inform NHS Protect.

SFI 15.9 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify the Board.

SFI 15.10 Any employee discovering or suspecting fraud, corruption or bribery, or anomalies which may indicate fraud or corruption, must inform the Trust's Local Counter Fraud Specialist (LCFS).

SFI 15.11 The LCFS and/or Chief Finance Officer must report all frauds in accordance with the provisions of the Trust's Local Protocol on the Conduct of Investigations and Application of Sanctions and Redress in Respect of Fraud and Corruption.

SFI 15.12 The Chief Finance Officer will

(a) refer any novel, contentious or repercussive cases to the Department of Health and Social Care for approval, including extra-statutory and extra-regulatory payments, in accordance with HM Treasury direction; and

(b) refer severance payments on termination of employment (not including Treasury-approved MAS scheme payments) to NHS Improvement, who will deal directly with HM Treasury to get the necessary approval.

NHS England and the general public are informed of specific individual losses and special payments which exceed £250,000 via the Annual Reports and Accounts process.

SFI 15.13 he delegated limits approved by the Board for the approval of losses are set out below:

Category of loss	Approval delegated to:	Nominated deputy
1. Losses of cash (a) Theft, fraud, arson etc. (b) Overpayments of salaries, wages, fees and allowances (c) Other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b), loss of cash by fire (other than arson), physical losses of cash, cash equivalents and stamps other than those covered by 1(a) **2. Fruitless payments and constructive losses** (including abandoned capital schemes, except where work is purely exploratory) **3. Bad debts and claims abandoned** (a) Private patients (b) Overseas visitors (c) Cases other than 3(a) and 3(b) **4. Damage to buildings, their fittings, furniture and loss of equipment and property in stores and in use** (a) Culpable causes e.g. theft, fraud, arson or sabotage, whether proved or suspected, neglect of duty or gross carelessness (b) Stores losses (c) Other causes e.g. weather damage or accidental fire	≤ £25,000: Chief Finance Officer ≤ £50,000: Chief Executive > £50,000: Audit Committee and Board of Directors	For Chief Finance Officer: Director of Operational Finance or Deputy Director of Operational Finance For Chief Executive: Executive Director

SFI 15.14 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in respect of bankruptcies and company liquidations. This shall include the requirement for parent company guarantees or banker's bonds in circumstances where a review of company financial credit ratings requires further guarantees to be made prior to awarding contracts.

SFI 15.15 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

SFI 15.16 The delegated limits approved by the Board for the approval of special payments are set out below:

Category of special payment	Approval delegated to:	Nominated Deputy
5. Compensation payments made under legal obligation (such as court order or arbitration award for personal injury, property damage or unfair dismissal) **6. Extra-contractual payments to contractors** (such as payments for non-contractual obligations which might arguably have been upheld in court)	≤ £25,000: Chief Finance Officer ≤ £50,000: Chief Executive > £50,000: Audit Committee and Board of Directors	For Chief Finance Officer: Director of Operational Finance or Deputy Director of Operational Finance For Chief Executive: Executive Director
7. Ex-gratia payments (a) Loss of personal effects (b) Clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied (c) Personal injury claims involving negligence where legal advice is obtained and relevant guidance has been applied (d) Other clinical negligence cases and personal injury claims (e) Other employment payments (f) Patient referrals outside the UK and EEA guidelines (g) Other (h) Maladministration, such as bias, neglect, or delay	≤ £10,000 Legal Services Department ≤ £50,000 Chief Nurse > £50,000 Audit Committee and Board of Directors	Not applicable
8. Severance payments on termination of employment (beyond contractual obligations and not including Treasury-approved MAS) **9. Extra statutory and extra regulatory payments**	See SFI 15.12	

SFI 15.17 The Chief Finance Officer shall maintain a Losses and Special Payments Register, which is completed on an accrual's basis.

SFI 15.18 All losses and special payments must be reported to the Audit Committee each quarter, as a minimum.

SFI 16. INFORMATION TECHNOLOGY AND GOVERNANCE

Responsibilities and duties of the Chief Finance Officer

SFI 16.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware, for which the Chief Finance Officer is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for current Data Protection Legislation;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.

SFI 16.2 The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

Responsibilities and duties of other directors and officers

SFI 16.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of trusts in the region wish to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirements; and

(c) support arrangements for the system including business continuity and disaster recovery plans.

Contracts for computer services with other health bodies or outside agencies

SFI 16.4 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

SFI 16.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

Risk assessment

SFI 16.6 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk.

Requirements for computer systems, which have an impact on corporate financial systems

SFI 16.7 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) only appropriate staff have access to such data; and

(d) computer audit reviews are carried out, as considered necessary.

Freedom of information

SFI 16.8 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

Information governance "principle 7 compliance statement"

SFI 16.9 The NHS holds the most sensitive and confidential information about individuals and is bound by current Data Protection Legislation. When sharing data with external parties or data processed by a third party, we must adhere to General Data Protection Regulations Article 5 (1) (f) which states that: " data must be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures." Therefore, all data processors acting on behalf of the Trust or under instruction from the Trust must adhere to all current Data Protection Legislation and afford the appropriate security to the information they may hold/process where the Trust is the Data Controller. Measures include statements regarding information security; implementation of physical security and access controls, and business continuity measures; information governance training for staff; and incident reporting procedures. Failures may lead to the Trust seeking damages if a breach/data loss occurs.

SFI 17. PATIENTS' PROPERTY

SFI 17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

SFI 17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are notified before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

SFI 17.3 This notification is through:

(a) notices and information booklets;

(b) hospital admission documentation and property records; and

(c) the oral advice of administrative and nursing staff responsible for admissions.

SFI 17.4 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patient's money.

SFI 17.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

SFI 17.6 Patient lockers are available for use by patients, and those wishing to use these facilities may do so following an assessment of competence and capability. For patients who have property that needs to be handed in for safekeeping, and who are unable to use the lockers provided, a Patient Property Record, in a form determined by the Chief Finance Officer, shall be completed in respect of the following:

(a) property handed in for safekeeping by any patient (or guardian as appropriate); and

(b) property taken into safe custody having been found in the possession of:

(i) mentally ill patients;

(ii) confused and/or disoriented patients;

(iii) unconscious patients;

(iv) patients dying in hospital;

(v) patients found dead on arrival at hospital; or

(vi) patients severely incapacitated for any reason.

A record shall be completed in respect of all persons in category (b) including a nil return if no property is taken into safe custody.

SFI 17.7 The Patient Property Record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient or their personal representative, where practicable. The record shall then be signed by both members of staff and the patient, except where the latter is restricted by mental or physical incapacity.

SFI 17.8 Property and money handed over for safe keeping shall be placed immediately into the care of the cashier or designated member of the General Office staff except where there are no administrative staff available, in which case the property shall be placed in the care of the most senior member of nursing staff on duty.

SFI 17.9 Except as provided in SFI 17.10 and SFI 17.11 below, refunds of cash handed in for safe custody will be dealt with in accordance with written instructions from the Chief Finance Officer. Property other than cash that has been handed in for safe custody shall be returned to the patient as required. The return shall be receipted by the patient (or guardian as appropriate) and witnessed. The receipts are then retained by the hospital cashier for audit inspection.

SFI 17.10 The disposal of the property of deceased patients shall be effected by the hospital cashier, or the staff member who has had responsibility for its security. Particularly where cash and valuables have been deposited, they shall only be released after written authority given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other persons entitled the deceased's property.

SFI 17.11 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

SFI 17.12 In respect of a deceased person's property, if there is no will and no lawful kin, the property vests in the Crown and the Chief Finance Officer shall notify the Duchy of Lancaster.

SFI 17.13 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. No other expenses or debts shall be discharged out of the estate of a deceased patient.

SFI 17.14 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

SFI 18. CHARITABLE FUNDS

The charity framework and the applicability of standing financial instructions to the Charity

SFI 18.1 The Trust's SFIs are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

SFI 18.2 The Standing Financial Instructions state the Board of Directors responsibilities as a Corporate Trustee for the management of charitable funds and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, Corporate Trustee responsibilities must be discharged separately, and full recognition given to its accountabilities to the Charity Commission. The Trustee must ensure compliance with the Charity Commission's latest guidance and best practice, and charity law, including the Charities Act 2022.

SFI 18.3 The discharge of the Board of Directors Corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. The Charitable Trust Committee is a Committee of the Trust Board with delegated powers to administer charitable matters and authorise expenditure.

SFI 18.4 Within these Standing Financial Instructions, 'charitable funds' are defined as the total net assets of Wrightington, Wigan and Leigh Health Services Charity (also known as 'Three Wishes'), which is a registered charity in support of purposes relating to the National Health Service. These chiefly represent the cumulative cash donated and bequeathed to the Charity, net of charitable expenditure to date. Management of the funds is governed by charity legislation.

Approvals

SFI 18.5 The Chief Finance Officer must prepare procedural guidance for raising, handling, and accounting for charitable income, and for the proper expenditure of charitable funds, and shall

ensure that each charitable fund is managed appropriately with regard to its purpose, the Charity Commission's latest guidance and best practice, and charity law.

SFI 18.6 No new fund or fundraising activity (except those 'for the general purposes of the Charity', and not undertaken during work time) shall be established without first obtaining the written approval of the Charitable Trust Committee.

SFI 18.7 As Corporate Trustee, the Committee has delegated limits for the approval of expenditure as follows:

Type of charitable fund	Nominated Deputy
Divisional funds and restricted funds (such as appeal funds)	≤ £20,000 including VAT and carriage Divisional Fund Committee > £20,000 Charitable Trust Committee
Fundraising expenditure	≤ £5,000 including VAT and carriage Associate Director of Financial Services and Payroll ≤ £20,000 including VAT and carriage Chief Finance Officer > £20,000 Charitable Trust Committee
The Charitable Trust Committee reserves the right to veto expenditure approved by Divisional Fund Groups and to recharge divisional funds for administrative, governance or other costs.	

Fund management and expenditure

SFI 18.8 All Divisional Fund Committees shall be responsible for the management of funds held within their areas of responsibility including the implementation of initiatives to increase donations.

SFI 18.9 Divisional Fund Committees will be responsible for ensuring that all expenditure incurred through charitable funds meets the public benefit test as outlined in the Charity Act 2022; and that such expenditure is timely, without the unnecessary accumulation of funds.

SFI 18.10 All expenditure must be for 'appropriate charitable purposes', in accordance with the Charity Policy and Guidance document. Exceptionally, strategic and governance expenditure is approved by the Charitable Trust Committee.

SFI 18.11 In the first instance, it is the responsibility of a Divisional Fund Committee or equivalent to ensure that all commitments against a charitable fund represent the best available value for money in terms of direct patient benefit, and are consistent with 'appropriate charitable purposes' as defined by

(a) the fund's objectives;

(b) Charity policies; and

(c) patient benefit criteria set out in charity law.

SFI 18.12 Under no circumstances shall a fund be allowed to go into deficit. It is a responsibility of the Divisional Fund Committee to ensure this does not occur.

SFI 18.13 Where possible, the use of exchequer funds to discharge charitable fund liabilities should be avoided, and any indebtedness to exchequer should be discharged by the charitable fund at the earliest possible time.

Income

SFI 18.14 All charitable gifts, donations and fundraising activities are governed by the Charity Policy and Guidance document. All charitable proceeds must be handed immediately to the Chief Finance Officer via an authorised Cash/General Office, to be banked directly to the Charity's charitable fund bank account. All gifts received shall be confirmed to the donor in the Trust's authorised form of receipt that will ensure the donor's wishes are observed without unnecessarily creating new trusts.

SFI 18.15 Gifts which are intended to personally and directly benefit staff, such as 'thank-you' presents, flowers or contributions to staff recreation are not charitable donations, as they have no link to public or patient benefit, but are, rather, gifts to individuals. As such, they are expected to be modest, and are covered by the Trust's Conflicts of Interest Policy.

SFI 18.16 Under no circumstances shall any income (cash, cheques, or other forms of payment) be retained on any Ward or Department, excepting when a Cash/General Office is closed. Where a donation occurs at night or at weekends, the income shall be retained in a secure environment, with an internal receipt given to the donor at the time the donation is made. In the event of this occurring, the income shall be deposited with a Cashier at the next earliest opportunity.

SFI 18.17 All gifts and income accepted shall be administered in accordance with the relevant fund's charitable objectives, subject to the terms of specific trusts. As the Charity can only accept cash or non-cash donations for all or any purpose related to the Health Service, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting gifts of any kind.

SFI 18.18 In respect of legacies and bequests, the Chief Finance Officer shall be kept informed of all enquiries regarding legacies and bequests, which should be filed on a case-by-case basis. Where required, the Chief Finance Officer shall:

(a) provide assistance covering any approach regarding the wording of wills and the receipt of funds/other assets from executors; and

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration.

Banking

SFI 18.19 The Chief Finance Officer shall be responsible for ensuring that appropriate banking services are available in respect of administering the charitable funds.

Investment management

SFI 18.20 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the Charity's approved Treasury Management Policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Trust Committee include:

(a) the formulation of a Treasury Management Policy, which meets statutory requirements and Charity Commission guidance with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers and, where appropriate, investment fund managers;

(c) pooling of investment resources in line with Charity Commission legislation;

(d) the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds; and

(e) the review of investment performance and of brokers and fund managers.

Asset management

SFI 18.21 Donated assets in the ownership of, or used by, the Trust as Corporate Trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Chief Finance Officer shall ensure that:

(a) appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; and

(b) appropriate measures are taken to protect and/or to replace assets. These are to include decisions regarding insurance, inventory control, and the reporting of losses.

Reporting

SFI 18.22 The Chief Finance Officer shall:

(a) ensure that regular reports are made to the Charitable Trust Committee with regard to, inter alia, fund balances, investments, expenditure, expenditure approvals, and any policies in line with Department of Health and Social Care and Charity Commission guidance;

(b) prepare annual accounts in the required manner, which shall be submitted to the Charitable Trust Committee and Audit Committee within agreed timescales;

(c) prepare an annual Trustee's report and required returns for the Charity Commission for adoption by the Committee;

(d) prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for charitable funds; and

(e) maintain such accounts and records as may be necessary to record and protect all transactions and funds of the charitable funds.

SFI 19. ACCEPTANCE OF GIFTS HOSPITALITY AND COMMERICAL SPONSORSHIP BY STAFF

SFI 19.1 The Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy, the Conflicts of Interest Policy, should follow the guidance contained in the NHS England model policy document. This policy guides officers and should be adhered to in all business dealings with organisations and people outside of the Trust.

SFI 19.2 The Trust will publish on its website, its Register of Interests and Register of Gifts and Hospitality on a bi-annual basis and Registers of Interests and Registers of Gifts and Hospitality will be discussed at each Audit Committee meeting.

SFI 19.3 Gifts to staff, including cash, intended to benefit individual staff members or teams, are not charitable donations to the Trust's charity.

SFI 19.4 Staff should not ask for or accept gifts, rewards or hospitality that may affect, or be seen to affect, their professional judgement. Gifts of cash or cash equivalent should always be declined.

SFI 19.5 Hospitality includes offers such as transport, refreshments, meals, accommodation etc, and should only be accepted where it is secondary to a business event i.e. there is a legitimate business reason. Hospitality must be appropriate and not out of proportion to the occasion i.e. subsistence only.

SFI 19.6 Commercial sponsorship agreements must always be declared. Before entering into a commercial sponsorship agreement written approval should be sought from the individual's line manager.

SFI 19.7 Sponsored post holders must not promote or favour the sponsor's products.

SFI 19.8 Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored post.

SFI 20. RETENTION OF RECORDS

SFI 20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines NHS Records Management Part 1 and Part 2.

SFI 20.2 The records held in archives shall be capable of retrieval by authorised persons.

SFI 20.3 Records shall only be destroyed in accordance with latest Department of Health and Social Care guidance and a record shall be maintained of those records so destroyed, together with the date of their destruction.

SFI 21. RISK MANAGEMENT AND INSURANCE

Programme of risk management

SFI 21.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS Improvement's Risk Assurance Framework, which must be approved and monitored by the Board.

SFI 21.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) promotion among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including internal audit, clinical audit, and health and safety review;

(f) a clear indication of which risks shall be insured; and

(g) arrangements to review the risk management programme.

SFI 21.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by Department of Health and Social Care Group Accounting Manual.

SFI 21.4 The Chief Finance Officer shall ensure that appropriate insurance arrangements exist in accordance with Department of Health and Social Care guidance. This will be a mixture of NHS Resolution cover and, in some instances, commercial insurance.

SFI 21.5 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some, or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

SFI 21.6 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, exceptions when trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

(b) private finance initiative (PFI) contracts where the other consortium members require that commercial insurance arrangements are entered into;

(c) pressure vessels such as boilers and other associated risks; and

(d) income generation activities – if not related to normal business activity, these should normally be insured using commercial insurance. If the income generation activity is an activity normally carried out by the Trust for an NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

SFI 21.7 All other commercial, or alternative insurance policies, are to be approved by the Chief Finance Officer.

Arrangements to be followed by the board in agreeing insurance cover

SFI 21.8 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

SFI 21.9 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed to the Trust.

SFI 21.10 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the ‘deductible’). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

SFI 22. INTELLECTUAL PROPERTY

Intellectual property (IP)

SFI 22.1 The Trust has an approved Intellectual Property Policy.

SFI 22.2 It is appropriate therefore to include IP references in the Standing Financial Instructions.

Definition of intellectual property

SFI 22.3 Intellectual Property can be defined as products of innovation and intellectual or creative activity and can include inventions, industrial processes, software, data, written work, designs and images. IP can be given legal recognition of ownership through intellectual property rights (IPR) such as patents, copyright, design rights, trademarks or "know how."

SFI 22.4 Examples of IP that may be developed in the NHS include: training manuals, clinical guidelines, books and journal articles, PowerPoint presentations, inventions, new or improved designs, devices, equipment, new uses for existing drugs, diagnostics tests, and new treatments.

Ownership of intellectual property

SFI 22.5 Ownership of IP will, in most cases, rest with the Trust. This applies to all IP produced by Trust employees in the course of their employment, specifically when undertaken on Trust premises, using Trust equipment and in contact with Trust patients. IP developed by an employee outside the course of their employment, not utilising Trust assets or Trust patients will usually belong to the employee, subject to agreement.

SFI 22.6 This is in accordance with the Patent Act 1977, and the Copyright, Designs and Patent Act 1988.

SFI 22.7 IP ownership can vary according to the circumstances under which the IP was generated. Such circumstances include:

(a) joint/honorary appointments/trainees;

(b) externally funded work;

(c) commissioned work; and

(d) collaborative projects.

Disputes of ownership

SFI 22.8 If the ownership of IP is disputed, dated written records relating to the IP in question will be assessed to establish the inventor(s), and their proportionate contribution. If such material is not available, the Chief Executive of the Trust will make a final decision, taking professional advice if necessary.

SFI 22.9 Persons covered by the Intellectual Property Policy include:

(a) all staff that are full time or part time employees of the Trust;

(b) full-time or part-time staff who are self-employed (e.g. private practice);

(c) trainee professionals (e.g. Specialist Registrars);

(d) staff seconded to other organisations; and

(e) staff with joint or honorary contracts with another organisation.

Intellectual property management

SFI 22.10 The Trust should use IP specialist legal advisors or NHS Innovation Hubs where relevant in the protection, management and development of commercial opportunities relating to IP. Staff obligations

SFI 22.11 All employees, including those covered by the Intellectual Property Policy, have an obligation to inform the Trust's Head of Research about identified or potential IP activities, and must not, under any circumstances, sell, assign, license, give or otherwise trade IP without the Trust's approval.

SFI 22.12 The Trust brand and logos should not be used unless in connection with Trust business.

Monitoring intellectual property

SFI 22.13 The Head of Research will provide to the Board updates with regards to:

(a) the risks and rewards in respect of approving IP initiatives; and

(b) potential and ongoing IP initiatives.

SFI 23. DECLARATION OF INTERESTS

General

SFI 23.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes.

SFI 23.2 Staff members at Agenda for Change band 8d and above, and any member of staff on any other salary scale at that level and above including all consultants and medical staff, will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

SFI 23.3 A declaration of interest must be submitted by any grade of employee in the event where a relationship exists when involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices and/or equipment.

Bribery Act 2010

SFI 23.4 Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

SFI 23.5 The offences of bribing another person or being bribed carry a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.

SFI 23.6 This Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor will it accept bribes or improper inducements. It is important that all employees, contractors and agents are aware of the standards of behaviour expected of them contained in this policy.

SFI 23.7 It is the duty of Trust employees, including all agency and contracted staff, who have the powers to enter into transactions on behalf of the Trust, not to influence or enter into negotiations or purchases with an individual or entity where a relationship with the other party

exists. For clarification relationships include, but are not limited to, spouse, parent, child, brother, sister (and relations of any of these). Relationships also include friendships and are deemed to exist when the employee has any financial interest in the other party.

SFI 23.8 If in doubt, Trust employees and representatives must inform their line manager and, in all circumstances, should declare his/her interest by completing a declaration of interest form which can be found in the Trust's Code of Conduct Policy, and should not take any part in the negotiation process.

Declaration of interest

SFI 23.9 An annual completion of declarations of interest exercise will be undertaken as part of the Trust's annual accounts process and is mandatory for all staff on band 8b and above. Any disclosures not made and later discovered will be considered a breach of Trust Standing Financial Instructions, which could subsequently lead to disciplinary action being taken.

SFI 24. BUSINESS CASE PROCESS

Introduction

SFI 24.1 The Trust's business case process has been established to ensure there is full involvement from any party within the organisation that could be affected by the intended direction of travel. Auditability, governance and financial principles are critical to ensure there is no unforeseen service, quality or financial consequences from our investment decisions.

SFI 24.2 All approved business cases must satisfy one of more of the investment criteria established by the Executive Team. Business cases must include key performance indicators for how the investment will be assessed or measured once implemented.

SFI 24.3 All business cases must have a reference number assigned by the finance department, referenced within the minutes of the meeting of the approving entity.

Revenue and capital expenditure

SFI 24.4 All revenue and capital investments must be submitted for a formal decision using the Trust's current business case process and template. Business cases for national funding should be on the appropriate NHSE template.

SFI 24.5 Should the Trust approve, it may also be necessary to seek approval from the Greater Manchester Integrated Care Board or NHS England.

SFI 24.6 Business cases will be approved in accordance with the following table:

Type of Business case	Capital Medical Equipment Group	Executive Team Meeting	Finance and Performance Committee	Board of Directors
Capital medical equipment, within the delegated capital limit for Capital Medical	£500k	N/A	£1m	>£1m

Equipment and with no revenue implications.		(CME cases over £500k still require ETM endorsement before going to F&P)		
All other business cases	N/A	£500k	£1m	>£1m

The value of a business case is defined as the total combined revenue and capital expenditure (calculated as total capital expenditure, plus recurrent revenue expenditure plus one-off revenue expenditure).

Executive Team may delegate the approval of business cases to the Wider Leadership Team (WLT) through its terms of reference.

Appendix 1

As an organisation that is publicly funded with stringent financial duties to achieve, it is essential for the Trust to have robust financial controls in place. This will ensure that we are providing value for money, that our colleagues are working within this guidance framework and that we do not become vulnerable to the risk of fraud. A strong financial governance and control framework will contribute toward the Trust managing its finances on an effective and sustainable basis.

The Standing Financial Instructions (SFI's) form a key role in the Trust's financial governance and control framework, and it is important that employees are aware of their responsibilities for financial governance by understanding and working within the guidance of this policy.

To support the Trust's governance and control framework, a monitoring and reporting process has been implemented to ensure that employees are following the SFI's correctly and that processes and procedures are working effectively.

The following matrix highlights the key areas of the SFI's, how monitoring of compliance will be undertaken and when issues or incidents arise, how these will be managed. In some cases, where there are repeated occurrences of issues or disregard for the framework that put the Trust at risk of Fraud, these will be escalated formally.

It is acknowledged that in the majority of instances staff will have acted in good faith, and there may be situations where further training or guidance is required to support staff to ensure they are working in line with the framework, however, it is important that the Trust does not leave itself open to the risk of fraud. Exploring and understanding issues or incidents that don't comply with this framework will allow for a review of the procedures and controls in place.

We aim to work collectively with staff to understand the root cause of issues and learn from these to prevent future incidents. Whilst our priority is to support staff in following this framework, careless disregard for the processes within this framework or fraud related matters are unacceptable and will be addressed via a formal process.

Chapter of SFI	**Areas for potential non-compliance** ***(This list is not exhaustive)***	**How it will be monitored**	**Applicable to**		**Monitoring by**	**Point at which breach will be escalated for review under Trust disciplinary policy.**
Audit fraud corruption bribery and security	• All instances of fraud, corruption or bribery ***(Section 2)***	Referrals to Local Counter Fraud Specialist	All employees		Local Counter Fraud Specialist	**Immediately**
Business planning budgets budgetary control and monitoring	• Exceeding budgetary total, or virement limits set by the board ***(3.2.2)***	Monthly monitoring of budget statements	Budget holders		Management Accounts	Clinical divisions report on their performance via bi-monthly divisional assurance meetings (DAMs) which are chaired by an Executive Director. An escalation process called RAPID (recovery, action, planning, implementation and delivery) has been introduced where performance metrics can trigger the DAM meeting to convert to a RAPID meeting to provide further scrutiny and support on the financial position.
	• Use of non-recurring expenditure to fund recurring budget expenditure without authority ***(3.2.4)***					
	• Use of approved budget for a purpose other than as specially authorised ***(3.3.2, c)***					
	• Engaging services of agency workers without approval ***(3.3.2, d)***	Budget statements Review of agency invoices	Budget holders		Financial Services	**After 3rd Notification**

Bank and GBS Accounts	• Opening a bank account in Trust name ***(5.1.3)***	As and when the situation arises.	All employees		Financial Services	**Immediately**
Income fees and charges	• Employees must report income due on transactions which they initiate/ deal with including all contracts, leases and tenancy arrangements ***(6.2.3)***	As and when the situation arises.	Budget holders		Management Accounts	**Immediately**
	• Use of Trust cash for private transactions, encashment of cheques bank to bank transfers and loans ***(6.4.2)***	As and when the situation arises.	Cash office		Financial Services	**Immediately**
	• Use of Trust Credit card for personal expenditure ***(6.4.4)***	Via monthly reviews of credit card statements	Credit card holders		Financial Services	**Immediately**
	• Use of Trust credit card for expenses which should be reimbursed through payroll without prior approval ***(6.4.5)***					**After 2nd notification**
	• Holders of safe keys should not accept unofficial funds for depositing in their safes without sealed envelopes or locked containers ***(6.4.7)***	Audits of Cash Office	Cash office		Financial Services	**Immediately**
	• Failure to report losses of cash cheques and other negotiable instruments ***(6.4.11)***	As and when the situation arises.	Cash office		Financial Services	**Immediately**

Tendering and contracting procedure	• Failure to obtain competitive quotes for expenditure expected to exceed £10,000 but not exceed £50,000 ***(7.3.1)***	Requisition entered onto Oracle and checked by buyer	Oracle users		Procurement	**After 2nd notification**
	• Failure to undertake competitive tendering exercise for expenditure that is equal to or reasonably expected to exceed £50,000 ex VAT ***(7.4.1)***	Requisition entered onto Oracle and checked by buyer				**After 2nd notification**
	• Waivers unsupported by procurement (7.6.1)	As and when the situation arises.				**After 2nd notification**
	• Failure to involve procurement in the tender process ***(7.14.1)***	As and when the situation arises.				**After 2nd notification**
	• Unauthorised approval of NHS and Non NHS Contracts ***(7.14.3)***	As and when the situation arises.				**After 2nd notification**
	• Failing to ensure that all items received under a prepayment agreement have been received ***(8.3.4,d)***	As and when situation arises				**After 2nd notification**
	• Failing to comply with requisitioning and ordering processes ***(8.3.6, a- n)***	Monthly reviews of invoice process via Non PO route.	Oracle users		Procurement	**After 2nd notification**
Contracting for provision of healthcare	• Failure to ensure that a SLA is in place for the supply or receipt of services either clinical or non- clinical ***(10.4)***		Legal Team		Legal team	**Immediately**

Terms of services allowances and pay	• Failure to remain within funded establishment without prior consent to changes ***(11.2.3)***	Monthly monitoring of budget statements	Budget holders		Management Accounts	Escalated through divisional internal reporting structure and review meetings with finance managers, Directorate Managers and Directors of Performance. Ultimate outcome is representation at the divisional assurance review with members of the executive team and then Finance and Performance Committee. Finance reports to include details of breaches."
	• Engagement, re-grade, hire of agency staff or changes to any employees remuneration unless authorised to do so ***(11.3.1)***	Monthly monitoring of budget statements	Budget holders		Management Accounts/Payroll	**Under review pending update to temporary staffing policy (Aug 2021)**
	• Late submission of time records to payroll ***(11.4.3,a)***	Monitoring of payroll related information	Payroll authorised signatories		Payroll	**After 3rd Notification**
	• Failure to submit termination forms to the payroll department immediately on					**After 2nd notification**

	knowing the effective date of the an employee's resignation, termination or retirement ***(11.4.3, c)***					
	• Changing an individual's pay outside of agenda for change terms and conditions without the appropriately authorised Local Pay Variation form ***(11.5.1)***					**Controls in place to prevent this happening**.
	• Damage to premises, vehicles and equipment or any of equipment stores or supplies must be reported. ***(13.3.5)***	As and when the situation arises.	All employees		Financial Services	**After 2nd notification**
Disposals and condemnations, losses and special payments	• Failure to dispose of assets in accordance with disposal policies. ***(14.1.2)***	As and when the situation arises.	Budget holders		Financial Services	**After 2nd notification**
	• Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery must immediately inform their head of department. ***(14.2.2)***	As and when the situation arises.	All employees		Financial Services	**Immediately**
Patients Property	• Failure to complete patient property record in respect of patient property handed in for safekeeping ***(16.6)***	As and when the situation arises.	Ward Staff		Financial Services	**After 2nd notification**

	• Failure to hand patient property into the Cash office ***(16.7)***					
Charitable Funds	• Undertaking fundraising activity for the Trust Charity without appropriate approval ***(17.2.2***	As and when the situation arises.	All employees		Financial Services	**After 1st notification**
	• Commitment to expenditure which does not meet charitable purposes and public benefit test ***(17.3.2, 17.3.3)***	Monthly review of expenditure purchases	Charitable Fund Managers		Financial Services	**After 1st notification**
Acceptance of gifts and hospitality	• Failure to disclose commercial sponsorships & Gifts and Hospitality ***(18.6, 8.3.6.n, 17.4.2)***	Gifts and hospitality register	All employees		Local Counter Fraud Specialist/Company Secretary	**After 1st notification**
Risk management and insurance	• Entering in to commercial insurance arrangements without authorisation ***(20.1.6)***	As and when the situation arises.	All employees		Financial Services	**After 2nd notification**
Intellectual property	• Selling, assign license or trade IP without approval ***(20.1.6)***	As and when the situation arises.	All employees		Financial Services	**After 1st notification**
Declarations of interest	• Influencing or entering into negotiations or purchases with an individual or entity where a relationship with the other party exists ***(22.2.4, 22.2.5 & 22.3.1)***	Via MES software	All employees		Local Counter Fraud Specialist /Company Secretary	**After 1st notification**
Business case and tender process	Incurring expenditure where the business case process has not been followed. **(S23)**	Via monthly budget statements and capital to revenue approvals	Budget holders		Management Accounts and Capital Accountant	**After 1st notification**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Seven Day Hospital Services Audit 2025/2026
Presented to:	Board of Directors
On:	01 April 2026
Presented by:	Dr S Arya, Medical Director
Prepared by:	Alison Unsworth Head of Clinical Audit and Effectiveness
Contact details:	Alison.Unsworth@wwl.nhs.uk

Executive summary

This audit compares WWL to the Seven Day Hospital Services (7DS) Clinical Standards set by NHS Services, Seven Days A Week forum. The audit was completed for a full seven-day period in January 2026 (**5th until 11th January)**. It indicates a high level of achievement of the standards despite current pressures within the service. **122** patient records were reviewed.

Summary

Summary of Standards:

- **Clinical standard 2** states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission.
  - **Result: 98%**

- **Clinical standard 5** states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day.
  - **Result: 100%**

- **Clinical standard 6** states that emergency and urgent access to appropriate consultant-led interventions should be available every day.
  - **Result: 100%**

- **Clinical standard 8** states that patients admitted in an emergency should be reviewed by a consultant or delegate once daily.
  - **Result: 91%**

It is evident from the Audit that patients routinely get a review by a Consultant during their stay, wherever that might be and that there is daily review thereafter.

Summary of findings:

- 120/122 (98.4%) patients were seen by a Consultant within 14 hours of admission to the ward.
- 2/122 (1.6%) patients were not seen within 14 hours by a consultant but did have appropriate Senior Review and plan within 14 hours of admission.
- The average time to be seen by a **CONSULTANT** from arrival in A&E is **18 hours 50 minutes**
- The average time from **referral** by the Emergency Department to be seen by a consultant is **14 hours 42 minutes**
- The average time to be seen by a **CONSULTANT** from admission to a ward **is minus 17 hours 20 minutes**
- 107/122 (**88%)** patients were seen by a **CONSULTANT** prior to admission to the ward (ie, in the Emergency Department).
- The average length of stay in the Emergency Department prior to admission to the Ward is **36 hours 2 minutes**
- Beyond the first day, the audit looks at whether there is a Consultant/Delegate review and shows this is provided 91% of the time (488/537 reviews):
  - Day 2 of admission: 100% of patients received a review
  - Day 3: 94%
  - Day 4: 90%
  - Day 5: 87%
  - Day 6: 83%
  - Day 7: 85%

Risks associated with this report and proposed mitigations

None known

Financial

implications None

known

Legal

implications

None known

People

implications

None known

Wider implications

The Audit provides a high level of assurance about Consultant delivered care within WWL and the 7-day standards set.

Equality, diversity and inclusion implications

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

Recommendation(s)

The Board of Directors are asked to review the report and note the contents. The report provides evidence that 98% of patients achieve Clinical Standard 2 (Review by a consultant within 14 hours of admission), the average daily review is 91% for Clinical Standard 8 (Daily review by Consultant or Delegate). Clinical standards 5 and 6 (availability of certain investigations/interventions) both achieve 100%.
All standards have been met.

Seven Day Hospital Services Main Report

Contents

1. Background

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

Further information is available here: https://www.england.nhs.uk/wp-content/uploads/2022/02/B1231- board-assurance-framework-for-seven-day-hospital-services-08-feb-2022.pdf.

The importance of ensuring that patients receive the same level of high quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. Delivery of the 7DS clinical standards should also support better patient flow through acute hospitals. The standards have been reviewed in 2021 by a clinical reference group that confirmed they remain relevant and important in the NHS today.

The purpose of this report is to provide evidence of compliance to the four priority standards.

Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI, ultrasound imaging, endoscopy and echocardiography.

Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.

Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the
patient's care pathway.

2. Methodology

The Board Assurance Framework suggest a snapshot or sampling approach should be used to identify the patients.

Patients were identified for **Standard 2 and 8** using Hospital Episode Statistics data for patients admitted via the Emergency Department for a seven-day period from: **5th to 11th January.**

122 patients were selected at random for review.
Patients who stayed less than 14 hours were excluded from
analysis. HIS was used to analyse the patient details.

Patients who were discharged from Jean Heyes Unit, Bryn Ward, and Highfield Ward were excluded.

A proforma was created on AMaT (Audit Management and Tracking – the Trusts electronic audit management system) and data was collected and analysed by members of the clinical audit and effectiveness team.

Information for **standards 5 and 6** was provided by the subject experts

3. Findings

3.1 Clinical Standard 2

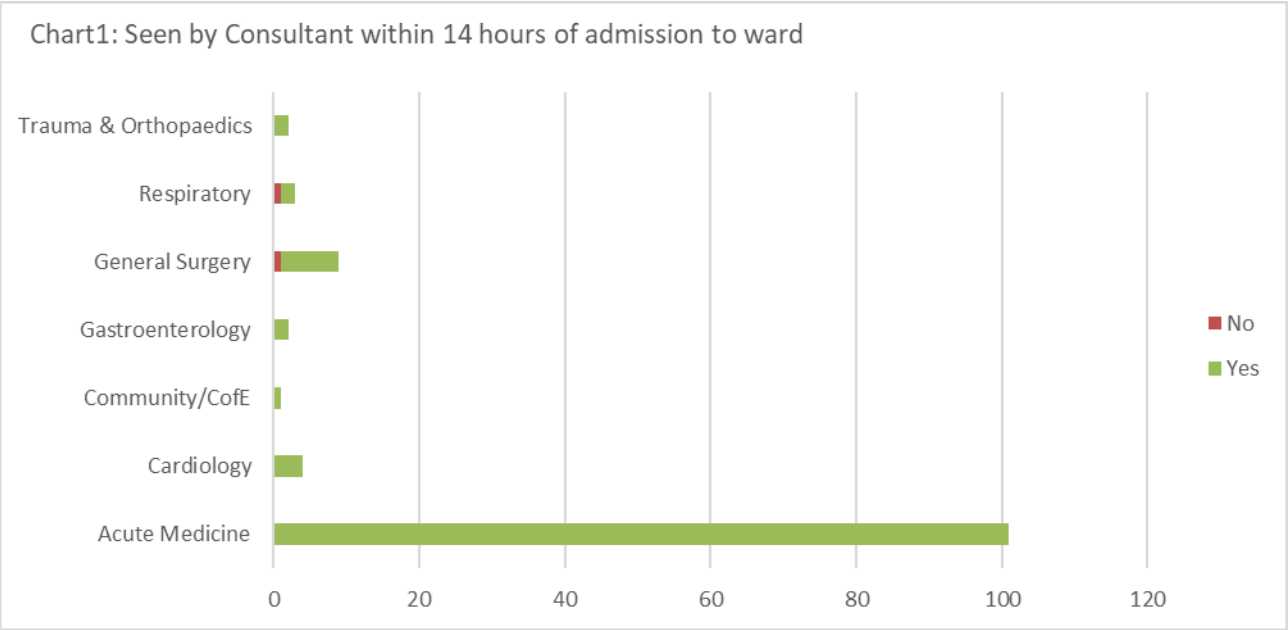
Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

Summary of Standard 2:

- 120/122 patients (98.4%) seen by a consultant within 14 hours of admission to the ward
- 2/122 patients (1.6%) seen by a consultant over 14 hours after admission to the ward
- 100% of patients were seen by a consultant

Breakdown of Standard 2 data:

Chart 1 shows the number of patients who were seen within 14 hours of admission to the ward per speciality by a consultant:



There were two patients who did not get seen within 14 hours of arrival to the ward by a consultant. Both patients had appropriate review. Details in Chart 2.

Chart 2 Admission Day	Time of ADMISSION to WARD	Speciality	Difference in 1st cons review and time of admission to ward	Summary of each patient.
Tuesday	6/1/26 14:27	Respiratory	20 hrs 24 mins	Seen by Medical Registrar in ED and appropriate plan made. Seen by ANP on transfer to Ward. Seen by consultant following day (7/1/26 10:51)
Friday	9/1/26 18:57	Surgery	16 hrs 15 minutes	Seen by Surgical SPR 10/1/2026 at 00:21, then review by Consultant on 10/1/26 at 11:12

3.2 Clinical Standard 8:

Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the
patient's care pathway.

This has been determined by analysing the notes of each of the 122 patients and determining if they had been reviewed by a consultant or a delegate on each day of their admission, up to 7 days after admission. Day 2 has been taken on the day following arrival, rather than day following admission. Patients who were transferred to Jean Heyes Unit, Bryn Ward or Highfield Ward are not included.

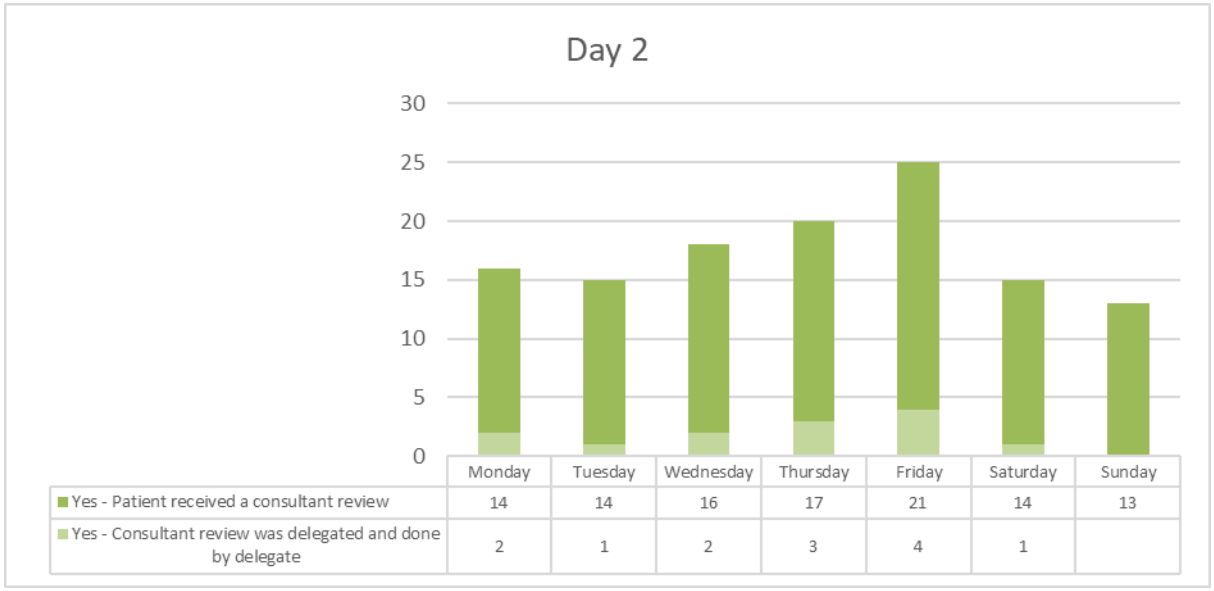
Chart 4 shows the number of patients admitted on day 1 (first day of admission) and the number of admissions per subsequent day. By day 7, 67 (55%) out of the 122 patients were still admitted.

Chart 3	Number of in patients
Day 1	122
Day 2	122
Day 3	109
Day 4	98
Day 5	86
Day 6	76

Medical Ward Information:
Shevington and Standish do not have daily consultant ward rounds.

Day 2:

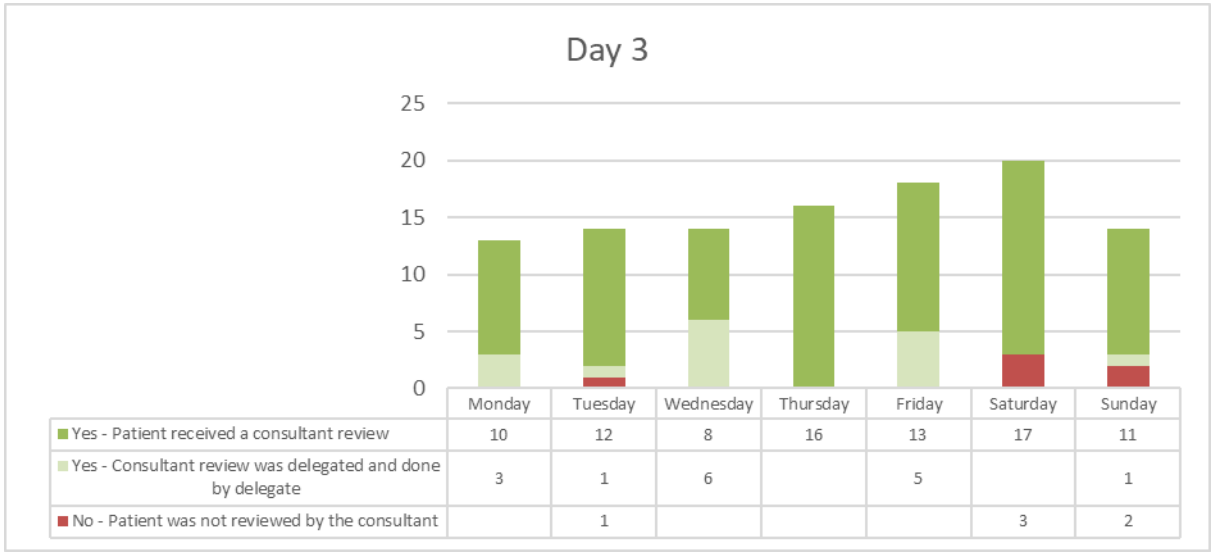
122 patients still admitted.
100% received a review. 109/122 (89%) were seen by the Consultant.



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Yes - Patient received a consultant review	14	14	16	17	21	14	13
Yes - Consultant review was delegated and done by delegate	2	1	2	3	4	1	

Day 3:

109 patients still admitted
94% received a review (103/109). 87/103 (84%) were seen by the Consultant.



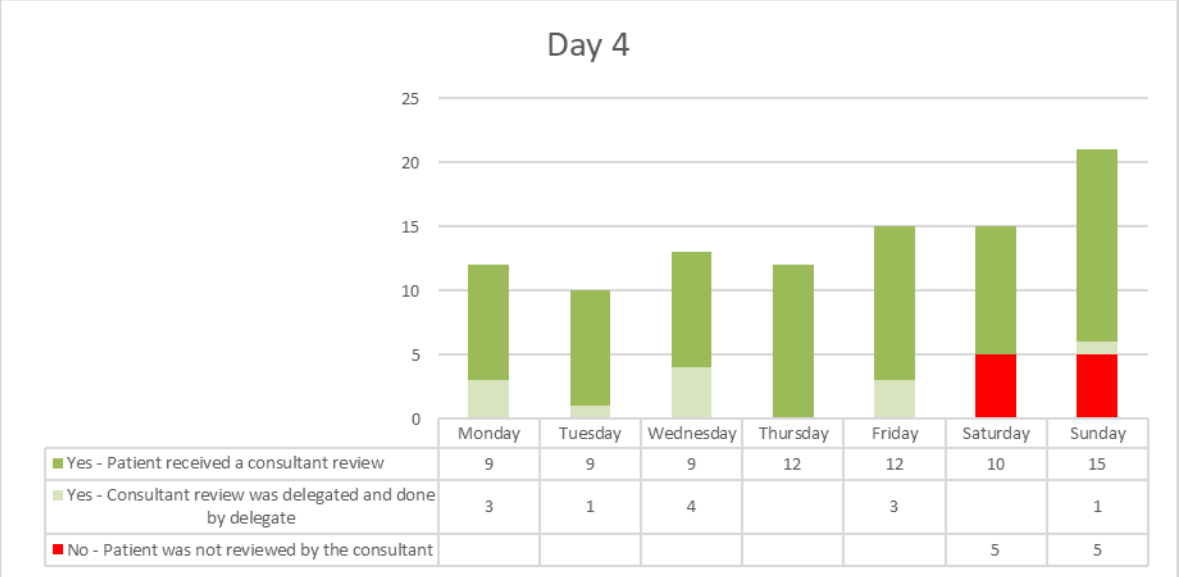
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Yes - Patient received a consultant review	10	12	8	16	13	17	11
Yes - Consultant review was delegated and done by delegate	3	1	6		5		1
No - Patient was not reviewed by the consultant		1				3	2

The weekend patients all had a review the following Monday. The Tuesday patient had a review the following day.

Day	Day 3 Ward	Specialty
Saturday	Shevington Ward - RAEI	Gastroenterology
Saturday	Astley Ward - RAEI	Care of the Elderly
Saturday	Ince Cardio-Resp Unit - RAEI	Respiratory
Tuesday	Shevington Ward - RAEI	Gastroenterology
Sunday	Shevington Ward - RAEI	Gastroenterology
Sunday	Shevington Ward - RAEI	Gastroenterology

Day 4:

98 patients still admitted.
88/98 (94%) received a review. 76/88 (86%) were seen by the Consultant.



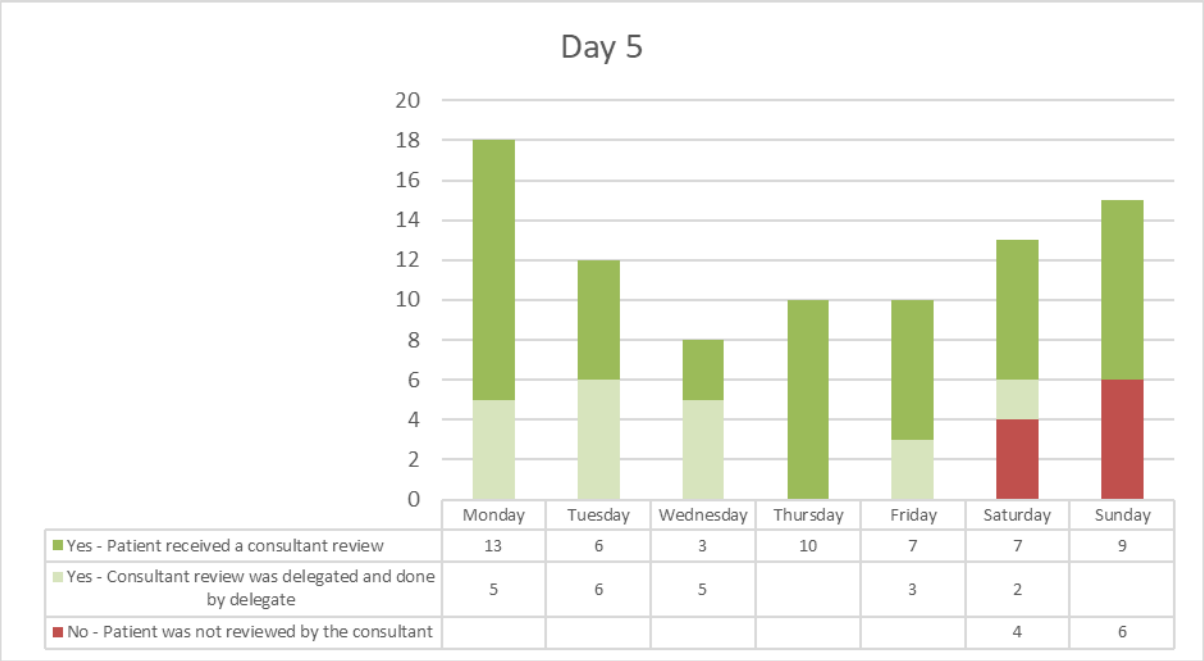
10 Patients not reviewed:

Day 4	Day 4 Ward	Specialty
Sunday	Shevington Ward - RAEI	Gastroenterology
Saturday	Astley Ward - RAEI	Care of the Elderly / Comm
Sunday	Astley Ward - RAEI	Care of the Elderly / Comm
Saturday	Community Assessment Unit - RAEI	Care of the Elderly / Comm
Saturday	Coronary Care Unit - RAEI	Cardiology
Sunday	Ince Cardio-Resp Unit - RAEI	Respiratory
Sunday	Langtree Ward - RAEI	Acute Medicine
Sunday	Standish - RAEI	Endocrinology
Saturday	Standish - RAEI	Endocrinology
Saturday	Winstanley - RAEI	Respiratory

All patients were reviewed at the weekend. Of the 5 Saturday patients, one was seen on Sunday and the remaining 4 seen on Monday. The 5 Sunday patients were reviewed on Monday.

Day 5:

86 patients still admitted
88% (76/86) received a review. 55/76 were seen by the Consultant.

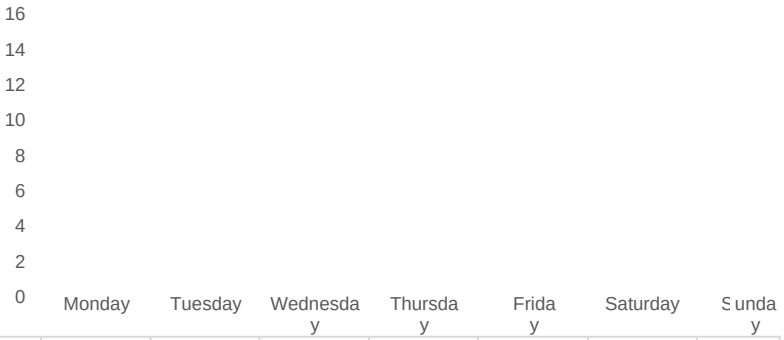


Day 5	Day 5 Ward	Specialty
Sunday	Aspull Ward - RAEI	Trauma & Orthopeadics
Sunday	Astley Ward - RAEI	Care of the Elderly
Saturday	Community Assessment Unit - RAEI	Community / CofE
Sunday	Community Assessment Unit - RAEI	Community / CofE
Saturday	Community Assessment Unit - RAEI	Community / CofE)
Saturday	Ince Cardio-Resp Unit - RAEI	Cardiology
Saturday	Pemberton Ward - RAEI	Care of the Elderly
Sunday	Standish - RAEI	Endocrinology
Sunday	Winstanley - RAEI	Respiratory
Sunday	Winstanley - RAEI	Respiratory

10 Patients not reviewed. All were
weekend. All patients were reviewed on
Monday.

Day 6:

76 patients still admitted
83% (63/76) received a review. 48/63 were seen by the Consultant.

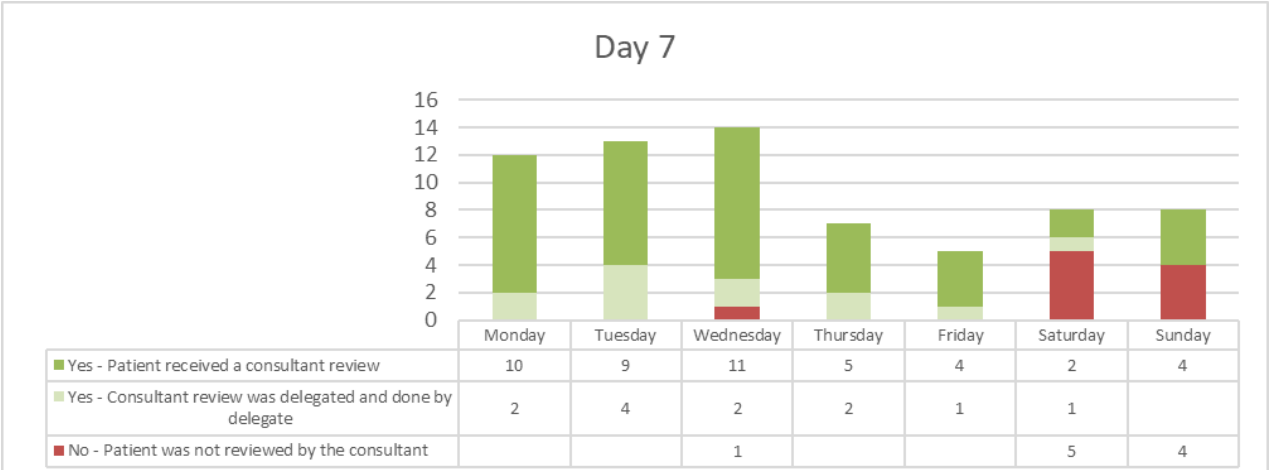


	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Yes - Patient received a consultant review	8	14	8	5	5	3	5
Yes - Consultant review was delegated and done by delegate	5	3	2	2	4		1
No - Patient was not reviewed by the consultant						4	7

Day 6:	Day 6 Ward	Specialty
Sunday	Community Assessment Unit - RAEI	Community / CofE
Sunday	Community Assessment Unit - RAEI	Community / CofE
Sunday	Pemberton Ward - RAEI	Care of the Elderly
Sunday	ASU on Billinge Ward - RAEI	Care of the Elderly
Saturday	ASU on Billinge Ward - RAEI	Care of the Elderly
Saturday	Standish - RAEI	Endocrinology
Saturday	Winstanley - RAEI	Respiratory
Sunday	Standish - RAEI	Endocrinology
Saturday	Winstanley - RAEI	Respiratory
Sunday	Winstanley - RAEI	Respiratory
Sunday	Standish - RAEI	Endocrinology

Day 7:

67 still admitted
85% (57/67) received a review. 44/76 were seen by the Consultant.



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Yes - Patient received a consultant review	10	9	11	5	4	2	4
Yes - Consultant review was delegated and done by delegate	2	4	2	2	1	1	
No - Patient was not reviewed by the consultant			1			5	4

Day 7:	Day 7 ~Ward	Specialty
Sunday	ASU on Billinge Ward - RAEI	Care of the Elderly
Sunday	Standish - RAEI	Endocrinology
Saturday	AAA - Ambulatory Assessment Area	Acute Medicine
Saturday	Community Assessment Unit - RAEI	Community / CofE

Sunday	Standish - RAEI	Endocrinology
Saturday	Ince Cardio-Resp Unit - RAEI	Cardiology
Saturday	Winstanley - RAEI	Respiratory
Saturday	Orrell Ward - RAEI	Acute Medicine
Wednesday	Standish - RAEI	Endocrinology
Sunday	Winstanley - RAEI	Respiratory

10 patients not reviewed.

All patients not reviewed at weekend were reviewed on Monday. The patient not reviewed on Wednesday was reviewed the following day.

3.3 Summary of daily Review per day of Admission

Chart 5 shows daily consultant or delegate review per day of admission. For example, on day 2, 100% of patients received a consultant / delegate review. On Day 7 of their stay 57/67 (85%) patients received a review.

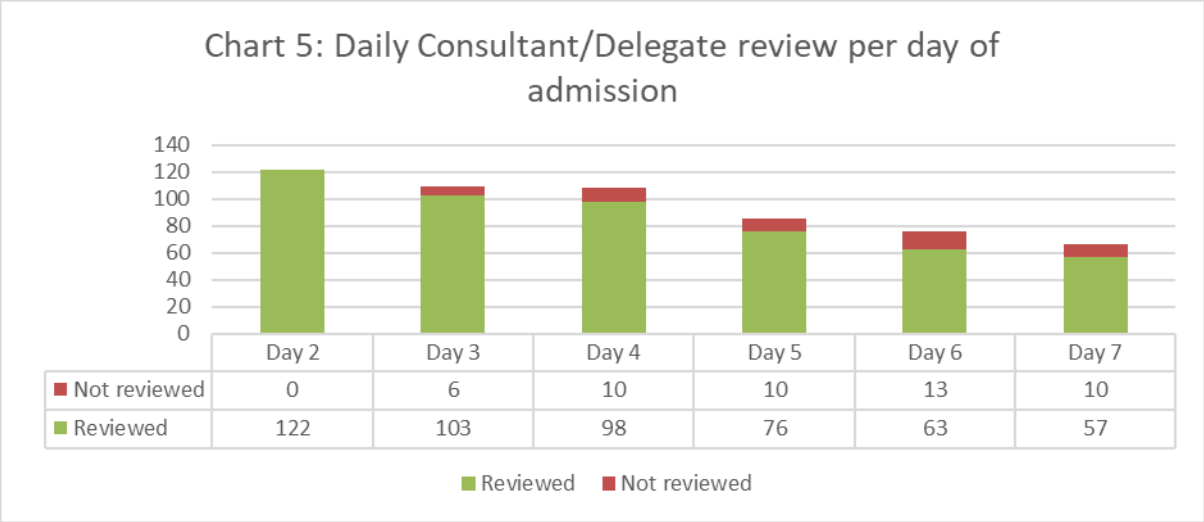


Chart 6 shows daily review by consultant / delegate per day of review. For example, on a Monday 99% of patients received a consultant / delegate review regardless of their length of stay. On a Saturday, 74% of patients received a review, however, if a Saturday was day 2 of their stay, 100% of patients received a review, if a Saturday was their 7th day of stay, 43% received a review.

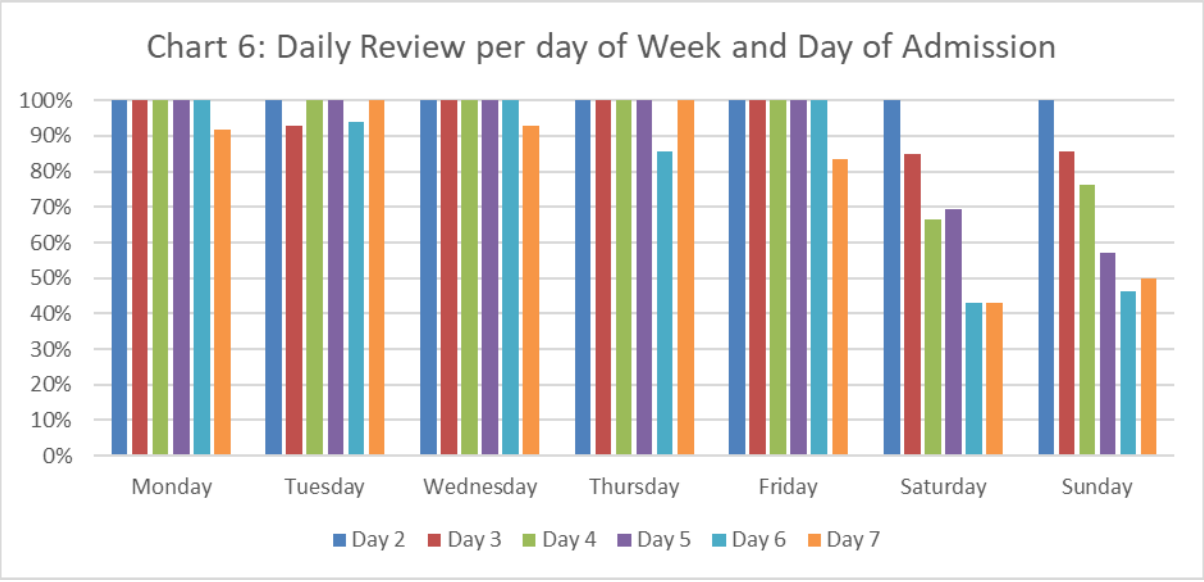
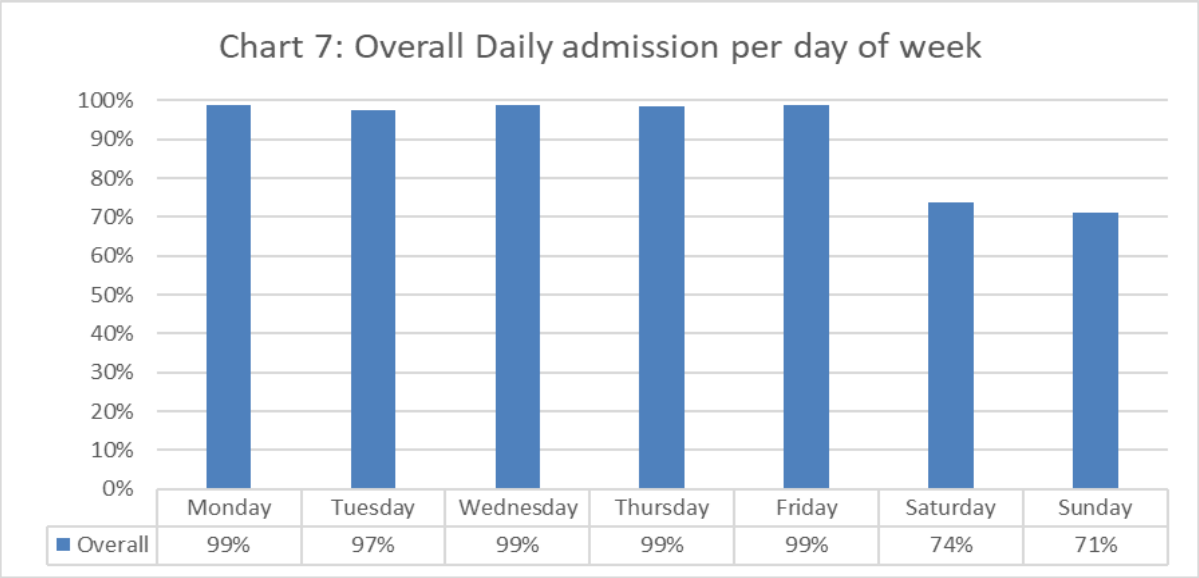


Chart 7 shows a summary of reviews Monday to Friday:



Patients are considered to have been reviewed within the expected timeframe if they are seen within 14 hours of admission to the ward. Historically, most patients would leave the Emergency Department within four hours and then be admitted to a ward, meaning the total expected time from ED arrival to consultant review was effectively 18 hours (4 hours in ED plus 14 hours on the ward). As current practice shows that relatively few patients are admitted to a ward within four hours, an additional 18-hour ED-to-review standard has been introduced to reflect the full patient journey more accurately.

The average length of stay for patients in the emergency department prior to admission to the ward is 36 hours 2 minutes.
The average time to be seen from arrival is 18 hours 50 minutes. 51 patients were seen within 18 hours of arrival.

4. Clinical Standard 5

Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.

Information has been sought from the relevant departments regarding availability of the tests. Chart S5.1 shows the diagnostic tests and availability. All are available:

S5.1 Emergency Diagnostic Test	Available on Site at weekends	Available via network at weekends	Not available
USS	Yes		
CT	Yes		
MRI	Yes		
Endoscopy	Yes		
Echocardiography	Yes		
Microbiology	No	Yes	

Additional narrative:
USS: Available 9am – 8pm with consultant discussion. Typically converted to CT scanning or deferred until the next working day
Echocardiogram: Available by the on-call consultants
MRI: Limited to spinal cord compression/cauda equina syndrome

Microbiology: On call service by microbiology consultants, done remotely

5. Clinical Standard 6

Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.

Information has been sought from the relevant departments regarding availability of the interventions. Chart S6.2 shows the intervention availability. All are available:

S6.2 Emergency Intervention	Available on Site at weekends	Available via network at weekends	Not available
Intensive Care	Yes		
Interventional radiology		Yes	
Interventional endoscopy	Yes	Yes	
Surgery	Yes		

Additional narrative:
Interventional endoscopy for gastrointestinal bleeding/foreign body removal/oesophageal stenting/polypectomy is available on site. Other interventions, such as ERCP are available via network at weekends.

Interventional radiology: Available via network at weekends, case by case referral with usually consultant to consultant discussion

6. Conclusion

The 2025–26 Seven Day Hospital Services Audit provides strong assurance that the Trust continues to deliver high-quality, consultant-led care consistently across the week. Performance against the four NHS priority clinical standards remains excellent, with 98% of patients receiving consultant review within 14 hours of admission (Clinical Standard 2) and 100% availability of urgent diagnostics and consultant-led interventions through either on-site or networked services (Clinical Standards 5 and 6).

Daily consultant or delegate review (Clinical Standard 8) was achieved for 91% of patient-days, demonstrating reliable continuity of care, with any missed weekend reviews completed the following day.
This is particularly noteworthy given the changing operational landscape and increasing reliance on non-traditional assessment areas.

The audit highlights a significant shift in patient flow patterns, with patients now spending an average of 36 hours in the Emergency Department before ward admission, compared to the historical assumption of 4 hours on which the original standards were based. Despite this, the Trust continues to meet the intent of the standards, achieving an average arrival-to-consultant review time of 18 hours 50 minutes, demonstrating sustained clinical commitment under operational pressure.

Overall, the audit evidences that all four priority seven-day standards have been met.

Appendix 1: Comparison of Years

Standard	Percentage Achieved 2022/23 Audit	Percentage Achieved 2023/24 Audit	Percentage Achieved 2024/25 Audit	Percentage Achieved 2025/26 Audit
Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.	**92%**	**89%**	**88%**	**98%**
Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.	**100% available**	**100% available**	**100% available**	**100% available**
Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.	**100% available**	**100% available**	**100% available**	**100% available**
Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.	**Day 2: 98% Day 3: 93% Day 4: 84% Day 5: 88% Day 6: 92% Day 7: 96% (average 93%)**	**Day 2: 97% Day 3: 91% Day 4: 91% Day 5: 87% Day 6: 84% Day 7: 91% (average 90%)**	**Day 2: 93% Day 3: 92% Day 4: 91% Day 5: 88% Day 6: 85% Day 7: 83% (average 90%)**	**Day 2: 100% Day 3: 94% Day 4: 90% Day 5: 87% Day 6: 83% Day 7: 85% (average 91%)**