Board of Directors - Public Meeting

Wednesday 7 October 2026, 10:15 - 15:45

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

10:15 - 10:16
1 min

1. Chair and quorum

Note *Prof Dame Robina Shah*

10:16 - 10:17
1 min

2. Apologies for absence

Information *Prof Dame Robina Shah*

- Mark Wilkinson
- Richard Mundon

10:17 - 10:18
1 min

3. Declarations of interests

Information *Prof Dame Robina Shah*

3.1. Directors' register of interests

Information

03.1. Directors DoIs - Sep 2026.pdf (2 pages)

10:18 - 10:28
10 min

4. Research story

Information *Rajyalakshmi Reddy*

10:28 - 10:33
5 min

5. Minutes of the previous meeting

Approval *Prof Dame Robina Shah*

05.Minutes_Board of Directors - Public meeting _050826.pdf (18 pages)

10:33 - 10:38
5 min

6. Action log

Assurance *Prof Dame Robina Shah*

06. Public Board Action Log Oct 2026 2.pdf (6 pages)

10:38 - 10:48
10 min

7. Chair's report and stakeholder update

Information *Prof Dame Robina Shah*

07. Chair's Report - BoD Oct 2026.pdf (6 pages)

10:48 - 11:03
15 min

8. Chief Executive's report

Information *Mary Fleming*

08. CEO Board Report_October 2026.pdf (4 pages)

11:03 - 11:08
5 min

9. Strategy: final position

Approval *Chris Clark*

09. Strategy refresh for Board 07 10 2026 (Public version).pdf (3 pages)
09a. Appendix 1_Strategy Doc 2026 PRELIM V7.pdf (19 pages)

11:08 - 11:08
0 min

10. Partnerships report

Chris Clark

10. Board - Partnerships Report October 2026.pdf (6 pages)

11:08 - 11:18
10 min

11. Board assurance framework

Assurance *Mary Fleming*

11. BAF Report Oct 2026 final1.pdf (42 pages)

11:18 - 11:33
15 min

12. Winter Plan and board assurance statement

Approval *Sarah Brennan*

12. Winter Plan Final 1.pdf (40 pages)
12a. Letter re Winter planning 2026 27 expectations and assurance 17 July 2026.pdf (3 pages)
12b. Equality Impact Assessment Winter Plan.pdf (3 pages)
12c. BAS Self Assessment - WWL.pdf (11 pages)
12d. Winter Plan 2026-27 - Quality Impact Assessment.pdf (1 pages)

11:33 - 11:38
5 min

13. Maternity and Neonatal 10 Point Plan

Assurance *Jo Lambert*

13. ETM National Maternity Traige Specification FINAL ETM.pdf (6 pages)
13a. Point Plan Report - For ETM - 10.09.2026.pdf (5 pages)

11:38 - 11:48
10 min

14. Biannual maternity staffing report

Assurance *Jo Lambert*

14. Maternity Biannual Staffing Report Feb 2026 v2.pdf (18 pages)

11:48 - 11:58
10 min

15. Maternity Triage Specification

Approval *Jo Lambert*

15. Executive Summary 10 Point Plan Final.pdf (6 pages)
15a. WWL Triage Spec Basline - Sept 26.pdf (28 pages)

11:58 - 11:58
0 min

16. Thirlwall Inquiry

Information *Kevin Parker-Evans*

16. Thirlwall Inquiry Report BoD Oct 2026.pdf (6 pages)
16a. Appendix 1 NHSE Letter Thirlwall Inquiry report and recommendations.pdf (4 pages)

11:58 - 12:03

17. Provider Capability Self-Assessment

5 min

Approval *Katharine Dowson*

- 17. Provider Capability Self Assessment BoD 7 October 2026.pdf (5 pages)
- 17a. Appendix 1 Provider-capability-self-assessment WWL Oct 2026.pdf (1 pages)
- 17b. Appendix 2 Provider Capability Evidence Worksheet 2026 BoD Oct 2026.pdf (6 pages)

12:03 - 12:13
10 min

18. Review of board and committee effectiveness including revised Terms of Reference

Assurance & Approval *Katharine Dowson*

- 18. Annual Board Committee Review - key themes for board review.pdf (5 pages)
- 18a. DRAFT ToR F&P 2026.pdf (6 pages)
- 18b. DRAFT Research Committee - ToR 2026.pdf (6 pages)
- 18c. DRAFT QS ToR - 2026.pdf (6 pages)
- 18d. DRAFT People Committee ToR 2026.pdf (5 pages)
- 18e. DRAFT ToR Audit 2026.pdf (7 pages)

12:13 - 12:18
5 min

19. Review of master workplan

Approval *Katharine Dowson*

- 19. Board workplan.pdf (6 pages)

12:18 - 12:23
5 min

20. Fit and Proper Persons Policy

Approval *Katharine Dowson*

- 20. FPP New Policy 7 Oct 2026.pdf (2 pages)
- 20a. Appendix 1 FPP Draft Policy October 2026.pdf (33 pages)

12:23 - 12:53
30 min

Break

12:53 - 13:13
20 min

21. Committee Chairs' AAA reports

Assurance

21.1. Quality and Safety Committee

Assurance *Francine Thorpe*

- 21.1. AAA Q&S Sep 2026.pdf (2 pages)

21.2. Finance and Performance

Assurance *Julie Gill*

- 21.2. AAA - FP - Sep 2026.pdf (3 pages)

21.3. People Committee

Assurance *Mary Moore*

- 21.3. People Committee - AAA - Sept (1).pdf (3 pages)

21.4. Audit Committee

Assurance *Simon Holden*

- 21.4. AAA - Audit Committee - 22 Sep 2026.pdf (2 pages)

21.5. Research Committee

Assurance *Robina Shah*

21.5. AAA - Research - Sep 2026.pdf (3 pages)

13:13 - 13:33
20 min

22. Integrated performance report

Assurance *Sanjay Arya, Tracy Narot, Sarah Brennan & Kevin Parker-Evans*

22. Board of Directors IPR M05 2627.pdf (3 pages)
22a. IPR_M05_2627.pdf (26 pages)
22b. Corridor Board Presentation.pdf (7 pages)

13:33 - 13:43
10 min

23. Primary and Secondary Care Agreement

Approval *Sarah Brennan*

23. Primary Secondary Care Interface Document.pdf (3 pages)
23. WLMC-FINAL-VERSION-21stJan-26.pdf (16 pages)

13:43 - 13:48
5 min

24. Mid Year Review Submission

Ratification *Katharine Dowson*

24. MYR - Board Self Assessment BoD 7 Oct 2026 Final.pdf (15 pages)

13:48 - 13:58
10 min

25. EPRR report & core standards self-assessment

Approval *Sarah Brennan*

25. EPRR Core Standards.pdf (8 pages)
25a. NHS Core Standards for EPRR 2026 WWL Self Assessment FINAL.pdf (23 pages)
25b. - Assurance process Statement of Compliance 2026-2027.pdf (1 pages)

13:58 - 14:18
20 min

26. Finance report

Incofmation *Tabitha Gardner*

26. Board Cover Sheet - Trust Finance Report Month 05 August 2026.pdf (2 pages)
26a. Trust Finance Report 26-27 Month 05 Board.pdf (16 pages)

14:18 - 14:28
10 min

27. Resident doctors Listening into Action Feedback

Assurance *Tracy Narot*

27. Resident Doctor Listening into Action Progress Update and Improvement Programme Final 270926 TN.pdf (2 pages)

14:28 - 14:38
10 min

28. Freedom to Speak Up Guardian’s report

Assurance *Tracy Narot*

28. Speaking Up at WWL Q1 Assurance and Substantive FTSU Service Transition 27092026 TN.pdf (5 pages)

14:38 - 14:48
10 min

29. Learning Review into Sexual Safety

Assurance *Tracy Narot*

29. NHS Staff Standards (Sexual Safety Charter) Learning Review 27092026 TN Final Draft.pdf (5 pages)

14:48 - 14:58
10 min

30. Lord Mann Report

Approval *Tracy Narot*

30. Lord Mann Recommendation Next Steps Assurance Paper for Board final draft 27092026 TN.pdf (4 pages)

14:58 - 15:13
15 min

31. Workforce Race Equality Standards and Workforce Disability Equality Standards

Discussion *Tracy Narot*

31. WRES WDES 202526 Board 27092026 TN Final Draft.pdf (5 pages)

15:13 - 15:18
5 min

32. Board Diversity Policy: update and next steps

Information *Katharine Dowson*

32. Board Diversity Policy Renewal 2026 v2.pdf (5 pages)

15:18 - 15:28
10 min

Break

15:28 - 15:43
15 min

33. Charity presentation

Information *Emily Mundon*

33. Three Wishes at Board Oct 26.pdf (12 pages)

15:43 - 15:44
1 min

34. Close

Information *Prof Dame Robina Shah*

Verbal item

15:44 - 15:44
0 min

35. Consent agenda

Information

The following items have been submitted for approval by the Board without discussion unless any board member requests to the Chair and/or Company Secretary prior to the start of the meeting that they wish a specified item to be withdrawn from the consent section for consideration at the meeting.

15:44 - 15:44
0 min

36. Medical revalidation report

Approval

36. Appraisal & Revalidation Report Board_Cover Sheet - Annex A FQAI.pdf (2 pages)
36a. Appraisal & Revalidation Report Annex A FQAI updated 2026 FINAL.pdf (25 pages)

15:44 - 15:44
0 min

37. Review of Standing Financial Instructions

Approval

37. SFI amendments Sept 2026 Trust Board.pdf (5 pages)
37a. SFIs 26-27 Sept 2026.pdf (75 pages)

15:44 - 15:44
0 min

38. Date and Time of next meeting

Information *Prof Dame Robina Shah*

15:44 - 15:45
1 min

39. Resolution: Exclusion of the Public

Approval *Prof Dame Robina Shah*

To resolve that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

Title of report:	Directors' declarations of interest
Presented to:	Board of Directors
On:	7 Oct 2026
Purpose:	Information
Prepared by:	Head of Corporate Governance and Deputy Company Secretary E: nina.guymer@wwl.nhs.uk

NON-EXECUTIVE DIRECTORS	
Name	**Declared interests**
BRADLEY, Rhona	Trustee, Addiction Dependency Solutions Charity Governor, Learning Training Employment (LTE) Group Non-Executive Director, Home Group Housing Association Spouse is The Rt Hon Lord Bradley of Withington Deputy Lieutenant of Greater Manchester
GILL, Julie	Nil declaration
HOLDEN, Simon	Director, Simon Holden Associates Limited (CRN: 09546681) Non-Executive Director, LocatED Property Ltd (No: 10385637)
MOORE, Mary	Nil declaration
SHAH, Robina	Professor of Medical Education and Psycho-Social Medicine, University of Manchester Director, Doubleday Centre for Patient Experience at University of Manchester Board member, Oldham Athletic Football Club Board member, Health Data Research UK Deputy Lieutenant of Greater Manchester Chair, Dame Robina Shah Foundation
WILKINSON, Mark	Chair, Be One Homes Ltd Non-Executive Director, Mastercall Healthcare Pro-Chancellor and Chair of Governors', Edge Hill University

	Director and shareholder, Fairway Consulting Services Ltd (CRN: 13767002) Wife employed by Lancashire County Council public health department Son works for Mersey and West Lancs NHS FT, but currently on secondment at WWL.
THORPE, Francine	Independent Chair, Salford Safeguarding Adults Board

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

One additional declared interest is held in the Trust's confidential records. The declaration has been reviewed by the Company Secretary and remains available for governance, audit and related party transaction purposes, however, it has been considered appropriate for details to be redacted from the published register.

Board of Directors - Public meeting

Wednesday 5 August 2026, 10:30 - 15:05

Boardroom, Trust Headquarters

Attendees

Board members

Robina Shah (Chair), Sanjay Arya (Chief Medical Officer), Rhona Bradley (Non-Executive Director), Sarah Brennan (Chief Operating Officer), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Richard Mundon (Deputy Chief Executive), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Mary Moore (Non Executive Director), Kevin Parker-Evans (Chief Nursing Officer), Tracy Narot (Chief People Officer), Mark Wilkinson (Non-Executive Director)

Absent: Nina Guymer (Head of Corporate Gov & Deputy Company Secretary), Simon Holden (Non-Executive Director), Francine Thorpe (Non-Executive Director)

Presenters

Abigail Callender-Iddon (Guardian of Safe Working, Present at: 61),
Cathy Stanford (Divisional Director of Maternity and Neonates, Present at: 55, 56, 57, 58, 59)

Attendees

Absent: Katharine Dowson (Director of Corporate Governance)

Meeting minutes

42. Chair and quorum

Note

Prof Dame Robina Shah

The Chair took the chair, declared that a quorum was present and therefore that the meeting was duly convened and constituted.

43. Apologies for absence

Information

Prof Dame Robina Shah

Apologies for absence had been received for:

- Francine Thorpe
- Simon Holden

44. Declarations of interests

Information

Prof Dame Robina Shah

No declarations of interests were raised and the content of the associated report was noted.

44.1. Directors' register of interests

Information

45. Patient story

The Board received a patient story highlighting the experience of a carer supporting a family member through a prolonged hospital stay and discharge process. The story provided a powerful account of the emotional impact on carers and the challenges caused by fragmented care across organisational boundaries.

The Chair reflected on the importance of looking beyond the patient and recognising the wider impact on carers. She noted the relevance of carers' rights under the Care Act 2014 and emphasised the need to ensure learning from the story is embedded across the organisation and system partners.

Board members discussed the need to balance operational pressures at the front door with safe and appropriate discharge arrangements. Mark advised that the organisation's redesign programme sought to better align acute and community services and highlighted investment in community-based and step-up provision to support patients with complex needs. He said the story demonstrated the need to move towards a more integrated health and care approach and would provide valuable learning for system partners.

Sanjay observed that the patient had experienced a combined stay of approximately eight and a half months and challenged the concept of being "medically fit for discharge", stressing the importance of ensuring patients are also "socially fit for discharge" with appropriate support in place.

In concluding the discussion, the Chair thanked the carer for sharing the story and noted that the learning would be shared through the Healthier Wigan Partnership to support wider health and care system improvement.

The Board noted the patient story and the learning arising from it.

46. Minutes of the previous meeting

Approval

Prof Dame Robina Shah

The Board reviewed the minutes of the public meeting held on 17 June 2026.

Mark noted that in regard to page 3, second paragraph, he had attended meetings of the 10-Year Health Plan Working Group, rather than being a member of the group.

Mark also wished to make clear that the Jean Hayes Reablement Unit (JHRU) whilst located on the Leigh site, is intended to serve the whole borough population, rather than solely the Leigh population.

Subject to the amendments outlined above, the minutes of the meeting held on 17 June 2026 were **APPROVED** as an accurate record.

05. Minutes_Board of Directors - Public Meeting_170626.pdf

47. Action log

Assurance

Prof Dame Robina Shah

The Board received the action log and progress updates, with action 60.2/26 and the below listed, **AGREED** to close.

69.2/26: People Committee (FTSU service)

Tracy advised that the Trust had successfully appointed Manchester University NHS Foundation Trust as the new provider of the Freedom to Speak Up service and that transition arrangements were underway.

37/26/26: Patient story (JHRU model and HIS support)

The Board noted that this action had been completed following the update provided in June and agreed its removal from the action log.

37/26.c Patient story

In relation to this referred action, it was noted that benefits realisation would be reported through the September meeting of the Quality & Safety Committee.

06. Public Board Action Log 2026 2.pdf

48. Chair's report and stakeholder update

Information

Prof DameRobina Shah

The Chair provided an update on recent stakeholder engagement activity and highlighted the positive feedback received regarding the JHRU. She described the project as an example of successful partnership working and collaboration across organisations, demonstrating the benefits that can be achieved through a shared approach.

Mary F highlighted the involvement of local college students in supporting the development of the raised beds within the scheme, noting the positive intergenerational benefits. She advised that the partnership with Wigan & Leigh College would continue through ongoing support and maintenance of the garden and wider site environment.

The Chair further recognised the contribution of the Wigan and Leigh Group consortium of local contractors who had created the space, thanking them for their support and commitment to the project. She also acknowledged the significant contribution of the Trust's Estates and Facilities teams in bringing the project to fruition.

The Board received an update on Non-Executive Director engagement activities. The Chair reflected on the value of NED visits in increasing visibility, engaging directly with colleagues and gaining firsthand insight into operational issues and staff experience.

Mary M welcomed the benefits arising from these visits but noted that NED contributions extended beyond walkabouts and site visits. She suggested that future Chair's reports should provide a broader overview of NED activity, including attendance at stakeholder events, workshops, partner meetings and other governance activities undertaken on behalf of the Board, which was endorsed by all present.

07. Chair Board Report - August 2026.pdf

49. Chief Executive's report

Information

Mary Fleming

Mary F presented her report, highlighting a range of strategic developments across the organisation, including work relating to resident doctors, maternity and neonatal services, elective care standards, workforce culture, capital investment and staff engagement.

Resident Doctors

Mary F reflected on the powerful staff story shared by resident doctors in June and advised that, whilst the Trust would continue to support delivery of the national 10-Year Health Plan, there was also a commitment to address the cultural issues raised locally. She reported that she and Tracy had met with a large group of resident doctors to listen to concerns and agree a supportive way forward. Ongoing oversight would be provided through the People Committee.

Sanjay welcomed the induction of approximately 130 new resident doctors and advised that a strong focus had been placed on medical training, wellbeing and understanding the experience of doctors working within the organisation. He noted that engagement activity was already providing valuable insight into organisational culture.

Maternity and Neonatal Services

Mary F highlighted the significant volume of national guidance and requirements currently being received in relation to maternity and neonatal services. Whilst a national pause remained in place whilst requirements were reviewed, immediate actions were being progressed in response to the national letter and associated recommendations. She emphasised the importance of ensuring women, families and babies received consistently safe, high-quality care, with oversight through the Quality & Safety Committee.

Mary M sought assurance that, in light of the Amos and Ockenden reports, the Quality & Safety Committee would receive assurance regarding the completeness of maternity incident records covering the previous ten-year period.

Elective Care Standards

Mary F advised that Boards had been asked by NHS England to review plans against the Elective Care Standards published in 2025, with a formal Board statement expected during 2026/27. She noted that the work extended beyond performance metrics and would focus on understanding patients' experiences of care. Sarah was leading the development of the supporting board assurance reporting.

Fundamentals of Care Academy

Mary F advised that the Fundamentals of Care Academy would formally launch in September 2026, supported by a communications campaign throughout August. The initiative would reinforce expectations regarding compassionate, high-quality care across all staff groups.

Capital Investment

Mary F went on to highlight the continued investment being made in modernising services despite ongoing financial constraints. The Board noted progress in relation to the new Surgical Assessment Lounge, the Bioskills Laboratory, the Joint Health and Recovery Unit Stepping Stones Garden and the new diagnostic facility at the Royal Albert Edward Infirmary. Mary F commented on the pride being expressed by staff in relation to these developments.

Staff Recognition and Culture.

She reported on a range of workforce engagement and recognition initiatives, including the STAR Awards, Patient Choice Awards, the #LoveWWL campaign and Pride Month activities. She emphasised that supporting, recognising and valuing staff remained a strategic priority for the organisation.

The Chair reflected on the importance of partnership working in delivering high-quality care and creating the right environment for patients and staff. She noted that continued investment in facilities and staff experience would help ensure services remained safe, supportive and fit for the future. She sought clarification regarding the appointment of a Consultant in Public Health referenced within the report.

Anne-Marie confirmed that this did not represent a new appointment but was an additional wellbeing leadership responsibility being undertaken by the existing consultant to support resident doctors.

Mark welcomed the positive focus on staff achievements within the report and suggested that future updates should also include examples of wider Wigan Borough achievements and public partnership working.

The Chair further reflected on the need to strengthen the way information was triangulated across Board reports. Referring to data presented through child death and safeguarding arrangements, she noted the importance of connecting intelligence from different reporting routes, including Learning from Deaths, safeguarding reporting and wider system datasets, to provide a more comprehensive picture for Board assurance.

Rhona advised that additional safeguarding reporting and information had recently.been presented through the Safeguarding Effectiveness Group and would be reported through future Board reporting.

The Board noted the Chief Executive's Report and associated updates.

08. CEO Board Report_August 2026_Public_Approved.pdf
08a. 30062026 system letter - Amos report FINAL.pdf
08b. PRN02340 Letter on minimum standards of patient experience 3 July 2026.pdf

50. Board assurance framework

Assurance

Richard Mundon

Katharine presented the Board Assurance Framework (BAF), advising that all principal risks had been reviewed and updated following the Board workshop in May to ensure alignment with the agreed 2026/27 corporate objectives. An exception was the People risk, where significant work led by the Chief People Officer and People Committee had resulted in the development of four separate risks. Associated controls, assurances and mitigating actions had also been refreshed. Katharine advised that the Finance & Performance Committee had considered the financial sustainability risk in detail and had agreed that whilst the risk score would remain at 16, the trend should be recorded as deteriorating rather than stable, reflecting the increasing financial challenge faced by the organisation.

The Board noted that previous discussions regarding improvements to the format and presentation of the BAF had not yet been progressed. Katharine advised that this would be considered as part of a wider review of the framework following the launch of the refreshed Trust Strategy.

The Chair emphasised the importance of the BAF being used as a live document to support Board decision-making and assurance, with key discussions, concerns and agreed actions reflected appropriately within the framework.

During discussion, Mary F noted that whilst progress with the implementation of Martha's Rule had been positive, the programme had not yet been rolled out within paediatric services. She highlighted that implementation across all relevant areas formed part of the urgent actions arising from the Baroness Amos review and requested that lessons learned from the rollout to date be reviewed before wider implementation.

Sanjay advised that a report on learning from the implementation of Martha's Rule was scheduled to be presented to the Quality & Safety Committee in September. He proposed that the learning could also be shared with the Board and advised that colleagues directly involved in the programme would be invited to contribute to the discussion.

The Board **APPROVED** the updates to the Board Assurance Framework and **ENDORSED** its continued development in line with the refreshed Trust Strategy.

ACTION: Learning from the implementation of Martha's Rule, including lessons learned to date and implications for further rollout, to be presented to the Board following consideration by the Quality & Safety Committee - Sanjay by December 2026 Board meeting.

09. BAF Report Board Aug 2026 final.pdf

51. Strategy refresh: 2030 Delivery ambitions

Approval

Richard Mundon

Richard presented the refreshed strategy and proposed delivery ambitions. He advised that the delivery ambitions had been reduced from ten to eight, with stronger references to research and prevention included in response to stakeholder feedback. The language had been simplified to improve accessibility and there was now a clearer link between the organisation's purpose and delivery ambitions. He confirmed that the strategy would run until 2031 to align with medium-term planning cycles. Publication remained planned for September 2026, with full deployment from April 2027. Work would now focus on refining the breakthrough objectives, agreeing metrics and aligning the Board Assurance Framework.

Mark sought assurance that the organisation was moving towards a more multi-year approach to service improvement and cost improvement planning, noting that discussions at previous Board meetings had highlighted a tendency to focus on annual planning horizons. Richard confirmed that the strategy incorporated a five-year planning perspective and advised that a three-year financial sustainability and CIP programme was also being developed, with further detail and associated metrics to follow.

Referring to staff engagement feedback, Mark observed that staff appeared to connect more readily with immediate operational and efficiency-focused objectives than with longer-term ambitions focused on effectiveness and transformational change. Richard agreed and noted the importance of considering how the more strategic ambitions could be communicated in a meaningful and relatable way for colleagues.

The Chair welcomed the strategy-on-a-page approach but suggested that greater emphasis should be placed on how the strategy would translate into programmes of work and deliverable outcomes. She also sought assurance that the strategy remained aligned to national priorities following recent changes in national political leadership.

Mary F advised that recent discussions with national colleagues continued to focus on the three shifts and fundamentals of care, whilst also reflecting a stronger emphasis on social care. Julie noted that any future requirement to redirect NHS resources to support social care reform could present a challenge.

The Chair commented that strong partnership working remained critical to the successful delivery of the strategy and welcomed the clear intent reflected throughout the document. Richard advised that whilst the overarching objectives were unlikely to change significantly over the life of the strategy, the breakthrough objectives and supporting metrics would remain sufficiently flexible to respond to changing circumstances and emerging priorities.

Anne-Marie outlined plans for a phased communications and engagement programme to support implementation of the strategy. She advised that extensive feedback gathered through the review process provided valuable intelligence regarding which messages resonated most strongly with staff and would inform the development of a range of supporting materials. Drawing on previous experience, she highlighted the value of demonstrating how individual roles and teams contributed directly to strategic objectives.

Sarah encouraged consideration of how the organisation's values could be more explicitly reflected throughout the strategy and suggested that concepts such as learning, discovery, improvement and curiosity should be embedded within the narrative. The Chair particularly welcomed the emphasis on curiosity as an important cultural enabler.

Reflecting on the role of partnerships, Mary F questioned whether this theme should feature more prominently within the strategy given its importance to future delivery.

The Chair further challenged whether sufficient engagement had been undertaken with all communities and stakeholder groups, including people with learning disabilities, Black and Minority Ethnic communities and people with hidden disabilities. Richard advised that engagement had included staff, partners, governors and the lived experience panel, whilst recognising further opportunities to engage wider audiences as part of the strategy launch. She requested that a cross-check be undertaken to ensure key communities could clearly see themselves reflected within the strategy narrative.

In response to a question regarding approval arrangements, Katharine confirmed that the draft strategy would be considered at the September Board Workshop ahead of formal approval at the October public Board meeting.

The Board supported the proposed direction of travel and noted the next steps in finalising the refreshed strategy ahead of formal approval in October 2026.

ACTION: Undertake a review of the strategy narrative to ensure the perspectives of people with learning disabilities, Black and Minority Ethnic communities, people with hidden disabilities and other key stakeholder groups are appropriately reflected prior to final Board approval - Richard by October 2026 Board meeting.

10. Strategy refresh for Board 050826.pdf

10a. Revised delivery ambitions and draft strategy on a page_Board 05 08 26.pdf

52. Board Committee Chairs' Reports

Assurance

Non-Executive Directors

52.1. Quality and Safety Committee

Assurance

Mary Moore

Mary M presented the Committee's AAA report, highlighting areas where assurance had not yet been fully achieved. The principal concerns related to pathology services, microbiology workforce resilience, deteriorating patients, sepsis performance and safe staffing. The Committee had, however, received assurance regarding progress against the corridor care action plan.

Kevin advised that the Committee had not been assured that sepsis improvement actions were being delivered at sufficient pace. Additional executive oversight was therefore being provided by himself and Sanjay, with Anne-Marie contributing an independent perspective through the associated working group. Targeted work was underway within the Emergency Department to improve performance in the "golden hour".

Sanjay updated the Board on actions being taken to strengthen microbiology resilience, including recruitment activity and the return of a consultant from long-term sickness absence.

The Chair emphasised that areas where assurance had not been achieved should be clearly identified within Committee reports, together with the actions being taken to address gaps in assurance.

The Board discussed the ongoing pathology programme and associated system risks. Kevin confirmed that the required submission had been made by the 31 July deadline but a response was still awaited. Sarah advised that discussions with the Northern Care Alliance were scheduled for the following week. Mary F noted the need to establish a clear end point for the programme and highlighted the potential impact on cancer turnaround times.

The Board noted the report and the areas where further work was required to achieve assurance.

ACTION: Executive Team Management to review the pathology programme and bring recommendations to a future Board meeting to support agreement of the preferred way forward - Mary F by 7 October 2026 Board meeting.

11.1. AAA QS Jul 2026.pdf

52.2. People Committee

Assurance

Mark Wilkinson

Mary M presented the report on behalf of the Committee Chair and highlighted that People Services metrics remained rated at NHS Oversight Framework (NOF) level 4, although overall performance had improved to level 3. The Committee had also considered the impact of ongoing organisational redesign activity, the MARS programme, resident doctor wellbeing, workforce transformation and emerging People risks.

Tracy advised that the Committee had undertaken its first review of the refreshed People risks following the Board workshop in May, noting that the previous single workforce risk had been developed into four separate risks to provide greater clarity and assurance. She advised that these risks may continue to evolve as the work progresses.

The Committee had focused its discussion on the effectiveness of workforce policies and whether their application was delivering the desired performance outcomes. Tracy noted concerns that, whilst significant effort had been directed towards policy compliance, improvements in areas such as sickness absence had not always followed. The Committee therefore supported a greater focus on the practical impact of policies, prevention, responsiveness and learning from evidence.

Tracy also highlighted ongoing work relating to resident doctor welfare and psychological safety, linked to the Trust's 10-point improvement plan, together with plans to strengthen assurance regarding professional standards through a learning review which would return through the People Committee.

During discussion, Tracy advised that delivery of the medium-term workforce plan relied significantly on the success of the MARS programme. Whilst applications had been received, numbers remained below those required to fully support the workforce plan. She suggested there may be value in further discussion regarding the use of voluntary redundancy arrangements.

Mary F noted that previous discussions with the Remuneration Committee had recognised the need for a range of workforce management tools but stressed the importance of undertaking appropriate due diligence before progressing any voluntary redundancy programme.

The Chair welcomed the Committee's focus on psychological safety and supported the application of a health inequalities lens to workforce matters. She also emphasised the importance of ensuring Board Committees had sufficient opportunity to review and provide assurance against the Board Assurance Framework and associated risks.

The Board noted the report and the areas of focus identified by the People Committee.

11.2. People Committee - AAA - Jul 2026.pdf

52.3. F&P Committee

Assurance

Julie Gill

Julie presented the Committee's AAA report and highlighted significant concerns regarding the Trust's financial position at the end of Quarter 1. She advised that performance against a number of key metrics remained challenging, including elective activity, workforce expenditure and financial recovery. The Committee had therefore escalated the financial position as an alert, noting that the overall position remained highly challenging. Members were also concerned about the potential impact of national changes relating to the National Oversight Framework and financial arrangements, together with the Trust's ability to maintain delivery of elective recovery targets. Whilst the Trust remained on track to eliminate 65-week waits, capacity constraints, including reliance on mutual aid, continued to create risks to the delivery of 52-week standards.

Julie noted that corridor care remained a concern. Whilst a robust action plan was in place, the Committee had highlighted the financial risks associated with implementation and welcomed the assurance provided earlier in the meeting regarding work underway. The Committee had also considered Urgent and Emergency Care oversight arrangements and welcomed improvements to the quality of data being reported. Four capital business cases had been approved.

The Chair reflected on the recurring themes emerging across Committee reports, particularly the relationship between financial recovery, service transformation and workforce capacity. She noted that delivery of financial plans and transformation programmes relied heavily on having sufficient capacity and capability within the workforce to implement change.

Mary F acknowledged the challenge of shifting activity and resources into community settings, noting that difficult decisions would be required to support the strategic direction of travel.

Tracy agreed that the focus should remain on the impact on patients and noted that approximately 1,200 patients had not received care in line with planned activity. She emphasised the need to maintain focus on delivery for patients, alongside the wider financial and operational recovery agenda.

The Board noted the report and the areas of concern highlighted by the Finance and Performance Committee.

53. Integrated performance report and NOF

Assurance

Richard Mundon

Richard presented the Integrated Performance Report, highlighting areas not already covered elsewhere on the agenda. Whilst RTT performance continued to improve, further progress was required. The imminent reopening of Theatres 5 and 6 was expected to support elective recovery. Cancer performance remained mixed, although improvement work continued through the transformation programme. The Trust remained focused on sustaining performance through the Better Lives programme during the summer months. Urgent and Emergency Care performance remained amongst the strongest in Greater Manchester and was just below the national four-hour standard despite increasing attendances. He advised that whilst the Trust had delivered its CIP target for the month, recurrent savings remained behind plan and the current run rate was not improving sufficiently, increasing pressure on the financial position and cash delivery.

Kevin provided a comparison between winter performance and June performance, demonstrating the impact of operational improvements on patient care. He highlighted the linkages between reduction in occupancy levels, A&E waits, corridor care and patient moves, together with improvements in four-hour performance. He noted that these changes had been associated with improvements in patient outcomes, including reductions in pressure ulcers, falls and Clostridioides difficile infections. He also outlined improvements in staff attendance at mandatory training and ongoing work to improve the complaints process, including understanding whether complaints reduced in areas where service improvements had been made.

The Chair welcomed the focus on the impact of operational improvements and advised that this type of narrative was particularly valuable to the Board. She emphasised the importance of supplementing performance metrics with information about the actions being taken, the benefits being achieved and the impact on patients and staff.

The Board noted the Integrated Performance Report and progress against the New Operating Framework requirements.

ACTION: Executive Team to consider how future Integrated Performance Reports can better demonstrate the relationship between improvement actions, performance metrics and outcomes for patients and staff - Richard by 7 October 2026 Board meeting. GET RID OF ACTION--XXX

12. Board of Directors IPR M03 2627.pdf
12a. IPR_M03_2627.pdf

54. Finance Report

Assurance

Tabitha Gardner

Tabitha presented the Month 3 financial position, advising that the Trust was £0.8m adverse to plan, driven primarily by elective underperformance and the costs associated with industrial action. It was anticipated that these costs would not recur through the remainder of the year. Tabitha reported that implied productivity had reduced during Quarter 1, although work was underway to recalculate and validate this relatively new measure.

The Committee noted that whilst the underlying deficit position had been significantly reduced during 2025/26, substantial work remained to achieve the planned trajectory for 2026/27. Tabitha advised that both the mid-case and worst-case scenarios reflected a return to the financial challenges experienced in previous years unless corrective action was taken.

Whilst the Trust had achieved its Cost Improvement Programme (CIP) target, Tabitha emphasised that the impact on the underlying financial position remained insufficient, with an over-reliance on non-recurrent savings. Work was underway on workforce modelling, the transformation programme and wider recovery actions, with further detail to be considered at the September Board Workshop.

Th Chair acknowledged the significant pressures facing the organisation and highlighted the fragility of the current financial recovery position.

Mary F advised that actions within the organisational redesign programme had been prioritised to date, but further measures would now be required to support delivery. She noted that the reopening of Theatres 5 and 6 would support elective activity and recovery plans and stressed the importance of supporting divisions to deliver agreed CIP schemes.

Th Chair also sought assurance that lessons had been learned from the closure of Theatres 5 and 6 and the resulting impact on patient activity. Sarah confirmed that the matter had previously been considered by ETM but agreed that the learning should be revisited once the theatres were fully operational. Members noted the importance of understanding how activity plans translate into capacity and patient access.

The Board noted the financial position and the recovery actions being progressed.

ACTION: Review and report the lessons learned from the closure and reopening of Theatres 5 and 6, including the impact on patient activity and capacity planning, to inform future service planning - F&P Committee by 7 October 2026

13. Board Cover Sheet - Trust Finance Report June 2026.pdf
13a. Trust Finance Report 26-27 Month 03 - Board.pdf

55. Perinatal quality oversight report (Q1)

Assurance

Kevin Parker-Evans

Cathy Stanford, Divisional Director of Midwifery and Neonates joined the meeting.

Cathy presented the report using the new national reporting template. She advised that there were no adverse trends within the data, training compliance remained on track and patient feedback continued to be positive. Workforce capacity remained the principal risk, reflecting increasing acuity, demand and capacity pressures. Outcomes were stable or improving across the majority of indicators and significant work continued to strengthen culture and embed improvement. She also highlighted the implementation of the new maternity information system, which would significantly enhance data quality, reporting and analysis.

The Chair welcomed the report but requested greater emphasis on gaps in assurance and the actions being taken to address them. Cathy advised that work was underway to complete a gap analysis against the urgent actions arising from the Amos and Ockenden reviews. Whilst the required systems and processes were largely in place, further work was required to strengthen data capture, analysis and business intelligence support. Members noted that the new maternity system would support this through improved reporting and live dashboard functionality.

The Board discussed delays in Category 2 Caesarean sections, noting that Caesarean deliveries now accounted for approximately half of all births. Cathy advised that delays were predominantly linked to competing clinical priorities, including Category 1 emergencies and the combined obstetric and gynaecology medical rota. Concerns were also raised regarding the reliability of some data capture processes. Work was

underway to improve data quality, review theatre processes and consider options to increase dedicated obstetric capacity.

Mary M noted that maternity champions had explored whether dedicated obstetric theatre teams operated elsewhere and encouraged further review of the findings from ongoing audit work.

Kevin emphasised the need to ensure maternity services remained a visible organisational priority alongside other major performance agendas. He highlighted the importance of considering obstetric capacity within future elective planning and challenged whether delays should be triangulated with patient harm data. He also asked whether a health inequalities perspective, including the experience of non-English speaking families, should form part of future analysis.

The Board also discussed delivery of the home birth service. Mary F questioned whether current activity levels were sufficient to maintain skills and whether alternative delivery models should be considered. Cathy advised that work was underway both locally and across Greater Manchester to review future arrangements and ensure staff maintained the required competencies.

Sarah sought assurance regarding the impact of increasing regulatory requirements and scrutiny on maternity staff and asked whether additional support was required. Cathy acknowledged the pressures associated with workload, training requirements and national scrutiny and stressed the importance of continuing to support staff wellbeing.

Tracy recognised the positive work being undertaken to support staff returning from sickness absence and maintain workforce resilience.

The Chair highlighted that the report had been referred from the consent agenda to ensure appropriate recognition of the significance of the issues presented and welcomed the continuing improvements in reporting quality and transparency.

Mary F noted that this would be Cathy's final Board meeting, thanking her for her leadership and contribution to maternity services at WWL and wished her a long and happy retirement.

The Board noted the report and the ongoing actions being taken to address workforce, capacity and maternity improvement priorities.

Cathy left the meeting.

14.1. Perinatal Quality Oversight Report Q1 Apr-Jun 26-27 Final 3.pdf

56. Learning from deaths quarterly report

Assurance

Sanjay Arya

Sanjay presented the refreshed Learning from Deaths report, explaining that the revised format placed greater emphasis on learning and improvement. He outlined the process for reviewing mortality data, including monthly mortality meetings which consider trends, themes and areas requiring further investigation. Key themes examined during the quarter included pneumonia, sepsis and referrals to palliative care services. Sanjay also highlighted new analysis relating to deprivation, which demonstrated that deaths from areas of higher deprivation were broadly proportionate to the patient population served.

Mary M asked whether any excess deaths identified during the quarter could be linked to periods of hot weather and requested that this be explored further in future reporting.

The Board discussed findings from the review of Electronic Palliative Care Co-ordination System (EPaCCS) records, which showed that fewer than half of patients had an EPaCCS record in place prior to admission and that documentation of key information, including Preferred Place of Care and Preferred Place of Death, was often incomplete.

Sanjay advised that the Learning from Deaths Lead Consultant had engaged with Health Innovation Manchester to support the development of recommendations, particularly in areas of higher deprivation, to improve the quality and completeness of EPaCCS records.

Mark sought clarification regarding palliative care arrangements and the use of EPaCCS, which Sanjay confirmed was led through primary care and accessed via the Greater Manchester Care Record.

The Chair welcomed the focus on learning but requested that future reports provide clearer assurance around actions taken and improvements achieved as a result of the learning identified.

The Board also discussed the six deaths involving patients with learning disabilities recorded during the quarter. Sanjay advised that no common themes had been identified.

Mary F suggested that the Medical Examiner's perspective may provide additional insight and Kevin proposed that the cases should also be reviewed through the Learning Disability Group to consider the wider patient journey and identify any opportunities for learning.

The Board noted the report and the learning identified through the Learning from Deaths process.

ACTION: Future Learning from Deaths reports to include analysis of any correlation between excess deaths and periods of extreme weather, alongside clearer reporting of assurance and actions arising from identified themes - Sanjay by December 2026 board meeting.

15. Learning From Deaths - Quarterly Report Q1 26_27.pdf

57. CDOP annual report

Assurance

Vineeta Joshi and Helen Lowey

Helen Lowey, Consultant in Public Health for Wigan Council and Vineeta Joshi, Paediatric Consultant joined the meeting.

Helen presented the annual report on behalf of the Bolton, Salford and Wigan Child Death Overview Panel (CDOP), highlighting the collaborative approach taken across the three localities and the continuing focus on learning, prevention and system improvement. She advised that six recommendations had been identified for 2024/25, including improvements to timeliness of processes, analysis of modifiable factors, demographic data quality and the understanding of deprivation. A dedicated working group had been established to take these areas forward.

Vineeta explained that every child death was subject to comprehensive multi-agency review to identify learning opportunities. For Wigan, child deaths typically remained below 20 per year, with neonatal deaths accounting for the largest proportion. She advised that trends were broadly in line with national data and that common modifiable factors remained high BMI, smoking and wider health inequalities. Members noted that Wigan was now performing positively in relation to smoking during pregnancy. Sarah highlighted the increased references to cannabis use within maternity reporting and sought assurance that learning was being shared with health visitors and other agencies responsible for prevention and early intervention. Helen advised that this was one of the key purposes of the annual report and confirmed that she would continue to take this work forward across the wider system.

Tracy reflected on discussions held during recent visits to maternity community services and raised concerns regarding the emotional impact on staff involved in safeguarding cases which subsequently resulted in child deaths. She wondered whether additional support could be provided to affected colleagues.

Mark highlighted a number of presentational issues within the report which he agreed to share outside the meeting. More fundamentally, he challenged how the report linked to other assurance and safeguarding processes across the organisation and noted that the recommendations appeared largely focussed on process improvement despite the richer learning themes described during the presentation.

The Chair acknowledged the challenges associated with the report and clarified that it had been prepared using a nationally prescribed template. The report formed one element of the wider child death review process, with further scrutiny and learning provided through the Bolton, Salford and Wigan Child Death Overview Panel. The Chair noted that WWL had not been given the opportunity to review the initial draft before it was presented to the Board. To support accuracy and ensure organisational feedback is reflected, the Chair requested that WWL be involved at an earlier stage in the drafting process for future reports, enabling its comments to be considered prior to Board presentation.

Members welcomed examples of wider learning arising from the work, including support for families experiencing expected deaths and the sharing of learning following water-related deaths. Mary M particularly commended the actions taken following a child drowning two years previously and welcomed evidence that learning had been shared across a wider footprint.

The Board noted the Child Death Overview Panel Annual Report and the learning arising from it.

16. Front Cover CDOP annual report.pdf
16a. Child Death Overview Panel Annual report 24-25.pdf

58. Ockenden Fuller Review Board Assurance Statement

Assurance

Kevin Parker-Evans

Kevin presented the Ockenden Fuller Review Board Assurance Statement, noting that the report had been circulated in advance of the meeting as the signed assurance statement was required to be submitted by 31 July 2026. He reminded the Board that a decision had already been taken to transfer responsibility for mortuary services into the Chief Nursing Officer portfolio, within the Patient Experience Team, to strengthen executive oversight and governance. The review had generated 75 recommendations overall, of which 29 were relevant to NHS providers. Twenty of these recommendations applied to WWL, with a further two relevant to the Bioskills Laboratory. An action plan had been developed and the majority of actions were progressing as planned. Two actions remained rated amber: one relating to estates and facilities, expected to be completed within six weeks, and one relating to workforce. He reported that work on workforce arrangements was already underway, including the agreement of a revised structure, appointment of a new manager and deputy manager, and recruitment to remaining vacancies.

The Board noted that future oversight of the action plan and Care After Death Service would be provided through the Safeguarding, Workforce and Assurance Group (SWAG), with onward reporting to the Quality and Safety Committee.

The Chair welcomed the proactive action taken to strengthen governance arrangements and noted that the Board Assurance Statement had been reviewed, accepted and submitted within the required timescales.

The Board noted the report and endorsed the submitted Board Assurance Statement. No further Board actions were required at this stage, with ongoing oversight to be provided through existing governance arrangements.

17. Fuller - Ockenden Mortuary Board Report July 2026 Final.pdf
17a. Appendix 1. PRN02500 System letter on mortuary oversight 26 June 2026.pdf
17b. Appendix 3. Mortuary Board Assurance Statement Final.pdf

59. Anti-microbial stewardship

Assurance

Kevin Parker-Evans

Kevin presented the report, noting that this was a mandated submission and that the information was required to be presented to the Board for assurance purposes. He advised that maintaining a sustainable microbiology workforce remained a key risk and echoed the concerns previously discussed through the Quality and Safety Committee. Kevin further noted that, whilst the Trust continued to perform well in relation to healthcare associated infections (HCAIs), it was currently identified as an outlier due to a modest increase from an historically low baseline. The Infection Prevention and Control Board Assurance Framework risk had been updated and continued to be monitored through the Quality & Safety Committee. He also advised that a specific focus on C. difficile would be considered at the next Quality & Safety Committee meeting.

Sanjay highlighted that the Trust's overall antibiotic usage remained the lowest in Greater Manchester. However, analysis demonstrated that the proportional use of intravenous (IV) antibiotics was significantly higher than peer organisations. He advised that this had been identified as a priority area for improvement and that work was underway to understand the causes and opportunities for improvement.

Sarah suggested that Quarter 1 performance information should be shared with operational teams and flow managers to demonstrate the positive impact that reducing patient moves had achieved in relation to infection rates and patient outcomes.

In response, Sanjay advised that a review of IV antibiotic prescribing had been undertaken during Quarter 4 of 2025/26 with support from Pharmacy colleagues. This had facilitated earlier conversion from intravenous to oral antibiotics and had contributed to improved discharge processes. Kevin added that reducing unnecessary IV antibiotic use would also provide benefits in terms of patient experience and resource utilisation.

The Board noted the report and the assurance provided regarding antimicrobial stewardship arrangements. No further Board actions were identified at this stage, with ongoing oversight to continue through the Quality & Safety Committee.

18. Antimicrobial Resistance (AMR) and Antimicrobial Stewardship (AMS).pdf
18a. Antimicrobial Resistance (AMR) and Antimicrobial Stewardship (AMS) Presentation.pdf
18b. AMR Board Assurance.pdf

60. Biannual Safe Nurse Staffing

Assurance

Kevin Parker-Evans

Kevin presented the biannual Safe Nurse Staffing Review. He explained that the point-in-time review undertaken in March 2026 indicated an establishment position 15 WTE above funded levels. However, this reflected a period of sustained escalation capacity, the Emergency Department sprint programme and the recent appointment of 20.4 WTE newly qualified nurses who remained supernumerary during their preceptorship period. The Trust had avoided 291 bank shifts through staff redeployment during March 2026 and had utilised 4,429 fewer bank hours compared with March 2025. Nursing vacancy rates remained low at 0.5%. Roster performance had improved significantly, with the Trust now performing in the top quartile nationally across most roster metrics. Whilst the review provided assurance regarding current staffing arrangements, he noted that it only covered inpatient wards and excluded areas such as theatres, paediatrics and midwifery. In response, a full site-wide establishment and enhanced care review would be undertaken to provide a more comprehensive assessment of nursing, midwifery and healthcare assistant provision. He also outlined plans to introduce clearer financial envelopes for wards and develop more flexible staffing models aligned to demand patterns.

Tabitha noted that the year-on-year reduction in bank spend was consistent with the objectives of the Better Care Programme.

Mary F sought assurance that staff understood the expectation that they may be redeployed between areas to meet operational needs. Kevin confirmed that this was understood and would be further formalised, with movement limited to areas where staff possessed the appropriate skills and competencies.

Sarah highlighted the 9% vacancy rate amongst unregistered support staff, observing that shortages in these roles were often most visible in the delivery of basic patient care. She suggested there may be opportunities to encourage colleagues affected by service transformation to move into patient-facing support roles. Kevin advised that healthcare assistant recruitment remained constrained by NHS Professionals limits on new starters and noted that turnover was often driven by staff progressing into more senior roles within the Trust.

The Chair concluded that the report provided only partial assurance given its limited scope and sought clarification regarding future reporting. Kevin confirmed that the next Safe Staffing Review would be undertaken in September and could be reported to the Board thereafter.

The Board noted the report and the assurance provided.

ACTION: Present the findings of the next Safe Nurse Staffing Review, including the wider site-wide establishment review and any proposed workforce reconfiguration, to the Board - Kevin by next available Board meeting following completion of the September review.

20. Biannual Safe Nurse Staffing Paper july 2026_.pdf

61. Guardian of Safe Working Hours report

Incofmation

Sanjay Arya

Abigail Callendor-Iddon, Guardian of Safe Working Hours, joined the meeting.

Sanjay introduced the Quarter 1 Guardian of Safe Working Hours report and invited Abigail to present the findings.

Abigail advised that whilst the number of exception reports remained broadly unchanged, the number of hours reported had increased by 33%, indicating that resident doctors were staying beyond their contracted hours more frequently. The main themes remained clinical workload, staffing pressures and supporting patient care, with over half of all exception reports arising from General Medicine. Abigail also noted that a new exception reporting framework had recently been introduced which may have contributed to the increase in reported hours.

Four immediate safety concerns had been raised during the quarter, primarily relating to staffing pressures and delayed handovers where no clinician was available to take over responsibility for the bleep. Abigail outlined the support arrangements available, including meetings with the doctor and educational supervisor to discuss concerns, although participation remained voluntary. The Board noted that thematic learning sessions involving the Deputy Medical Director would commence from September 2026 to support organisational learning and align with the Resident Doctor 10-Point Improvement Plan.

The report showed a reduction in rota breaches and associated financial penalties. Abigail also highlighted a positive increase in engagement with breach reporting, rising from 10% to 20%, which she considered indicative of an improving reporting culture.

Tracy reported that Abigail had recently attended the People Committee, where discussion had focused on establishing a stronger resident doctor voice and applying an equality, diversity and inclusion lens to understand whether particular demographic groups were disproportionately affected.

Sarah welcomed the report and highlighted the importance of understanding how operational management could better support the issues being raised. She suggested that professional standards and the impact of delayed handovers on colleagues should be reinforced.

Mary F welcomed the report and reflected on recent discussions held with resident doctors, who had indicated that Foundation Year 1 doctors and female doctors appeared to be disproportionately affected by

some of the issues identified. Abigail advised that Foundation Year 1 doctors were often more affected due to the way work was allocated and that a number of potential solutions had been identified through resident doctor engagement.

Sanjay confirmed that future work arising from the report would be aligned to both resident doctor wellbeing initiatives and delivery of the 10-Point Improvement Plan. He thanked Abigail for her leadership and the compassionate manner in which she championed the interests of resident doctors.

The Chair emphasised the importance of triangulating the report with Freedom to Speak Up information and future GMC survey results to ensure a comprehensive understanding of resident doctor experience and culture across the organisation.

The Board noted the report and endorsed the six recommendations contained within it, with ongoing monitoring to be taken forward through the resident doctor improvement programme and People Committee arrangements.

Abigail left the meeting.

21. GOSWH Quarter 1 - April to June 2026.pdf

62. Health and safety annual report

Approval

Rhona Bradley

Rhona presented the annual Health and Safety Report, advising that the report provided assurance that the Trust continued to meet its statutory and regulatory health and safety requirements. She emphasised the importance of training compliance and highlighted the need for assurance from multiple sources, including Board walkabouts and direct engagement with operational teams, to complement the formal reporting arrangements.

Mary F noted that the Health and Safety Team had commenced a programme of inspections across all clinical areas from September 2025 and observed that the impact of this work was not yet reflected within the annual report. She suggested that it would be valuable to review the outcomes of these inspections within future reports.

In response, Kevin highlighted the links between the Health and Safety programme and the ASPIRE ward accreditation process, noting that both programmes contributed to the wider safety and quality agenda and that future reporting should help demonstrate how identified risks were being addressed.

Tabitha reinforced the importance of maintaining a zero-tolerance approach to health and safety risks, particularly ensuring that corridors and circulation spaces remained clear and free from obstruction.

Members acknowledged the positive assurance provided by the report whilst recognising the importance of continuing to strengthen oversight through inspection activity, accreditation programmes and Board visibility across clinical areas. The Board **APPROVED** the Health and Safety Annual Report.

22. H&S Annual Report 2025-26 Board.pdf

63. Council of Governor elections

Approval

Katharine Dowson

The Chair introduced the report, noting the uncertainty created by the proposed legislative changes affecting NHS Foundation Trust governors. She emphasised the importance of maintaining sufficient quorum arrangements to enable the Council of Governors to continue fulfilling its statutory duties whilst recognising and valuing the significant contribution made by governors. She also highlighted the need to consider how

the skills and experience of existing governors could continue to be utilised should formal governor responsibilities change in the future.

Katharine presented the report and advised that the first recommendation was to pause governor elections pending enactment of the NHS Modernisation Bill. She explained that, should elections be paused, three options were available to manage the position of governors whose terms of office were due to expire. She outlined the implications of each option, including legal, governance and quorum considerations.

Board members **AGREED** that any approach adopted should remain compliant with existing legislation and therefore concluded that extending governors' terms of office beyond their statutory term (Option 2) would not be appropriate.

Mary F sought assurance regarding quorum arrangements and asked whether the Council of Governors had previously failed to achieve quorum. Katharine advised that this had not occurred, although proactive work was sometimes required to ensure sufficient governor attendance when formal decisions were required.

Mary F further commented that, where individuals wished to remain involved, there would be value in retaining their skills, experience and organisational knowledge, even if this were through a co-opted, non-voting governor role. Tracy agreed, observing that providing affected governors with options during a period of uncertainty could help alleviate unnecessary difficulties and demonstrate that their contribution continued to be valued.

Following discussion, the Board supported pausing governor elections and endorsed the principle of exploring the co-option of affected governors as the preferred way forward. It was agreed that this position should be discussed further with the Council of Governors before any final decision was implemented.

The Board **APPROVED** the recommendation to pause governor elections and supported the proposal to discuss co-optive arrangements with the Council of Governors as the preferred approach to retaining governor skills and experience whilst remaining compliant with legislative requirements.

ACTION: Preferred option for managing governor vacancies following the pause in elections to be discussed with the Council of Governors and feedback brought through the appropriate governance route - Katharine - by 7 October 2026 board meeting.

64. ED&I and health inequalities reflections

Discussion

All

Tracy questioned whether the Board had given sufficient attention to health inequalities and equality impacts throughout the meeting.

Richard reflected that a number of agenda items had incorporated discussion of health inequalities and equality considerations, including the Learning from Deaths report, Perinatal Quality Oversight Report and resident doctor experience and wellbeing discussions.

Members agreed that there was an opportunity to make these considerations more visible within Board reporting and assurance processes. It was proposed that Committee AAA reports should explicitly identify any equality, diversity, inclusion and health inequalities issues relevant to the matters being reported.

The Board noted the discussion and supported the continued integration of equality, diversity, inclusion and health inequalities considerations within Board reporting and assurance processes.

ACTION: Committee AAA reports to include explicit commentary on relevant Equality, Diversity & Inclusion and Health Inequalities considerations to support Board assurance and discussion - Katharine by 7 October 2026

65. Consent agenda

Information

The following items have been submitted for approval by the Board without discussion unless any board member requests to the Chair and/or Company Secretary prior to the start of the meeting that they wish a specified item to be withdrawn from the consent section for consideration at the meeting.

66. Fit and proper persons report

Assurance

The report was noted.

27. F&PP Annual report.pdf

67. Modern Slavery Statement 26/27

Approval

Members supported approval of the statement but noted that clarification was required regarding the title of the legislation referenced within the document, specifically whether the wording should refer to the Modern Slavery Act 2015 or include a reference to human trafficking legislation.

The Modern Slavery Statement 2026/27 was **APPROVED** subject to verification and correction of the legislative title referenced within the document.

28. Modern Slavery Statement 2026-27.pdf

68. Maternity reports dashboard

Information

The report was noted.

14.2. Maternity Dashboard Report - June 26.pdf
14.2a. Maternity Dashboard - June 26.pdf
14.2b. Neonatal Dashboard - June 26.pdf

69. Date and Time of next meeting

Information

Prof Dame Robina Shah

Wednesday 7 October, 10:30am, Boardroom, Trust Headquarters

70. Resolution: Exclusion of the Public

Approval

Prof Dame Robina Shah

To resolve that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

Action Log: 5 August 2026

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
17 Jun 2026	68/26	Integrated Performance Report	Carry out a deep dive in to: • Sickness absence within the resident doctors workforce	S Arya	7 Oct 2026	
5 Aug 2026	51/26	Strategy refresh: 2030 Delivery ambitions	Undertake a review of the strategy narrative to ensure the perspectives of people with learning disabilities, Black and Minority Ethnic communities, people with hidden disabilities and other key stakeholder groups are appropriately reflected prior to final Board approval - Richard by October 2026 Board meeting.	R Mundon	7 Oct 2026	**Paper on agenda.**
5 Aug 2026	53/26	Integrated performance report and NOF	Executive Team to consider how future Integrated Performance Reports can better demonstrate the relationship between improvement actions, performance metrics and outcomes for patients and staff	R Mundon	7 Oct 2026	David / \Chris to advise – Board workshop in November to pick up how transformation is working to improve statutory metrics and performance targets – Dec 2027

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Aug 2026	56/26	Learning from deaths quarterly report	Future Learning from Deaths reports to include analysis of any correlation between excess deaths and periods of extreme weather, alongside clearer reporting of assurance and actions arising from identified themes	S Arya	7 Oct 2026	Feedback has been provided to author and will be actioned in next report. **Action closed.**
5 Aug 2026	60/26	Biannual Safe Nurse Staffing	Present the findings of the next Safe Nurse Staffing Review, including the wider site-wide establishment review and any proposed workforce reconfiguration, to the Board - Kevin by next available Board meeting following completion of the September review.	K Parker-Evans	Dec 2026	Not yet due.
5 Aug 2026	63/26	Council of Governor elections	Preferred option for managing governor vacancies following the pause in elections to be discussed with the Council of Governors and feedback brought through the appropriate governance route - Katharine following the next Council of Governors meeting.	K Dowson	7 Oct 2026	Governors agreed with the board that those due for election this year would need to conclude their terms if elections are paused but that they should be asked to stay with WWL as associate governors. **Action closed.**

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Aug 2026	64/26	ED&I and health inequalities reflections	Committee AAA reports to include explicit commentary on relevant Equality, Diversity & Inclusion and Health Inequalities considerations to support Board assurance and discussion.	K Dowson	7 Oct 2026	Updated section now integrated in to AAA reports. **Action closed.**

Referrals Logs

Referred in

Date of meeting	Minute ref.	Item	Action required	Owner	Assigned by	Target date	Update

Referred out

Date of meeting	Minute ref.	Item	Action required	Owner	Assigned to	Target date	Update
5 Feb 2026	11.3/26	Perinatal Quarterly Report	Complete thematic review of fracture injuries (3 cases)	C Stanford	Q&S Committee	9 Sep 2026	**Ongoing - report was withdrawn for further work.**
1 Apr 2026	37/26.c	Patient story	• Receive assurance around the action plan having appropriately addressed the issues, risks and • Receive a benefits realisation report on the effectiveness of the new ways of working implemented	K Parker-Evans	Q&S Committee	9 Sep 2026	**Closed at Sep 2026 meeting.**

			(Advanced Care Practitioner prescribing and other revisions to staff roles)				
5 Aug 2026	50/26	Board assurance framework	Learning from the implementation of Martha's Rule, including lessons learned to date and implications for further rollout, to be presented to the Board following consideration by the Quality & Safety Committee	S Arya	Q&S Committee	Dec 2026	Not yet due.
5 Aug 2026	52.1/26	Quality and Safety Committee AAA	Executive Team Management to review the pathology programme and bring recommendations to a future Board meeting to support agreement of the preferred way forward.	S Brennen	Q&S Committee	Dec 2026	Not yet due.
5 Aug 2026	54/26	Finance report	Review and report the lessons learned from the closure and reopening of Theatres 5 and 6, including the impact on patient activity and capacity planning, to inform future service planning	S Brennan	F&P Committee	Dec 2026	Final position in terms of lost activity was not available for this meeting. Board are asked to delegate this action to Finance and Performance Committee to review in the November meeting and report back to the Board

							through the triple AAA report in December.

Title of report:	Chair's Report
Presented to:	Board of Directors
On:	7 October 2026
Item purpose:	Information
Presented by:	Professor Dame Robina Shah, Chair
Prepared by:	Professor Dame Robina Shah, Chair Katharine Dowson, Director of Corporate Governance
Contact details:	E: company.secretary@wwl.nhs.uk

Executive summary

This report summarises activity undertaken by the Chair and Non-Executive Directors since the August 2026 Board meeting. Key areas of focus include Board succession planning and development, the Council of Governors' consideration of the recent CQC inspection findings, arrangements for governors affected by the pause in elections, service visits and engagement with system partners and other stakeholders.

Link to strategy and corporate objectives

The activities outlined in this report support delivery of the organisational strategy, particularly through effective leadership, partnership working, stakeholder engagement and continuous improvement.

Risks associated with this report and proposed mitigations

There are no direct risks arising from this report. Relevant strategic and operational risks referred to within the report are managed through the Trust's established risk-management and assurance arrangements.

Financial implications

There are no direct risks arising from this report.

Legal implications

There are no direct risks arising from this report.

People implications

There are no direct risks arising from this report.

Equality, diversity, and inclusion (EDI) implications

Equality, diversity and inclusion considerations are reflected in the approach to recruitment, stakeholder engagement and the other activities described in this report.

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

N/A

Publication under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

Recommendation

The Board is invited to note the content of this report and to highlight any areas for discussion or clarification.

Board of Directors Meeting – 7 October 2026

CHAIR'S REPORT

Introduction

This is a regular report for information and accountability, summarising Chair, Non-Executive Director (NED), Governor and stakeholder engagement activities and key events relating to the Care Quality Commission (CQC) Well-Led framework.

The report includes details of key activities undertaken during the August/September 2026 reporting period, including NED development and resourcing, key items of business from Council of Governors (CoG) meetings; service visits and NED visibility; and external meetings with system partners and other stakeholders.

Activities relating to formal Committees of the Board are reported separately at the meeting through assurance reports.

Board of Directors Succession Planning

The process to appoint two new NEDs is well underway and there has been a positive response to the recruitment process. Longlisted candidates are being interviewed by our executive search partners ahead of a Nominations and Remuneration shortlisting meeting which is scheduled to take place on 13 October. Final interviews are scheduled for the first week of November.

Board Development

A Board Development session was held on 2 September 2026. During the first half of the day, the Board was joined by primary care colleagues to discuss how best to work together to support the shift from acute to community care, as set out in the NHS 10 Year Plan. The proposed agreement with primary care to improve this interface is included on the 7 October 2026 Board agenda for formal approval.

The Board also heard from colleagues leading a respiratory pilot across the Leigh Primary Care Network. The pilot has provided faster specialist care closer to home for patients experiencing breathlessness and has reduced the number of patients waiting for a hospital appointment.

In the afternoon the Board considered the Provider Capability Self-Assessment in some detail which is on the Board agenda for 7 October. They also considered the financial position.

The next Board development session and workshop is scheduled for 4 November 2026.

Informal Visits and Events

All relevant meetings, events and visits for the period (August/September 2026) are detailed in Appendix 1.

Activity with Governors and Members

Council of Governors
The Council of Governors met on 16 September and heard from the Chief Executive about the recent CQC report for the Royal Albert Edward Site in Wigan following an unannounced inspection in May to the Emergency Department and the medical wards. Governors shared the Board's disappointment that the overall rating for the site had reduced to 'Requires Improvement'. The Chief Executive and Chief Nursing Officer presented the plans in place to address the issues raised and get this site back to 'Good'.

Governors discussed the future of the governor role and received information about the new Fundamentals of Care Governor role, which will focus on membership and public engagement. This role could continue should the statutory governor role be removed through forthcoming legislation. Governors supported the Board's August recommendation that those unable to stand for re-election because of the pause in elections should be offered the opportunity to continue as Associate Governors pending further clarity. All affected governors have indicated that they wish to take up this opportunity.

Governors also approved a new code of conduct and heard in detail about the work of the People Committee and Audit Committee from the NED Chairs.

Recommendation

The Board is invited to note the content of this report and to highlight any areas for discussion or clarification.

Professor Dame Robina Shah
Chair

October 2026

Appendix 1

NED and Chair Meeting and Visits (August/September)

Summary of Chair's Informal Visits, Events and Activities – August/ September 2026	
Date	**Visit/Event/Meeting**
10/8/2026	Attended a meeting for Trust, ICB and Regional Chairs with Penny Dash, Chair of NHS England, and Duncan Burton, Chief Nursing Officer for England, to discuss the findings of the Amos and Ockenden reviews.
10/8/2026	Met with Richard Mundon and Sanjay Arya to review our current University Hospital position.
12/08/2026	Mary Fleming and I met with representatives of the Holocaust Memorial Day Trust (HMDT) to discuss how we can work together to address the Lord Mann recommendations, especially education and training in the context of Antisemitism and Islamophobia.
17/08/2026	Mary and I met with senior representatives of the University of Manchester to explore developing a closer partnership between our two organisations.
18/08/2026	Met with Safina Nadeem, Director of Purple Infusion Ltd who supports organisations to build inclusive cultures.
19/08/2026	Met with Jonathan and Rebecca Davenport from The Old Courts, Wigan to explore areas for opportunity and ways to work together on the wellbeing and health of both our patients and staff.
09/09/2026	Along with other representatives from across the Health Sector, I was delighted to be invited to attend a Round Table Event with Florence Eshalomi MP, Faith Minister and Baroness Merron, Parliamentary Under-Secretary of State for Health at 10 Downing Street. The meeting provided an opportunity to discuss the experiences of Muslim staff and patients, faith and belief literacy within the health service.
14/09/2026	Chaired a successful Consultant Interview Panel to appoint Consultant Hepatologist.
15/09/2026	I had the pleasure of presenting Long Service Award's celebrating and recognising staff who had reached the milestones of 20, 30 and 40 years' long service.
16/09/2026	Chaired the Council of Governor's Formal meeting, followed by an excellent taster session of the new patient food menus provided by our wonderful catering department.
22/09/2026	Along with Kevin Parker-Evans I visited the Old Courts to further explore the possibilities of working together. We both came away feeling very positive about the potential, which fits really well with the direction we are taking at WWL, particularly as we develop our neighbourhood model and look at how we can support wellbeing and prevention, provide more care closer to home and, importantly, make sure that what we do is shaped with and by the communities we serve.

NED ‘Go See’ Service Visits – August/ September 2026	
Date	**Service**
19/08/2026	August’s visit was to the Transfer of Care Hub (TOCH) and the Acute Discharge Team (ADT). These teams are co-located on the Wigan site currently and managed by Karen Atkinson, Clinical Lead and they coordinate and facilitate discharge for patients who are medically fit to leave hospital but do not have an appropriate place to be discharged to.
16/09/2026	This month we split into two groups to maximise the time and space available in the departments. Group 1 – ED, Urgent Treatment Centre (UTC), Frailty SDEC and SDEC (Same Day Emergency Care) and Group 2 – ED, SDEC, Frailty SDEC and Urgent Treatment centre (UTC). This was an excellent visit, which NEDs really appreciated seeing all these areas which are often such a central part of discussions.

Individual NED Commitments	
	Mary Moore: TLC antenatal clinic where we discussed ways of working and culture informed by the Safety Champions meeting the week before. No new issues highlighted. A follow-on introductory meeting with our new Director of Maternity and Child Health. Online meetings with GM Local Maternity Network (GM ICB) progressing joint work with the Quality Governance Collaborative in identifying Mat/Neo challenges and developing a suite of Board Assurance prompts for Boards. These will be tested locally adapted and rolled out nationally. Continue on the steering Group for Northwest NED's steering group with planning next event which will run in conjunction with the Northwest Leadership Academy's Festival of Leadership on 22nd of October, this year hosted here in Wigan at The Edge

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	07 October 2026
Item purpose:	Information
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	anne-marie.miller@wwl.nhs.uk

Executive summary
This report updates the Board on matters of interest since the previous meeting.

Link to strategy and corporate objectives
The matters reported are aligned with the organisational strategy.

Risks associated with this report and proposed mitigations
No new risks arise; relevant risks are managed through existing arrangements.

Financial implications
No direct financial implications arise.

Legal implications
No legal implications arise.

People implications
Workforce implications are managed through established governance arrangements.

Equality, diversity, and inclusion (EDI) implications
The report supports work to reduce health inequalities and improve access. Equality impacts are considered through established programme governance.

Which other groups have reviewed this report prior to its submission to the committee/board?
Relevant matters have been reviewed by the Executive Team and through established programme governance.

Recommendation(s)
The Board is asked to receive and note the report.

CQC Report Publication
Since our last Board meeting, the Care Quality Commission (CQC) published its full report on 16 September following the unannounced inspections of urgent and emergency care and medical care services at the Royal Albert Edward Infirmary (RAEI) in May. The report rates RAEI as Requires Improvement overall, with Safe, Responsive and Well-led rated Requires Improvement. Effective and Caring remain rated Good. Although not part of this inspection, it is important to note that maternity services at RAEI continue to be rated Good by the CQC. We acknowledge the findings, recognise where improvement is required and are taking action to address the issues identified. Providing safe, compassionate and high-quality care is our absolute priority, and we remain fully committed to delivering the improvements needed for our patients and communities.

Since the inspection, we have accelerated improvement work through our Emergency Department Transformation Programme, the Trust-wide Fundamentals of Care Programme and our established system-wide Better Lives Programme. This includes strengthening patient flow and the care environment, improving the consistency of fundamental standards of care, and working closely with mental health and wider system partners. The Better Lives Programme continues to bring partners together across Wigan Borough to address wider health and care pressures and help people receive the right care, in the right place, at the right time.

Importantly, the report recognises the compassion, kindness and professionalism of our staff. These strengths, combined with a clear focus on improvement, provide a strong foundation for delivering safer, better and more responsive services for the people we serve. The wider organisational performance picture, including areas of strength and areas requiring further improvement, is also reflected through the NHS Oversight Framework.

NHS Oversight Framework
WWL remains in Segment 3 of the NHS Oversight Framework (NOF), consistent with its position at the end of 2025/26. However, the 2026/27 framework introduced significant changes to its structure, methodology and underlying metrics, including a substantial number of new indicators. Direct comparison with the previous year should therefore be treated with caution. The latest assessment highlights strengths in diagnostics, cancer pathways, community waiting times, innovation and aspects of workforce performance. It also identifies areas where further and sustained improvement is required, particularly across access to services, effectiveness of care and population health, patient safety, patient experience and workforce measures.

While the CQC and NOF use different assessment approaches, both provide important perspectives on the Trust's performance and reinforce the need to improve access, patient flow and experience, and the consistent delivery of safe and responsive care. These priorities are being addressed through the Trust's improvement programmes outlined above. Performance against the NOF and associated improvement actions is scrutinised regularly by the Executive Team, with updates provided to the Board through the Integrated Performance Report.

CQC Adult Inpatient Survey
The CQC Adult Inpatient Survey 2025 was also published following our last Board meeting in August. The survey gathered feedback from patients who stayed in hospital for at least one night during November 2025. Patients reported positive experiences of compassion, kindness, dignity and respect, and WWL achieved an overall experience score of 8 out of 10. While these findings are encouraging, the survey also reinforces known areas where we are focusing our improvement efforts, including discharge planning and ensuring patients and their families are fully informed and involved in decisions about care and treatment. These findings provide an important patient perspective on priorities where the Trust is committed to delivering more consistent, high-quality experiences for patients.

Fundamentals of Care Academy
Last month, we launched the Fundamentals of Care Academy, a Trust-wide programme bringing colleagues together to support consistent standards of care across the organisation. Supported by our Chief Nursing Officer and developed with the Quality Improvement and Patient Safety Team, the staff-led community will share learning, advocate for patients and reinforce the fundamental principles of safe, compassionate and high-quality care.

The Academy provides a mechanism for translating insight from patients, families and colleagues into practical action by connecting learning from feedback, incidents, complaints, regulatory findings and performance information. It provides further assurance that WWL is listening, learning and acting on what patients and colleagues tell us, ensuring that evidence from patient experience, staff feedback and wider organisational learning informs tangible improvements and supports consistently high standards of care. Its launch involved colleagues from across the Trust, recognising the contribution of every role to the patient journey and creating a shared community committed to improving care and advocating for patients.

Healthier Wigan Partnership
Across the Wigan Borough, partnership working through the Healthier Wigan Partnership continues to support delivery of shared priorities and increasingly provides the platform for service transformation across organisational boundaries. The Better Lives Programme is providing the foundations for sustained improvement in admissions avoidance, timely discharge, support for people to remain independent at home and wider system flow, and has been shortlisted for a Health Service Journal Award in the Data Driven Transformation category. Building on these strong foundations, partners are now shaping the next phase of integrated neighbourhood working in response to the national Neighbourhood Health Framework, with a greater focus on prevention, proactive care and reducing health inequalities. This collaborative approach is also being applied to outpatient transformation, including the development of a Single Point of Access model to help ensure patients receive the right care, in the right place, at the right time.

Launch of QICN Faculty for Homeless and Inclusion Health
WWL hosted the launch of the Queen's Institute of Community Nursing's (QICN) newly established Faculty for Homeless and Inclusion Health. The Faculty will support work to reduce severe health inequalities affecting people experiencing homelessness regionally and nationally. At the event, WWL's Health Outreach and Inclusion Service shared its work in providing specialist care to marginalised groups. As an active member of the new national hub, the team will contribute to and learn from emerging best practice.

New Thompson Suite Opens
Patients with urological health concerns are benefiting from faster and more coordinated care following the opening of the Thompson Suite at the Richmond Urology Unit at Leigh Infirmary. The facility reduces the need for multiple appointments and is designed to improve patient comfort and experience. The expanded suite was made possible by a £425k funding award to WWL from NHS England's Community Diagnostics Programme. It has been named in honour of Consultant Urologist Mr Andy Thompson, whose work has helped transform local urology care ahead of his retirement in December.

New Breast Screening Service
A new breast screening service has been launched to provide faster diagnostic results and support earlier breast cancer detection. The South Lancashire Breast Screening Unit, based at the Thomas Linacre Centre in Wigan, is one of the first NHS departments in Greater Manchester to introduce Contrast Enhanced Mammography technology. The service is expected to improve diagnostic turnaround times and patient experience. The project was supported by a donation of almost £60,000 from the Boot Out Breast Cancer charity.

Staff Involvement and Winter Preparedness
Last week, we launched the 2026 NHS Staff Survey and Mission Winter. For the National Staff Survey, our priority is to sustain the increase in participation achieved last year, ensure colleagues have protected time to respond and demonstrate how previous feedback has informed change. We have introduced a community of practice to empower leaders and engaged colleagues to increase participation and showcase local You Said, We Did actions, with staff from a range of professions featuring in the campaign's photography and video content.

Mission Winter, launched on 1st October, supports vaccination uptake to protect colleagues, patients and families during the winter period. Delivery includes drop-in and roaming clinics, with start times to improve access for night staff finishing shifts and colleagues starting early. Communications will also address common concerns about vaccination and encourage participation across the Trust. Our uptake increased last year, and we aim to improve on this as it's a key part of our Winter Plan and overall service resilience.

Title of report:	*Our Strategy 2031* Refresh
Presented to:	Board of Directors
On:	7th October 2026
Item purpose:	Review and endorsement
Presented by:	Chris Clark, Director of Strategic Transformation
Prepared by:	John Humphreys, Head of Business Planning
Contact details:	John.Humphreys@wwl.nhs.uk

Executive summary
The work to refresh *Our Strategy 2031* has now concluded. This paper presents a draft production version for approval prior to its publication and Trust-wide launch, enclosed as Appendix 1.

The refreshed strategy responds to the extensive engagement undertaken, updates the context and evidence base, and sets clearer Delivery Ambitions for the period to 2031. It retains the core purpose, values and strategic framework that continue to serve WWL well, while placing greater emphasis on population health, reducing inequalities and partnership working.

Subject to approval, the remaining work will be limited to final proof-reading and presentational amendments.

Link to strategy and corporate objectives
This paper presents the Trust's overarching strategy through to 2031. It will provide the framework for future organisational priorities, plans and objectives.

Risks associated with this report and proposed mitigations
The refreshed strategy will be deployed within an existing health and care locality system where partner organisations have their own strategies and defined priorities, such as the Local Authority's *Progress with Unity*. Engagement throughout the refresh has ensured that Our Strategy 2031 complements the wider direction for Wigan Borough and Greater Manchester.

Financial implications
Financial sustainability and making the best use of available resources are central to the refreshed strategy. Approval of the strategy does not commit the Trust to additional expenditure. Any investment decisions arising from its delivery will be considered through established planning and business case processes.

Legal implications

There are no identified legal implications.

People implications
Our Strategy 2031 has been generated via engagement and input from a wide range of stakeholders. The content reflects the feedback provided to produce a richer document which is intended to support colleagues in feeling the connection between their roles and wider organisational priorities.

Equality, diversity and inclusion implications
Reducing health inequalities and ensuring that services are inclusive and responsive to the communities we serve are central to the refreshed strategy. Equality considerations will continue to inform the plans and programmes through which it is delivered.

Which other groups have reviewed this report prior to its submission to the committee/board?
The strategy has been developed through engagement with the Executive Team, Wider Leadership Team, Trust Board, Council of Governors, colleagues, patients and carers (including the Lived Experience Panel), and system and place partners.

Recommendation(s)
The Board of Directors is asked to:

- Approve *Our Strategy 2031* prior to publication, subject to final proof-reading and minor presentational amendments; and
- Note that delivery and assurance will be taken forward through the Trust's established planning, governance and improvement arrangements

1.0 Background and purpose

The Trust began considering an update to *Our Strategy 2030* during 2025. This reflected several changes since the current strategy was published in 2021. This included evolving national NHS priorities, publication of the 10-Year Health Plan and Medium-Term Planning Framework, changes in the health and care system, and publication of *Progress with Unity* for the Wigan Borough. The existing strategy had also reached the mid-point of its lifecycle.

An early review considered whether the Trust should recommit to the existing strategy, refresh it or recreate it. It concluded that the core objectives and themes remained relevant, but that the context, evidence and ambitions needed to be updated. It was agreed therefore to proceed with a refresh of the strategy.

The purpose of this paper is to present the completed refreshed strategy to the Board for approval.

2.0 Development Process

The refresh has been informed by a structured programme of engagement and Board oversight. During Quarter 1 of 2026/27, views were gathered through staff listening events, a Trust-wide survey, discussions with Governors, engagement with the Lived Experience Panel, patient feedback and conversations with partners. The evidence gathered was then analysed and used to develop the refreshed document during Quarter 2.

The emerging strategy was considered by the Trust Board at its September workshop. The final document reflects the engagement undertaken and the feedback received through the development process.

3.0 Our Strategy 2031: Delivering on Our Ambitions

Our Strategy 2031 sets out the Trust's direction for the next five years. Its purpose is to deliver outstanding care and improve the health of all the people and communities we serve, breaking down the barriers that create health inequalities. The duration for the strategy aligns with the NHS England medium-term planning horizon.

The strategy retains the well-recognised 4Ps of Partnerships, Patients, People and Performance, together with Improve, Integrate and Innovate as the ways in which the Trust will deliver its ambitions. Something new that it introduces is a set of Delivery Ambitions with complementary descriptions of what these will mean for patients, communities, colleagues and partners. Reflecting both the strategic shifts outlined in the NHS *10 Year Health Plan*, and our commitment to *Progress with Unity*, the strategy places greater emphasis on population health, reducing inequalities and partnership working.

The document has been written for a broad audience. It explains the context in which the Trust operates, why the strategy has been refreshed, how it has been shaped, and the ambitions that will guide WWL through to 2031.

4.0 Next Steps

Following approval, final proof-reading and presentational amendments will be completed before the strategy is published and launched. The detailed work to translate it into clear organisational improvement priorities, which will inform divisional and team priorities will continue through the Trust's established planning and improvement arrangements.

5.0 Recommendation(s)

The Board of Directors is asked to:

- Approve *Our Strategy 2031* prior to publication, subject to final proof-reading and minor presentational amendments
- Note that delivery and assurance will be taken forward through the Trust's established planning, governance and improvement arrangements

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Our Strategy 2031









www.wwl.nhs.uk

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

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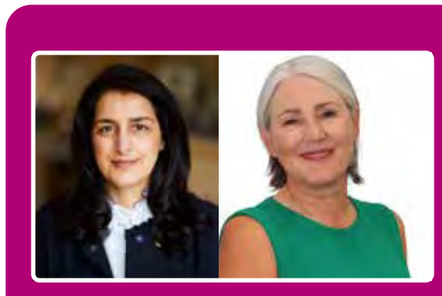
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Foreword



Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) is a special organisation. Every day, our colleagues make a difference to the lives of patients, families and communities across Wigan Borough, Greater Manchester and beyond. We are proud of what we have achieved together and grateful for the commitment, compassion and professionalism that our people bring to work each day.

Since the launch of Our Strategy 2030 in 2022, we have made significant progress. We have expanded diagnostic and elective capacity, invested in modern facilities and technology, strengthened community services, secured substantial external funding, and continued to improve the quality and experience of care for the people we serve. These achievements have only been possible because of the dedication of our staff and the strength of our partnerships.

Whilst there is much to be proud of, we know that the challenges facing health and care services remain significant. Demand for services continues to grow, health inequalities persist within our communities, workforce pressures remain, and public resources must be used wisely. At the same time, the NHS is entering a period of major transformation, with increasing emphasis on prevention, neighbourhood-based care, digital innovation and long-term sustainability.

We see these changes not simply as challenges, but as opportunities. Opportunities to improve the health of our communities, reduce inequalities, strengthen partnerships, embrace innovation and ensure more care is delivered in ways that better meet the needs of the people we serve.

The NHS 10-Year Health Plan, Greater Manchester's ambitions for health and care, and the continued development of the Healthier Wigan Partnership all create a strong foundation for the next phase of our journey.

This refreshed strategy builds on our established foundations. Our vision and our **'Four Ps' - Patients, People, Performance and Partnerships** strategic framework that guides the Trust's development and improvement continue to provide a strong foundation for the future.

Our ambition remains clear: to deliver outstanding care and improve the health of all the people we serve, breaking down the barriers that create health inequalities. Achieving this will require all of us to play our part. Whether you are a member of staff, volunteer, patient, carer, or partner organisation, this strategy belongs to all of us.

The years ahead will require courage, collaboration and innovation. By working together, listening to one another and remaining focused on what matters most, we are confident that we can build on our successes, deliver our ambitions, improve the health and wellbeing of the people we serve and create an even stronger future for WWL our communities.

We have much to be proud of, but even more to look forward to. Together, we will build on our achievements, deliver our ambitions and continue to improve the health and wellbeing of the people and communities we serve.

Professor Dame Robina Shah - Chair, 2026
DBE CPsychol FRCGP(Hon) FRSM(Hon)

Mary Fleming
Chief Executive and Accounting Officer - 2026



Introduction

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) is a high-performing Trust, proud of our people, and our partnership role in the Wigan Borough.

We provide a wide range of patient centred, high-quality health and care services; from community services embedded within local areas, to acute care including world-class specialist services. Our achievements are a result of the commitment and hard work of our exceptional staff, and our collective passion to provide the very best care and experience for our patients and residents.

We have a strong foundation on which to build for the coming years, continuing to be guided by 'Our Four Ps' – **Patients, People, Performance and Partnerships.**

Since the launch of Our Strategy 2030 in 2022, WWL has made significant progress across each of our strategic priorities. We have strengthened integrated care within our communities, expanded diagnostic capacity, invested in modern healthcare facilities, secured substantial external funding, and accelerated the digital transformation of our services. Alongside these developments, we have continued to invest in our workforce, strengthen partnerships and improve the quality, safety and resilience of the services we provide.

Since 2022, the context in which health and care services are delivered has continued to evolve. Demand for NHS services remains high, our population is living longer with increasingly complex needs, and significant health inequalities persist across our communities. At the same time, advances in technology, data and medical innovation are creating new opportunities to improve outcomes and transform the way care is delivered.

In response, we undertook a refresh of Our Strategy 2030 to ensure it remains relevant for the next phase of our journey. Whilst our four Ps remain unchanged, Delivery Ambitions have been developed through engagement with patients, carers, staff and partners to reflect the opportunities and challenges ahead.

This document represents a refresh of Our Strategy 2030, updating our context and evidence base to guide our organisation through to 2031. It sets out how we will continue to improve care, strengthen partnerships and deliver sustainable services for the people and communities we serve.

Our Story…

WWL is a medium-sized acute and community foundation trust in the Northwest of England, within the Greater Manchester region.

In 2020 we became Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust which proudly reflects our commitment to education and training, and we have an ambition to achieve university teaching hospital status in the near future.

We provide healthcare to a local population of over 344,000 and provide specialist services to a much wider regional, national and international catchment area.

Care is delivered through a broad network of locations across the borough. Community services are delivered in patients' homes and community facilities, while acute services are centred on the Royal Albert Edward Infirmary (RAEI), Wrightington Hospital, Leigh Infirmary, the Thomas Linacre Centre and Boston House, providing a range of specialist, elective, outpatient and diagnostic services for our local population and beyond.

- Wrightington Hospital opened in 1933 as a tuberculosis facility and post-war, was developed into an internationally renowned specialist orthopaedic hospital famous for the work of Professor Sir John Charnley who performed the first total hip replacement in 1962. It now hosts multiple modern theatres with scope for further development. Our orthopaedic private patient unit, fertility unit, bioskills laboratory and conference centre are also located on the site.
- RAEI is our main district general hospital site, located in central Wigan. This is where our Emergency Department (ED) is located, and where most of our inpatient services are provided. There has been a hospital on this site since 1873, and it was named after the then-Prince of Wales who officially opened it in 1875. Much of our current investment in buildings and facilities is focused on the RAEI site; patients, visitors and staff will benefit from several new developments over the period of this Strategy.
- Leigh Infirmary is an elective and diagnostic hospital. It is one of GM's designated Surgical Hub sites and offers day-case procedures for a variety of specialties. Its diagnostic capacity has expanded significantly in recent years with the addition on site of the Trust's Community Diagnostic Centre. It provides a 24-bed rehabilitation unit to support patients in moving from hospital back into their usual place of residence. The Hanover Diagnostic and Treatment Centre offers Women's Health, Urology and Endoscopy services. There is also an Urgent Treatment Centre on the Leigh site.





- The Thomas Linacre Centre was formerly a grammar school in Wigan town centre and was converted in 2002 by WWL for use as an outpatient clinic. It hosts 96 consultant-led clinics every week, with more than 100,000 patient visits a year.
- Boston House is located close to Wigan town centre. It is the base for ophthalmology services and several community services, including physiotherapy.

Since Our Strategy 2030 was published in 2022, we have completed a series of schemes to modernise the facilities which our patients and visitors use. Examples include:

- Securing national elective recovery funding to optimise our theatre capacity and reduce the long waits for surgery that patients were experiencing. This investment includes:
  - The re-opening of an unused theatre at Wrightington.
  - Development of two new state-of-the-art theatres and a supporting recovery area on the Wrightington site, enabling us to reduce waiting times for trauma and orthopaedic patients.
  - A new ultra-modern theatre at Leigh Infirmary alongside a complementary new recovery area, the latter of which supports all four theatres on site; and refurbishment of supporting accommodation within the theatre block. This development allowed us to reconfigure use of our overall theatre stock and move more day case surgery away from over-subscribed theatres on the RAEI site.
  - An expansion to our endoscopy facilities on both the Wigan (RAEI) and Leigh sites which enabled both units to achieve compliance with modern standards. The development at Wigan was a multi-storey building which also provided new diagnostic accommodation supporting our urgent and emergency care (UEC) services, and a new surgical admissions lounge, located next to our elective theatres on site.
- Coinciding with the new theatre development at Leigh, we developed a Community Diagnostic Centre, which hosts a range of diagnostic services on the site.
- Creation of intermediate care beds at Leigh Infirmary, via the building of our Jean Heyes Reablement Unit (JHRU), offers patients dedicated rehabilitation/reablement input to support them in returning to their usual place of residence after hospital stays.
- In late 2025, we completed building a new multi-storey car park near to the RAEI, which has been a critical development in resolving long-standing parking pressures for visitors to this site.

Our achievement in strengthening patient experience, inclusion, sustainability and organisational exellence include:

- Being named the cleanest NHS Trust in the country for the third consecutive year, ranking joint first out of 119 trusts in the Patient-Led Assessments of the Care Environment (PLACE). Over the last eight years, WWL has consistently been ranked within the top 10% of Trusts nationally.
- Establishing a new patient information library on our website, making it easier for patients and carers to access trusted health information and support.
- Achieving a Bronze Award in recognition of our anti-racist framework from the Northwest Black, Asian and Minority Ethnic Assembly.
- Developing our Green Plan 2025-2030, setting out how WWL will reduce its environmental impact and work towards a more sustainable future.

Since 2022, WWL colleagues and teams received regional and national recognition for excellence in healthcare, innovation, inclusion and leadership. Highlights have included:

- Our Chief Medical Officer receiving an OBE for services to healthcare.
- The Trust's Chair being awarded the Freedom of the City of London in recognition of her contribution to public life.
- WWL teams and colleagues being shortlisted for numerous awards, including the HSJ Digital Awards.
- Two members of our nursing workforce receiving gold and silver awards from NHS England's Chief Nursing Officer in recognition of their exceptional contribution to nursing.
- Our Global Majority Practice Development Nurse and Chief Nursing Officer Fellow, won Nurse of The Year at the Caribbean and African Health Network (CAHN) Black Healthcare Awards
- WWL's Health Outreach Inclusion Service (HOIS) won the Committee Nominated Award at the Wigan and Leigh Hospice Palliative and End of Life Care Awards, recognising the team's impactful partnership with the local Hospice.





Performance

The NHS has been making progress to return to delivering performance in line with its constitutional standards. At the conclusion of 2025/26, WWL's contribution to that performance looked like this:

82% performance against the 28-day Faster Diagnosis Standard whereby patients with suspected cancer have a diagnosis confirmed or ruled out within this timeframe.

Providers were expected to reach **80%** by March 2026 and then maintain that position as an average across the year beyond that.

81% performance against 6-week diagnostic standard for a range of 15 diagnostic modalities. By March 2029, providers are expected to meet the constitutional standard of 99%.

WWL met its 2025/26 target to improve the percentage of patients waiting less than 18 weeks for elective treatment to **60%**.

Providers are expected to meet the constitutional standard of 92% by March 2029.

We also met our target to improve A&E (Accident and Emergency) 4-hour performance to **78%** by March 2026.

There is a national target to continue improvements to reach **85%** across the full year in 2028/29.

In 2025/26, we invested **£32m** of capital (£14.5m of internal cash, and **£17.5m** from successful bids to national capital funds) to spend on new builds, refurbishments, infrastructure, digital systems, medical equipment and essential safety and maintenance.

WWL in Figures

Patients

In 2025/26 we saw:

103,483 ..... **ED attendances**

47,436 .....**Walk-in centre attendances**

40,480 . .....**Day-cases**

7,567 .....**Elective (planned) procedures**

532,649 ..... **Outpatient appointments**

2,336 ..... **Babies born in hospital**



People

WWL has **7,323** staff

There are **300** volunteers working across the Trust

WWL has **7,950** members



Partnerships

WWL is one of a number of organisations that make up the Healthier Wigan Partnership (HWP)

WWL is a local community and secondary healthcare provider working alongside **56** GP practices within **7** Primary Care Networks (PCNs), which will evolve into a neighbourhood model in line with the NHS 10-year plan.



Our People



"Received amazing care from the ultrasound department. The team were super friendly, smiley and made me feel comfortable and safe."

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

6/19

"The path to being an excellent provider of health and care services can only be achieved through our people. Prioritising the health and wellbeing of our colleagues will enable delivery of high quality and compassionate care for our population."

The evidence is clear that teams which deliver the best care and outcomes for patients are those in which colleagues feel supported, respected, and valued.

We also know that an environment in which colleagues feel comfortable to put forward their improvement or innovative ideas, and where they are empowered to deliver them, is one which is both attractive to work in and will lead to improvements in care and outcomes for our population.

We will continue to build on the effective partnerships we have, to ensure that we put our community, patients, and people first. Empowering our people to go and see beyond organisational boundaries will be key to this, helping to develop and deliver services that are truly centred around the needs and experience of our community.

Developing the right culture and ensuring that our current and future leaders are supported to nurture this, is therefore an essential enabling factor to unlock the maximum potential from the Improve, Integrate and Innovate priorities.

We are committed to:

- Placing compassion and diversity at the heart of everything we do; creating a caring, inclusive, respectful working environment where everyone can flourish.
- Supporting our people to achieve their career ambitions, providing development and training and flexible career paths.
- Focusing on the health and wellbeing of our people, providing activities and services that prioritise their health and wellbeing, and ensuring that there is personalised support when required.
- Ensuring that our people have a voice which shapes their experience and environment, and where people feel safe to make suggestions and to call out any concerns.

We will build upon our key strengths over the coming years to secure the future workforce we need to meet the needs of our patients and residents through attracting and developing talent from our Borough, across the country and internationally. There is much that makes WWL a unique place in which to train, work and develop and we will have a specific focus on:

- Increasing the opportunities for local people to train and develop careers within WWL, developing a future pipeline of local talent through our role as a key influencer within the Wigan Borough.
- Strengthening our links with Higher Education to support the development of tomorrow's workforce including through the Wigan Education and Skills Partnership (WESP), a collaboration between Wigan Council, the Trust, Wigan and Leigh College, and Edge Hill University.



Supporting staff wellbeing and recognising the importance of creating a healthy and supportive working environment.

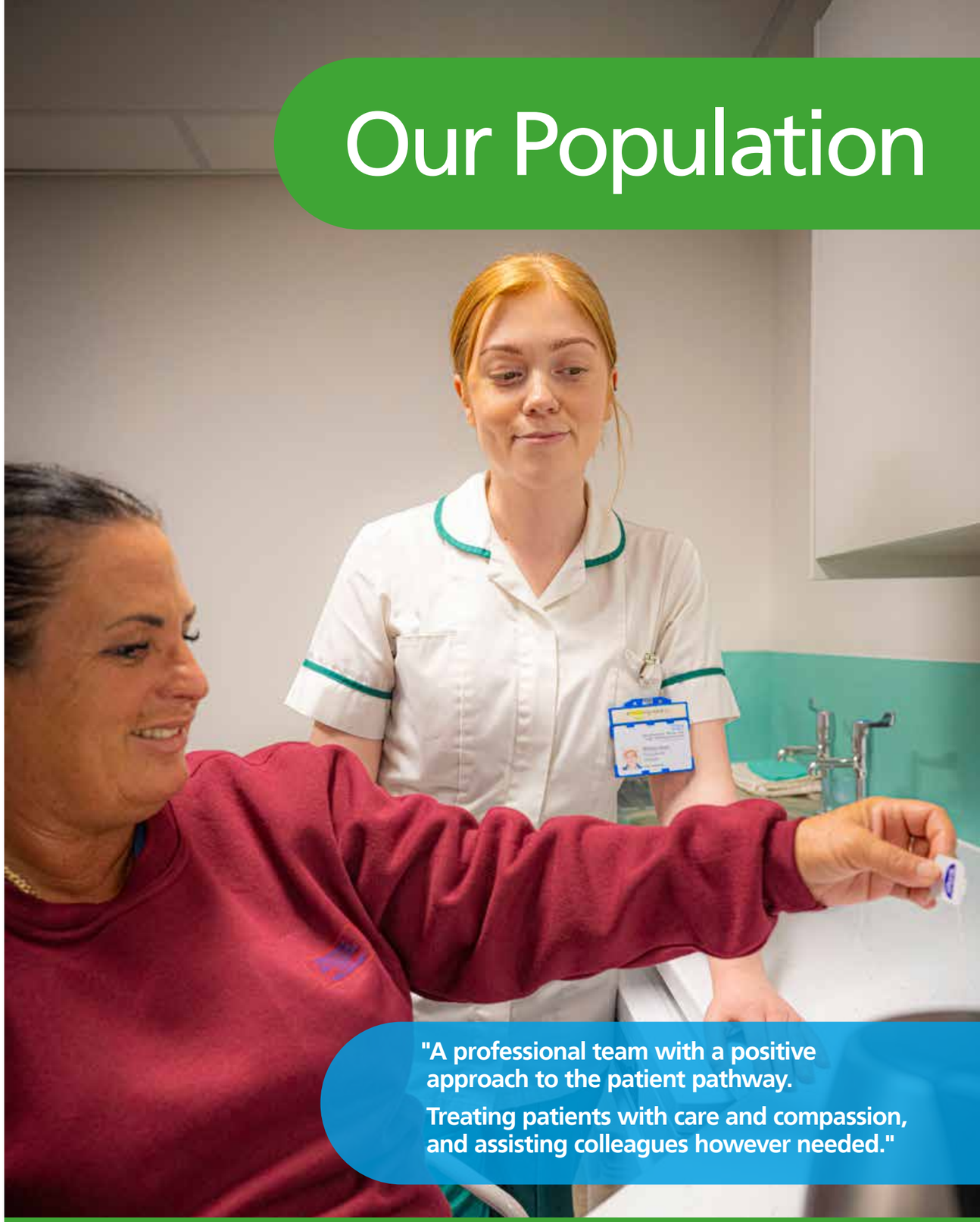
The Staff Experience Team coordinates a range of wellbeing initiatives and activities that are available to all colleagues across the Trust, for example the Steps4Mindful Living programme, wellbeing conversations and adjustments guidance, and our Trauma Risk Management (TRiM) service. In addition, an Employee Assistance Programme (EAP) provides confidential support for staff on personal and workplace matters, while also offering guidance and advice to managers on how best to support their teams when needed.
The Trust also benefits from a large network of Wellbeing Champions who help to promote wellbeing initiatives, share information, signpost colleagues to appropriate sources of support, and organise activities that encourage positive health and wellbeing.

Ensuring the Trust continues to adhere to our statutory duties under the NHS Standard Contract and Public Sector Equality Duty to promote staff wellbeing, attendance, retention, equality, and inclusion.

The National Staff Survey plays a vital role in supporting these obligations by providing insight into staff experiences, with further feedback being sought from staff listening events as part of our Staff Engagement Plan, through which we remain committed to a "You Said, We Did" approach.

Survey findings are also used to inform the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), helping the Trust monitor and improve the experiences of staff from Black and minority ethnic backgrounds and those with disabilities.

Our Population



"A professional team with a positive approach to the patient pathway.

Treating patients with care and compassion, and assisting colleagues however needed."

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



A review of Wigan's Joint Strategic Needs Assessment (JSNA) has supported our understanding of the health and wellbeing needs of the local population.

Wigan's JSNA adopts a strengths-based approach, highlighting local assets while identifying barriers to good health, with the aim of improving outcomes for all residents, particularly in deprived area. Notable within the findings are:

- Nearly **one in five residents (19.3%) are aged 65 or over.**
- Wigan is the **75th most deprived local authority in the country (out of 317)**, but deprivation is also very unequal within the Borough.
- There is a life expectancy gap of **8.1 years between the most and least deprived men and 9.1 years between the most and least deprived women;** this is one of the clearest indicators of inequality across the borough.
- Average life expectancy at birth is **77.1 years for males in Wigan** compared to the average in England of 79.3 years, and **80.7 years for females in Wigan** compared to the average in England of 83.2 years.
- Healthy life expectancy is **just over 59 years for males and just over 61 years for females.** This means many residents spend almost two decades of later life living with ill health.
- Obesity is one of the borough's biggest health challenges; **70.8% of adults are overweight or obese**, significantly higher than Greater Manchester (65.9%) and England (64.0%).
- Mental wellbeing is highlighted as a key emerging issue. **Around 1 in 6 residents are diagnosed with depression. 5,800 new cases of depression were recorded in a single year (2023-24). 42% of residents reported high anxiety** and another **16% reported medium levels of anxiety.**
- **Suicide rates in Wigan are higher than the average figures for England.** Between 2021 and 2023 Wigan's suicide rate was **15.7 deaths per 100,000 population.** England's rate was **10.7 per 100,000** which is a significant public health concern.

- Falls among older people remain a major issue. There were **2,645 hospital admissions due to falls per 100,000 residents aged 65+ in 2022/23.** This has reduced from **3,272 per 100,000 older people in 2021/22** but remains worse than England (1,933 per 100,000) and the Northwest (2,139 per 100,000).
- **The emergency admission rate for intentional self-harm was 100.9 per 100,000**, which is lower than both the England average (126.3) and the Northwest average (139.3).
- **Smoking prevalence has fallen from 22.5% in 2011 to 11.3% in 2023.** This is one of Wigan's biggest public health success stories, with smoking rates now slightly below the England average of 11.6%
- Residents report high levels of happiness, according to the Greater Manchester Residents Survey: **78% of residents reported feeling generally happy, 64% were satisfied with their life, 64% felt the things they do are worthwhile.** These are strong indicators of wellbeing despite the health challenges within the borough.
- **18.4% of the total population of Wigan Borough are aged 15 years or younger**
- Between 2020 and 2022 there were **3.7 infant deaths per 1,000 live births** in Wigan, compared with **3.9 per 1,000 in England** and **4.4 per 1,000 in the Northwest.** This is one of Wigan's strongest child health indicators.
- **47%** of 16–24-year-olds reported high anxiety.
- In 2022/23, **63.4% of children in the Wigan Borough had achieved a good level of development by the end of school reception year;** this was roughly the same as the average in Greater Manchester and the Northwest (63.3% and 64.3% respectively), although significantly lower than the England average (67.2%).



Our Partners



"The whole experience was very reassuring. Waiting time was accurately predicted. All staff were very competent, and patient centred."

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

9/19

WWL is a founding member of the Healthier Wigan Partnership (HWP), a joining together of the main health and care providers across primary, community, mental health, social care and secondary and specialist care.

This partnership ensures the delivery of joined up and sustainable health and care services that meet the needs of local residents and improves the population's health in the longer-term.

All partners are committed to working together to transform local services, with an initial focus on improving services based in the community.

The HWP membership currently includes:

- **WWL**
- **Wigan Council**
- **NHS Greater Manchester (Wigan Place)**
- **Greater Manchester Mental Health NHS Foundation Trust**
- **GP Clinical Leads representing the seven Primary Care Networks of GP practices in the Wigan Borough**

We also work in partnership with Greater Manchester Police, Local Voluntary and Community Sector organisations and the Northwest Ambulance Service.

HWP is focused on ensuring high-quality health and care services at the point of access for residents but also tackling the wider social and economic determinants of illness to improve the health of the population throughout their lives.

Since the launch of Our Strategy 2030, the HWP has continued to strengthen this joint working and our partnership approach is now framed through Progress with Unity, Wigan Borough's shared movement for change, which brings residents, businesses, public services and community organisations together around two missions:

- **Creating fair opportunities for all children, families, residents and businesses**
- **Making all our towns and neighbourhoods flourish for those who live and work in them**

Through Progress with Unity, partners have reaffirmed their commitment to putting integrated health and care services at the heart of communities, with a focus on addressing health inequalities, transforming local services and developing a sustainable workforce. This provides a strong shared framework for tackling the wider determinants of health, strengthening neighbourhood working, listening deeply to communities and designing services around what matters most to local people.

WWL will continue to play an active role in this partnership, supporting prevention, improving population health, reducing inequalities and delivering more joined-up care closer to home.

The core of partners' commitment to seamless and joined up services for residents remains the alignment of public services within the seven established Primary Care Networks of the Wigan Borough, forming communities of well-integrated and informed teams. This will support our joined-up aim to provide the right care, at the right time and in the right place for our local population.

Our Region



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

10/19

Greater Manchester's health and care system is organised through the Greater Manchester Integrated Care Partnership, bringing together NHS organisations, local authorities, primary care, Voluntary, Community, Faith, and Social Enterprise organisation (VCFSE) partners, Healthwatch, trade unions and wider public sector partners.

The partnership works within the wider Greater Manchester Strategy 2025-35 vision of creating "a thriving city region where everyone can live a good life." For health and care, this means improving population health, reducing inequalities, supporting people to live well, and ensuring access to high-quality, sustainable services when they are needed.



This is particularly important in a city-region where people continue to experience significant differences in health outcomes and life expectancy. The Greater Manchester ICP's six missions provide the shared framework for responding to these challenges: strengthening communities; supporting people to get into, and stay in, good work; recovering core NHS and care services; helping people stay well and detecting illness earlier; supporting our workforce and carers; and achieving financial sustainability.

WWL also provides services to populations in the neighbouring ICPs of Cheshire and Merseyside, and Lancashire and South Cumbria.

National Health Policy & System Reform

The UK Government published the 10-Year Health Plan for England: Fit for the Future in 2025.

The Plan sets out a long-term vision for transforming health and care services to ensure the NHS remains sustainable, accessible and responsive to the changing needs of the population.

Central to the plan are three major shifts in the way health and care services are designed and delivered:

1. From hospital to community: expanding neighbourhood-based models of care so that more services are delivered closer to home, reducing reliance on hospital-based provision and supporting people to manage their health independently wherever possible.
2. From analogue to digital: accelerating the adoption of digital technologies, data and artificial intelligence to improve access, productivity and patient experience, whilst enabling citizens to take greater control of their own care and health information.
3. From sickness to prevention: increasing investment in prevention, early intervention and population health approaches to reduce avoidable illness, tackle health inequalities and improve healthy life expectancy.



To support delivery of these ambitions, the plan highlights a number of priority areas:

- Developing integrated neighbourhood health services that bring together primary care, community services, mental health, hospital services, local authorities and the voluntary sector around the needs of local populations.
- Improving access to urgent, emergency and elective care whilst reducing waiting times and ensuring patients receive timely treatment.
- Strengthening workforce capacity, productivity and staff experience through new approaches to recruitment, retention, training and flexible working.
- Expanding digital services, including further development of the NHS App, digital pathways, remote monitoring and improved information sharing across organisations.
- Addressing persistent health inequalities through targeted interventions, prevention programmes and population health management approaches focused on those communities experiencing the poorest outcomes.

Alongside the 10-Year Health Plan, NHS England introduced a new Medium-Term Planning Framework in 2025. This signals a move away from annual planning cycles towards integrated multi-year planning across systems and organisations. The framework places greater emphasis on long-term financial sustainability, delivery of productivity improvements, workforce planning, quality outcomes and collaborative working across Integrated Care Systems. It reinforces the need for NHS organisations to plan collectively with partners, aligning resources and services around the needs of local populations while delivering improved value and outcomes.

Within Greater Manchester and the Wigan Borough, these national developments strengthen the direction of travel towards place-based partnership working, neighbourhood health models and integrated services. They create significant opportunities for the Trust to work with partners across health, care and the voluntary sector to improve population health, reduce inequalities and deliver sustainable services for the future.

For organisations across Greater Manchester, this approach provides an opportunity to strengthen collaboration with partners and take a longer-term view of how services are designed and delivered. The emphasis on integrated medium-term plans encourages providers, commissioners and system partners to work collectively to improve productivity, tackle health inequalities, develop the workforce and deliver better outcomes for local populations. For WWL, this provides a stronger framework within which to pursue our strategic ambitions, ensuring that our priorities are aligned with both local needs and the long-term direction of the NHS.

"On our recent visit to your A&E department. The staff were amazing. Extremely efficient, thorough and caring. We couldn't have asked for better treatment."

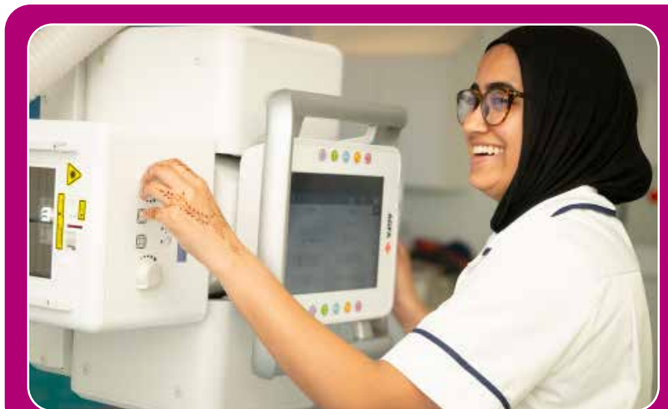
The Opportunities Ahead

The health and care system continues to face significant challenges, including increasing demand, workforce pressures, financial constraints and persistent health inequalities.

However, the national policy direction set out in the NHS 10-Year Health Plan presents a significant opportunity to reshape services and improve outcomes for local people. The plan's focus on shifting care from hospitals to communities, accelerating digital transformation and placing greater emphasis on prevention aligns strongly with our ambition to deliver person-centred, sustainable healthcare. These changes create opportunities to maximise the use of our resources, strengthen partnership working and improve the experience of patients and staff alike.

The changing national and local landscape also presents opportunities to strengthen neighbourhood-based care, address health inequalities and support people to live healthier and more independent lives. Medium-term planning arrangements will enable a greater focus on long-term transformation, workforce development and financial sustainability, helping us to deliver better outcomes for the populations we serve.

In response to these developments, WWL began work during 2026 to refresh Our Strategy 2030. The Delivery Ambitions were developed and tested with a wide range of stakeholders to ensure they reflect both the opportunities and challenges facing our organisation, communities and partners.



Our Strategy 2030/31



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

12/19

Why Refresh Now?

This refresh of Our Strategy 2030 comes at an important point in both the Trust's journey and the wider NHS planning cycle.

During 2025, the Trust began considering a review of the existing strategy to assess progress against our priorities, revisit areas requiring further focus and ensure that the remaining years of the strategy continue to support the delivery of our long-term ambitions. While the core purpose, strategic aims and values of the organisation remain unchanged, the environment in which we operate has evolved significantly since the strategy was first developed.

Over recent years there have been substantial changes in national health and care policy, culminating in the publication of the NHS 10-Year Health Plan and the introduction of a national move towards medium-term planning. With NHS organisations now expected to operate within rolling three to five-year planning horizons, and national guidance encouraging providers to refresh their organisational strategies, there was a clear opportunity to review Our Strategy 2030 and ensure it remains relevant in the context of the changing NHS landscape.

In addition at a local level, the publication of Wigan Council's Progress With Unity framework has refreshed the borough's ambitions and priorities, creating an opportunity to further strengthen alignment between the Trust and our wider place-based partners. At the same time, both the Trust and the wider health and care system have experienced significant organisational and leadership changes, alongside evolving structures and responsibilities across Greater Manchester and Wigan Borough partnerships.

An initial review of the existing strategy considered a number of potential approaches. This concluded that a 'Refresh' of the current strategy represented the most appropriate option, rather than either a 'Recommit' approach involving only minimal updates, or a 'Recreate' approach requiring a complete redesign of the strategy. The review found that the core principles, ambitions and structure of Our Strategy 2030 remain fundamentally sound and continue to reflect the values and long-term direction of the organisation.

The refresh approach therefore seeks to retain the established framework of the strategy while updating the supporting narrative, evidence base and priorities to reflect current circumstances. It also provides an opportunity to articulate more clearly the specific ambitions and deliverables that will guide our work through the remainder of the strategy period. In particular, the refreshed strategy enables the Trust to respond to emerging national policy priorities, strengthen alignment with system and place partners, reflect changes in organisational leadership and governance, and reinforce our commitment to restoring and maintaining long-term financial sustainability.

To inform the refresh, a programme of engagement was undertaken throughout the first quarter of 2026/27. This engagement has helped to strengthen the evidence base underpinning the strategy, drawing on the views of colleagues, partners and stakeholders to ensure that the refreshed strategy reflects both the opportunities and challenges facing the organisation over the coming years and provides a clear framework for delivery through to 2031.



How We Refreshed Our Strategy 2030

Between May and July 2026, we undertook a programme of engagement to gather views on the Trust's proposed Delivery Ambitions and future priorities.

Feedback was received through staff listening events, a Trust-wide staff survey, discussions with Governors, engagement with our Lived Experience Panel, patient feedback, and conversations with system partners. This approach ensured a wide range of perspectives helped shape the final Delivery Ambitions.

Several consistent themes emerged across all stakeholder groups:

- Visible and responsive leadership that listens and acts on feedback.
- Greater involvement of patients, carers and staff in the design and improvement of services.
- A supported, valued and resilient workforce with access to development opportunities.
- Simpler, more efficient systems and processes, enabled by digital technology and innovation.
- Safe, high-quality, personalised care delivered consistently across all services.
- Better integrated and coordinated care pathways across health and care organisations.
- Clear communication, involvement and transparency in decision-making.
- A stronger focus on prevention, early intervention and reducing health inequalities.

This feedback has directly informed and strengthened our Delivery Ambitions, helping to ensure they reflect the priorities of our patients, communities, staff and partners and support the delivery of Our Strategy 2031.

Our Vision for the Next Five Years

Our vision is for WWL to deliver outstanding care and improve the health of all the people and communities we serve, breaking down the barriers that create health inequalities.

We will work together with our patients, communities, staff and partners to improve population health, reduce health inequalities and deliver the best possible outcomes for the people we serve. Through strong partnerships across Wigan Borough, Greater Manchester and beyond, we will support a shift towards prevention, earlier intervention and more integrated models of care that help people live healthier and more independent lives.

We are committed to delivering consistently high standards of quality, safety and patient experience. Our ambition remains to provide timely access to care, achieve excellent clinical outcomes and ensure every patient receives care that is personalised, effective and centred on what matters most to them.

Our people will be at the heart of everything we do. We will create an inclusive, supportive and empowering culture where colleagues can thrive, develop their skills and contribute to continuous improvement. By investing in our workforce, leadership and wellbeing, we will ensure we remain a great place to work and learn.

Innovation, research and digital technology will play an increasingly important role in helping us improve services and outcomes. We will continue to embrace new ways of working, harness data and technology to support better decision-making, and create modern healthcare environments that enable staff to deliver outstanding care.

As digital transformation progresses at pace, we will ensure that our approach remains person-centred and equitable. We recognise that varying levels of digital capability, access and confidence can affect how people engage with healthcare services, and we are committed to addressing digital exclusion by designing accessible solutions, providing appropriate support, and maintaining alternative routes to care where required. This will help ensure that the benefits of innovation are realised by all of our communities, without widening existing health inequalities.

As an integrated provider of acute and community services, we will continue to redesign pathways around the needs of patients, improving flow through our services whilst supporting more care to be delivered closer to home. We will work collaboratively with partners to strengthen neighbourhood services, improve population health and make best use of the collective resources available across the health and care system.

We recognise the significant challenges facing the NHS and wider public services. By improving productivity, delivering value for money and ensuring the responsible use of resources, we will create a financially sustainable organisation that can continue to invest in high-quality services for future generations.

"We are committed to delivering consistently high standards of quality, safety and patient experience."

Delivery Ambitions

The Delivery Ambitions, developed through engagement with patients, carers, staff, Governors, system partners and the Trust Board, are described below.

They reflect what matters most to the people and communities we serve, whilst ensuring alignment with Fit For The Future and other national policies, Progress with Unity and the priorities of the Healthier Wigan Partnership. Aligned to the 4Ps, they provide a clear focus for improvement and transformation over the next five years.

Key to delivering these ambitions are the strategic priorities that we identified as part of our original strategy: Improve, Integrate and Innovate. These set out "how" we are going to deliver over the next five years and will be used to guide the decisions that we make.

	Summary ambition	Our Ambition	By 2030/31
Partnerships	Help people stay well	Working with our partners through Progress with Unity, we will support people to live healthier lives, reduce inequalities, promote independence and intervene earlier to prevent avoidable ill health.	Prevention, early intervention and health equity will be embedded within our services, with more people supported to stay well and live independently for longer.
Partnerships	Help people stay well	Through Progress with Unity, we will work with local people, communities and partners to design and deliver joined-up neighbourhood services around what matters most to them.	More people will experience seamless care across hospital, community, primary care and neighbour-hood services, with more care delivered closer to home wherever it is safe, effective and preferred.
Patients	Outstanding care, every time	We will provide safe, personalised and compassionate care, with patients listened to, informed and involved as partners in decisions about their care.	Every service will consistently deliver outstanding care, listening to and involving patients, using evidence, patient feedback and continuous improvement and learning to improve outcomes, experience and safety.
Patients	Right care, first time	We will work with patients, carers and partners to make it easier for people to receive the right care, in the right place, first time.	Patients will have timely access to advice, assessment and treatment through simpler pathways designed with partners, and accessible digital services that improve convenience whilst maintaining choice and inclusion.
People	Give our people time to care	We will simplify the way we work, ensuring our people have the time, capability, support and voice to deliver outstanding care, while promoting wellbeing and reducing unnecessary pressures.	Our people will spend less time on unnecessary administration and more time caring for patients, improving services, feeling listened to and valued, and supported by digital technology where it adds value.
People	Learn, discover and improve	We will embed curiosity in everything we do, through making research, innovation and continuous improvement part of everyday care.	More patients and colleagues will benefit from research and innovation, supporting our ambition to become a University Teaching Hospitals organisation.
Performance	Valuing people's time	We will value the time of our patients, people and communities by reducing unnecessary waiting and making every interaction as simple and effective as possible.	People will receive timely care, enabled by real-time and predictive insight to improve flow and reduce delays.
Performance	Making every pound count	We will make the best use of every pound we spend, by improving productivity, reducing waste and investing in what matters most to patients.	We will be financially sustainable and delivering productive services that continually improve quality whilst making the best use of our resources.



Our Strategic Framework

At WWL, it's not just what we do, but the way we do it that is important to us.

Underpinning delivery of our strategic ambitions over the next five years are the four shared values. Developed through engagement with colleagues as part of our People and Culture work, our shared values capture the culture we want to create at WWL.

They provide a common set of expectations and behaviours that guide how we work with patients, communities, partners and each other every day.

- **We put people at the heart of what we do**
- **We listen and involve**
- **We are kind and respectful**
- **We are one team**

Strategic Objectives

The four Ps: **Partnerships, Patients, People, and Performance,** continue to encapsulate the areas on which we will focus our development and improvement.

Our strategic objectives within each are pillar are:

Partnerships: Strong partnerships improving health, reducing inequalities and helping our communities thrive.

Patients: Safe, personalised and compassionate care, shaped with patients and carers, leading to excellent outcomes and patient experience.

People: A healthy, skilled and empowered workforce, with the time, capability and support to deliver outstanding care.

Performance: Timely, productive and financially sustainable services that value the time of our patients and people.

These four Ps form the focus of our Delivery Ambitions, which will endure for the duration of the strategy. To provide assurance that we are achieving our Delivery Ambitions, we have developed a small number of strategic metrics, ensuring that we remain on track or early identification of areas that require attention.

Through doing this we will ensure that we achieve our vision to deliver outstanding care and improve the health of all the people and communities we serve, breaking down the barriers that create health inequalities.



We will…Improve

By placing quality at the heart of everything we do, we will continuously improve the care, services and experience we provide for our patients, communities and staff.

We will listen to and involve patients, carers and communities in shaping our services, ensuring that their experiences help us understand what matters most and where improvement is needed. We will support people to become active partners in their care, helping them to make informed choices and ensuring care is personalised around individual needs.

We will work to ensure that high standards of care are consistently delivered across all services. By reducing unwarranted variation, learning from best practice and using evidence, insight and improvement methodologies, we will improve quality, safety, outcomes and experience for the people we serve.

Improving access to care and flow through our services will be a major focus. We will simplify pathways, reduce delays and eliminate waste, ensuring patients receive timely advice, assessment and treatment through services that are responsive, reliable and easy to use.

We recognise that great care depends upon great people. We will create the conditions that enable our colleagues to spend more time caring for patients and less time navigating unnecessary complexity. By streamlining processes, removing barriers and embedding continuous improvement into everyday work, we will empower our workforce to improve the services they deliver.

We will use data, insight and learning to improve how care is planned, delivered and evaluated. By valuing the time of our patients and our people, and ensuring every pound is used effectively, we will deliver sustainable services that continually improve quality, outcomes and experience.

"As a learning organisation, we will continue to adapt to emerging opportunities and support our ambition to become a University Teaching Hospitals organisation."

We will…Integrate

By working together across organisations, professions and communities, we will create more joined-up services that improve population health, reduce inequalities and help people stay well for longer.

As a founding member of the Healthier Wigan Partnership, we will continue to work alongside primary care, mental health services, local government, education providers, the voluntary, community and social enterprise sector, and wider system partners to improve the health and wellbeing of our communities. Through Progress with Unity, we will play our part in creating fair opportunities for residents and helping our towns and neighbourhoods flourish.

We will support the shift from hospital to community by strengthening neighbourhood-based models of care and delivering more joined-up services closer to home. Working collaboratively across organisational boundaries, we will support prevention, early intervention and personalised care that helps people remain independent and reduces avoidable reliance on hospital services wherever appropriate.

Reducing health inequalities will be a core focus. Working with our partners and communities, we will take action on the wider determinants of health, supporting better health outcomes for those populations experiencing the greatest disadvantage and ensuring that services are designed around the needs of local people.

Patients and carers consistently tell us that services should feel more connected and coordinated. We will therefore work with partners to improve continuity of care, ensuring people experience a seamless journey through health and care services and receive the support they need when and where they need it.

As an integrated provider of acute and community services, we are uniquely placed to bring people, expertise and resources together around the needs of the population. Through partnership, shared responsibility and collective action, we will contribute to stronger communities, a more sustainable health and care system, and better outcomes for future generations.

Our role as an Anchor Institution will continue to grow. Through employment, education, procurement and investment decisions, we will support local communities, create opportunities for local people and contribute to the wider social and economic wellbeing of the Borough.





We will…Innovate

Innovation will enable us to improve outcomes, enhance experiences and deliver sustainable services for the future.

We will foster a culture that encourages curiosity, learning, improvement and the confidence to challenge existing ways of working.

Innovation is not simply about technology. It is about creating an environment where colleagues are empowered to test ideas, solve problems, share learning and continuously improve the services they provide. We will support our people with the skills, tools and freedom to innovate, recognising that many of the best ideas come from those closest to patients and services.

We will strengthen our role as a research-active organisation and work collaboratively with academic, clinical, industry and system partners to develop and adopt new approaches to care. Through research, education and evidence-based practice, we will ensure patients benefit from the latest advances in healthcare whilst creating opportunities for our staff to learn, develop and lead.

Digital technology, automation, artificial intelligence and data science will play an important role in transforming services, improving decision-making and increasing productivity. Our focus will be on applying these innovations in ways that improve quality, safety and patient experience whilst creating more time for care.

We will also encourage innovation in the way services are designed and delivered, embracing new models of care, modern workforce practices and collaborative approaches that help us respond to changing population needs. By combining innovation, research and continuous improvement, we will remain agile, forward-looking and well placed to deliver outstanding care for future generations.

As a learning organisation, we will continue to adapt to emerging opportunities and support our ambition to become a University Teaching Hospitals organisation.

Our Strategy 2031



"I was given an excellent standard of care throughout the day on the ward and in theatre by all. I would like to thank all the staff on the unit for their time and efforts throughout my stay."

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

Delivery

The success of Our Strategy 2031 will be determined not only by what ambitions we want to achieve but crucially how we will achieve them.

Our strategy is supported by a range of enabling strategies which set out, in greater detail, how we will develop our people, modernise our estate, harness digital technology and strengthen the foundations required to deliver our ambitions.

To understand whether our strategy is succeeding, we have developed a small number of strategic metrics linked directly to our Delivery Ambitions. These measures will help us assess progress, identify areas requiring attention and ensure we remain focused on delivering the outcomes that matter most to our patients, people, partners and communities.

We will deliver our strategy through a Quality Management System (QMS) approach. This brings together quality planning, quality control, quality assurance and quality improvement to create a clear line of sight between our long-term ambitions and the work undertaken every day across the organisation. Through this approach, quality becomes the organising principle for how we plan, deliver, measure and improve our services.

To translate strategy into action, we will deploy our ambitions through three interconnected levels:

Breakthrough Objectives

A small number of organisation-wide priorities, typically three to five at any one time, which focus collective effort on the areas most critical to delivering our strategy. These objectives will normally be refreshed every 12 to 18 months, ensuring that we remain focused on what matters most whilst retaining the flexibility to respond to emerging challenges and opportunities.

Transformation Programmes

Major improvement and change programmes which support delivery of our strategic ambitions. These programmes will typically run over one to three years and provide the governance, resources and focus required to deliver complex improvements that cannot be achieved through business-as-usual activity alone.

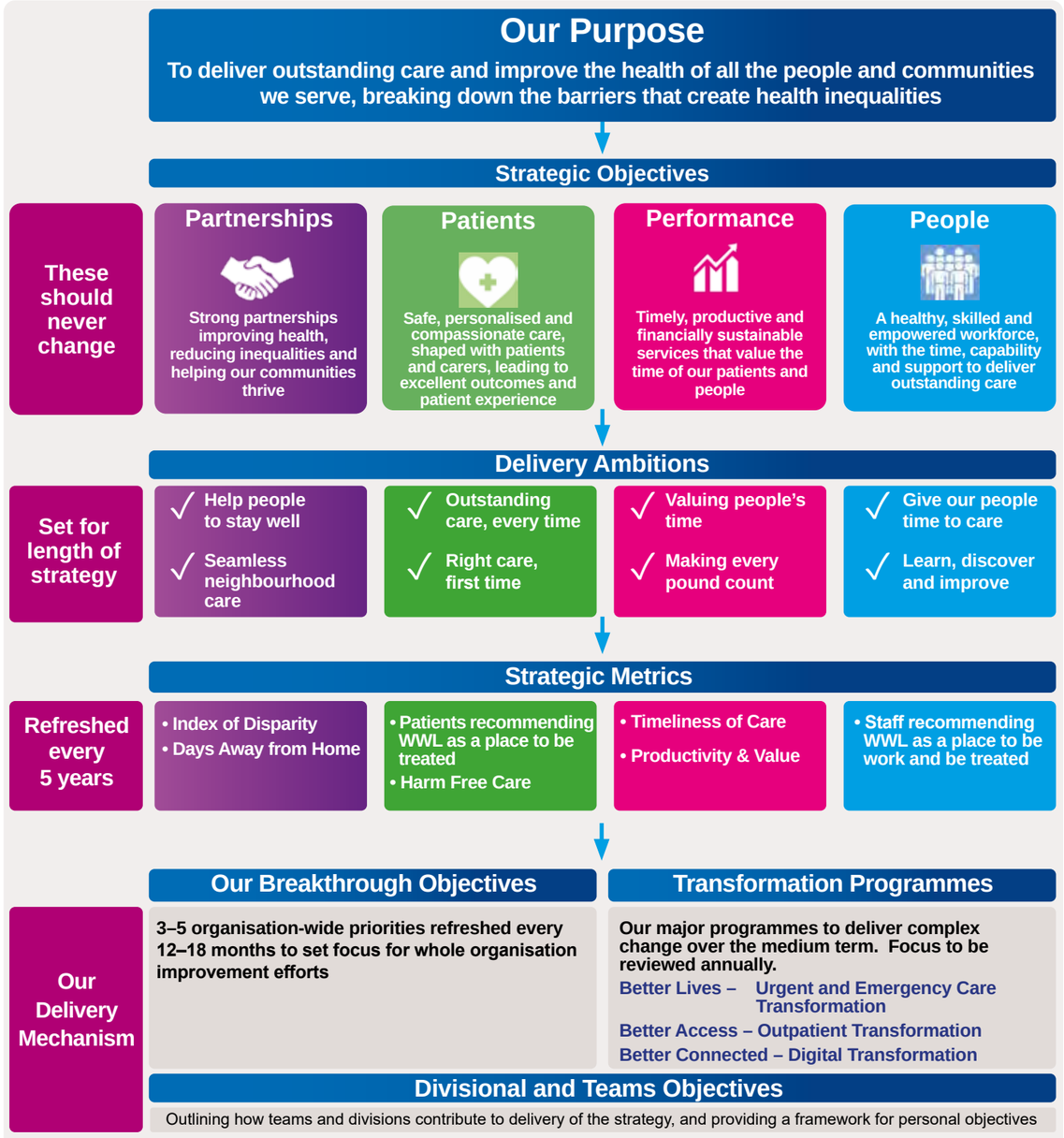
Divisional and Team Objectives

The goals and priorities developed by Divisions, departments and teams will demonstrate how they contribute to delivery of the Trust's strategic ambitions. These objectives will create a clear "golden thread" from the Board to frontline services and provide the framework through which colleagues can contribute to improvement within their own areas of responsibility.

Strategy on a Page

Our strategy-on-a-page draws together each respective element of our approach and ensures that every colleague can see how their work contributes to the delivery of our strategy and to improving the lives of the people and communities we serve.

Our strategy is ambitious but achievable. Some ambitions will require investment, whilst others can be realised through better use of the resources, skills and capabilities we already possess. We recognise that we cannot do everything at once. By remaining focused on what matters most and aligning our improvement efforts behind a shared set of priorities, we will maximise our ability to deliver meaningful and sustainable change over the next five years.





Next Steps

Risks to Implementation

Our Board Assurance Framework provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy and the Delivery Ambitions.

This considers those risks that are most likely to materialise and those that are likely to have the greatest adverse impact on delivering the strategy.

The environment in which we are operating in can change quickly. A proactive approach to risk identification and management is therefore a pre-requisite to the successful delivery of Our Strategy 2031. We will continue to work with our staff, through our governance structure and committees, to ensure that we are responding to these changes, identifying risks as they emerge and developing effective plans to manage them.

Future Engagement

Our refreshed strategy sets the ‘roadmap’ for our future over the next five years and providing the guide by which we will make our strategic decisions.

It has been shaped by our patients, staff, and our partners, and it will ensure that we focus on the vision and sustainability of WWL. It sets out the key ways in which we will create our future. It will evolve as we continue to engage with all stakeholders over the lifetime of the strategy and as we respond to changes in the policy and operating environments.

We will also need ongoing engagement with, and input from, staff, partners, and patients to help prioritise elements of the strategy and lead their implementation through our Delivery Ambitions to ensure that we deliver on our vision to deliver outstanding care and improve the health of all the people and communities we serve, breaking down the barriers that create health inequalities.



NHS
Wrightington, Wigan and
Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Partnerships Report
Presented to:	Board of Directors
On:	7th October 2026
Presented by:	Chris Clark, Director of Strategic Transformation
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.

As previously noted by the Board, there have also been a few publications from NHS England over the last year 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.

Against this backdrop, effective partnership working remains essential to the Trust's ability to deliver its strategic objectives, support the wider ambitions of the Greater Manchester system and Healthier Wigan Partnership, and respond proactively to future opportunities arising from neighbourhood health reform.

This is the latest biannual report to the Board providing a summary update of the system partnership work that we are undertaking, specifically across Greater Manchester (GM) and the Wigan Locality.

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

No financial implications to this report.

Legal implications
No financial implications to this report.

People implications
No financial implications to this report.

Wider implications
None noted.

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

Why partnerships matter & national drivers

Partnership working continues to be a central expectation of NHS providers. The NHS Foundation Trust Code of Governance makes clear that trusts are expected to contribute not only to their own organisational objectives, but also to the wider ambitions of the Integrated Care System (ICS). This includes working collaboratively with system partners, aligning organisational strategies with the Integrated Care Partnership's integrated care strategy, contributing to reductions in health inequalities, and supporting the delivery of shared system plans.

Since the publication of the NHS 10 Year Health Plan in July 2025, the national policy direction has become increasingly focused on the three shifts from hospital to community, analogue to digital, and sickness to prevention. Delivery of these ambitions depends upon stronger partnership working across primary care, community services, acute providers, local authorities, mental health services and the voluntary, community, faith and social enterprise sectors.

The Neighbourhood Health Framework and *Fit for the Future: Towards Population Health Delivery Models*, both published in March 2026, remain the principal policy documents underpinning this direction. Together, they set out a model based on Integrated Neighbourhood Teams, population health management and more joined-up planning and delivery across organisational boundaries.

Since the last report, NHS England has progressed this agenda further through a national consultation on proposed Single Neighbourhood Provider (SNP) and Multi-Neighbourhood Provider (MNP) contracting models. The consultation explores how new contract forms might support delivery of neighbourhood health services for defined populations, simplify commissioning arrangements and strengthen accountability for outcomes across neighbourhoods and localities. Alongside the proposed Integrated Health Organisation (IHO) model, these developments signal a continued move towards population-based commissioning, partnership-led delivery and greater integration of services around the needs of local communities.

Against this backdrop, effective partnership working remains essential to the Trust's ability to deliver its strategic objectives, support the wider ambitions of the Greater Manchester system and Healthier Wigan Partnership, and respond proactively to future opportunities arising from neighbourhood health reform. 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 *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.

In the first half of 2026/27 we have been undertaking a process to refresh Since *Our Strategy 2030,* both to reflect that we are broadly half way through the life of the strategy and also to reflect that much has changed including we have moved beyond the post-pandemic phase; *Progress with Unity* has been launched across the Borough; we are 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; and we have completed major organisational and leadership changes. We have engaged extensively with staff, patients and partners as part of this strategy refresh, and whilst the core strategic framework remains the relevant and unchanged (including our “4 Ps” of Partnerships, Patients, People and Performance), eight clear delivery ambitions have been developed aligned to this. These place a greater emphasis on the importance of partnerships to achieve the improvements we are aiming to deliver for all our population, including

recognising the critical importance of reducing inequalities if we are to truly deliver these improvements, and align closely with *Progress with Unity.*

The refreshed strategy is due to be taken to Board for approval on the 7th October 2026, with publication to follow shortly after.

To date, 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 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). From 2027/28 we intend to replace the Corporate Objectives with a set of 3-5 clear Breakthrough Objectives – this will form the focus of our whole organisation improvement work and will be focussed on those areas where we have the greatest opportunity to make progress on Our Strategy over the coming 12-18 months. Work will be undertaken in Quarters 3 & 4 both to set these, and to develop the approach to embedding a Continuous Improvement methodology in support of delivery.

Greater Manchester System Working

WWL continues to play an active role across the Greater Manchester health and care system. Executive Directors are engaged in GM-wide programme boards, professional networks and leadership forums that support the delivery of system priorities and provide opportunities to influence emerging policy and service developments. Several members of the Executive Team continue to hold key leadership roles within the GM Trust Provider Collaborative (TPC), including the Chief Executive's role as Chair of the GM Elective Recovery Board. We also remain closely involved in GM capital planning and prioritisation processes through the Chief Finance Officer's membership of the GM Capital Resource Allocation Group (CRAG).

The Greater Manchester planning process for 2027/28 and beyond is now underway. As in previous years, we are working closely with GM partners to ensure local plans align with wider system assumptions and priorities. We continue to contribute actively through the GM planning hub, the GM Directors of Strategy and Directors of Finance networks, and the GM Trust Provider Collaborative.

Alongside the formal planning process, there is increasing national and regional focus on the future operating model for Integrated Care Systems. The continued shift of Integrated Care Boards towards a more strategic commissioning role, combined with the development of neighbourhood health services and the consultation on new Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contractual models, is expected to further increase the importance of provider collaboratives and partnership-led delivery models over the coming years. The Trust continues to engage actively in these discussions to ensure we are well positioned to respond to future opportunities and risks.

We remain committed to delivering service improvements in partnership with organisations across Greater Manchester. This includes our long-standing pathology partnership with the Northern Care Alliance, support for GM-wide shared services initiatives, and active participation in a number of clinically-led collaborative programmes. Increasingly, this also includes work with neighbouring providers to identify opportunities for greater collaboration where this will improve quality, resilience, sustainability or patient outcomes.

Within the Trust Provider Collaborative, particular focus continues to be given to areas such as elective recovery, outpatient transformation, cancer improvement, digital enablement and frailty. These priorities align closely with the Trust's own transformation programmes and provide opportunities to share learning, reduce variation and accelerate improvement at scale across Greater Manchester.

The ongoing financial challenges facing both providers and commissioners continue to create a degree of uncertainty across the system. However, partnership working remains critical to securing the benefits of service integration, improving patient outcomes and maximising the impact of scarce resources. The Trust therefore continues to invest significant leadership capacity in system relationships and collaborative programmes at both Greater Manchester and locality level.

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 Surgical Admissions Lounge has opened. This is now situated in a purpose-built facility adjacent to theatres, improving patient dignity and experience.
- The refurbishment of Theatres 5&6.

Since the last partnerships report to Board we have also had capital funding for 2026/27 approved by the national and regional NHSE teams, following GM support for them. These include funding to:

- Relocate our Same Day Emergency Care (SDEC) service to Christopher Home, co-locating this with the Urgent Care Centre
- Redevelop the old, and now vacated, x-ray area within the Emergency Department to support improvements in the facilities and patient flow
- Develop a diagnostics hub at Wrightington Hospital. This will create a purpose-built, modern which can in future be expanded to consolidate all diagnostic activity on the site into a single location. This will support the site strategy and support us to vacate old accommodation which has a critical infrastructure risk (CIR) valued at £7m.
- Deliver a permanent extension to the Endoscopy Unit at Leigh Infirmary, providing fit-for-purpose staff accommodation required to safely and efficiently operate the expanded 6-room endoscopy unit, thereby completing the improvements to our endoscopy facilities.

Collaboration with Bolton NHS Foundation Trust

Our collaboration with Bolton NHS Foundation Trust continues to develop in line with the principles previously agreed by both Boards. These principles remain unchanged, including the commitment to optimise functions rather than organisational form, ensure service changes are clinically led and patient focused, and prioritise opportunities that improve quality, sustainability and value.

The Collaboration Board has now met on two further occasions since the last report and has increasingly focused on identifying practical opportunities where joint working can address shared challenges and deliver tangible benefits for patients and staff. Whilst the shared Urology on-call model remains the most mature example of service collaboration, a broader programme of work is now emerging across community services, diagnostics, medicine, surgery and corporate services.

Specific attention is being given to working up opportunities in pharmacy services and commercial development and also exploring further opportunities across services where there are workforce and service sustainability challenges. A key part of the collaboration is also ensuring that we share learning between our organisations including areas such as virtual wards and hospital at home services, and operational resilience.

The collaboration continues to be characterised by a pragmatic, opportunity-led approach, with both organisations seeking to share expertise, learn from one another and pursue joint solutions where these

add value. As national policy increasingly emphasises provider collaboration, neighbourhood health and service integration, the relationship with Bolton provides an important platform through which both organisations can respond to future challenges and opportunities whilst retaining their independence and local focus.

Healthier Wigan Partnership

WWL Executives continue to play an active role within the Healthier Wigan Partnership, working alongside Wigan Council, the locality ICB team, Healthwatch and voluntary, community and faith sector partners to improve outcomes for the people of Wigan Borough. Key WWL leaders also continue to contribute to the Partnership's supporting boards and workstreams.

We continue to develop new ways of working with locality partners, including the delivery of a joint Infection Prevention and Control service with Wigan Council, alongside our broader work on prevention, health inequalities and workforce development. The joint appointment of a Consultant in Public Health continues to strengthen our ability to embed prevention and health improvement within clinical pathways and organisational decision-making, supported by the development of a Trust Health Inequalities and Prevention Plan.

A particular area of progress has been the continued development of the Better Lives programme, our jointly designed approach to improving independence, transforming urgent and emergency care and creating a more sustainable model of care for local people. Over the last two years, the programme has strengthened relationships across partner organisations and helped create a genuinely shared approach to solving some of the most complex challenges facing the locality. The recent "Better Lives: Two Years On" event demonstrated both the maturity of these partnerships and the progress being made in delivering improved outcomes for residents.

The programme is now delivering sustained improvements across a range of measures, including reductions in avoidable admissions, improvements in timely discharge, increased support for people to remain independent at home and improved patient flow across the wider system. Whilst further work remains to fully realise the programme's long-term ambitions, these improvements have contributed to stronger operational performance and have established a solid foundation on which to build future neighbourhood health services. Recognition of this progress is reflected in the programme being shortlisted for the HSJ Awards 2026 in the Data Driven Transformation category.

We have now built on this partnership approach in other areas, working jointly with partners on our Outpatient Transformation programme, focussed initially on the development of a Single Point of Access for GPs into our specialties. This work will ensure that patients receive the right care in the right place, and that patients are only required to attend hospital for an appointment when absolutely necessary.

Looking ahead, partners are increasingly focused on how the locality can build on these foundations to support delivery of the Neighbourhood Health Framework and wider neighbourhood health reforms. This includes further development of integrated neighbourhood working, greater emphasis on prevention and proactive care, and continued collaboration across organisational boundaries to improve outcomes and reduce health inequalities for the residents of Wigan Borough. WWL are working with other system partners and with an independent facilitator called Uncommon Ground to help shape the evolution of HWP to reflect this neighbourhood health focus.

Recommendation

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

Title of report:	Board Assurance Framework (BAF) 2026/27
Presented to:	Board of Directors
On:	07 October 2026
Item purpose:	Approval
Presented by:	Director of Corporate Governance
Prepared by:	Head of Risk Director of Corporate Governance
Contact details:	E: john.harrop@wwl.nhs.uk

Executive summary

The trust's key strategic risks to the achievement of the annual corporate objectives 2026/27 are presented here for the committee's review and approval.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations

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

Financial implications

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

Legal implications

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

People implications

There are four strategic people risks identified within this report.

Equality, diversity and inclusion implications

SR6: Anchor Institution and Health Inequalities includes equality, diversity and inclusion implications.

Which other groups have reviewed this report prior to its submission to the committee/board? Finance & Performance Committee People Committee, Executive Team Meeting (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 The Board Assurance Framework (BAF) provides a robust foundation to support the understanding and management of the strategic risks that may impact the delivery of Our Strategy 2030 and the annual corporate objectives.

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

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

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

2. BAF Review

2.1 The trust's key strategic risks to the achievement of the corporate objectives 2026/27 are presented here for approval. The BAF is included in this report with detailed drill-down reports into each risk.

2.2 **Patients:** There are currently three patient focussed strategic risks. The risks were reviewed and updated at the Q&S Committee meeting on 09 September 2026

2.3 **People:** There was previously one people focussed strategic risk. The people risks were reviewed and updated at the People Committee meeting on 15 September 2026 and it is proposed to add four new risks to replace this one. These are included in the BAF document.

2.4 **Finance and Performance:** There are now four finance and performance focussed strategic risks as a cyber security strategic risk has been added, this was agreed by Finance & Performance Committee on 30 September 2026.

2.5 **Partnership:** There is currently one partnership focussed strategic risk. The risk has been reviewed and updated for approval by the Board.

3. New Risks Recommended for Inclusion to the BAF

There are four new risks and one updated risk for approval by the Board. Four of these risks are people focussed risks and one risk is a performance focussed risk.

- PR4 - Workforce Advocacy, Engagement and Reputation
- PR5 - Workforce Burnout and Patient Safety
- PR6 - Anchor Institution and Health Inequalities
- PR7 - Developing a Productive, Affordable and Sustainable Workforce Model (risk updated)
- PR11 - Cyber Security and Digital Resilience

4. Review Date

4.1 The BAF is reviewed bi-monthly by the Board. The next review is scheduled for December 2026.

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

2026/27

The content of this report was last reviewed as follows:

Board of Directors	August 2026
Finance and Performance Committee:	September 2026
People Committee	September 2026
Quality and Safety Committee	September 2026
Executive Team:	October 2026

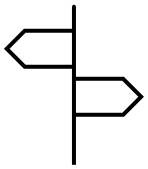


“ **assurance** (/əˈʃɔːrəns/) *noun*

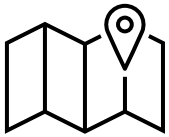
The process by which a board of directors gains confidence in the organisation's governance, risk management, and internal control frameworks. It involves evaluating the effectiveness of these frameworks and identifying areas that need improvement to ensure the organisation achieves its objectives. ”

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

How the Board Assurance Framework fits in



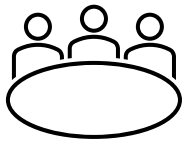
Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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



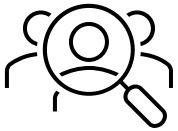
Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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



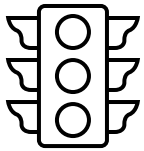
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have 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, Senior Information Risk Owner (SIRO)
CFO:	Chief Finance Officer	CPO:	Chief People Officer
CN:	Chief Nursing Officer	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 and Corporate Objectives 2026/27



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

Our ambition is 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

Our ambition is to ensure wellbeing and motivation at work and to minimise workplace stress

- To make WWL a great and inclusive place to work, ensuring that our staff feel safe, engaged, empowered and valued

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

- To foster a sustainable, efficient and productive financial environment
- To drive improvements in our overall performance, placing patients at the centre of everything we do
- To optimise delivery of our elective and non-elective services

Our ambition is to improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

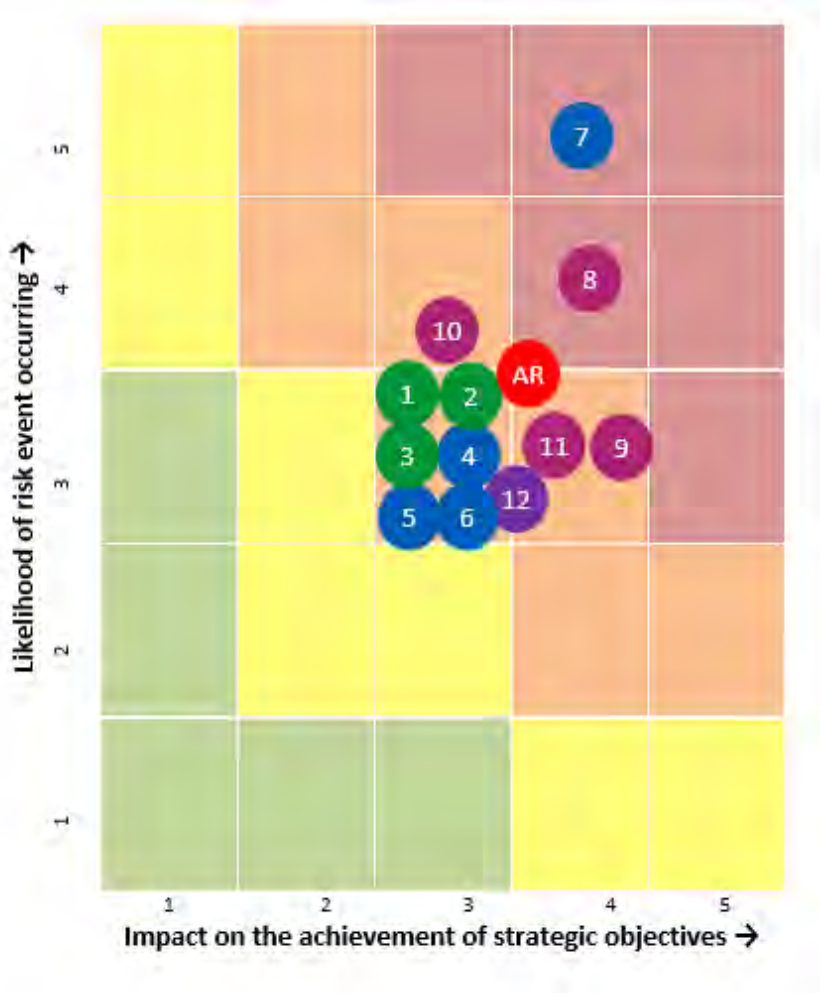
- To strengthen existing and develop new partnerships at place, system and wider network level in response to NHS reforms – supporting our NHS services and research activities

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
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**

The heat map below shows the distribution of all 12 strategic principal risks based on their current scores:



WWL Board Assurance Framework
September 2026

Corporate Objectives

CO1	CO2	CO3	CO4	CO4	CO4	CO4	CO5	CO6	CO7	CO7	CO8

Principal Risks

PR1	PR2	PR3	PR4	PR5	PR6	PR7	PR8	PR9	PR10	PR11	PR12
Quality of Care	**Patient Experience**	**Early Detection and intervention, preventing avoidable ill-health**	**Workforce Advocacy, Engagement and Reputation**	**Workforce Burnout and Patient Safety**	**Anchor Institution and Health Inequalities**	**Developing a Productive, Affordable and Sustainable Workforce Model**	**Delivery of the Financial Recover Strategy**	**Performance**	**Optimise delivery of our performance**	**Cyber Security and Digital Resilience**	**Partnership working**
Current Score **3** (L) **x 3** (I) = **9**	Current Score **3** (L) **x 3** (I) = **9**	Current Score **3** (L) **x 3** (I) = **9**	Current Score **3** (L) **x 3** (I) = **9**	Current Score **3** (L) **x 3** (I) = **9**	Current Score **3** (L) **x 3** (I) = **9**	Current Score **5** (L) **x 4** (I) = **20**	Current Score **4** (L) **x 4** (I) = **16**	Current Score **4** (L) **x 3** (I) = **12**	Current Score **4** (L) **x 3** (I) = **12**	Current Score **3** (L) **x 4** (I) = **12**	Current Score **3** (L) **x 3** (I) = **9**
Trend **Stable** ⇔	Trend **Stable** ⇔	Trend **Stable** ⇔	Trend **Stable** **NEW**	Trend **Stable** **NEW**	Trend **Stable** **NEW**	Trend **Deteriorating** **NEW**	Trend **Deteriorating** ⇔	Trend **Stable** ⇔	Trend **Stable** ⇔	Trend **Stable** **NEW**	Trend **Stable** ⇔
Year End Target **2** (L) **x 3** (I) = **6**	Year End Target **2** (L) **x 3** (I) = **6**	Year End Target **2** (L) **x 3** (I) = **6**	Year End Target **2** (L) **x 3** (I) = **6**	Year End Target **2** (L) **x 3** (I) = **6**	Year End Target **2** (L) **x 3** (I) = **6**	Year End Target **2** (L) **x 4** (I) = **8**	Year End Target **2** (L) **x 4** (I) = **8**	Year End Target **2** (L) **x 2** (I) = **4**	Year End Target **6** (L) **x 3** (I) = **6**	Year End Target **3** (L) **x 3** (I) = **9**	Year End Target **2** (L) **x 3** (I) = **6**
Final Target Score **6** (2030)	Final Target Score **6** (2030)	Final Target Score **6** (2030)	Final Target Score **6** (2030)	Final Target Score **6** (2030)	Final Target Score **6** (2030)	Final Target Score **6** (2030)	Final Target Score **6** (2030)	Final Target Score **4** (2030)	Final Target Score **6** (2030)	Final Target Score **6** (2030)	Final Target Score **4** (2030)
Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Open to Eager	Risk Appetite: Open to Eager	Risk Appetite: Open to Eager	Risk Appetite: Open to Eager	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open

Patients

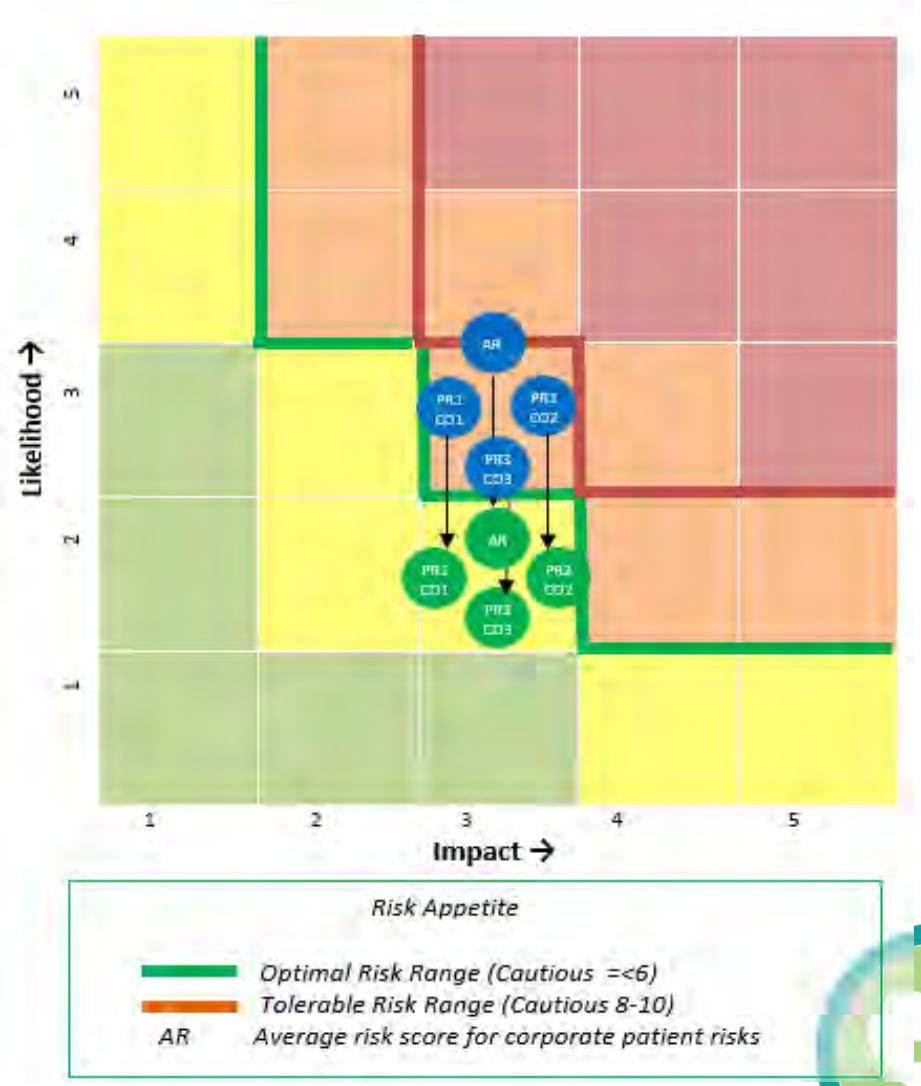
To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

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

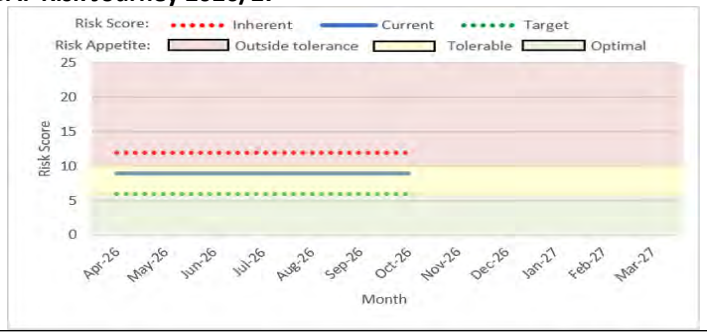
Ref.	Purpose of the objective	Scope and focus of objective
CO1	To improve the quality of care for our patients and residents.	• To reduce harm through the application of Internal Professional Standards – ensuring we get the right patients to the right ward/speciality, within the right time for patients presenting with heart attack, acute abdomen, stroke or fractured neck of femur. • 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.
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 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.
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 in 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

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 2026/27		
BAF RISK PR 1: Quality of Care There is a risk that patients are not being admitted to the right place at the right time, due to the patient flow transformation programmes not delivering will increase the risk of harm to patients. There is a risk that the inability to manage the care of frail elderly patients across the borough, due to increased elderly population and pace at which system wide transformation is required, may result in frail elderly patients being cared for in suboptimal areas increasing the risk of harm and poor patient experience.	**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:	01.04.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q1				26/27 Target	Risk Appetite
	9	9	9				6	6-10
	3x3	3x3	3x3				2x3	
	LxC	LxC	LxC				LxC	
Risk Appetite	Within	Within	Within				Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q2 is 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 Q3: Deteriorating
Stable
Improving

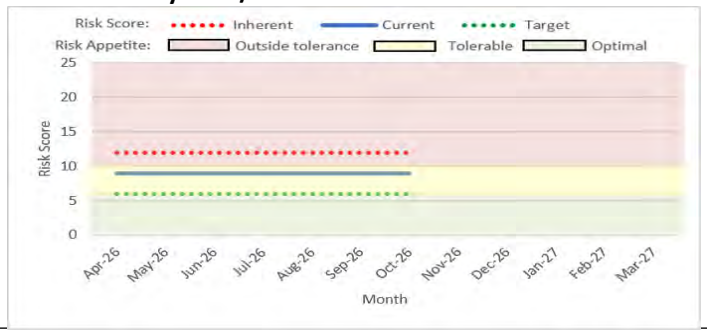
Rationale: Stable
Risk score is a stable 9.

CONTROLS →	ASSURANCES →	EVIDENCE
• **Right Patient, right ward:** Defined as a corporate objective for 2026/27, supported by clear improvement actions, strengthened clinical leadership of site and bed management, and ongoing monitoring through the Committee workplan.	• 2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – May 2026
• **Patient Safety Incident Response (PSIRF):** PSIRF is operating effectively, with proportionate investigation approaches, earlier learning through rapid reviews and after action reviews, and strengthened governance through established patient safety oversight arrangements.	•2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – May 2026
• **Martha's Rule**: Implemented across adult inpatient wards, with clear staff and patient escalation routes in place, emerging learning identified, and further rollout	•2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – May 2026

actions defined targeted at reducing variation between wards.					
• **Maternity safety standards (Ockenden/CNST):** Compliance with maternity safety standards, including oversight through the maternity dashboard, learning from complaints, and continued progress against Ockenden and CNST (Maternity Incentive Scheme) requirements.	•2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – May 2026			
• **CQC oversight:** Alignment between regulatory intelligence and internal assurance through committee scrutiny.	•3rd Line / External – CQC	Quality and Safety Committee AAA Report – May 2026			
• **Incident response and investigation:** policies, procedures and processes in place.	• 2nd Line – SAFEty Meeting – Daily • 2nd Line – LFPSE Meeting – Weekly • 2nd Line – Safety, Quality, Assurance Group - Monthly	Daily Safety Log LFPSE Minutes Safety, Quality, Assurance Group AAA Report			
Gaps in Controls / Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Right Patient, right ward: Low baseline position, particularly within specialist pathways including stroke and fractured neck of femur.	Clear improvements actions and ongoing monitoring through the Committee workplan. Sustained focus ahead of winter pressures with continued scrutiny by the Committee and further triangulation of outcome measures to strengthen assurance.	CNO	31.03.27	Q&S Committee	Action underway
Sepsis Performance: Continued under-performance against key sepsis measures, including timely blood culture collection and appropriate care scores, recognising the associated patient safety risk and the need for sustained improvement.	Non-compliance with Sepsis Six pathway risk added to corporate risk register with action plan implemented.	CNO	31.03.27	Q&S Committee / People Committee	Action underway
Deteriorating patients: Continues to feature as a recurring theme across PSIRF reporting and wider quality intelligence.	Ongoing focus and oversight on deteriorating patients required.	CNO	31.03.27	Q&S Committee / People Committee	Action underway

BOARD ASSURANCE FRAMEWORK 2026/27		
BAF RISK PR 2: Patient Experience There is a risk that an inability to transform services which meet the expectations of our population, due to us not always listening to our patient voice and mechanisms, may result in inequitable patient experience and care at an individual level.	**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:	01.04.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
	9	9	9			6	6-10
	3x3	3x3	3x3			2x3	
	LxC	LxC	LxC			LxC	
Risk Appetite	Within	Within	Within			Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q1 is 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 Q3: Deteriorating
Stable
Improving

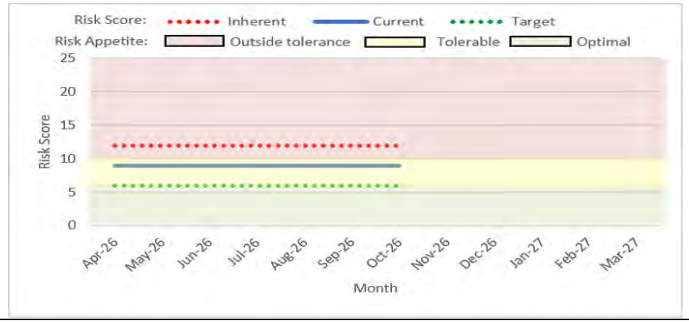
Rationale: Stable
Risk score is a stable 9.

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 Quality, Safety and Assurance Group – monthly • 2nd Line - Quality and Safety Committee – bi-monthly	Quality and Safety Committee AAA Report – May 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. • Senior Leadership walkabouts triangulate any complaints themes which have been noted.	• Complaints report – quarterly • Patient Experience and Engagement Group – quarterly	Complaints annual report Weekly Complaints Report for LFPSE meeting.

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
• **Patient Safety and litigation:** 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.	Work to be undertaken to strengthen triangulation between PSIRF, learning and clinical	CNO	31.03.27	Q&S Committee	Action underway
• **Patient Experience and Engagement Group:** Complaints and PALS data notes underrepresented patient voices within our communities.	National Oversight Framework action plans that underpin the patient safety domain.	CNO	31.03.27	Q&S Committee	Action underway

BOARD ASSURANCE FRAMEWORK 2026/27		
BAF RISK PR 3: Early Detection and intervention, preventing avoidable ill-health There is a risk that a lack of system wide engagement with preventing ill health agenda, due to worsened health inequalities, may result in poor health population reliant on acute care.	**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:	01.04.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
	9	9	9			6	6-10
	3x3	3x3	3x3			2x3	
	LxC	LxC	LxC			LxC	
Risk Appetite	Within	Within	Within			Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score at Q2 is 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 Q3: Deteriorating
Stable
Improving

Rationale: Stable
Risk score is a stable 9.

CONTROLS →	ASSURANCES →	EVIDENCE
• **Cancer Care:** Harm reviews for patients breaching the 104-day standard are in place on a sampled basis, subject to Greater Manchester oversight, and that no clinical harm has been identified through reviews completed to date.	• 2nd Line - Quality and Safety Committee- bi-monthly	Quality and Safety Committee AAA Report – May 2026

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Cancer care – 104 day breaches: Potential psychological and mental wellbeing harm associated with prolonged waits for cancer treatment, noting that current harm reviews focus on clinical harm and do not routinely capture psychological impact.	Wording in reports to be clarified to reflect 'no clinical harm identified', and that enhanced divisional deep-dive reviews, including equality considerations, will strengthen assurance.	CNO	31.03.27	Q&S Committee / People Committee	Action underway

People

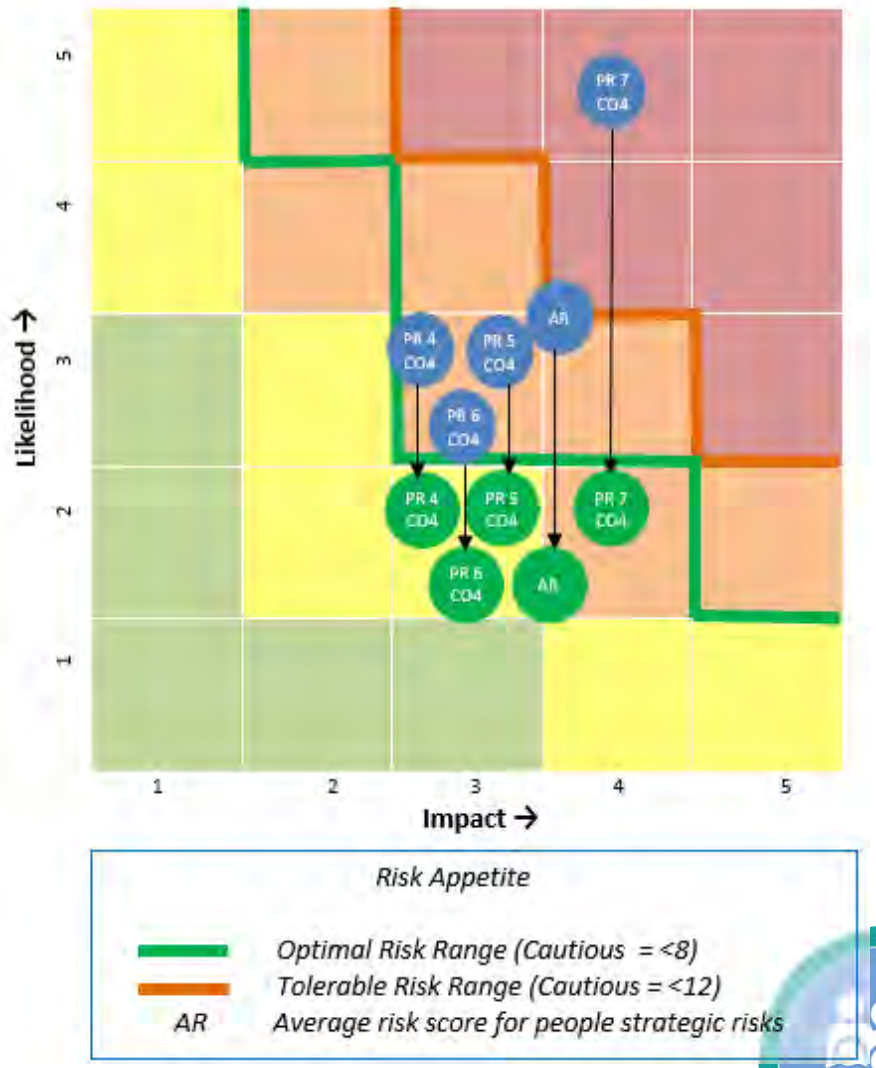
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

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

Ref.	Purpose of the objective	Scope and focus of objective
CO4	Make WWL a great place and inclusive place to work, ensuring that our staff feel safe, engaged, empowered and valued	• Develop compassionate, capable and accountable leaders who are visible, listen to colleagues, act on feedback and create psychologically safe, inclusive teams. • Improve colleague advocacy, engagement and organisational reputation by strengthening staff voice, speaking up, recognition, listening and visible follow-through. • Support colleagues to remain well, safe and in work through a workability approach, early intervention, flexible working, wellbeing support and action to reduce burnout and fatigue. • Strengthen staff safety, including prevention of and response to violence, aggression, harassment, discrimination and staff harm. • Improve working lives for the whole workforce, including targeted action for priority groups such as resident doctors where experience, wellbeing or retention requires additional focus. • Advance equality, diversity, inclusion and anti-racism by reducing systemic bias, improving workforce equity, strengthening lived experience insight and raising the voices of under-represented colleagues. • Work with Progress with Unity partners to strengthen WWL's role as an anchor institution, supporting local people into employment, improving social mobility and contributing to the reduction of health inequalities. • Develop a productive, affordable and sustainable workforce model that supports transformation, improves workforce productivity, reduces reliance on high-cost staffing and aligns with the NHS 10 Year Plan. • Enhance learning, development, talent and succession opportunities through accessible, flexible training, inclusive career pathways and stronger partnerships with local organisations. • Use an Integrated People Performance Report to provide triangulated assurance across workforce, finance, quality, safety, staff experience, inclusion, wellbeing, productivity and transformation outcomes.

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 2026/27

BAF RISK SR4: Workforce Advocacy, Engagement and Reputation

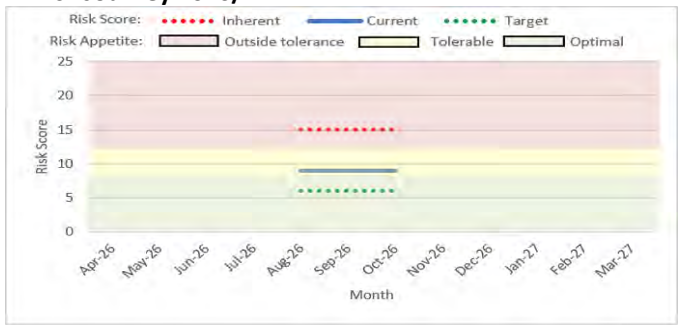
1. Workforce Advocacy, Engagement and Reputation

There is a risk that colleague advocacy and engagement declines, caused by reduced psychological safety, lack of confidence that staff voice is heard and acted upon, and limited career progression opportunities, leading to reduced attraction and retention of talent (vacancy & turnover rates) and a decline in the Trust's reputation as an employer of choice i.e. staff recommending WWL as a place to work.

Note: NHS Staff Survey advocacy, engagement and speak up sub-scores highly likely to feature in 2026/27 NOF

Executive Director Lead:	CPO
Strategic Aim:	C04: Make WWL a great place and inclusive place to work, ensuring that our staff feel safe, engaged, empowered and valued
Risk Category:	Staff Capacity & Capability, Staff Engagement
Risk Opened:	15.09.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
		9	9			6	8-12
		3x3	3x3			2x3	
		LxC	LxC			LxC	
Risk Appetite		Within	Within			Within	

RATIONALE FOR CURRENT RISK SCORE:

The score remains at 9 because controls are in place, but the assurance is not yet mature enough to evidence sustained improvement in advocacy, engagement, psychological safety and reputation.

Projected Forecast Q3: Deteriorating / Stable / Improving

Rationale: Stable

Risk score is a stable 9.

CONTROLS →	ASSURANCES →	EVIDENCE
Integrated People Performance Report providing triangulated assurance across workforce, finance, quality, safety, staff experience, inclusion, wellbeing, productivity and transformation measures.		
Three-year Staff Survey improvement programme, including divisional improvement plans and agreed advocacy, engagement and morale trajectories.	People Committee receives regular assurance reports on Staff Survey feedback, mapped to NHS People Promise themes and NHS Staff Standards. Executive Team and Wider Leadership Team review high-level Trust-wide and divisional scores and improvement priorities.	Staff Survey reports, NHS People Promise and NHS Staff Standards mapping, Trust-wide and divisional score reports, People Committee papers, Executive Team updates, Wider Leadership Team updates and improvement action plans.
Freedom to Speak Up and staff voice framework, including Guardian reporting, thematic review and feedback loops.	FTSU Guardian reporting to People Committee and Board is not yet fully operating as a regular assurance route, with a gap reported in Q1 and Q2. Interim assurance is through staff voice, Staff Survey and Executive Team review of speaking-up themes where available.	Available FTSU themes, Staff Survey speaking-up indicators, staff voice feedback and records of escalation or improvement actions. Formal Q1 and Q2 FTSU Guardian reports remain a gap in assurance.

Colleague Working Lives Improvement Programme, including targeted engagement with priority workforce groups such as resident doctors, developed through Board, Executive and colleague engagement.	Executive Team and relevant senior leadership routes review progress on improving working lives, including priority colleague groups and resident doctor working lives. Progress is aligned to wider staff advocacy, engagement, retention and workforce experience improvement.	Colleague Working Lives action plans, resident doctor action plan updates, engagement outputs, Staff Survey and Pulse indicators, retention and morale data, and evidence of actions completed or escalated.
Listening into Action methodology to strengthen organisational listening, co-design and visible response to colleague feedback.	This is an emerging assurance route. The absence of a mature Divisional Assurance process for organisational listening is a material gap, particularly following management of change that reduced four divisions into two.	Listening into Action outputs, colleague feedback themes, engagement records and early action logs. Evidence of systematic divisional listening, closed-loop feedback and measurable improvement remains a gap.
Staff safety framework, including prevention and response arrangements for violence, aggression, harassment, discrimination and staff harm.	Assurance on the staff safety framework is not yet sufficiently mature or triangulated for this BAF risk. This should be treated as a gap in assurance until regular reporting on staff harm, violence and aggression, harassment, discrimination and learning is established.	Datix Staff Harm data, violence and aggression information, Staff Survey safety indicators and incident learning are available in parts, but there is not yet a clear integrated assurance report demonstrating themes, actions, learning and impact.
Colleague Concern Meeting(s) providing senior oversight of complex colleague concerns, employee relations, conduct, capability, professional practice, patient safety links, cultural learning themes and medical workforce concerns within a single whole-workforce governance approach.	Current assurance is partial. Doctor Concern Meeting reporting is provided to People Committee through the AAA report, but timeliness data, thematic reporting and evidence of learning remain gaps. The non-medical Colleague Concern Meeting will stand up in September 2026 and report through AAA to People Committee for the first time in November 2026, Q3.	Doctor Concern Meeting AAA reports, available case logs and escalation records. Non-medical Colleague Concern Meeting terms of reference, reporting template, case log, thematic reports, timeliness data and evidence of learning are expected to develop during Q3.
Board and Executive engagement programme to support visible leadership, psychological safety and direct colleague feedback	Board and Executive engagement provides direct senior listening and visibility of colleague experience, with themes escalated through Executive Team and relevant governance routes.	Board and Executive engagement schedules, feedback themes, action logs, escalation records and communications confirming action taken in response to colleague feedback.
Board and Executive succession planning programme, including Remuneration Committee oversight.	Remuneration Committee oversight of Board succession planning, with Executive Team review of wider senior leadership resilience, succession risk and leadership continuity.	Remuneration Committee papers, Board succession review outputs, Executive Team succession discussions, senior leadership talent information and agreed actions arising from the succession review.
Leadership standards implementation framework aligned to NHS leadership expectations and the Trust's compassionate leadership approach.	People Committee and Executive Team receive assurance on implementation of leadership standards, compassionate leadership development and links to culture, advocacy and inclusion improvement.	Leadership standards implementation plan, leadership development participation, appraisal and talent data, Staff Survey and Pulse indicators on leadership, line management, compassion and inclusion, and evidence of targeted leadership interventions.

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
· Limited evidence that colleague feedback consistently leads to measurable organisational improvement and visible "you said, we did" outcomes across the whole workforce, despite regular Staff Survey assurance to People Committee, Executive Team and Wider Leadership Team. · Divisional Assurance arrangements for staff voice, listening, culture and advocacy are not yet sufficiently mature, particularly following the management of change from four divisions into two.	Establish an integrated organisational listening framework, including divisional listening arrangements, clear feedback loops, thematic learning and evidence of action taken.	CPO	Q3 2026/27	People Committee	In development; should address the post-management-of-change divisional listening gap and provide evidence of closed-loop colleague feedback.
· Weak triangulation between Staff Survey, Pulse, FTSU, employee relations, Datix Staff Harm, staff safety, Colleague Concern Meeting(s), retention, vacancy, turnover and sickness information. · FTSU Guardian reporting has been a gap in Q1 and Q2, limiting the Committee's ability to triangulate formal speaking-up assurance with Staff Survey, ER and staff safety intelligence.	Develop a staff advocacy recovery trajectory for the whole workforce, using Staff Survey, Pulse, FTSU, retention, colleague concern and staff safety intelligence.	DCA/CFO/CPO	Q3 2026/27	People Committee	Trajectory to be agreed and aligned to 2026 Staff Survey improvement planning, NHS People Promise themes and NHS Staff Standards.
· Staff safety and Colleague Concern Meeting(s) are material gaps in assurance: Doctor Concern Meeting reports are provided through the AAA report, but timeliness, thematic review and evidence of learning require strengthening; the non-medical Colleague Concern Meeting stands up in September 2026 and will report via AAA to People Committee for the first time in November 2026, Q3.	Integrate FTSU, Datix Staff Harm, employee relations, staff safety and Colleague Concern Meeting(s) reporting to strengthen triangulation, thematic learning and escalation of whole-workforce cultural risks.	CPO / CN / CMO	Q4 2026/27	People Committee	Reporting model to be developed. Doctor Concern Meeting to strengthen timeliness, themes and learning; non-medical Colleague Concern Meeting to report through AAA to People Committee for the first time in November 2026, Q3.

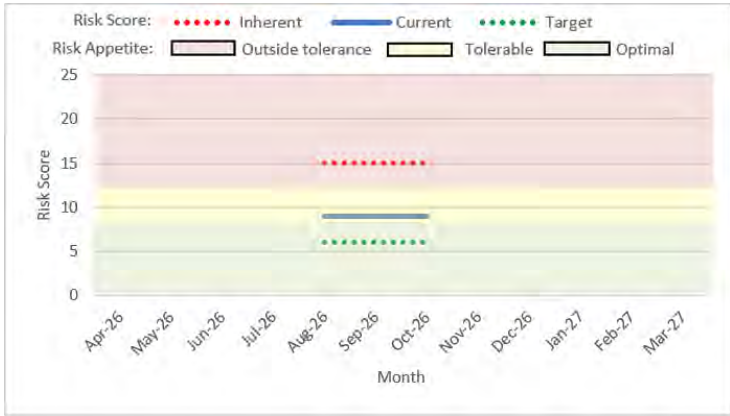
BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK SR5: Workforce Burnout and Patient Safety

There is a risk that colleagues experience burnout and fatigue, caused by sustained operational and financial pressures and workforce shortages, leading to increased sickness absence and turnover, compromised safe staffing levels, and reduction in patient safety and quality of care.
Note: WWL sickness target 5% and aligned with MTP guidance

Executive Director Lead:	CPO
Strategic Aim:	C04: Make WWL a great place and inclusive place to work, ensuring that our staff feel safe, engaged, empowered and valued
Risk Category:	Staff Capacity & Capability, Staff Engagement
Risk Opened:	15.09.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
		9	9			6	8-12
		3x3	3x3			2x3	
		LxC	LxC			LxC	
Risk Appetite		**Within**	**Within**			**Within**	

RATIONALE FOR CURRENT RISK SCORE:
The risk score remains at 9 because controls are in place across sickness absence, workability, wellbeing, safe staffing and early intervention. However, assurance is not yet sufficiently mature to demonstrate that these controls are consistently reducing burnout, improving workability, protecting patient safety or improving workforce productivity. The key assurance gap is the lack of triangulated intelligence linking colleague wellbeing, workforce availability, safe staffing, patient safety and productivity.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Stable
Risk score is a stable 9.

CONTROLS →	ASSURANCES →	EVIDENCE

Integrated People Performance Report providing triangulated assurance across workforce, finance, quality, safety, staff experience, inclusion, wellbeing, productivity and transformation measures.

· Workability Framework aligned to the Keep Britain Working methodology. · Workforce health and wellbeing programme, including Occupational Health, EAP, psychological support and early intervention. · Early intervention absence arrangements, including return-to-work, reasonable adjustments and case management.	· People Committee receives assurance on sickness absence, workability, wellbeing, staff experience and progress against the 5% sickness target. · Executive Team reviews Trust-wide and divisional workforce health, attendance, safe staffing and productivity risks.	· Sickness absence data against the 5% target, including stress, anxiety, depression and musculoskeletal absence. · Long-term and short-term absence trends. · Occupational Health referral volumes, themes, timeliness and outcomes. · EAP and wellbeing support usage, themes and uptake where available.

· Flexible working framework to support retention, workability and sustainable attendance. · Colleague Working Lives Improvement Programme, including resident doctor wellbeing and experience priorities. · Safe staffing triangulation using workforce, quality, acuity, rostering and patient safety intelligence. · Workforce hotspot review process for areas with high sickness, turnover, vacancy, staff harm or safe staffing pressures. · Manager capability programme for compassionate absence, workability, wellbeing and psychological safety conversations. · Psychological safety and speaking-up programme linked to burnout, fatigue and patient safety learning. · Workforce productivity and wellbeing improvement approach to link workforce health interventions with productivity, affordability and quality outcomes.	· Wider Leadership Team reviews workforce pressures, high-risk hotspots and divisional improvement priorities. · Safe staffing assurance is provided through established quality and nursing governance routes and triangulated with workforce data where available. · Occupational Health and wellbeing services provide operational assurance on demand, timeliness, themes and intervention uptake. · Finance and workforce routes review the impact of sickness absence, vacancies and turnover on bank, agency and productivity. · Staff-side and partnership forums provide colleague feedback on workability, workplace pressures and wellbeing interventions. · Assurance on the impact of burnout and fatigue interventions remains developing and should be strengthened through the proposed wellbeing dashboard and burnout metrics.	· Return-to-work completion, reasonable adjustment and case management data. · Staff Survey and Pulse indicators relating to burnout, workload, morale, health and wellbeing, line management and engagement. · Safe staffing reports, fill rates, acuity, roster gaps, escalation records and temporary staffing usage. · Patient safety and quality indicators where staffing, fatigue or workforce pressures are contributory factors. · Turnover, vacancy, retention, redeployment and flexible working data. · Bank, agency and overtime usage linked to sickness absence, staffing gaps and workforce hotspot areas. · Resident doctor working lives, wellbeing and experience indicators, once embedded into routine assurance. · Evidence of actions completed, hotspots improved and interventions adjusted following learning.

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Limited evidence that current wellbeing, workability and absence interventions are reducing burnout and fatigue, rather than only managing sickness absence.	Implement a workability maturity assessment to assess how consistently workability principles are embedded across divisions and identify priority improvement areas.	CPO / DCEO/COO/CFO	Q3 2026/27	People Committee / Divisional Assurance / Wider Leadership Team	In development; will provide a maturity baseline and identify priority improvements for workability, early intervention and manager capability.
Weak triangulation between wellbeing, sickness absence, staff experience, safe staffing, patient safety, turnover, vacancy and productivity data.	Establish a workforce wellbeing dashboard bringing together sickness, wellbeing, Occupational Health, staff experience, productivity and workforce cost indicators.	CPO / CFO	Q3 2026/27	People Committee / Divisional Assurance / Wider Leadership Team	In development; dashboard to support routine triangulation of wellbeing, workability, absence, productivity and safety intelligence.

Manager capability remains inconsistent in relation to compassionate absence management, workability, reasonable adjustments and psychological safety.	Introduce burnout and fatigue metrics to strengthen the link between workforce wellbeing, safe staffing, patient safety, staff experience and productivity.	CPO / CN / CFO	Q4 2026/27	People Committee / Quality Governance/ Divisional Assurance / Wider Leadership Team	Metrics to be defined with Finance, Nursing, People Analytics and Quality colleagues and incorporated into the workforce wellbeing dashboard.
Limited productivity measures linked to wellbeing, workability and absence interventions.	Triangulate sickness, safety and turnover intelligence to support proactive identification of workforce hotspots and targeted intervention.	People Analytics / Digital Team	Q4 2026/27	People Committee / Divisional Assurance / Wider Leadership Team	Data model to be developed with digital and analytics colleagues so workforce, safety, turnover and absence intelligence can be reviewed together.
Resident doctor wellbeing and experience indicators are not yet embedded into routine workforce and patient safety assurance	Embed resident doctor wellbeing and experience indicators into routine workforce and patient safety assurance, including quarterly review of the action plan and escalation of barriers.	CMO / CPO	Q3 2026/27	Executive Team / People Committee/ Resident Doctors 10-point plan meeting	Action plan reporting to be aligned with Colleague Working Lives and linked to routine wellbeing and safe staffing assurance.
Divisional workforce hotspot review arrangements require strengthening to support proactive intervention and Board-level visibility of high-risk areas.	Review high-risk workforce hotspots quarterly where there are combined pressures across sickness, turnover, vacancy, staff harm, safe staffing, patient safety or productivity.	Wider Leadership Team / Divisional Leadership	Quarterly from Q3 2026/27	Executive Team / People Committee	Quarterly hotspot review process to be established and aligned to divisional assurance, workforce analytics and patient safety escalation routes.
The Trust does not yet have a mature workforce wellbeing dashboard that brings together health, workability, productivity and patient safety intelligence.					

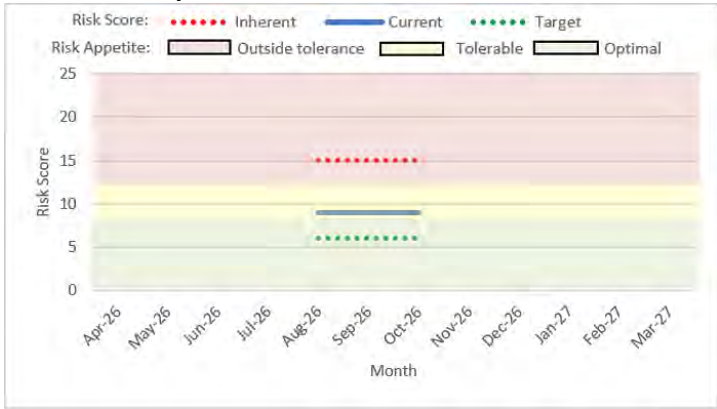
BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK SR6: Anchor Institution and Health Inequalities

There is a risk that the Trust does not fully realise its role as an anchor institution in addressing health inequalities, caused by barriers to employment for disadvantaged groups, systemic bias in workforce processes, and underutilisation of local talent, leading to continued health inequalities, increased demand on services, and poorer patient outcomes.
Note: Aligns with ICB Good Employment risk

Executive Director Lead:	CPO
Strategic Aim:	C04: Make WWL a great place and inclusive place to work, ensuring that our staff feel safe, engaged, empowered and valued
Risk Category:	Staff Capacity & Capability, Staff Engagement
Risk Opened:	15.09.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
		9	9			6	8-12
		3x3	3x3			2x3	
		LxC	LxC			LxC	
Risk Appetite		Within	Within			Within	

RATIONALE FOR CURRENT RISK SCORE:
The risk score remains at 9 because the Trust has established controls for EDI, anchor institution work, workforce inequalities reporting and staff network engagement. However, assurance is not yet sufficiently mature to demonstrate that these controls are consistently reducing workforce inequalities, improving social mobility, strengthening anti-racism practice or evidencing the health inequality impact of workforce redesign and transformation programmes.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Stable
Risk score is a stable 9.

CONTROLS →	ASSURANCES →	EVIDENCE

Integrated People Performance Report providing triangulated assurance across workforce, finance, quality, safety, staff experience, inclusion, wellbeing, productivity and transformation measures.

· EDI Strategy Group providing whole-organisation oversight of EDI priorities, workforce inequalities, staff network insight and delivery of the Trust's inclusion ambitions. · Health inequalities assessment framework to strengthen consideration of workforce, patient and	· People Committee receives assurance on EDI, workforce inequalities, Staff Survey inclusion indicators, WRES, WDES, Gender Pay Gap and delivery of inclusion priorities. · EDI Strategy Group provides oversight of delivery, staff network insight, lived experience feedback and areas requiring executive escalation.	· EDI Strategy Group papers, minutes, action logs and escalation records. · WRES, WDES, Gender Pay Gap, Staff Survey inclusion indicators and workforce inequalities dashboard reports. · EDI and health inequalities assessments for transformation schemes, workforce redesign, organisational change and business cases.

population impact in major change, transformation and business case approvals. · Mandatory EDI and health inequalities assessment gateway for transformation, workforce redesign and significant organisational change programmes. · Inclusive recruitment framework, including widening participation, local employment access and reduction of bias in attraction, selection and appointment processes. · Inclusive talent and succession programme to support fair progression, leadership diversity and stronger internal pipelines. · Workforce inequalities dashboard and equity scorecard to monitor variation by protected characteristic, staff group, band, division and employment outcome. · Staff networks and lived experience review mechanism to inform policy, workforce redesign, transformation and culture improvement. · Anchor institution workforce strategy to strengthen local employment, social mobility, skills development and partnership contribution to reducing health inequalities. · Staff networks, EDI Strategy Group and lived experience routes. · Social value and procurement approach supporting local employment and skills. · Workforce inequalities dashboard and hotspot review process. · Governance through People Committee, Transformation Board and business case approval routes.	· Executive Team, Transformation Board and business case approval routes review whether major change programmes include EDI and health inequalities assessment. · Assurance remains stronger on reporting variation than on demonstrating sustained reduction in inequality, social mobility impact or anti-racism implementation maturity. · ICB/system reporting on Good Employment and anchor institution contribution. · Divisional Assurance Meeting scrutiny of recruitment, retention, progression and workforce equality metrics. · Staff network and partnership forum feedback. · Workforce dashboard reporting by protected characteristic and, where available, local employment indicators. · Internal audit or external review of EDI, recruitment, workforce transformation or equality impact processes, if available.	· Recruitment, appointment, promotion, talent, disciplinary, grievance, turnover and retention data by protected characteristic, band, staff group and division. · Staff network feedback, lived experience themes and evidence of changes made following colleague insight. · Local employment, apprenticeship, volunteering, work experience, supported employment and widening participation data, where available. · Local recruitment and widening participation data, where available. · Staff Survey and Pulse results relating to discrimination, inclusion, belonging and equal opportunities. · Staff network feedback and lived experience themes. · Evidence of changes made to workforce policies or processes following equality review. · Social value/procurement evidence linked to local employment or skills. · ICB Good Employment reporting and system partnership outputs.

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
· Good reporting of workforce inequalities, but weaker evidence that interventions are reducing inequity, systemic bias or health inequality impact. · Equality impact assessments and EDI/health inequalities assessments vary in quality and are not	Introduce mandatory EDI and health inequalities core gateway for major change programmes, workforce redesign, transformation and business case approvals.	CPO / CMO / CN	Q3 2026/27	Executive Team / Transformation Board / People Committee	Gateway to be embedded into major change documentation and approval routes, with quality review of

yet consistently used as a gateway for major change decisions. · Limited measurement of social mobility outcomes, local employment access and anchor institution workforce impact. · Organisational capability for anti-racism implementation requires strengthening, including evidence of sustained behaviour, policy and outcome change. · Workforce redesign and transformation programmes do not yet consistently evidence their impact on health inequalities, workforce equity or local employment outcomes. · Need to strengthen evidence that interventions are reducing systemic bias, not simply reporting workforce inequalities. · Need for clearer governance link between WWL's anchor institution role and the ICB Good Employment risk.					completed assessments.
	Establish a workforce equity scorecard to show variation, improvement trajectories and priority action across recruitment, progression, employee relations, retention and colleague experience.	CEO / CPO / EDI Strategy Group	Q3 2026/27	People Committee / EDI Strategy Group	Scorecard to be developed from existing workforce inequalities data and used to evidence reduction, not only reporting of variation.
	Create an annual inequality reduction plan, prioritising the areas where the Trust has the greatest workforce inequality, social mobility or health inequality opportunity.	CEO / CPO / EDI Strategy Group	Q4 2026/27	People Committee / EDI Strategy Group	Plan to define priority inequality reduction measures, improvement trajectories, owners and reporting route.
	Embed a lived experience review requirement for major workforce redesign, policy change and transformation schemes.	CEO / CPO / EDI Strategy Group	Q4 2026/27	Transformation Board / People Committee / EDI Strategy Group	Requirement to be incorporated into EDI/health inequalities gateway and staff network engagement approach.

	Link anchor institution workforce metrics to Board reporting, including local employment, widening participation, social mobility, workforce equity and contribution to the ICB Good Employment risk.	CPO / DCEO / CFO	Q4 2026/27	Board / People Committee / ICB reporting	Metrics to be aligned to Board reporting cycle and system Good Employment reporting so anchor institution contribution is visible and measurable.

BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK SR7: Developing a Productive, Affordable and Sustainable Workforce Model

There is a risk that the Trust does not develop a productive, affordable and sustainable workforce model, caused by incomplete delivery of recurrent workforce savings, ongoing demand pressures, limited productivity measures, weak triangulation between quality, finance and workforce outcomes, and unwarranted variation in pay costs, particularly within the medical workforce, leading to continued reliance on higher-cost staffing, inability to demonstrate recurring savings through redesign, and increased cost within a constrained provider and system context.
Note: reframed from delivering workforce reductions to developing a productive, affordable and sustainable workforce model, aligned to national workforce productivity and financial sustainability expectations.

Executive Director Lead:	CFO / CPO
Strategic Aim:	C04: Make WWL a great place and inclusive place to work, ensuring that our staff feel safe, engaged, empowered and valued
Risk Category:	Financial Duties, Staff Capacity & Capability, Staff Engagement
Risk Opened:	15.09.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
		20	20			8	8-12
		5x4	5x4			2x4	
		LxC	LxC			LxC	
Risk Appetite	**Within**	**Within**	**Within**			**Within**	**Within**

RATIONALE FOR CURRENT RISK SCORE:
The current risk score remains at 20 because the Trust has material workforce savings, productivity and affordability requirements within a constrained provider and system context.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Deteriorating
Risk score is a significant 20.

CONTROLS →	ASSURANCES →	EVIDENCE
Integrated People Performance Report providing triangulated assurance across workforce, finance, quality, safety, staff experience, inclusion, wellbeing, productivity and transformation measures.		
Workforce Productivity Framework to define productivity measures, expected benefits, improvement trajectories and links to quality, safety, finance and colleague experience.	· Executive Team receives assurance on Trust-wide workforce productivity, affordability, pay run rate and delivery of workforce savings.	· Pay run rate, establishment, vacancy, bank, agency, overtime and variable pay data.
Establishment Control Group to maintain grip on funded establishment, workforce growth, vacancy approvals and affordable staffing models.	· Finance Improvement Group reviews pay, agency, bank, vacancy control, establishment and financial recovery trajectories.	· Workforce savings tracker and recurrent/non-recurrent savings analysis.
Vacancy Control Panel to ensure recruitment decisions are affordable, aligned to service need and consistent with workforce plans.	· Transformation Board reviews workforce redesign schemes, benefits realisation and alignment with transformation priorities.	· Establishment Control Group and Vacancy Control Panel decisions, logs and exception reports.
Integrated pay governance to review pay run rate, variable pay, agency, bank, overtime and workforce cost drivers.	· Establishment Control Group and Vacancy Control Panel provide operational grip on workforce growth, vacancy approvals and affordable staffing decisions.	· Finance Improvement Group reports and pay control updates.
Medical workforce optimisation programme to identify opportunities to improve deployment, job planning, rota design, productivity and value.	· Medical workforce optimisation reporting provides assurance on areas of high cost, variation and productivity opportunity.	· Transformation Board papers, scheme documentation and benefits realisation tracking.
Workforce redesign governance to ensure workforce change is linked to recurrent savings, quality impact and colleague experience.	· Board and People Committee receive strategic assurance through the workforce productivity dashboard once established.	· GIRFT benchmarking, Model Health System and specialty-level productivity data where available.
Benefits realisation framework to track whether workforce schemes deliver recurrent pay bill impact and service improvement.	· Assurance remains limited where productivity, quality, finance and workforce outcomes are not yet routinely triangulated.	· Medical workforce job planning, rota, locum, agency and premium pay analysis.
GIRFT benchmarking and specialty-level review to identify unwarranted variation in medical workforce models and productivity.		· Business case affordability assessments and workforce impact assessments.
Corporate benchmarking programme to compare workforce cost, structure, productivity and support function efficiency.		· Board workforce productivity dashboard, once implemented.
Board workforce productivity dashboard to support strategic oversight of pay, productivity, establishment, quality and workforce outcomes.		· Quality, safety, activity, productivity and workforce metrics used together to test whether savings are sustainable.



Workforce affordability checks within business cases, service changes and transformation proposals.					
Gaps in Controls / Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Limited productivity metrics and pay bill impact focus	Introduce workforce productivity scorecard covering pay, establishment, activity, productivity, quality and colleague experience.	CFO / CPO	Q4 2026/27	Board / Executive Team / People Committee / Finance Improvement Group	Scorecard to be developed as part of the Board workforce productivity dashboard.
Limited evidence of recurrent savings through redesign	Establish workforce redesign assurance process to test recurrent savings, workforce impact, quality impact and benefits realisation.	CFO / CPO	Q4 2026/27	Transformation Board / Executive Team / Finance Improvement Group	Process to align workforce redesign, benefits realisation and financial recovery reporting.
Medical workforce variation not sufficiently understood	Implement specialty-level medical pay review, including job planning, rota design, locum use, premium pay and productivity variation.	MD / CFO	Q4 2026/27	Executive Team / Finance Improvement Group / People Committee	Review to identify specialty-level opportunities and risks requiring action.
No agreed triggers for future strategic workforce options	Review strategic workforce options, including criteria and governance for any future voluntary redundancy consideration.	CPO/CFO/DCEO	Q4 2026/27	Remuneration Committee / Board	Criteria to be developed only if required, ensuring alignment with workforce strategy, affordability and employment obligations.
Weak triangulation between quality, finance and workforce outcomes	Establish monthly triangulated workforce affordability review across pay, workforce, quality, productivity and transformation data.	CN/CMO/CFO/CPO	Monthly from Q4 2026/27	Executive Team / Finance Improvement Group / People Committee	Review to strengthen grip on workforce affordability and identify early warning triggers.

Performance

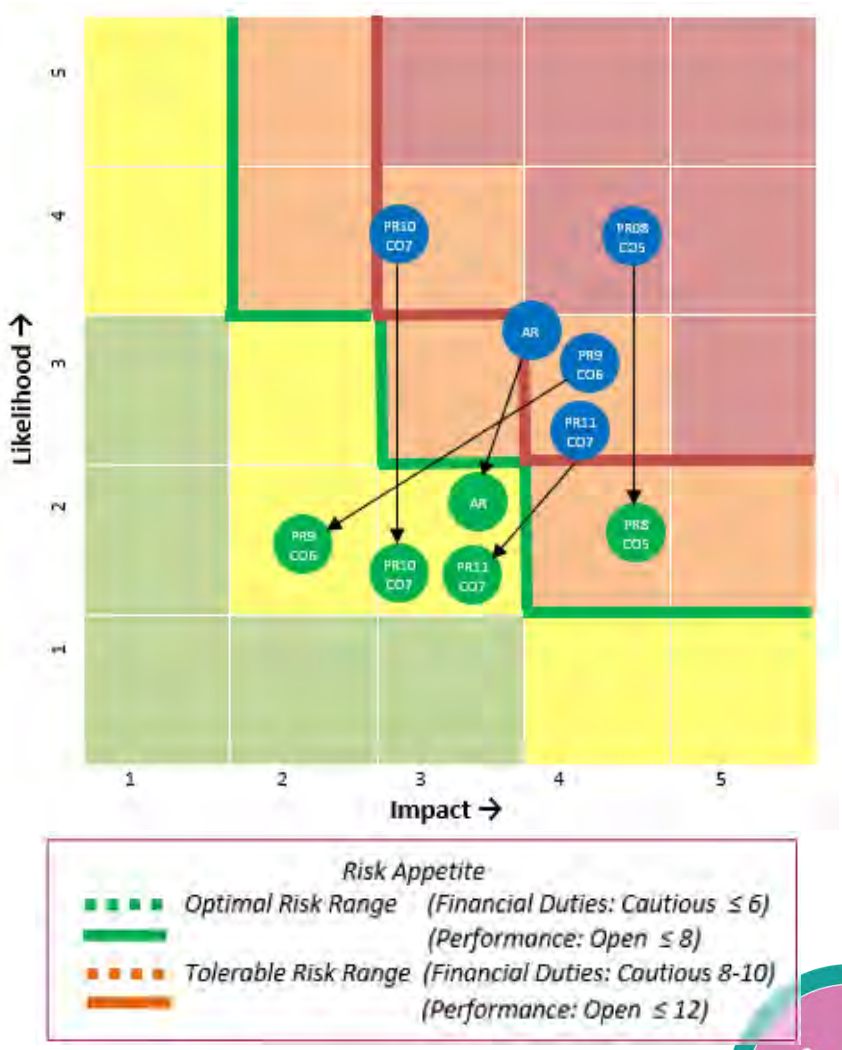
To consistently deliver efficient, effective and equitable patient care

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
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
CO6	Drive improvement 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
		• 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
CO7	Optimise delivery of our performance	• 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 Getting It Right First Time (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

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



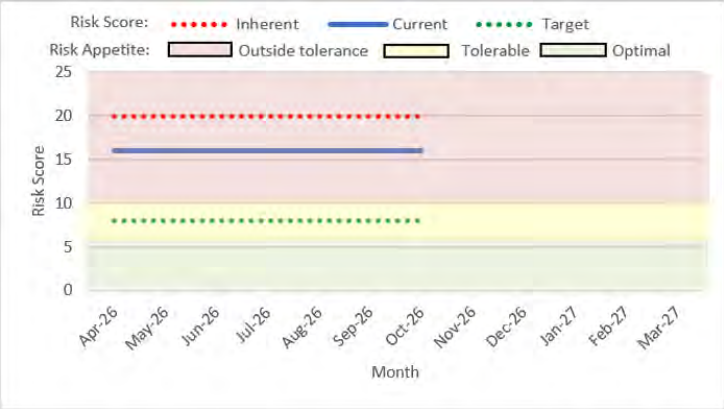
BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK PR 8: Delivery of the Financial Recover Strategy

There is a risk that the Trust may fail to deliver the Financial Recovery Strategy and in year financial duties, due to failure to deliver the revenue, capital and cash position, underdelivering CIP and activity, non-delivery of the workforce plan and not achieving the productivity metrics, 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:	01.04.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
	16	**16**	16			**8**	**6-10**
	4x4	**4x4**	**4x4**			**2x4**	
	LxC	**LxC**	LxC			**LxC**	
Risk Appetite	**Outside**	**Outside**	Outside			**Within**	**Outside**

RATIONALE FOR CURRENT RISK SCORE:

The Trust's year to date revenue position is currently behind plan, with material in year delivery risk flagged in the Trust mid case forecast scenario. The Trusts best case forecast assumes risks are mitigated and full delivery of the Trusts breakeven plan is achieved.

The Trusts capital position is broadly on plan YTD and forecast to deliver in line with plan for 26/27.

The cash position continues to deteriorate and based on the current run rate there is a risk that external cash support will be required towards the end Q4 of 2026/27 or Q1 of 27/28.

CIP delivery is in behind plan year-to-date; with a substantial proportion of savings achieved through non-recurrent measures. As a result, the underlying financial run rate has worsened during Q1 and Q2, reflecting a reliance on one-off savings. Implied productivity at Month 5 indicates an improvement compared with same period in 2025/26 however, this is still not at the target level required for sustained recurrent improvements to support financial recovery and long-term sustainability.

Projected Forecast Q3: **Deteriorating**
Stable
Improving

Rationale: **Deteriorating**

F&P Committee agreed that whilst the risk score should remain unchanged, the narrative should be amended to 'deteriorating' to reflect the Committee's concerns regarding the current financial trajectory and the need for recovery actions.

CONTROLS →	ASSURANCES →	EVIDENCE
• Revenue position: • Final plan signed off by Board and submitted to NHSE – April 26. • Draft and final plans scrutinised through monthly Provider Oversight meetings with GM ICB. (Ext)	• 1st Line - Monthly Performance Review meetings for all clinical divisions and Finance Improvement Group (FIG)	F&P Performance Report

• Draft and final plans discussed through Executive Team Meetings and Board meetings including risks to delivery, consequences of a deficit plan and difficult decisions. • Executive oversight and challenge of CIP & Financial performance through Divisional Performance Review Meetings, Financial Improvement Group, Transformation Board. • Establishment control groups ongoing for non-medical and medical staffing with scrutiny and rigour over agency spend in line with national agency controls • Discretionary non-pay controls ongoing for specific categories of spend. • Stringent business case criteria remains to ensure only business critical investments are approved. • Finance Improvement Group meeting monthly, chaired by Chief Finance Officer and attended by Chief Executive • Monthly Provider Oversight Meetings ongoing (Ext) • All headcount increases are required to be taken through an Exec led process • GM vacancy control panel established (Ext) • 2026/27 contract signed in line with planned activity and income • 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) • Recovery plans being implemented to support delivery of the financial position • Accelerated Divisional Turnaround Support started September 2026 to restore elective performance, improve income delivery and accelerate CIP	• 2nd Line - Finance & Performance Committee July 2026 • Monthly Divisional Assurance Meetings (DAM) • External - Monthly Provider Oversight Meeting with GM ICB (Ext)	
• 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 2026/27 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)	• 1st Line - Monthly Divisional Performance Review meetings and monthly finance improvement group (FIG) • 2nd Line - Finance & Performance Committee July 2026 • Bi-weekly CIP huddles attended by Execs and divisions • External - Monthly Provider Oversight Meeting with GM ICB (Ext)	F&P Performance Report

• 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. • 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		
• 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. • WWL capital plan is within operational CDEL envelope including a 5% planning tolerance to be managed locally during 2026/27. • 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 • All drawdown requests for nationally funded schemes submitted to NHSE in advance of deadline • Operational Capital Group to support delivery of the 2026/27 capital allocation	• 1st Line - Monthly Capital Strategy Group • 2nd Line - Finance & Performance Committee July 2026	F&P Performance Report
• Cash:	• 1st Line – Cash management group	F&P Performance Report

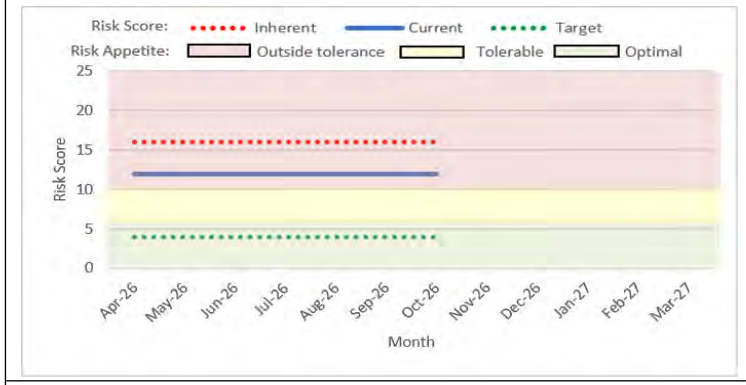
• Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT. • Enhanced balance sheet reporting including cash metrics to SFT and within monthly finance report. • Internal cash management group to be established and strategy being reviewed in line with national changes to cash support. • Cash forecast reviewed monthly. • 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 • 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) • Cash forward look presented to FIG • MIAA internal audit of cash flow forecasting and management review provided substantial assurance 2025	• 2nd Line - Finance & Performance Committee July 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	• Bi-weekly CIP huddles in plan with Executive and Divisional Teams. • CIP recovery plans to be developed.	CFO / COO	Throughout 2026/27	F&P Committee/ETM	Action underway
• PDC Business cases awaiting formal approval by NHSE.	• Close monitoring of Capital spend in line with trajectory.	CFO	Throughout 2026/27	F&P Committee	Action underway
• Establishment of internal cash management group	• Close monitoring and forecasting of the cash balance	CFO	Throughout 2026/27	F&P Committee	Action underway
• Divisional level month on month forecasting - reflecting gross risks and agreed mitigations/recovery plans.	• Forecasting of worst, mid, best case scenarios completed monthly in line with NHSE practice. • Risks reflected along with mitigations.	CFO	Throughout 2026/27	F&P Committee	Action underway

	• Develop process at divisional level.				

BOARD ASSURANCE FRAMEWORK 2026/27		
BAF RISK PR 9: Performance There is a risk that performance will not meet the national care standards in relation to referral to treatment (RTT), Urgent Emergency Care (UEC), diagnostics, cancer and community standards, 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, neighbourhood models and admissions avoidance schemes not implements and productivity metrics not achieved, resulting in poor performance, adverse publicity, business continuity disruptions and patients not choosing WWL as their first choice for any future treatment and long waits to be seen resulting in a poor patient experience and harms.	**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:	Performance Targets
	Risk Opened:	30.07.2025

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
	12	12	12			4	6-10
	3x4	3x4	3x4			2x2	
	LxC	LxC	LxC			LxC	
Risk Appetite	**Outside**	**Outside**	**Outside**			**Within**	**Outside**

RATIONALE FOR CURRENT RISK SCORE:
The risk score is a stable 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 Q3: Deteriorating
Stable
Improving

Rationale: Stable
Robust control measures and assurances are in place. However, there are outstanding actions to reduce this risk to a moderate target score of 4.

CONTROLS	ASSURANCES	EVIDENCE
Corridor Care • The Committee reviewed progress against the Corridor Care Improvement Plan.	• 2nd line – Finance & Performance Committee – July 2026	Finance and Performance Committee AAA Report
Elective Recovery	• 2nd line – Finance & Performance Committee – July 2026	Finance and Performance Committee AAA Report

• The Trust remains on track to eliminate 65-week waits by September 2026.					
Urgent Community Response • Performance remains above the national standard and with improvements in data quality and reporting arrangements. • A Frailty and admission avoidance pilot has been introduced.	• 2nd line – Finance & Performance Committee – July 2026	Finance and Performance Committee AAA Report			
Gaps in Controls / Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
• Risks to delivery arising from capacity constraints, limited mutual aid availability across Greater Manchester and emerging industrial relations issues affecting theatre staff.	Board to remain sighted on the potential impact on delivery of the 65-week and 52-week waiting time standards.	DCOO	Throughout 2026/27	Weekly meetings chaired by DCOO.	In progress
• Community waiting lists are reducing overall, but the school age autism pathway remains a high risk.	• While process improvements are embedded, the introduction of the pan-GM triage and assessment model will require significant review of current referrals and is expected to reshape future demand, case mix and throughput.	DCOO	Throughout 2026/27	F&P Committee	In progress
• Frailty and admissions avoidance pilot.	• Future update on the outcomes achieved and its impact on reducing hospital admissions and improving patient flow.	DCOO	Throughout 2026/27	F&P Committee	In progress

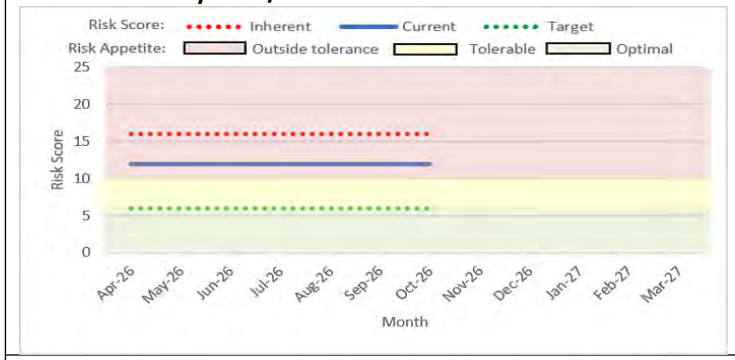
BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK PR 10: Optimise delivery of our performance

There is a risk that we will be unable to meet our performance targets with our funded activity, due to demand management schemes not being implemented and 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 performance
Risk Category:	Performance Targets
Risk Opened:	30.07.2025

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
	12	12	12			6	6-10
	4x3	4x3	4x3			2x3	
	LxC	LxC	LxC			LxC	
Risk Appetite	**Outside**	**Outside**	**Outside**			**Within**	**Outside**

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 Q3: Deteriorating / Stable / Improving

Rationale: Stable

The risk score is a stable 12. Robust control measures and assurances are in place. However, there are outstanding actions to reduce this risk to a moderate target score of 6.

CONTROLS →	ASSURANCES →	EVIDENCE
Urgent Care Performance • Operational actions remain in place to manage sustained urgent care pressures, improved patient flow and support admission avoidance.	2nd line – Finance & Performance Committee – July 2026	Finance and Performance Committee AAA Report
Capital Business Cases	2nd line – Finance & Performance Committee – July 2026	Finance and Performance Committee AAA Report

• Capital business case approved for Emergency Department flexible space improvements.					
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 2026/27	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 2026/27	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 BetterLives: The In-hospital flow workstream	COO / CFO	Throughout 2026/27	F&P Committee	Action underway

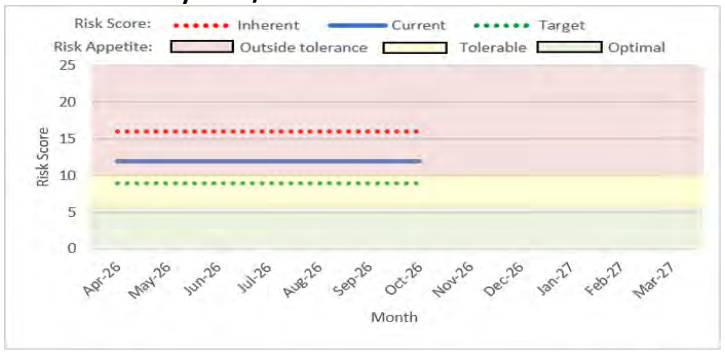
BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK PR 11: Cyber Security and Digital Resilience

There is a risk that the Trust is unable to maintain effective digital services and information governance due to external factors including increasing cyber threat levels, ransomware moving quickly across the health and care IT estate, legacy systems, inconsistent compliance with data security standards, insufficient cyber assurance across partners and inadequate incident response or recovery arrangements. This may result in incidents compromising digital services and lead to breaches of confidentiality and integrity as well as disruption to services which may take time to recover from, which could all impact on patient safety, staff morale and lead to reduced public confidence and expose the Trust to regulatory, financial and reputational consequences.

Executive Director Lead:	DCE (Senior Information Risk Owner)
Strategic Aim:	CO7 Optimise delivery of our performance
Risk Category:	Performance Targets / Technology
Risk Opened:	09.06.2025

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
	12	12	12			9	6-10
	3x4	3x4	3x4			3x3	
	LxC	LxC	LxC			LxC	
Risk Appetite	**Outside**	**Outside**	**Outside**			**Within**	**Outside**

RATIONALE FOR CURRENT RISK SCORE:

It is possible that the risk outlined in the risk statement may happen with a moderate impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q3: **Deteriorating**
Stable
Improving

Rationale: **Stable**

The risk score is a stable 12. Robust control measures and assurances are in place. However, there are outstanding actions to reduce this risk to a target score of 9.

CONTROLS →	ASSURANCES →	EVIDENCE
• The Trust was awarded cyber funds October 2025; further funds have also been released from this year's capital programme. • WWL is part of the GM Cyber Network Group. • Trust Incident Response Plan • Security Incident Management Plan 2025 • Loss of IT Services Plan • Departmental Business Continuity Plans • Specific IT Systems Loss Plans (e.g. HIS, PAS, etc.)	**1st Line** • Review of Cyber Alerts – high-priority alerts discussed at the weekly IT mgt meeting. • Monthly SIRO meeting. • Quarterly Caldicott meeting. • Monthly Digital Risk meeting. • Monthly Root Cause Analysis meeting. **2nd Line**	• Meeting AAA reports • EPRR annual report • DSPT annual audit report

• Patching Process • Strong Password Policy • Where available, MFA has been implemented • Third Party Security Operational Centre • Microsoft Defender for Endpoints • Microsoft Defender for Office 365 • AV deployed to all endpoints • Supplier access controls in place • Strong user account management in place • Various monitoring tools in place • Annual network penetration test • National Cyber Security Centre Early Warning Service • NHS England Threat Intelligence dashboard and alerts • Annual Cyber Assessment Framework (CAF) review by MIAA • NHS High Severity Alerts monitored on NHS Cyber Alert website.	• DSPT progress tabled at SIRO and Caldicott meeting. **3rd Line** • MIAA audit of DSPT. • External penetration testing. • Gm Cyber Exercise. • Internal cyber and BCP exercises. • 3rd party cyber security operational **centre.** • NHSE EPRR Core Standards annual audit • NHSE Cyber Assurance • NHSE Cyber Exercise	

Gaps in Controls / Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
• Gaps in loss of digital services outage plans.	•Improve loss of digital services outage plans to include work around solutions and both corporate and departmental BC plans.	COO	Throughout 2026/27	F&P Committee	Action underway
• There are several outstanding NHS High Severity Alerts to be progressed, although some have already been actioned.	Monitor NHS Cyber Alert website and progress outstanding NHS High Severity Alerts	DCE	Throughout 2026/27	F&P Committee	Action underway

Partnerships

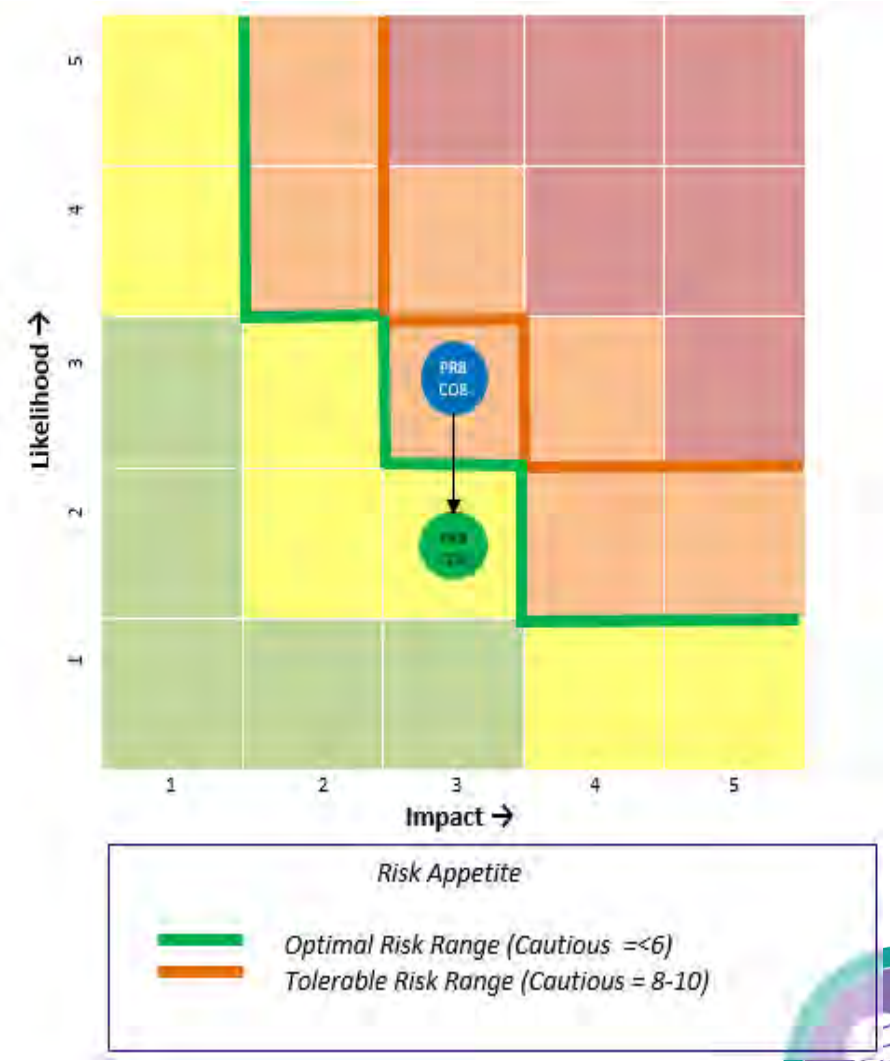
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

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

Ref.	Purpose of the objective	Scope and focus of objective
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 our 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 though private patients and corporate opportunities, while maintaining our primary commitment to NHS patient care

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 2026/27

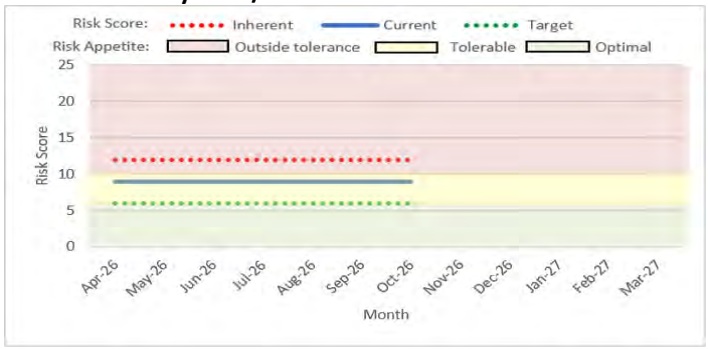
BAF RISK PR12: Partnership working

There is an overarching risk of a change in demography or health need of the Wigan population due to more houses, movement into the Borough, world affairs such as immigration, cost of living increase (organised) crime resulting in resources and models of care which would not be sufficient to enable us to improve the lives of the population.

There is a risk that working more closely with local health and care partners may not fully deliver the required benefits, due to national and local political changes, instability at ICB and NHSE/DHSC, and a lack of engagement from relevant local authorities, resulting in lack of pace of change, broadening health inequalities, poorer outcomes for patients and deterioration of existing relationships and financial position.

Executive Director Lead:	DCE
Strategic Aim:	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.
Risk Category:	Strategy
Risk Opened:	01.04.2026

BAF Risk Journey 2026/27



BAF RISK SCORE JOURNEY:

	01.04.26	Q1	Q2	Q3	Q4	26/27 Target	Risk Appetite
	9	9	9			6	8-12
	3x3	3x3	3x3			2x3	
	LxC	LxC	LxC			LxC	
Risk Appetite	Within	Within	Within			Within	Within

RATIONALE FOR CURRENT RISK SCORE:

The risk score at Q2 is a high score of 9. It is possible that the risk outlined in the risk statement may happen with a moderate impact on achievement of the annual corporate objective if it was to occur.

Projected Forecast Q3: Deteriorating / Stable / Improving

Rationale: Stable

Risk score is a stable at 9.

CONTROLS →	ASSURANCES →	EVIDENCE
• Delivery of the Trust's strategy is focussed on an annual basis as part of the corporate objective setting and supporting divisional plans.	• Our Strategy 2030 • Annual Corporate Objectives	Partnership report to Board – April 2026
• Greater Manchester System Working. All Executive Directors have 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.	Partnership report to Board – April 2026

• Our collaborative work with Bolton NHS Foundation Trust continues in line with the principles that have previously been agreed and reported to Trust Board.	• GM ICS Plan	Partnership report to Board – April 2026			
• WWL Executives continue to have an active role in the Healthier Wigan Partnership Board which brings together key partners across the Wigan Locality.	• Healthier Wigan Partnership Board	Partnership report to Board – April 2026			
Gaps in Controls / Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
• Whilst the core strategic intent of Our Strategy 2030 remains valid, it no longer reflects the changes or the scale of opportunity and challenge facing the Trust.	Strategy 2030 to be refreshed following a structured programme of engagement with patients, staff and system partners.	DCE	31.12.26	Board	Action underway
• Except for the urology shared on call model, collaborative work with Bolton has largely focussed on sharing of ideas and expertise across teams, rather than significant service changes.	• It is planned to refocus the collaboration with Bolton in 2026/27, where there are benefits in working together.	DCE	31.03.27	Board	Action underway

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Winter Plan 2026/27

Prepared, together,
for a safe and resilient winter

Working with our patients, staff and partners to maintain safe, high-quality care and support our communities this winter.

ACCEPT THE MISSION.
GET YOUR FLU VACCINE.

HOME FOR CHRISTMAS

WEEK 1 PLAN EARLY

Start planning now for a smooth Christmas discharge

Early discharge planning helps patients spend the festive period at home. Begin conversations today.





BetterLives
Transforming Care.
Promoting Independence.



PROTECT YOURSELF | **PROTECT YOUR TEAM** | **PROTECT YOUR PATIENTS** | **PROTECT YOUR LOVED ONES**

ONE TEAM.
ONE MISSION.
Stronger Together.

BE MISSION READY. BE WINTER READY.

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

Winter Plan 2026/27

Executive Summary

Prepared together for a safe and resilient winter

Working with our patients, staff and partners to maintain safe, high-quality care and support our communities throughout winter.

BetterLives
Transforming Care.
Promoting Independence.

Wrightington, Wigan and Leigh Teaching Hospitals NHS
NHS Foundation Trust



Right care.
Stronger communities.
All year round.

1 Our challenge
Key pressures this winter

Sustained demand
High levels of ED attendances and admissions, with continued pressure from frailty, respiratory and flu.

Flow and occupancy risk
Maintaining timely discharge and reducing length of stay will be critical to avoid escalation.

Bed requirement
Forecast modelling indicates increased bed requirement in December–January compared with autumn.

Access performance
We enter winter with 4-hour, >12-hour and RTT performance below planned trajectory, increasing the risk of operational pressure.

2 Our response
Six priorities for winter

Prevention
Reduce demand and keep people well.

Occupancy and discharge
Home first, reduce NCTR and length of stay.

Capacity
Maximise and flex capacity safely.

Flow
Timely clinical decision-making and efficient pathways

Infection prevention and control
Minimise the spread of respiratory and other seasonal illness.

Leadership and operational grip
Robust governance, escalation and system working

What is different this winter?
Building on our progress

BetterLives and Home First
Expanding admission avoidance, community support and proactive care in place.

Strengthened SPOA
Integrated approach for urgent care, community and social care.

SDEC and frailty
7-day senior clinical decision-making and enhanced frailty pathways.

Corridor care programme
Clear standards, red lines and sustained focus to elminate corridor care.

Enhanced operational grip
Earlier escalation, strengthened oversight and clear executive accountability.

Protected elective care
Maintaining planned care, reducing down-time and making best use of capacity.

What you can take assurance from
Clear plans, oversight and accountability

Demand and capacity plan
Forecasts and mitigation plans in place, including additional bed requirements in peak weeks.

Evidence-based interventions
Targeted actions across all six domains with measurable impact.

Executive accountability
Named executive leads for each domain and routine oversight through ETM, committees and Trust Board.

Defined escalation arrangements
Clear red lines, OPEL framework and system escalation in place.

System and partner working
Joint planning with NWAS, local authority, primary care and care sector.

Ongoing monitoring
Key metrics reviewed daily, weekly and monthly to track delivery and respond to emerging risk.

Our aim this winter

Safe, high-quality care for our patients, with reduced harm, improved flow and continued progress against our priorities.

Patients | Our people | Our communities

Our WWL values in action this winter

People at the Heart
We put people at the heart of everything we do

Listen and Involve
We listen, involve and value different views

Kind and Respectful
We are kind and respectful to everyone

One Team
We work together as one team

Wrightington, Wigan and Leigh Teaching Hospitals NHS
NHS Foundation Trust

Winter Plan 2026/27

Prepared, together, for a safe and resilient winter

Proud to care for our WWL communities

Prevention

Keeping people well and out of hospital

- Targeted communications and public health campaigns (e.g. winter wellbeing, vaccinations, self-care).
- Support to care homes, vulnerable groups and high-risk populations.
- GP, community pharmacy and primary care at the heart of prevention.
- Maximise use of virtual and community services to avoid admission.
- Work with system partners to address wider determinants of health.

Occupancy and discharge

Right patient, right place, right time

- Deliver and monitor occupancy reduction plans across all inpatient areas.
- Early and proactive discharge planning for all patients.
- Effective use of all discharge pathways (0–3) including out of area discharges.
- Timely senior decision-making for patients with long lengths of stay.
- Partnership working with health, social care and voluntary sector.
- Ensure community beds are fully utilised to support timely discharge.

Capacity

Having the right capacity in the right place

- Escalation and surge capacity plans in place.
- Flexible use of beds, including community and step-up/step-down.
- Workforce plans to ensure safe staffing levels, including enhanced staffing during peak periods.
- Diagnostic and clinical support services available and resilient.
- Mutual aid and system support arrangements confirmed.

Safe care this winter

Working together to keep our patients, staff and communities safe

Flow

Keeping patients moving through the system

- Rapid assessment and streaming in ED and urgent care.
- Maximise SDEC, frailty services, virtual wards, hospital at home and community response.
- Timely diagnostics, clinical decision-making and access to specialty advice.
- Daily operational oversight of flow, with escalation when required.
- Strong coordination with community and social care to prevent delays.

Infection Prevention and Control (IPC)

Reducing the risk of infection this winter

- Delivery of seasonal vaccination programme (flu, RSV).
- Continued focus on hand hygiene, PPE and isolation practices.
- Early identification and management of infectious patients.
- Outbreak management plans in place.
- Ongoing monitoring of infection trends and timely escalation.

Leadership and Operational Grip

Clear leadership, oversight and timely decision-making

- Robust governance with daily operational oversight (including System Visibility Dashboard).
- Clear escalation arrangements and Executive oversight.
- Defined roles and responsibilities across the Trust and with system partners.
- Regular review of performance against plan and proactive actions.
- Strong communication with staff, patients, families and partners.

Our WWL values in action this winter

We put people at the heart
Patients, families and our communities come first

We listen and involve
We value different views and work together

We are kind and respectful
We treat everyone with compassion and dignity

We are one team
We work together across WWL and with our partners for the best outcomes

A healthier tomorrow together

Learning from winter 2025/26

Building on what worked well, making the changes needed for a more resilient winter 2026/27.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Continue

What worked well and we will build on

Supportive, solution-focused culture
Effective working in the Winter Cell / Incident Coordination Centre.

Strong multidisciplinary working
Collaboration across clinical and corporate teams.

Timely digital response
Effective incident response and useful system partner input.

Visible leadership and practical support
During periods of extreme pressure.

Turning learning into action

Change

What we will do differently to be more resilient

Define incident arrangements
Set incident triggers, objectives, command roles and stand-down criteria in advance.

Separate governance and operational forums
Keep the Winter Cell, bed meetings and incident management arrangements distinct.

Improve communication
Strengthen notification cascades and increase discipline for hybrid meetings.

Strengthen infrastructure and readiness
Enhance digital, estates and business continuity arrangements.

Support our people
Plan wellbeing and leadership resilience for prolonged escalation.

The result

A stronger, more resilient winter 2026/27

- **Better prepared for pressure**
- **More joined-up working**
- **Faster, more effective decision making**
- **Safer, more sustainable care for our patients and communities**

Our Values

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

Compassionate care, for every person, every time.

WINTER 2026/27

Forecast Demand and Bed Requirement

Stable demand. Flow is the critical risk.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

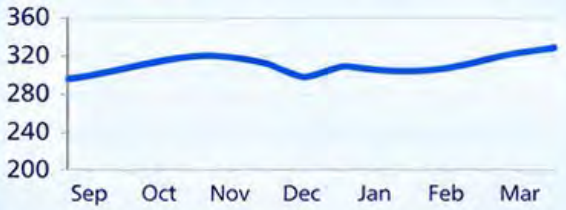
Safe care.
Stronger communities.
All year round.

Our winter challenge is not simply more patients arriving – it is maintaining flow through the whole system.

Attendances remain relatively stable and admissions peak before Christmas. The greatest bed pressure is forecast in January, making discharge, length of stay and operational grip critical to maintaining capacity.

1 ED Attendances (RAEI)

Actual and forecast (attendances per day)



284 – 301
attendances per day

Attendances are stable through winter with no significant surge envisaged.

2 Admissions

7-day rolling average



Peak 231
(in November)
Falls to 191
(in January)

3 Discharges

7-day rolling average

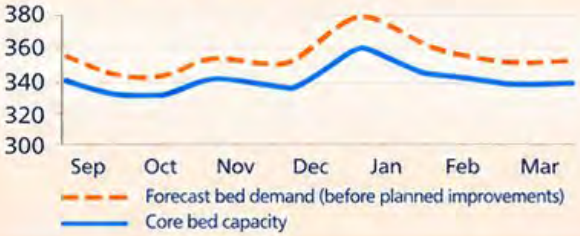


197 – 232

Broadly keeping pace with admissions throughout winter.

4 Bed requirement

Forecast (before planned improvements)



Peak bed requirement forecast in January,
reflecting higher admissions, longer length of stay and system pressures.

Key messages

Attendances are stable
No significant winter surge envisaged.

Admissions peak in November
7-day rolling average peaks at 231, falling to 191 in January.

Discharges keep pace
7-day rolling average ranges from 197 – 232 across winter.

Bed pressure peaks in January
At 374 beds before planned improvements, reflecting longer length of stay and system pressures.

Our focus this winter

Turning insight into action

Avoid admission
- SPOA
- Call Before You Convey
- Care Home project
- UCR, SDEC, Frailty and Virtual Wards

Improve discharge and reduce LOS
- Home First
- BetterLives
- NCTR
- Community capacity

Enhance operational grip
- Christmas and New Year planning
- Winter Cell
- OPEL and bed meetings
- System visibility and escalation

Protect patient safety
- Maintain safe staffing
- Monitor risks and red lines
- Early intervention
- Work with system partners

Our WWL values in action this winter

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

Working together for a healthier Wigan Borough

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust



Prevention

MISSION: WINTER

YOUR MISSION.

Protect our patients, workforce and communities this winter.



Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Vaccination Programme

Protecting our patients, workforce and communities this winter.



Our assurance

The Trust has a comprehensive Winter Vaccination Programme overseen by a Vaccination Task and Finish Group led by the Chief Nursing Officer's team and Consultant in Public Health. All aspects within the NHS England checklist have been factored in, with a 10% increase in vaccination uptake achieved last year and a continued focus on further increasing uptake this winter.

Leadership and governance

Strong executive leadership and oversight

- Vaccination Task and Finish Group led by the Chief Nursing Officer's team.
- Consultant in Public Health provides clinical leadership.
- NHS England checklist requirements incorporated into the programme.
- Regular oversight of progress and performance.

Maximising staff vaccination

Making vaccination as easy as possible

- Line managers trained to vaccinate staff.
- Ward leaders will be trained to vaccinate staff.
- Roaming vaccination teams across the site.
- Static drop-in clinics.
- Community clinics to support all staff.
- Out of hours leaders trained to deliver vaccinations.
- Developing a Patient Group Direction (PGD) to prevent delay and increase flexibility.

Supporting patient vaccination

Protecting our most vulnerable patients

- Consultant in Public Health working with the Consultant body to support patient roll out.
- Vaccination status will be included in the long length of stay review checklist.
- Opportunities to vaccinate identified throughout inpatient stay.
- Focus on protecting vulnerable patients before discharge.

Population health and partnership working

A joined-up approach across Wigan Place

- Consultant in Public Health employed in a hybrid role across WWL and Wigan Council.
- System working and partnership working across the borough.
- Using patient data and population health intelligence to inform and target this year's vaccination plan.
- Support for equitable access across our communities.

Monitoring progress

Tracking uptake and driving improvement

- Staff vaccination uptake (monitored by staff group and clinical area).
- Patient vaccination uptake.
- Comparison with previous year (10% increase achieved last year).
- Regular review through the Task and Finish Group.
- Delivery against NHS England campaign requirements.

PROTECT YOURSELF | **PROTECT YOUR TEAM** | **PROTECT YOUR PATIENTS** | **PROTECT YOUR LOVED ONES**

ONE TEAM. ONE MISSION. *Stronger Together.*

BE MISSION READY. BE WINTER READY.

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust



Occupancy and discharge

Our WWL values

We put people at the heart

We listen and involve

We are kind and respectful

We are one team

Discharge Pathway Capacity

Supporting more people home, with the right support, this winter

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Better care. Stronger together.

Through the work of the BetterLives and GIRFT programmes we understand how many discharges we need each day, enabling us to plan and act early.
Our focus is to support as many patients as possible to return to their own homes, to live with their families and loved ones.

Our Discharge Pathways

The right support, in the right place, for the right patient.

Pathway 0

Home

Support to return directly home with no ongoing support needs.

Our preference for all patients.

Pathway 1

Low-level Support

Discharge home with short-term health and/or social care support.

Community resources are understood and in place across health and care to support this pathway.

Pathway 2

Rehabilitation

Time-limited rehabilitation to maximise independence.

Used to support rehabilitation and to enable further assessment in relation to a decision about long term care where required.

Pathway 3

Complex Needs

Longer-term care and support in the right setting.

Multidisciplinary team decisions are made to agree the most appropriate pathway for individual patients.

Our Commitment

- Support as many patients as possible to return to their own homes
- Help people to live with their families and loved ones
- Right care, right place, right time
- Work together with our partners to maintain safe patient flow this winter

How we know how many discharges we need

BetterLives and GIRFT provide the data and modelling to understand how many discharges we need each day.

This enables proactive planning to manage bed demand and occupancy throughout winter.

Continuous review with partners

The review of discharges required is continuously ongoing with partners through the BetterLives programme governance.

Weekly SRO review

Capacity requirements are reviewed weekly by the Senior Responsible Officers for the Trust, the Council and the ICB.

Steering group oversight

Capacity and the impact of transformation work are discussed in the BetterLives steering group.

System visibility dashboard

The system visibility dashboard enables trends to be seen and delays to be identified in pathways. The dashboard is available and utilised by all health and care staff.

Community bed capacity

A full review of community bed capacity has been undertaken. The beds available at Jean Heyes, Bedford and Richmond have been defined and there is a shared system understanding of how these are used to maximise the opportunity.

Key enablers

- Integrated health and care teams
- Community resources and services
- Patient transport arrangements
- Voluntary sector support
- Data, modelling and insight (BetterLives & GIRFT)

Our outcome

- Timely discharge for every patient
- Reduced hospital occupancy
- Better outcomes and experience
- A more resilient health and care system

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

NHS

MODEL DISCHARGE PATHWAY

The right patient, to the right place, at the right time

Safe, timely and sustainable discharge to improve patient outcomes and support flow across the system.

THE 7 KEY PRINCIPLES

1. Discharge is a **clinical decision,** not an administrative one.
2. Staying in hospital longer than necessary **causes harm.**
3. Timely discharge is essential for **patient flow and safety** across the urgent and emergency pathway.
4. Discharge home or to the usual place of residence is the **default.**
5. Discharge is **everyone's business, every day** – with empowerment and clear decision rights.
6. Patients and carers (including parents of children and young people) are **partners** in achieving high-quality discharge.
7. Decisions are informed by timely, **high-quality data** and **transparency.**

WWL position and progress

Turning the principles into practice at WWL.

Always a clinical decision

Discharge is always a clinical decision and not an administrative one. Staying in hospital for longer than necessary causes harm. Patients lose their ability to care for themselves, losing their independence and becoming dependent on others to deliver care.

Timely discharge to improve flow and safety

We have worked with GIRFT to implement ward and board rounds with senior decision makers to facilitate timely discharge, supporting safer patient flow across our urgent and emergency pathway.

Home first

In line with the BetterLives programme, our priority is to support everyone to be discharged home where possible. We have embedded a 'home first' approach to discharge.

Patients and carers as partners

Patients and carers are involved in decision making with the aim of supporting the patient to remain in their own home for longer.

Data and transparency

The System Visibility dashboard and Trust Apps give timely access to high quality data and a shared version of the truth for partners, enabling informed decisions and proactive discharge planning.

Better outcomes

Supporting patients, families and our communities.

Healthier patients

- Less time in hospital
- Reduced risk of harm
- Greater independence

Improved experience

- Patients and carers involved
- Clearer communication
- Smoother transitions home

More efficient care

- Reduced length of stay
- Better use of hospital and community resources
- Improved patient flow

Stronger communities

- More people cared for at home
- Reduced pressure on urgent and emergency care
- Sustainable system flow

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

HOME FOR CHRISTMAS

Pre-Christmas and Holiday Occupancy Plan

Planning ahead to keep people safe, support discharge and help as many patients as possible spend the festive period at home.

1 December 2026

Campaign starts

- Launch 'Home for Christmas' campaign across all bedded areas including Jean Hayes, Bedford and Richmond.
- Communications shared with all system partners (including primary care) to support the campaign.
- Communicate required occupancy levels by ward to Divisional Teams and Ward Managers.
- Manage increased ED attendances to support the delivery of the 4 hour and 12 hour targets.



From 16 December 2026

Increased communication and preparation

- Increase communications to Wigan residents about supporting their families to come home for Christmas.
- Communications to patients and families to encourage and support preparations to come home for Christmas.
- Communicate with out of area teams any delays for discharge.
- Achieve discharge targets for pathways 0–3.
- Ensure all long length of stay patients have a full review by a senior decision maker.
- Achieve the required occupancy level by 24 December.

25 – 29 December 2026

Christmas resilience period

- Manage occupancy carefully and ensure that criteria to admit is met and this is not reduced due to available bed capacity.
- Ensure correct staffing levels so that discharges can continue to be facilitated.
- Support as many patients as possible to spend Christmas with their families and loved ones.



29 – 31 December 2026

New Year discharge focus

- Targeted discharge initiatives across the Trust, with executive oversight.
- Enhanced focus on Pathway 0 discharges.
- Ensure all community beds are utilised.
- Encourage families to cover any delays to implementation of packages of care or community health services support where appropriate.
- System reviews to maximise capacity ahead of the New Year bank holiday.



1 – 4 January 2027

New Year resilience period

- Manage occupancy carefully and ensure that criteria to admit is met and this is not reduced due to available bed capacity.
- Ensure correct staffing levels so that discharges can continue to be facilitated.
- Ensure all community beds are utilised.
- Encourage families to cover any delays to implementation of packages of care or community health services support where appropriate.
- Support as many patients as possible to return to their own homes.



Our objective

To reduce hospital occupancy ahead of the Christmas and New Year holiday periods, maintain safe and effective care, and maximise opportunities for patients to return to their own homes or the most appropriate community setting.

Our commitment

Working with our partners to ensure safe, effective and timely care for our patients and communities during the Christmas and New Year period.

Key enablers

- Enhanced discharge planning across all wards from 1 December.
- Joint operational planning with community health, social care and the voluntary sector.
- Seven-day discharge arrangements
- Daily monitoring of predicted vs actual discharges.
- Use the BetterLives Strategic Group to identify any areas which may not be following the anticipated trends or any actions which the system needs to take to ensure that capacity is managed to facilitate the delivery of safe, effective care.

SDEC – Maximising Same-Day Emergency Care This Winter

Right patient. Right pathway. Senior decision-making. Better outcomes.

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1 Identify and stream early

At the front door



- Appropriate acute medical patients identified by ED Streamer or ISAT.
- People aged 65+ and/or with frailty risk (ESW ≥ 4 where applicable).
- Stream to the right pathway within 30 minutes.
- Senior decision-making at the front door.
- Reduce unnecessary entry into ED Majors.

Right patient, right pathway, earlier in their journey.

2 SDEC by day

Same-day assessment and treatment



- Chair-based assessment where clinically appropriate.
- Rapid diagnostics and treatment.
- Senior clinical decision-making.
- Protect SDEC for same-day activity and minimise review patients.
- Ensure timely access to diagnostics and specialty advice.

Timely assessment, treatment and discharge.

3 MRU overnight

A clear pathway when SDEC is closed



- Separate space from SDEC.
- Overnight acute medical patients received directly into MRU.
- 24-hour provision.
- Move to MAU or Lowton at the morning post-take round rather than remaining in ED.

Safe overnight care and planned onward flow.

4 Frailty SDEC

Specialist pathway for people living with frailty



- Frailty streaming from the front door.
- Increase use of frailty chairs.
- Specialist multidisciplinary assessment (CGA).
- Link with CRT and Virtual Ward.
- Avoid admission wherever clinically appropriate.
- Work across ED and SDEC footprint.

Specialist frailty care to support independence.

5 Right outcome

Move away from ED as the default destination

- **Home same day**
- **Home with CRT / Virtual Ward**
- **Admission to Community Assessment Unit (CAU)** for short stay assessment
- **Admission to Orrell for ongoing care**
- **Community unit**

The right care, in the right place, for the right patient.

What this delivers for winter

Reduce ED crowding
More patients streamed to same-day and alternative pathways.

Shorter time in ED
Earlier assessment and decision-making for acute medical patients.

Admission avoidance
More people treated and supported in their own home or usual place of residence.

Better patient experience
Timely care, less time in ED and support to remain independent.

Winter intent

Maximise same-day care, support alternatives to admission and maintain safe, effective flow through winter.

Our Values

People at the Heart | Listen and | Kind and Respectful | One Team

Compassionate care, for every person, every time.

Frailty Pathway

Earlier identification. Specialist assessment. Better outcomes this winter.

Providing the right care, in the right place, at the right time for people living with frailty.

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1 Identify and stream early



- Patients identified in ED by streamer or ISAT.
- Aged 65 and over with Electronic Frailty Score (ESW) ≥ 4.
- Assessment of mobility (e.g. able to sit in a chair).
- Direct to frailty pathway for specialist assessment.

2 Specialist frailty assessment



- Frailty team: ACPs, AHPs and RGN's.
- Comprehensive geriatric assessment (CGA).
- Functional assessment and discharge planning.
- Working across ED and Frailty SDEC.

3 Frailty SDEC



- Same-day specialist assessment and treatment.
- Senior clinical decision maker.
- Coordinated MDT approach.
- Home First mindset – maximising alternatives to admission.
- Close working with CRT, Virtual Wards and community services.

4 Potential outcomes

Discharge home with CRT safety netting

Discharge home with CRT / Virtual Ward

Admission to Community Assessment Unit (CAU) for short stay assessment

Admission to Orrell for ongoing care

Community Frailty Clinic (Phase 2)
Community-based assessment and ongoing management

5 Supported in the community



- Community Frailty Clinic to enable frailty pathways to start and finish in the community.
- Frailty Coordinator to support pathway navigation.
- Integrated nieighbourhood working with primary care, community services and social care.
- Ongoing monitoring of outcomes and continuous improvement.

Our aims this winter

- Reduce avoidable ED attendance and hospital admission.
- Maximise use of Frailty SDEC and community alternatives.
- Support more people to remain in, or return to, their usual place of residence.
- Provide safe, timely and effective care for people living with frailty.

Our workforce

- ACP led model with Frailty Practitioners (RGNs / AHPs).
- Frailty Coordinator.
- Senior clinical decision maker.
- Therapy support and administrator.
- Ongoing frailty-specific training and development (Enhanced Practitioner Framework).

Working together

- Integrated with Wigan SPOA.
- Close links with CRT, Virtual Wards, GPs, care homes and community teams.
- Supporting the wider system to deliver care closer to home.
- Aligns with WWL strategy and BetterLives programme.

Measuring success

- Reduced frailty-related ED attendances.
- Increased proportion of patients managed without admission.
- Reduced length of stay for those admitted.
- Positive patient and carer experience.
- Sustainable model with measurable benefits.

Winter intent | Reduce avoidable ED attendance | Prevent avoidable admission | Maximise community capacity | Better outcomes for frail patients

Our Values People at the Heart | Listen and Involve | Kind and Respectful | One Team | Compassionate care, for every person, every time.

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Capacity

Our WWL values

We put people at the heart

We listen and involve

We are kind and respectful

We are one team

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Safe Staffing

Maintaining safe staffing throughout winter 2026/27

Safe Staffing Framework

Evidence-based staffing decisions

- Safe Staffing (Nursing) Policy supports inpatient, emergency, theatre and community services.
- Staffing decisions informed by SafeCare acuity, dependency and professional judgement.
- Shift-by-shift assessment of staffing requirements.
- Board assurance through established governance arrangements.

Workforce Planning

Planning ahead to minimise staffing gaps

- Forward roster planning with defined KPI standards.
- Vacancies, sickness and recruitment proactively managed.
- HealthRoster supports workforce planning and deployment.
- NHS Professionals (NHSP) utilised as the Trust's primary temporary staffing provider.

Safe Staffing Escalation

A structured escalation process

- **Business as Usual** – effective roster management and local staffing solutions.
- **NHSP** – temporary staffing through Trust Bank (matron approval).
- **Trust-wide Redeployment** – SafeCare acuity review and staffing huddles to redeploy available staff.
- **Golden Key** – agency staffing only after all mitigations have been exhausted, with executive approval required.

Executive Oversight

Strong governance and accountability

- Daily Safe Staffing reviews.
- Divisional oversight by Matrons and Divisional Directors of Nursing.
- Trust-wide Safe Staffing meetings.
- Golden Key approvals by the Chief Nursing Officer / Deputy Chief Nursing Officer.
- Executive on Call approval out of hours.
- Corporate Safe Staffing Assurance Group provides strategic oversight.

Monitoring and Assurance

Real-time monitoring of staffing risk

- Planned versus actual staffing.
- SafeCare acuity and dependency.
- Roster KPI compliance.
- Temporary staffing utilisation.
- Vacancies, recruitment and sickness.
- Staffing incidents and escalation events.
- Professional judgement alongside operational intelligence.
- Divisional and corporate assurance reporting.

Board Assurance

Providing confidence throughout winter

- Comprehensive policies and Standard Operating Procedures in place.
- Escalation processes tested and embedded.
- Agency staffing used only as a last resort through the Golden Key process.
- Executive oversight supports timely decision-making.
- Continuous monitoring and governance provides assurance that staffing arrangements remain safe, sustainable and responsive to patient need.

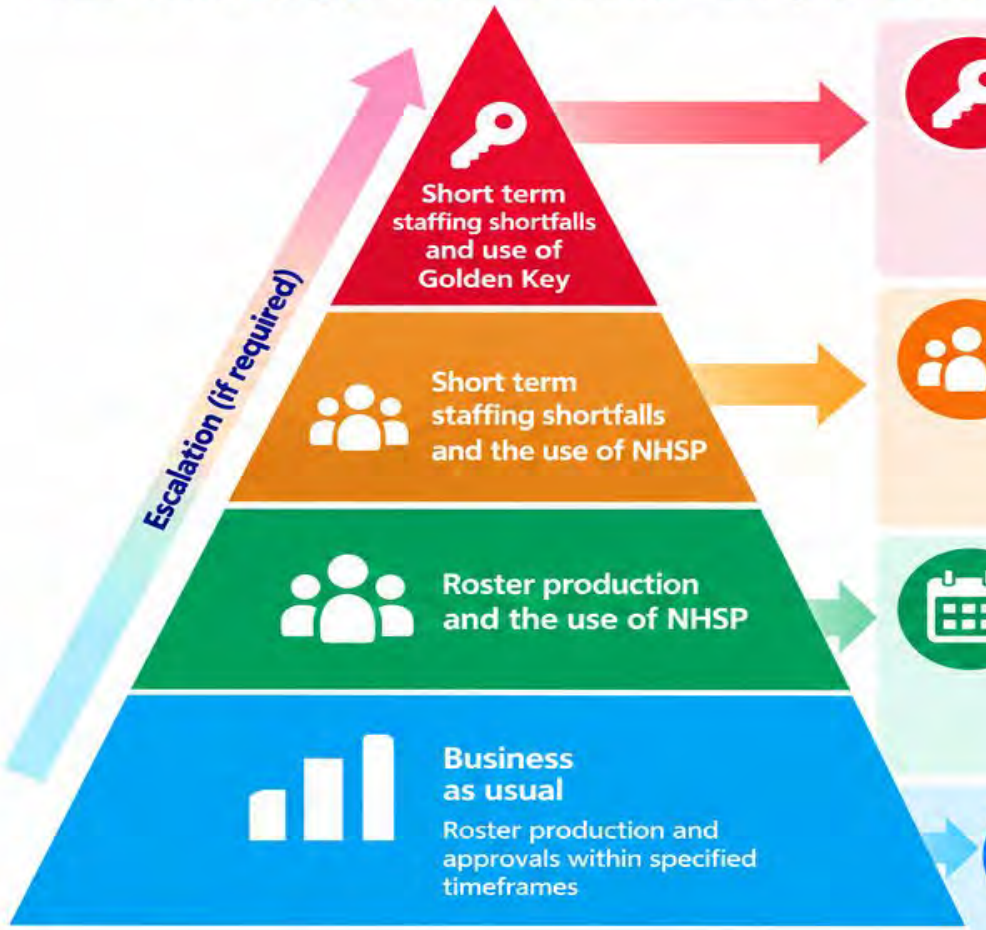
Safe staffing | Workforce planning | Structured escalation | Executive oversight | Safe patient care

Safe Staffing

Temporary Staffing Escalation Process

A structured approach to ensure safe, effective and sustainable staffing

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Golden Key (Agency) – last resort

All other options must be exhausted

- All areas in amber exhausted with evidence (checklist / proforma).
- Escalate to Chief Nursing Officer / Deputy CNO to seek authorisation for Golden Key.
- Evidence stored on Safe Staffing Teams channel.

Actions

- Assess divisional and Trust wide redeployment opportunities (including non-bedded areas such as outpatients, theatre etc).
- Stand down non-urgent meetings to release clinical support.
- Explore substantive shifts to cover the gap (with caution).
- Cancel TOIL and management time.
- Cancel non-mandatory / non-safety critical training.
- Escalate to speciality Divisional Directors of Nursing.

Short term staffing shortfalls – use of NHSP

When local options are not sufficient

- Temporary staffing cannot be used to cover short notice absence including sickness, emergency/unplanned leave, study leave, escalated areas and birthday leave.
- Consider if care can be delivered by reprioritising tasks.
- If not, escalate to matron / service lead.

Actions

- Ward leader/deputy to review acuity and dependency via SafeCare and use professional judgement.
- Include all available resources (coordinator role, educators, supernumerary staff and learners) in the data.
- Ensure changes are reflected in real time.
- Escalate to matron / service lead if required.

Roster production and use of NHSP

Utilise all available staffing resources

- Reasons for registered and unregistered staffing gaps include:
  - Filled vacancies awaiting start date (including filled maternity leave).
  - Supernumerary status (as per guidance).
  - Long term sickness.

Actions

- Revise rosters to align with roster KPI's and use all available staffing hours (including accrued hours owed by staff).
- Submit NHSP request to draft roster ensuring the correct booking reason.
- Matron to review and partially approve roster.
- DDON/M final approval via roster performance meeting process.
- Regular review by ward leader (with matron oversight) to assess NHSP shift pick up and whether the shift is still required.

Business as usual

Effective workforce planning

- Produce rosters in line with process and timescales.
- Ensure roster KPI's are met.
- Utilise all available staffing hours.

Roster KPI's met including:

- Annual leave.
- Sickness below Trust target.
- Sickness and attendance management adhering to process.
- All available staffing hours utilised (including accrued hours owed by staff).

Safe staffing | Maximising internal opportunities | Escalate when needed | Safe patient care

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

Protecting Elective Activity This Winter

Maintaining planned care while responding safely to winter pressure.

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1 Two elective hubs
Wrightington & Leigh



Wrightington Elective Hub | Leigh Elective Hub

- Use both elective hubs to protect planned activity from acute-site pressures.
- Maximise activity through dedicated elective capacity.
- Maintain separation between elective and emergency pathways wherever possible.
- Work flexibly across both sites to optimise capacity.

2 Protect priority patients
Cancer • Urgent • Time-critical



- Cancer activity prioritised and protected.
- Urgent patients prioritised according to clinical need.
- Clinical prioritisation informs decisions if capacity becomes constrained.
- Avoid cancellation of priority patients wherever possible.

3 Protect elective capacity
Keep planned care moving



- Protect elective beds, theatres and workforce wherever clinically safe.
- Avoid inappropriate use of elective capacity for escalation.
- Maintain elective hub activity during periods of increased emergency demand.
- Use available capacity across both hubs effectively.

4 Active operational grip
Know the position and intervene early



- Daily visibllive of elective activity and emerging pressures.
- Early identification of risks to planned activity.
- Divisional escalation where delivery is at risk.
- Executive oversight during significant winter pressure.

5 Recovery & resilience
Minimise the impact of winter on waiting patients



- Minimise avoidable cancellations.
- Rapidly rebook any activity that cannot safely proceed.
- Maintain focus on waiting-list delivery throughout winter.
- Balance winter resilience with delivery of elective, cancer and diagnostic standards.

Planned care for our patients

- Cancer
- Urgent / Time-critical
- Routine elective

Our elective hubs – protected and focused on planned care



Dedicated elective capacity | Separate from emergency pathways | Working as one team

- Planned operations
- Planned outpatient care
- Diagnostics and procedures
- Shorter waits, better experiences

What this delivers for winter

Protected cancer care
Continuing to treat patients who need it most.

Fewer avoidable cancellations
Keeping planned care on track.

Continued elective activity
Maintaining our elective programme through winter.

Reduced impact on waiting patients
Minimising disruption and protecting our performance.

Our Values

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Compassionate care, for every person, every time.

Access Performance Trajectory 2026/27

Delivering safe, timely and high-quality care through winter and beyond

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A&E 4-HOUR PERFORMANCE

Percentage of patients seen, treated, admitted or discharged within 4 hours

Higher is better



Month	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Plan	75.0	76.0	77.0	78.0	79.0	80.0	77.3	76.1	74.2	73.3	75.1	82.0
Actual	76.5	75.5	74.6	75.4	72.2	-	-	-	-	-	-	-
Variance (pp)	+1.5	-0.5	-2.4	-2.6	-6.8	-	-	-	-	-	-	-

August 2026
72.2% actual
vs 79.0% plan
6.8pp below trajectory

A&E >12-HOUR WAITS

Percentage of patients waiting >12 hours in ED from decision to admit

Lower is better



Month	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Plan	17.0	16.7	16.5	16.2	16.0	15.8	15.5	15.3	15.0	14.8	14.6	14.3
Actual	15.5	15.3	15.8	17.0	-	-	-	-	-	-	-	-
Variance (pp)	-1.5	-1.2	-0.7	+1.0	-	-	-	-	-	-	-	-

August 2026
17.0% actual
vs 16.0% plan
1.0pp above trajectory

RTT 18-WEEK PERFORMANCE

Percentage of patients waiting <18 weeks for planned treatment

Higher is better



Month	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Plan	60.6	61.2	61.8	62.3	62.9	63.5	64.1	64.7	65.3	65.8	66.4	67.0
Actual	60.2	60.4	61.0	60.6	60.4	-	-	-	-	-	-	-
Variance (pp)	-0.4	-0.8	-0.8	-1.7	-2.5	-	-	-	-	-	-	-

August 2026
60.4% actual
vs 62.9% plan
2.5pp below trajectory

Key messages

1. 4-hour performance is 6.8pp below plan in August (72.2% vs 79.0%) and is expected to come under further pressure through winter.
2. >12-hour waits increased to 17.0% in August, 1.0pp above plan, following an improving trend between May and July.
3. RTT performance remains below plan at 60.4% in August (62.9% plan), 2.5pp behind trajectory.
4. Our winter plan focuses on admission avoidance, improved flow, and maintaining elective capacity to mitigate winter pressures and deliver our trajectories.

Our winter priorities

- **Admission avoidance** — Community, primary care and system partnerships
- **SDEC & Frailty** — Early assessment and same day care
- **Improved ambulance handover** — Flow through the front door
- **GIRFT & corridor care programme** — Safe, timely and appropriate care
- **Inpatient flow and discharge** — Reduce length of stay and NCTR
- **Protect elective capacity** — Maintain planned care through winter

Our Values

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

Compassionate care, for every person, every time.

WINTER PLAN 2026/27

Senior Decision-Making Capacity

Consistent clinical leadership to support timely decisions and patient flow

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Right people | Right time | Right decisions
Supporting safe, timely and high-quality care this winter

1 ROTAS REVIEWED
Planned for peak pressure

- Medical and operational rotas reviewed for winter (Oct–Mar)
- Peak-pressure periods identified (evenings, weekends and bank holidays)
- Weekend and out-of-hours cover assessed across key specialties and site teams
- Gaps escalated and mitigated with robust recruitment, bank and locum arrangements
- Ongoing review through weekly oversight and real-time monitoring

2 SENIOR DECISION-MAKERS AVAILABLE
Clinical leadership across 7 days

- **ED Consultants** — 24/7 senior presence
- **Acute Medicine Consultants** — 7-day cover
- **Cardiology** — Senior decision-maker in hours and on-call out of hours
- **Gastroenterology** — Senior decision-maker in hours and on-call out of hours
- **Surgery and Trauma** — Senior decision-maker in hours and on-call out of hours
- **Senior Nursing Leadership (ED, Site and Patient Flow)** — 7-day leadership

Supported by a 24/7 Patient Flow Team

3 CLEAR ESCALATION & SUPERVISION
Defined and well communicated

- Clinical / Operational Team
- ↓
- 24/7 Patient Flow Team (Site Operations Centre)
- ↓
- Senior Manager on Call (SMOC)
- ↓
- Executive on Call (EXOC)

- ✓ Clear supervision arrangements for junior staff
- ✓ Medical on-call support for specialty advice
- ✓ Escalation criteria aligned to Trust policy
- ✓ Real-time communication and decision support
- ✓ Regular senior presence on site at peak times
- ✓ Escalation log reviewed daily

4 HOW WE KNOW IT IS WORKING
Monitoring impact and assurance

- **Senior review at weekends** — % of patients reviewed by a consultant within target timeframe
- **Specialty response times** — Time to senior clinical review for key specialties (e.g. medics, surgery, gastro, cardiology)
- **Decision-to-admit delays** — Time from decision to admit to departure from ED
- **ED >12-hour waits** — Trend and reduction supported by timely senior decision-making
- **Weekend discharge** — Number of weekend discharges and comparison to weekday average
- **Escalation events** — Number of occasions senior cover required to be escalated due to gaps / delays
- **Uncovered shifts** — Monitored and reported through divisional governance and Executive Team

ASSURANCE — Senior decision-making capacity is planned around periods of greatest operational pressure, with 24/7 escalation arrangements and ongoing monitoring of impact on patient flow.

Safe care. Supported teams. Better outcomes this winter.

Wigan Single Point of Access (SPOA)

Strengthening admission avoidance this winter

One clinical hub connecting people to the right care, at the right time, in the right place.

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Multiple routes into urgent care

A single point of access for our communities

- **GPs** — Referrals, advice and guidance
- **Care Homes** — Referrals, admissions avoidance, support
- **NWAS** — Urgent referrals and handovers
- **Community HCPs** — Community teams, therapists, social care
- **Patients and Carers** — Self-referrals seeking support

WIGAN SPOA

Single Point of Access (Clinical Hub)

One number.
One clinical conversation.
One coordinated response.

Integrated Neighbourhood Working

Connecting primary care, community services, NWAS, acute services and social care to maximise care closer to home throughout winter.

Better outcomes. Stronger communities.

Alternatives to ED attendance and hospital admission

Rapid access to the right care

- **UCR** — Rapid community response — *Care at home often within 2 hours*
- **Virtual Ward / Hospital at Home** — Acute-level care at home — *Hospital care in the comfort of home*
- **OPAT** — Outpatient Antimicrobial Therapy — *Treatment without hospital admission*
- **SDEC** — Same Day Emergency Care — *Rapid assessment and treatment*
- **Frailty SDEC** — Specialist frailty assessment — *Direct access for frail patients*

Winter intent

- Reduce avoidable ED attendance
- Prevent avoidable admission
- Maximise community capacity
- Support care closer to home

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

Compassionate care, for every person, every time.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Flow

Our WWL values

We put people at the heart

We listen and involve

We are kind and respectful

We are one team

Eliminating Corridor Care at WWL

Safer care. Dignity and privacy. The right care, in the right place, first time.

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Our commitment

No patient should receive care in a corridor. We are taking a whole-system approach to eliminate corridor care, reduce ED crowding and improve flow, in line with GIRFT Clinical Operational Standards.

1 Prevent crowding

Avoid attendance and admission where possible

- Wigan Single Point of Access (SPOA) and stronger primary and community integration
- Call Before You Convey pilot (including geriatrician input)
- Care home programme
- Urgent Community Response and intermediate care
- Virtual Wards and Hospital at Home
- Direct booking to SDEC/UTC (where available)

More people cared for in the community, avoiding unnecessary ED attendance.

2 Act early at the front door

Right patient, right pathway, faster decision-making

- Streaming at first contact / ISAT within 30 minutes
- Senior clinical decision-making at the front door
- SDEC and Frailty pathways (maximising same-day care)
- Clear pathways for UTC, SDEC, Frailty, Acute Medicine and community services
- Minimise time in ED through timely assessment, diagnostics and treatment

Early assessment and the right care in the right place.

3 Escalate at red lines

Clear thresholds. Immediate action. Executive oversight.

WWL RED LINES

Ambulance handover > 45 minutes
Director of the Day to notify COO/CNO. OOH PFM/Bed Manager to SMOC/EXOC.

Any patient waiting > 24 hours in ED
Director of the Day to notify COO/CNO. OOH PFM/Bed Manager to SMOC/EXOC.

Any requirement for corridor care
Director of the Day to notify COO/CNO. OOH PFM/Bed Manager to SMOC/EXOC.

Corridor care is not routine capacity. It requires senior escalation and executive oversight.

4 Assure on safety

Board oversight of experience, dignity and harm

- Routine reporting of corridor care events (frequency, duration and circumstances)
- Executive and Board oversight (monthly)
- Monitoring of patient safety, clinical harm, dignity and privacy
- Performance metrics: ambulance handover, ED occupancy, 4-hour and 12-hour waits, SDEC utilisation, admissions, length of stay, NCTR and Pathway 0 discharge
- Learning from incidents, patient feedback and quality reviews
- Implementation of GIRFT Clinical Operational Standards across the whole patient pathway

Visible oversight, continuous improvement and assurance to the Board.

Underpinned by GIRFT standards

- Front-door streaming and same-day care
- Timely specialty review and decision-making
- Inpatient flow and discharge
- Clinical ownership across specialties
- Elimination of corridor care

What this delivers

- Fewer people in ED and reduced crowding
- No corridor care – safer, more dignified care
- Reduced risk of clinical harm
- A better experience for patients and staff
- Sustained improvement in flow and performance

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Patient Flow and Escalation Framework

Right patient, right place, right time – every day

Proud to care for our WWL communities

Patients Safe, effective and compassionate care

People Supported, listened to and valued

Performance High quality, sustainable care and outcomes

Partnerships Stronger together for healthier communities

Patient Flow and Escalation Policy

Our single framework for safe, effective and timely patient flow.

Sets out our principles, governance, roles and responsibilities, escalation hierarchy and how we maintain safe patient flow across the organisation, aligned to national guidance and our WWL values.

Safe care | Supported people | High quality, sustainable performance | Stronger together with our partners

Business as Usual (BAU) SOP

Optimising flow every day

How we manage patient flow during normal operational pressures (OPEL 1–2) to maximise existing capacity.

- Timely senior clinical decision-making
- Early discharge planning
- Admission avoidance
- Effective use of community services, Virtual Wards and Hospital at Home
- Daily bed meetings (09:00, 12:30, 16:00)
- System working and collaboration

Escalation SOP

Responding to increased pressure

How we manage patient flow when operational pressures escalate (OPEL 3–4) to maintain safety and flow.

- Activation of escalation actions
- Additional bed meetings (10:00, 14:00)
- Use of escalation / assessment area capacity (as authorised)
- Enhanced discharge and system working
- Executive oversight and decision-making
- Preparation for potential EPRR activation

ED Escalation SOP and WWL Red Lines

Keeping our patients safe

How we respond to specific ED triggers and WWL Patient Safety Red Lines, with clear escalation to senior leaders.

- ED escalation triggers and required actions
- Monitoring of key ED metrics (e.g. waits, ambulance handovers)
- Immediate escalation for WWL Red Lines
- Clear roles and responsibilities (Director of the Day, CNO/COO)
- Out of hours escalation via SMOC to Executive On Call (EXOC)
- Focus on patient safety and risk management

Escalation Capacity

A structured approach to maintain safe patient flow

Clinical & Operational Teams Manage flow and escalate risks

Director of the Day (Operations / Nursing) Oversees daily pressures and directs actions

COO or CNO Executive responsible for decision to utilise additional escalation capacity

Out of Hours SMOC escalates to Executive On Call (EXOC)

Governance and Oversight

Monitoring, assurance and continuous improvement

Divisional Governance Monitoring and performance

Executive Team Daily oversight

Quality & Safety Committee Patient safety and quality

Finance & Performance Committee Operational and financial oversight

Trust Board Assurance

Our aim

Safe, timely and effective patient flow for better care and healthier communities.

People. Partnership. Progress.

A healthier tomorrow together

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

PREPARED PEOPLE
RESILIENT SERVICES
HEALTHIER COMMUNITIES

MODEL EMERGENCY DEPARTMENT

A safer, more effective ED for patients who need it most

Applying the Model ED principles to improve care, reduce overcrowding and support flow across the system.

THE 5 KEY PRINCIPLES

1. The ED must be **prioritised** for those patients who are in **most need** of emergency medical care.
2. **Overcrowding increases risk** in the ED environment, making it harder to identify and clinically prioritise the sickest patients and those with vulnerabilities (e.g. frail, newborns, those with learning difficulties or mental health conditions).
3. Overcrowding also **increases the inefficiency** within UEC pathways, driving up staffing levels and pressures, and causing more delays.
4. Patients requiring emergency medical care, whether to be admitted or discharged from the ED, should receive care in an **appropriate setting** and not be put at risk of delay-related harm with undue waits for investigation, treatment, specialty care or admission.
5. The ED team cannot deliver effective and high-quality care without **engagement and leadership from the whole hospital** and effective patient flow and discharge pathways from all specialty teams.

WWL position and focus

How we are applying the principles to improve care for our patients.

Streaming patients to the right service

Patients are streamed to our Urgent Treatment Centres and SDEC to prioritise ED for patients in need of emergency medical care. On arrival our frailty patients are reviewed by our Community Assessment Practitioner to determine whether they can be treated in their own home or the place they call home. Frailty patients are also streamed to our frailty assessment and seen by our specialist practitioners with the aim of reducing the likelihood of a hospital admission or, where admission is required, cared for on our Community Assessment Unit or in a Care of the Elderly bed. Newborns and children are seen in our paediatric ED department. Patients with mental health conditions are supported by colleagues from Greater Manchester Mental Health and, if they have a mental health need only, they may be streamed into the Makerfield Suite.

Reducing ED attendances

Implement the Acute Medical Offer, expanded Same Day Emergency Care pathways and strengthened community alternatives to reduce the number of patients who are initially seen in ED, relieving pressure on our small ED department and improving patient experience.

Growing the frailty pathway

Build on the success of streaming people from ED and increase the number of patients who are conveyed directly to frailty SDEC or who are referred by the Community Response Team, ensuring older people receive specialist assessment and intervention in the most appropriate setting.

Supporting all our patients

Provide the right care for our paediatric, mental health and vulnerable patients through dedicated pathways and strong partnership working with Greater Manchester Mental Health and community services.

Clinical Operational Standards underpin the Model Emergency Department

Safe Emergency Department care is dependent upon every specialty meeting the agreed Clinical Operational Standards.

THESE STANDARDS ENSURE:

- Senior clinical decision-makers review patients within agreed timescales.
- Specialty teams respond promptly to referrals and clinical requests.
- Investigations and treatment are completed without unnecessary delay.
- Patients are transferred promptly to the most appropriate care setting.
- Every specialty shares responsibility for patient flow across the hospital.

WHY THIS MATTERS

Consistent adherence to the Clinical Operational Standards enables the Emergency Department to deliver safe, effective and high-quality care. Timely specialty review and decision-making reduce overcrowding, minimise delays, improve patient flow and ensure patients receive the **right care, in the right place, at the right time.**

OUR INTENT — The right patient, in the right place, at the right time.

System Escalation and Partnership Working This Winter

One system. Shared visibility. Earlier action. Better outcomes for our people and communities.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

1 Wigan Place

Working together to keep people well and out of hospital

- Wigan Council and WWL working as system partners.
- Joint focus on admission avoidance, NCTR, discharge, community capacity and supporting people at home.
- Weekly Strategic Group for SROs provides senior system leadership, oversight and escalation.
- Programme of work to strengthen community services and support people to remain at home.

Stronger communities. Fewer avoidable admissions.

2 Primary Care Interface

Joined-up working to improve access and reduce unnecessary ED attendance

- GP Board provides primary care leadership and engagement.
- Primary–Secondary Care Interface identifies and resolves pathway issues.
- Supports development of alternatives to ED, direct pathways and access to specialist advice.
- Links to SPOA, community services and wider system work.

Right care, right place, closer to home.

3 Shared System Visibility

Real-time intelligence to focus action

- System Visibility Dashboard provides a shared view of operational pressures across WWL, Wigan Council, primary care, community and other system partners.
- Enables earlier identification of emerging capacity and flow constraints.
- Supports joint decision-making and targeted system action.
- Used by the Wigan Place Strategic Group and wider partners to identify where additional intervention is required.

One shared view. Better, faster decisions.

4 Greater Manchester Escalation

Coordinated support when pressures increase

- Escalation to NHS Greater Manchester ICB when pressures require support beyond Wigan Place.
- System escalation arrangements support coordination across providers.
- Visibility of OPEL pressures across Greater Manchester supports consideration of mutual aid.
- Executive-to-executive discussion in-hours and EXOC-to-EXOC escalation out-of-hours.
- ICB can coordinate requests for system support, including ambulance diversion and mutual aid where appropriate.

Working together to maintain safe, resilient care.

Escalation pathway

From early action to system support

WWL Operational Pressure
Internal actions and escalation (Trust flow and OPEL process)

→ **Wigan Place System Partners**
Joint operational response across health and social care

→ **Primary & Secondary Care Partners**
GP Board and Primary–Secondary Care Interface

→ **NHS Greater Manchester ICB**
Escalation for additional system support

→ **Mutual Aid & System Action**
Coordinated response across Greater Manchester

System visibility dashboard

One shared view of pressure › Early identification of emerging issues › Joint decision-making and intervention › Targeted system action to maintain flow

Real-time intelligence. Real impact.

What this delivers for winter

- **More care in the community** — Fewer avoidable admissions and improved NCTR.
- **Joined-up working** — Across council, primary care, hospitals and partners.
- **Earlier intervention** — To prevent escalation and maintain flow.
- **A more resilient system** — Supporting safe, high-quality care throughout winter.

Our Values

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

Compassionate care, for every person, every time.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Ambulance handover improvements

Improving handovers. Supporting flow. Getting ambulances back to the community.



We have a **comprehensive improvement plan in place,** working with North West Ambulance Service (NWAS), to **reduce ambulance handover delays, improve flow** through the Emergency Department and ensure ambulances are **returned to the community as quickly as possible.**

Prevention
Reducing queues and managing demand at the front door

- Early streaming of arriving ambulances to the most appropriate area (ED, SDEC, UTC and specialist receiving areas).
- Rapid clinical assessment and triage.
- Direct conveyance to SDEC and frailty pathways where clinically appropriate.
- Cohorting of patients awaiting assessment.
- Real-time monitoring of ambulance arrivals and expected conveyances.

Flow
Improving movement through the Emergency Department

- Senior clinical decision making.
- Criteria to Admit applied consistently.
- Timely specialty review.
- Early discharge and inpatient flow improvements.
- Whole hospital ownership of flow.
- Community capacity maximised through BetterLives (e.g. Hospital at Home, Virtual Wards, Community Response).

Escalation
Responding rapidly to increased pressure

- ED Escalation SOP.
- WWL Patient Safety Red Lines.
- Escalation capacity SOP.
- Director of the Day oversight.
- Executive escalation where required.

Partnership working
Working with NWAS to deliver sustained improvement

- Joint operational meetings and improvement plan with NWAS.
- Shared performance review and learning from delays.
- Real-time communication and visibility of expected arrivals.
- Mutual aid discussions through Greater Manchester where required.

Capital works (October – December)
Investing in our infrastructure to support safer and more efficient handovers.

- Expansion of our Ambulance Receiving Areas to increase capacity.
- Reconfiguration to improve patient flow and reduce congestion.
- Works scheduled between October and December with minimal disruption to services.
- Improved facilities for patients and staff.

Monitoring progress
We are monitoring key metrics daily to track improvement and ensure timely action.

Ambulance conveyances	(number per day)
Mean handover time	(minutes)
>30 minute handovers	(number and %)
>45 minute handovers (WWL Red Line)	(number and %)
See and treat (S&T)	(%)
ED occupancy	(%)

Expected outcomes
These improvements will:

- Reduce ambulance handover times.
- Fewer >30 and >45 minute handovers.
- Less time lost for ambulance crews.
- Improved patient flow through the Emergency Department.
- Better patient experience.
- Ambulances returned to the community sooner.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust



Infection Prevention and Control (IPC)

Our WWL values

We put people at the heart

We listen and involve

We are kind and respectful

We are one team

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Infection Prevention and Control

Protecting patients, protecting capacity, maintaining safe flow.

Our assurance

The Trust has robust Infection Prevention and Control arrangements in place to support **operational resilience** throughout winter. The Chief Nursing Officer (Director of Infection Prevention and Control) has been actively involved in the development of the Winter Plan and remains a key stakeholder in supporting the operationalising of the plan.

Isolation capacity

Maintaining capacity to respond to outbreaks

- Dedicated ward comprising entirely of side-room accommodation available within the Trust.
- Provides additional isolation capacity to respond rapidly to infectious outbreaks.
- Supports maintenance of patient flow whilst protecting vulnerable patients.

Real-time side room management

Visibility of isolation capacity across the Trust

- Robust system in place to identify and RAG rate side-room capacity across the Trust.
- Provides real-time visibility of available isolation capacity.
- Enables timely isolation decisions and the flexibility to manage capacity across the Trust.

Executive leadership

Director of Infection Prevention and Control

- Chief Nursing Officer is the Trust Director of Infection Prevention and Control (DIPC).
- Engaged in the development of the Winter Plan.
- Provides executive oversight and remains a key stakeholder in supporting the operationalising of the plan.

Prepared workforce

Ensuring staff are equipped to respond safely

- High risk and/or vulnerable areas have a fit testing training plan.
- Training provided through a hybrid divisional and Health and Safety Team approach.
- ITU, Emergency Department and Respiratory Care areas have robust training matrixes.

Operational resilience

Maintaining safe services during periods of increased infection risk

- Ability to respond rapidly to outbreaks.
- Isolation capacity managed flexibly to maintain patient flow.
- Close working between IPC, operational teams and estates.
- Supports continuity of safe care for patients and staff throughout winter.
- Integrated within wider winter planning arrangements.

Safe isolation | Executive oversight | Prepared workforce | Protected patient flow

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Leadership and Operational Grip

Our WWL values

We put people at the heart

We listen and involve

We are kind and respectful

We are one team

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Governance of Winter

Proud to care for our WWL communities

Our focus this winter

- Maintain safe patient flow
- Deliver operational performance
- Support our people
- Work closely with our partners

Trust Board

Sets the strategic direction and provides assurance

Executive Team

Provides leadership, oversight and decision-making

Our shared commitment

Working together to ensure safe, effective and timely care for our patients and communities every day throughout winter.

Executive Winter Triumvirate

Chief Nursing Officer

- Lead transformation programmes associated with patient flow
- Nursing, midwifery and AHP workforce and escalation capacity
- Site flow, discharge and patient experience
- Work with divisions and system partners to deliver sustainable improvement

Chief Operating Officer

Executive Winter Sponsor

- Operational flow and performance across the Trust
- System flow, admission avoidance and corridor care reduction
- Maintain elective, cancer, diagnostic and RTT performance
- EPRR and winter operational response
- Work closely with the CNO and CMO

Chief Medical Officer

- Clinical Operational Standards (including GIRFT)
- Implementation of national standards and clinical pathways
- Clinical decision-making, safety and quality
- Clinical and consultant leadership
- Medical workforce leadership

Collective executive leadership for winter resilience

Safe care for our patients | **Supported** and engaged people | **High quality,** sustainable performance | **Stronger together** with our partners



Wrightington, Wigan and Leigh Teaching Hospitals NHS
NHS Foundation Trust

Proud to care for our WWL communities

WINTER OPERATING MODEL

Triuvirate Executive Team. Three levers for winter.

A single executive team working together to provide clear leadership, support and assurance to our divisions.

SAFE CARE

Safe, timely, evidence-based care

- Clinical standards and GIRFT
- Patient safety and quality
- Evidence-based practice and pathways
- Safe and effective care within financial envelopes

AUTONOMY

Cohesive support for divisional teams

- Workforce (nursing, midwifery and AHP)
- Flow, discharge and patient experience
- Transformation programmes (e.g. BetterLives)
- Escalation capacity and support

SYSTEM LEADERSHIP

Operational delivery and performance

- Operational performance (UEC, elective, diagnostics, cancer)
- System flow and admission avoidance
- EPRR and winter operational response
- Partnership working (primary care, community, NWAS)

Divisional ownership
Clear ownership, visible accountability and executive support.

DIVISIONAL TRIUMVIRATES
Local delivery and impact

Executive support
A single point of access for expertise, decision-making and escalation.

HOW IT WORKS

01 **LISTEN**
Engage divisional triumvirates to understand the support required.

02 **DECIDE**
Use a weekly Executive Triumvirate meeting with clear terms of reference.

03 **ACT**
Deploy executive support where it adds the most value.

04 **ASSURE**
Create clear reporting lines for major workstreams.

OUTCOME — Great care, a great place to work, and divisions equipped to deliver this winter.

- **Patients** — Safe, compassionate care
- **People** — Supported and valued
- **Performance** — High quality, sustainable care
- **Partnerships** — Stronger together

A healthier tomorrow together



WINTER OPERATING MODEL

Clarity by design: one line of sight from division to executive

A united executive focus to support delivery through winter.



WINTER-SPECIFIC OVERSIGHT

01 OWNERSHIP
A named executive lead for each winter portfolio.

02 OVERSIGHT
Divisional visibility of who is accountable for what.

03 ESCALATION
Clear routes for support, decisions and assurance.

THE PRINCIPLE
Add winter clarity without diluting core portfolio accountability.

01

CHIEF MEDICAL OFFICER

Prof Sanjay Arya

Clinical standards and medical leadership anchor winter safety.

WINTER PORTFOLIO

Four workstreams create a clear clinical line of sight

Targeted focus areas to drive safer care and improved outcomes this winter.

1 

WORKFORCE

Medical workforce leadership.

- Ensure sufficient and sustainable medical staffing
- Support wellbeing and retention
- Develop leadership for winter and beyond

2 

PATHWAYS

Clinical pathway development • Acute Medical National programme.

- Standardise and optimise clinical pathways
- Implement Acute Medical National programme
- Reduce variation and improve flow

3 

SAFETY & METRICS

Sepsis improvement with CNO • right patient, right place, right time • Board and Ward Round metrics.

- Improve early recognition and treatment of sepsis
- Embed right patient, right place, right time
- Use Board and Ward Round metrics for visible assurance

4 

SHARED ACCOUNTABILITY

Triumvirate ownership of the corridor reduction and elimination plan.

- Joint clinical, nursing and operational ownership
- Deliver the corridor reduction and elimination plan
- Maintain focus on safe, timely and effective care

 **CLINICAL INTENT — Safer decisions, consistent standards, visible assurance.**

02

CHIEF NURSING OFFICER

Kevin Parker-Evans

Nursing leadership turns escalation capacity into safer flow.

WINTER PORTFOLIO

A single flow chain — from staffing to discharge

Joined up nursing leadership to keep patients moving, safely and effectively.

ESCALATION Capacity + staffing → **SITE FLOW** Daily flow leadership → **DISCHARGE** Discharge coordination → **OUTCOMES** 12-hour waits + LoS

01 PEOPLE & PROFESSIONS

- Leadership for nursing, midwifery and AHP colleagues
- Workforce support through winter escalation

02 FLOW IMPROVEMENT

- Patient flow, site management and discharge teams
- Inpatient flow
  - ED waits over 12 hours
  - Length of stay

03 ASSURANCE

- CQC improvement plan and enforcement notices
- Shared corridor reduction and elimination accountability

FLOW INTENT — Right care, right place, coordinated end to end.

03

CHIEF OPERATING OFFICER

Sarah Brennan

Operational leadership and grip, stronger primary care links and system wide flow.



WINTER PORTFOLIO

Protect today. Transform tomorrow. Connect the system.

Operational leadership to deliver safe, effective care this winter and beyond.

01 PROTECT
Maintain safe and reliable services today

- Operational management teams.
- Maintain RTT, diagnostic, cancer and elective performance.
- EPRR Executive Lead.
- Winter Executive Lead.

02 TRANSFORM
Improve flow and reduce demand

- Strengthen admission avoidance through Call Before Convey, care-home support and primary care pathways.
- Lead UEC transformation and improvements to inpatient flow.

03 CONNECT
Work together across the system

- Build effective links across primary care, community services, NWAS and mental health.
- Ensure patients reach the right service without unnecessary conveyance or admission.
- Provide executive accountability for reducing and virtually eliminating corridor care.

DELIVERY INTENT — Operational grip with system reach.

Wrightington, Wigan and Leigh Teaching Hospitals NHS
NHS Foundation Trust

On-call arrangements

Executive On Call (EXOC)

Executive decision-making and organisational oversight.

Senior Manager on Call (SMOC)

Operational leadership and coordination across the Trust.

24/7 Patient Flow Team (Nursing)

Senior nursing leadership on site, providing 24/7 operational oversight of patient flow, capacity and escalation.

Escalate any concerns to the Senior Manager on Call.

Medical On Call

Access to senior clinical decision-makers, including:

- Acute Medicine Consultant on Call
- Emergency Department Consultant on Call
- Consultant Cardiologist on Call
- Consultant Gastroenterologist on Call
- Consultant General Surgeon on Call

System partners

- Greater Manchester ICB Executive On Call
- Greater Manchester System Control Centre
- North West Ambulance Service (NWAS) Tactical Commander

Community capacity

Accessible in the hours of service operation for Virtual Wards and the Community React Team, with 24 hour cover from the District Nurses.

Enhanced arrangements

Weekend, Christmas and New Year operational plans are in place to support the on-call teams, with increased oversight and agreed system escalation processes.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Operational monitoring and escalation using the OPEL framework

Real-time visibility. Clear triggers. Timely operational response to keep our ED and hospital site safe.

Real-time monitoring and reporting

We monitor and report real-time operational pressures using the OPEL framework, with live data available via GM Tableau.

The 10 OPEL parameters (acute)

- Average ambulance handover (mins)
- 4-hour ED performance (%)
- ED Majors and Resus occupancy (%)
- Median time to treatment (mins)
- Patients in ED over 12 hours (%)
- Patients in ED referred to service (%)
- Bed occupancy (%)
- Patients no longer meeting criteria to reside (%)
- Patients discharged (%)
- Beds closed for IPC (%)

The OPEL framework

The OPEL framework is clearly referenced in our escalation policy and associated SOPs to manage flow and ED escalation. Associated action cards are part of the procedures and have been utilised on a number of occasions to manage periods of pressure.

OPEL 1	OPEL 2	OPEL 3	OPEL 4
Normal pressure	Increased pressure	Significant pressure	Extreme pressure
Business as usual	Enhanced monitoring and early intervention	Escalation procedures activated	Full Trust and system response

Policies, SOPs and action cards

Our operational policies set out clear processes for escalation and response, including:

- Escalation policy
- Patient Flow SOP
- ED Escalation SOP
- Trust Escalation SOP
- OPEL action cards

Triggers for escalation

We have clear triggers for escalation, including:

- ED trigger points
- Escalation capacity
- WWL Patient Safety Red Lines

Roles and responsibilities

There is a clear understanding of roles and responsibilities in relation to the required actions, ensuring a timely and coordinated operational response.

Operational teams
↓
Clinical leaders
↓
Director of the Day
↓
Director of Nursing of the Day
↓
Chief Operating Officer
↓
Chief Nursing Officer
↓
Chief Medical Officer
↓
Senior Manager on Call (out of hours)

System visibility and Greater Manchester alignment

- Live OPEL scores for all providers available via GM Tableau, allowing real-time system oversight.
- GM ICB support mutual aid requests for divert of ambulance activity up to a maximum of three ambulances.
- Use of Tableau to ascertain OPEL scores for other providers to see if mutual aid is likely.
- Executive to Executive discussions during working hours and EXOC to EXOC during out of hours periods.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Prepared for all scenarios

Robust contingency planning to maintain safe, resilient services through winter and beyond.

Business Continuity Plans (BCPs)

Maintaining critical services through effective planning, testing and continuous improvement.

- Services have tested BCPs through events which have happened during the year and table top exercises.
- The Head of EPRR supports services with the development of BCPs and offers training.
- BCPs will be a focus going into winter to align with the updates required by the EPRR core standards review.



Plan | Test | Train | Improve | Be ready

Severe Weather and Infrastructure Disruption

Prepared to respond to external threats and minimise disruption to services.

- Policies and procedures are in place for severe weather.
- There are regular operations, estates and EPRR meetings in place to review any disruption contingencies.
- Infrastructure disruption has been tested on a number of occasions due to planned and unplanned events during the year.



Plan | Monitor | Respond | Maintain services

Industrial Action Contingencies

A planned and coordinated approach to maintain safe care during industrial action.

- Industrial action contingencies have been reviewed where relevant.
- There have been a number of periods of industrial action during the year.
- There is a planned approach to how this is managed and the infrastructure that supports this, led by the Chief Operating Officer and supported by the Chief Medical Officer.



Plan | Coordinate | Communicate | Maintain safe care

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

HOME FOR CHRISTMAS

Supporting Our People This Winter

Healthy, supported and resilient teams. Safer care for our patients and communities.

Our commitment

We value and support our people. We will provide practical, visible and compassionate support to help all staff stay well, safe and resilient throughout winter.

Caring for the people who care for others

Visible leadership and support

We will be there, together.

- Leaders visible in clinical and operational areas, who are available to check in, hear and respond to concerns.
- F2SU guardian and champions accessible for concerns.
- Confidential advice and guidance for leaders via PAM Wellness to help them support the wellbeing of their staff and respond effectively to concerns.

Visible, approachable leadership for our people.

Health and wellbeing support

Support when you need it.

- Access to WWL Occupational Health.
- PAM Wellness Employee Assistance Programme (EAP).
- Access to trained TRiM (Trauma Risk Management).
- Access to staff physiotherapist.
- Proactive wellbeing resources available on the Steps for Wellness intranet page.
- Financial advice available through PAM Wellness and resources on the intranet page.
- PAM Wellness App, powered by Champion Health – online and app-based health and wellbeing platform.
- Flu vaccination access.
- Access to chaplaincy and spiritual care service.

Your wellbeing matters.

Safe staffing, rest and recovery

The right support. In the right place.

- Use of SafeCare, acuity/dependency and professional judgement to identify pressure early.
- Ensure safe working environments and adherence to rest requirements.

A safe and supported workforce.

Team resilience and recognition

Recognising and supporting our people.

- Encourage local team debriefs after significant periods of escalation.
- Recognise the contribution of our teams.
- Managers to be alert to fatigue and cumulative pressure.
- Culture and engagement toolkit available on the intranet.
- Monthly staff and team recognition awards.
- Wellbeing check-ins and peer support approaches.

Our people make the difference.

Wellbeing support | Leadership guidance | Rest and recovery | Recognition and culture | Useful resources

Our Values

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

Compassionate care, for every person, every time.

WINTER PLAN 2026/27

How will we know if the plan is working?

Clear measures. Regular oversight. Early action.

We will know the plan is working when operational performance is delivering to plan, patient safety risks are controlled, flow is maintained and deviations trigger early action.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust



Safe care.
Stronger communities.
All year round.

Key measures of success

We will monitor the following indicators to track the impact of our Winter Plan:

A&E 4-hour performance
Performance against agreed trajectory

>12-hour waits
Performance against agreed trajectory

Ambulance handovers
Performance against plan and improvement trajectory

Bed occupancy
Performance against planned capacity and forecast requirement

No criteria to reside (NCTR)
Delivery against BetterLives / discharge plan

Average length of stay
Trend and delivery against plan

RTT <18 weeks
Performance against agreed trajectory

Corridor care episodes
Episodes, duration and compliance with WWL Red Lines

Workforce
Staffing, sickness, vacancies and escalation reviewed against plan

How we will monitor progress

Daily
- Operational control
- Bed meetings
- OPEL and Red Lines
- Live performance and escalation

Weekly
- Winter oversight meeting
- Review trajectory
- Risks and mitigations
- System engagement

Monthly
- Executive Team review
- Committee assurance (Quality & Safety, Finance & Performance)
- Performance to plan

Board
- Exception reporting
- Delivery against plan
- Patient safety
- Outcomes and learning

Our WWL values in action this winter

People at the Heart | Listen and Involve | Kind and Respectful | One Team | Working together for a healthier Wigan Borough

NHS England

To:
- All NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
- ICB:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
- Primary care networks
- Local government chief executives
- Directors of Adult Social Services
- Directors of Public Health

cc.
- Regional:
  - directors
  - chief operating officers
  - medical directors
  - chief nurses
  - directors of commissioning
  - chairs

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

17 July 2026

Dear colleagues

Winter planning 2026/27 – expectations and assurance

Last winter was the best in 3 years for 4-hour performance and ambulance response times, despite an early flu season, a January norovirus peak and industrial action. That was the result of early planning and strong collaboration across health and care, for which we thank you. This letter sets out the national approach to winter 2026/27 and the actions we need every part of the NHS and local government to take, starting now.

Every local area must have a robust, clinically led and deliverable winter plan. The core expectations are:

- draft winter plans completed by the end of August, developed jointly by all local partners: acute, ambulance, community, mental health, primary care, local authorities, social care and the third sector
- a named Executive Winter Lead in every ICB and provider, accountable for preparedness and response
- plans tested at the NHS England regional stress test exercises in September
- plans signed off by boards using the attached Board Assurance Statements (BAS), submitted to england.eecpmo@nhs.net by 30 September 2026

Responsibilities for winter reflect the new operating model set out in the Model ICB and Model Region Blueprints: ICBs commission, providers deliver, and regions oversee. The BAS templates set out in full what boards will be asked to assure; use them now to shape your plans rather than as a retrospective checklist. In summary:

ICBs

ICBs are responsible for the winter plan for their area, agreed with all partners and signed off by their board. Plans must be built on a whole-area demand and capacity analysis with robust planning assumptions, tested against surge and extreme surge scenarios. As strategic commissioners, ICBs must lead prevention now – vaccination uptake (particularly maximising uptake in children to help reduce spread), and proactive support for people most at risk from winter viruses and cold weather – and commission the right level of activity for winter so that people are treated closer to home wherever possible. That means sufficient commissioned capacity across:

- primary care: same day urgent appointments, enhanced access, NHS 111 direct booking, community pharmacy and out-of-hours provision including during holidays and over Christmas, alongside delivery of the seasonal vaccination campaigns
- community services: urgent community response, virtual wards and Hospital at Home, with senior clinical decision-making accessible through a single point of access at least 12 hours a day, 7 days a week
- mental health: resilient all-age crisis services, including urgent mental health helplines via NHS 111, crisis alternatives and liaison psychiatry, with crisis plans in place ahead of winter for high-risk patients and frequent attenders
- social care and intermediate care: commissioned jointly with local authorities, with discharge planned together, sufficient capacity through winter and agreed plans to reduce hospital occupancy ahead of Christmas
- infection prevention and control (IPC): commissioning safe IPC practice in care homes and the wider care sector

ICBs must also co-ordinate the winter response day-to-day through their co-ordination centre, operating 7 days a week and using the OPEL framework, with tested escalation, surge and mutual aid arrangements agreed by all partners.

NHS trusts and foundation trusts

Providers are accountable for operational delivery through winter. Trusts must:

- complete an organisational winter plan by the end of August, with staff flu vaccination programmes ready to launch and preparatory actions under way now
- implement the Model Emergency Department, Model Acute Pathway and Model discharge pathway requirements ahead of winter, with the elimination of corridor care

treated as a patient safety priority, while maintaining elective capacity throughout the winter period
- assure tested arrangements for escalation, infection prevention and control, on-call leadership and staff welfare, and protect delivery of agreed 2026/27 trajectories

Ambulance services

- Plan to deliver the 2026/27 Category 2 response time trajectory, maximising hear and treat, see and treat and referral into alternatives to ED, to reduce conveyance rates.
- Work with acute partners to deliver 15-minute handovers, with none exceeding the 45-minute maximum.

Regional teams

In line with the Model Region Blueprint, regional teams will oversee winter preparedness and performance across providers and ICBs, arrange the September stress test exercises, assure plans across their geographies and co-ordinate mutual aid across ICB boundaries where needed, including specialised services and pathways commissioned outside of ICB arrangements.

Support available

We will share performance data to support planning by the end of July via NHS Futures, run online sessions in July on improving vaccination uptake, and publish further guidance on Urgent Community Response and community beds shortly. We will continue to work with ICBs and providers to support communication on 111, Pharmacy First, vaccination, and alternatives to ED.

Thank you for everything you and your teams are doing to prepare. Early, collaborative planning delivered a better winter for patients last year; together we can do so again.

Yours sincerely



Sarah-Jane Marsh CBE

NHS England Chief Operating Officer

EQUALITY IMPACT ASSESSMENT FORM - STAGE 2

FULL ASSESSMENT / IMPROVEMENT PLAN

MUST be completed if any negative issues have been identified in Stage 1

Title of Service / Policy being assessed:	Trust Winter Plan 2026/27
Assessment Date:	30th September 2026
Is the service aimed at a specific group of users? (e.g. men, women, older people etc.)	No. The Winter Plan applies to the whole population accessing WWL services. Some elements are particularly relevant to people who may be more vulnerable during winter, including older people, people with frailty, disabilities or long-term conditions, pregnant women, carers and people experiencing health inequalities.

Protected Characteristic	What negative impacts were identified in Stage 1 and which groups were affected?	What changes or actions do you recommend to improve the service to eradicate or minimise the negative impacts on the groups identified?	Lead	Time- Scale
Sex (assigned at birth) male / female	No specific adverse impact identified. Differences in health needs, service use and caring responsibilities may affect experience during winter pressures.	Monitor access, patient experience and outcomes through routine quality and performance reporting; investigate material variation where identified.	Divisional Triumvirates / EDI Lead	Throughout winter
Age (18 years+)	Potential disproportionate impact. Older people, particularly those living with frailty, dementia, multimorbidity or care dependency, are more vulnerable to winter pressures, prolonged stays and deconditioning. Seasonal pressures may also affect younger people.	Use frailty, SDEC, admission-avoidance, community and discharge pathways to provide timely care in the most appropriate setting. Maintain early senior decision-making and monitor access/outcomes by age where possible.	Divisional Triumvirates / Clinical Directors	Throughout winter
Race / Ethnicity	Potential barriers may arise from language, communication, cultural factors and differing patterns of healthcare access, including understanding vaccination messages or pathway changes.	Maintain interpreting and translation support; provide accessible information; use appropriate communication routes for vaccination and service changes; review any evidence of differential access, experience or outcomes.	Divisional Triumvirates / EDI Lead / Communications	Throughout winter
Disability (hearing / visual / physical / learning disability / neuro diverse / mental health)	Potential disproportionate impact for people with physical or sensory disability, learning disability, autism/neurodivergence, dementia or mental-health needs. Crowded environments, pathway changes, prolonged waits	Maintain reasonable adjustments, accessible communication and individualised care planning. Consider disability and communication needs in moves and discharge. Avoid corridor/escalation care wherever possible	Divisional Triumvirates / Senior Nursing Team	Throughout winter

	or non-standard care areas may create additional barriers and distress.	and use dynamic risk assessment where escalation is unavoidable.		
Religion / Belief	No specific adverse impact identified, although operational pressure may affect the ability to accommodate individual religious or cultural requirements.	Continue to respect requirements relating to diet, personal care, privacy, visiting and spiritual support. Ensure escalation decisions consider individual needs.	Divisional Nursing Teams	Throughout winter
Sexual Orientation (LGBTQIA+)	No specific adverse impact identified. Risk may arise if assumptions are made about relationships, next of kin or carers during urgent admission or discharge.	Use inclusive communication and recognise the patient's identified partner, carer and support network, subject to patient consent. Maintain equality, privacy and dignity standards.	Divisional Teams	Throughout winter
Gender Re-Assignment (trans / non-binary / gender fluid)	No specific adverse impact identified. Privacy, dignity and respectful communication could be affected in pressured or escalation environments.	Maintain privacy and dignity, use appropriate names/pronouns and ensure escalation arrangements do not compromise respectful care.	Divisional Teams	Throughout winter
Marriage & Civil Partnership	No specific impact identified	Recognise spouses and civil partners appropriately in communication, involvement in care and discharge planning, subject to patient consent.	Divisional Teams	Throughout winter
Pregnancy & Maternity	Potential disproportionate impact. Pregnant and postnatal patients require timely access to appropriate assessment and must not be disadvantaged by generic escalation arrangements or operational pressures.	Maintain appropriate clinical pathways and prioritisation according to clinical need. Ensure escalation capacity and flow decisions take account of pregnancy and maternity requirements and avoid unsuitable care environments.	Start Well and Planned Care Divisional Team and Maternity Leadership	Throughout winter
Carer	Potential disproportionate impact. Increased winter demand, discharge activity and greater use of home/community pathways may increase pressure on unpaid carers or reduce their opportunity to participate in decisions.	Identify carers early; involve them in care and discharge planning; assess whether arrangements are sustainable; provide information and links to community/social-care support. Do not assume carers can provide additional care without discussion and agreement.	TOCH and IDT, Clinical Site Lead and Divisional Teams	Throughout winter

Other Group (please specify)	Socioeconomic disadvantage / inclusion health: people experiencing deprivation, homelessness, digital exclusion or social isolation may face additional barriers to access, self-management, appointments and safe discharge.	Use individual assessment; maintain non-digital routes; identify social factors affecting safe discharge; work with community, primary care, local authority and voluntary-sector partners to reduce barriers and support safe care.	Divisional Teams / TOCH / System Partners	Throughout winter
How do you intend to communicate or engage in relation to the actions and proposals for improvements?		The Winter Plan will be communicated through established Trust operational, clinical and governance arrangements and with system partners. Patients, families and carers will be involved in decisions about care, discharge and changes of care setting. Feedback, complaints, incidents, patient experience and equality concerns will inform actions that need to be taken to address areas of concern.		
How will actions and proposals be monitored to ensure their success? Which Committee will you report to?		Delivery will be monitored using operational performance, patient flow, workforce, quality and safety measures. Equality impacts will be considered alongside patient experience, complaints, incidents and safeguarding concerns. Emerging inequalities or unintended consequences will be escalated through divisional teams and then into Executive Management Team with overall winter assurance through established performance oversight i.e. Divisional Assurance Meetings, Executive Management Team, Sub Committees and Board.		
When is the date of the next review?		January 2027, or earlier if a significant equality issue is identified through operational delivery, patient experience, incidents or complaints.		
Who will be responsible for monitoring these actions?		Chief Operating Officer / Chief Nursing Officer, supported by Divisional Triumvirates and EDI Lead.		

PLEASE RETURN COMPLETED FORMS VIA E-MAIL TO: ***EDI Service Lead*** ***debbie.jones@wwl.nhs.uk***

Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	Wrightington, Wigan And Leigh Foundation Trust
If Other, write Provider/Trust Name:	
Contact details (email, phone number):	Sarah Brennan, Chief Operating Officer sarah.brennan@wwl.nhs.uk
Date:	30/09/2026

		Assurance statement	Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
			Please complete these sections		
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.		Winter Plan developed and ready for Board sign off on 7th October 2026	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Quality Impact Assessment and Equality Impact Assessments have been completed and have been included in the Board Pack as part of the sign off process	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Plan has been developed with appropriate engagement from system partners including an engagement event on 23rd September 2026	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Winter led exercise took place on 23rd September and the outcomes have been reviewed and lessons learnt incorporated	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Chief Operating Officer Sarah Brennan is the Executive Winter Sponsor. Chief Nursing Officer Kevin Parker-Evans is the lead for vaccinations but the Chief Operating Officer has the overall accountability for the delivery of winter preparedness, escalation and overall delivery	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Clear winter governance and escalation arrangements are in place including OPEL based escalation, daily operational oversight / bed meetings, Director of the Day / Director of Nursing of the Day and Manager of the Day supported by the Executive Triumvirate. Executive on	

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Please complete these sections

Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	FHCW Flu vaccination programme is in place through the Trust Vaccination Task and Finish Group with Chief Nursing Officer leadership.	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Targeted staff vaccination and IPC measures are in place	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home	Yes	Arrangements are in place for identification and vaccination of long stay patients and patients who are being discharged to care homes	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Population health intelligence insight from joint Trust and Public Health role	and winter interventions include call before you convey and admissions avo

Occupancy and discharge				
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	**Yes**	Discharge requirements have been reviewed with system partners and review will be ongoing throughout the winter period as part of the BetterLives pro
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow	**Yes**	Executive leadership for flow sits with the Chief Nursing Officer. Seven day discharge arraments are in place.
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	**Yes**	As described in the Winter Plan
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	**Yes**	Working towards the Acute Medical Offer in October to ensure that pathways are optimised
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	**Yes**	Frailty pathways have been reviewed and the frailty SDEC capacity has been enhanced

Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	**Yes**	Safe staffing arrangements are in place through established processes.	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	**Yes**	Rotas and operational cover are aligned to demand and there are processes in place for escalation.	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	**Yes**	Elective, cancer and diagnostic plans include winter resilience and protection of planned activity	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	**Yes**	The plan has been developed recognising the seasonal pressures and there are actions in place to protect the capacity required to deliver the plan.	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	**Yes**	Urgent community capacity is prioritised towards patients with the greatest clinical need.	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	**Yes**	Elimination of corridor care is the priority	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	**Yes**	Ambulance handover improvement actions in place which includes reducing conveyances through call before you convey and care home interventions	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	**Yes**	System escalations arrangements support transfer of care and flow thorugh coordinated OPEL response and system calls. Established forums and me	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	**Yes**	The winter plan incorporate actions aligned to model ED and Model Discharge including front door streaming and assessment, SDEC, senior decision	

Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	IPC and estates arranfgements support safe cohorting and reconfiguration during period of respiratory/ gastrointestinal pressure, with escalation subje	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	IPC leadership has been engaged in winter planning and is embedded in operational escalation arranagements including bed meetings and cohortirg	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Fit testing, PPE supply / stock management and escalation arrangements are included within IPC preparedness	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	Risk based patient cohorting arrangements are in place and form part of site management and IPC escalation with activation nased on infection risk an	

Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	**Yes**	On call arrangements are defined across operational, medical, nursing and executive leadership with access to senior clinical advice and clear escalat	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	**Yes**	Real time pressures are monitored through OPEL and daily operational governance with defined triggers, bed meeting and escalation actions. Addition	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	**Yes**	Mutual aid and system escalations arrangements have been reviewd and can be activated through Greater Manchester SCC where local mitigations are	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	**Yes**	Business continuity arrangements support winter resilience and escalation with Trust EPRR and business continuity processes	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	**Yes**	Severe weather and infrastructure disruption are included within winter / business continuity arrangements with escalation through established EPRR /	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	**Yes**	Industrial action contingencies and command arrangements are established and can be activated when required drawing on previous operational learn	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	**Yes**	Staff welfare is incorporated within safe staffing and resilience arranagements including escalation, redeployment and leadership during sustained pre	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name:	Wrightington, Wigan and Leigh Teaching Hospitals NHS Trust
Provider CEO name:	Mary Fleming
Date reviewed:	07/10/2026
Provider Chair name:	Robina Shah
Date reviewed:	07/10/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Sarah Brennan sarah.brennan@wwl.nhs.uk

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Yes the SRO has reviewed the responses and confirms that they are correct

Please confirm date reviewed

30/09/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	Awaiting assessment

Full Quality Impact Assessment

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Section A: Scheme Details

Programme Name	Winter Plan 2026/27
Director of Operations / Head of Service	Chief Operating Officer / Divisional Directors of Operations and Performance
Programme Lead	Head of EPRR

Description of project and the change to be delivered	The WWL Winter Plan 2026/27 sets out the Trust's approach to maintaining safe, effective and timely care during the winter period, when increased demand, seasonal illness and operational pressures are anticipated. The plan brings together a range of interventions across urgent and emergency care, inpatient services, community services and planned care to improve resilience, reduce avoidable hospital attendance and admission, improve patient flow and discharge, and protect capacity for patients requiring urgent and elective treatment. The changes include strengthening admission avoidance and community-based care; improving front-door assessment and Same Day Emergency Care; optimising acute medical and frailty pathways; reducing unnecessary length of stay and delays to discharge; improving ambulance handover and patient flow; maintaining safe staffing and infection prevention arrangements; and protecting elective activity wherever clinically appropriate. The overall aim is to ensure that patients receive care in the most appropriate setting, minimise avoidable deterioration and deconditioning, reduce prolonged waits and non-clinical care environments, and maintain safe, high-quality services throughout periods of increased winter pressure.

Section B: Quality Impact Assessment

	Impact Details and Consequence - What, Why, Who and How?	Positive or Negative	Risk score before controls			Mitigation/Control	Risk score after mitigation / control		
			Consequence	Likelihood	Score		Consequence	Likelihood	Residual risk score
1) Patient Safety	Winter pressures may increase the risk of delayed assessment/treatment, crowding, ambulance handover delay, prolonged waits for beds, use of escalation spaces, hospital-acquired harm and staffing pressure. Older/frail patients and people requiring reasonable adjustments may be particularly vulnerable.	**Positive overall; potential negative risk**	**4**	**4**	**16**	Daily operational oversight and OPEL escalation; WWL patient-safety red lines and dynamic risk assessment; avoidance/minimisation of corridor care; senior clinical review; frailty/SDEC and admission-avoidance pathways; ambulance handover actions; infection prevention controls; safe-staffing escalation; discharge and inpatient-flow actions; incident and harm monitoring.	4	2	8
2) Clinical Effectiveness	Seasonal demand and constrained capacity may reduce timely access to evidence-based care, create pathway variation and prolong length of stay, with associated deconditioning and avoidable admission risk. The plan is designed to improve clinical effectiveness through earlier assessment, alternatives to admission and more reliable flow.	**Positive overall; potential negative risk**	**4**	**3**	**12**	Frailty SDEC and acute medical flow models; community and virtual/hospital-at-home pathways; care-home and call-before-convey initiatives; senior decision-making and board/Grand Round processes; discharge/TOCH coordination; bed-days and pathway performance monitoring; protection of clinically urgent and time-critical care.	3	2	6
3) Patient Experience	High demand, crowding, long waits, changes in care location and discharge under pressure may adversely affect dignity, privacy, communication and overall patient/carer experience. Patients with dementia, autism, sensory impairment, mobility needs or communication needs may be disproportionately affected.	**Positive overall; potential negative risk**	**3**	**4**	**12**	Maintain privacy, dignity and reasonable adjustments; accessible communication and interpreting support; involvement of patients and carers in care/discharge decisions; minimise non-standard care environments; senior oversight of escalation; monitor complaints, PALS, patient experience, incidents and themes throughout winter.	3	2	6
4) Operational / Non Clinical	Winter demand may create operational pressure across ED, ambulance handover, bed capacity, community services, diagnostics, elective activity and workforce, with risk of cancellation, reduced productivity, delayed discharge and staff fatigue.	**Positive overall; potential negative risk**	**4**	**4**	**16**	Winter command and control/OPEL arrangements; daily bed and flow meetings with enhanced frequency at higher escalation; workforce deployment matched to demand; safe-staffing escalation; vaccination programme; capacity and escalation plans; community alternatives to admission; inpatient-flow and complex-discharge actions; elective prioritisation and recovery oversight; system escalation with	3	2	6

Section C: Performance Metrics to Measure

Reference	Measure	Baseline	Target
1	Type 1 / all-type 4-hour emergency access performance	August 2026: 72.2%	Improvement through winter trajectory; March 2027 ambition 82%
2	12-hour waits/ prolonged ED waits and instances of corridor care	August 2026: 17.3%, incidences of corridor care 187	Reduce to <10% and sustain improvement
3	Ambulance handover performance, including >30-minute delays	39.6% of handovers over 30 minutes and average handover time 28 minutes 10 seconds	Reduce delayed handovers and improve compliance with agreed handover standard of 22 minutes and 10 seconds
4	Inpatient flow: bed days / length of stay / discharge and NCTR	NCTR % 25.7%	Reduction in avoidable bed days, length of stay and discharge delays. NCTR 12.5%

Section D: QIA Sign Off

Signed - Director of Operations / Head of service	Sarah Brennan	**Date**	30th September 2026
Signed - Programme Lead	Sarah Brennan	**Date**	30th September 2026
Signed - Medical Director		**Date**	
Signed - Chief Nurse		**Date**	

Please return the completed and signed document via email to:-
Transformation.Team@wwl.nhs.uk

Title of report:	Maternity Triage Specification Benchmarking
Presented to:	Board of Directors
On:	07 October 2026
Item purpose:	Approval
Presented by:	Chief Nursing Officer
Prepared by:	Director of Maternity and Child Health
Contact details:	T: 01942 773107 E: joanne.lambert@wwl.nhs.uk

Trust Position

Following publication of the National maternity triage specification on 7 July 2026, providers are required to undertake a review of their maternity triage services, complete a gap analysis against the national standards and develop an implementation plan within three months of publication. The specification provides a national framework for providers to ensure the delivery of safe, timely and effective maternity triage services and aims to reduce variation, improve women's experiences, strengthen safety and promote consistent access to urgent and unscheduled maternity care.

The document places clear responsibility on Trust Boards to seek assurance regarding the safety, effectiveness and resourcing of maternity triage services and expects organisations to achieve full implementation of the maternity triage specification within 12 months of publication.

The Trust has completed the benchmarking assessment against all ten principles of the NHS England Maternity Triage Specification and is in the process of collating the supporting evidence to demonstrate current compliance and identify areas requiring further development. The assessment provides an update on the Trust's current position against the national standard and establishes a baseline from which future improvement can be monitored and measured.

The assessment identified an overall AMBER rating, reflecting that whilst many elements of the specification are established, further work is required to achieve full compliance across several domains. Overall, 22% of standards were assessed as fully in place, 55% as partially in place and 21% as not currently in place, with 1% deemed not relevant to the Trust's service model. No standards were identified as having incomplete data.

A cautious and evidence-based approach has been adopted throughout the benchmarking process, with full compliance assessed only where there is clear evidence that requirements have been implemented and embedded in practice. Where standards are established but require further development, supporting evidence or additional assurance, they have been assessed as partially compliant. The accompanying benchmarking tool therefore provides a balanced and accurate reflection of the Trust's current level of assurance and the actions required to achieve full compliance.

Opportunities for further development were identified in relation to workforce, infrastructure and estates, equity and equality, and data and measurement. These areas are being incorporated into an associated improvement plan which will be monitored through existing maternity governance arrangements

A high-level financial costing estimation of the potential infrastructure and workforce implications associated with achieving full compliance has also been undertaken. This has provided an initial assessment of the estate, environmental and staffing requirements needed to meet the national specification and will inform future workforce planning, service development and any subsequent business case considerations.

It is anticipated that capital investment may be offered to support compliance with the specification standards across all Trusts. However, the initial costings are indicative only and are intended to inform discussions with NHS England regarding potential future funding requirements, which have yet to be determined.

The completed benchmarking tool and supporting evidence will be submitted via the NHS England Futures Platform for regional and national review.

To conclude, this assessment represents the Trust's baseline position against the National Maternity Triage Specification and provides assurance regarding current compliance whilst establishing a clear trajectory towards full implementation. Included within Appendix 1 is the Maternity Triage Specification Improvement Plan 2026/27, outlining the outstanding key priorities, actions, milestones and reporting requirements necessary to achieve compliance with national standards.

The Board of Directors is asked to:

I. Approve the Maternity Triage Specification Benchmarking Assessment and submission of the completed benchmarking tool and supporting evidence to the NHS England Futures Platform when instructed.

II. Receive the outcome of the benchmarking assessment, including the Trust's overall AMBER compliance rating with the associated high level action plan.

III. The Triage Specification will be shared with the Board on 7 October 2026 for review and formal approval.

Appendix 1

High Level Maternity Triage Specification Improvement Plan 2026/27

RAG	Status	Progress
Red	Not Started	Action not yet commenced or significant gaps remain. Requires support, investment or decisions to progress.
Amber	On Track / In Progress	Action underway with clear plans in place. Progress is being made but implementation is not yet complete.
Green	Completed with Evidence	Action completed with evidence available to demonstrate implementation and compliance.

Priority	Key Action	Current Position	RAG	Board Support Required
1.0 Access & integration System-wide referral pathways are incomplete, including Primary Care routes.	Confirm pathway for 24/7 covering early pregnancy to six weeks postnatal, with GP, ED, NWAS, NHS 111, community and safeguarding interfaces is in place	Pathways and Standard Operating Procedures in place.		System partner engagement and executive sponsorship as required.
1.1 Access & integration Wayfinding and online access information are inconsistent.	Install additional maternity triage signage at ED, entrances and corridors; update website, maps and patient information.	Partial signage in place. Signage to be installed at agreed access points; website updated. Awaiting confirmation of Trust electronic way finder project all entrances.		Confirmation of Electronic Wayfinder and implementation plan
2.0 Dedicated Triage Environment	Review the maternity triage estate to reconfigure with dedicated reception, waiting area, private examination/consultation facilities which located in a separate clinical area away from Day Assessment Unit.	National specification standards are not met. Estates survey undertaken to provide high level costings to reconfigure environment.		Support and approve the initial specification and costings included in benchmarking tool.
2.1 Service model Triage and Day Assessment activity are not clearly separated operationally.	Approve separate Triage and Day Assessment SOPs defining scope, exclusions, navigation, staffing and escalation.	Estates Survey undertaken to review options for estates reconfiguration		Support and approve the initial specification and costings included in benchmarking tool.

3.0 Clinical model Implement Modified BSOTS model as part of maternity digital EPR	Implement a modified BSOTS system reflective of what good looks like specification for maternity triage	Contact BSOTS team to undertake bespoke training Include BSOTS configuration in K2 Athena implementation plan.		Support and approve the initial specification and costings included in benchmarking tool.
3.1. Safe Staffing Model	Review triage establishment and implement a staffing model aligned to RCOG, Birthrate Plus and Maternity Triage Specification standards, including dedicated separate telephone triage staffing.	Dedicated telephone triage staffing is not fully supported overnight.		Approval of workforce BR+ business case and recurrent funding.
4.0. Competency & Training Framework	Implement a mandatory maternity triage competency framework, BSOTS-aligned training programme, annual competency assessment and revalidation process.	Formal competency framework and training programme not fully established. Contact BSOTS team to undertake bespoke training		Protected training time and workforce backfill. Requested as part of benchmarking tool.
5.0. Telephone Triage Service	Establish a sustainable 24/7 dedicated telephone triage provision with protected confidential workspace and resilient staffing arrangements.	Overnight staffing and dedicated environment are required. Scoping exercise of the estate undertaken to review location of telephone triage.		Support and approve the initial specification and costings included in benchmarking tool.
6.0. Athena/K2 Digital Enablement	Implement electronic triage documentation, discharge communications, escalation workflows, audit functionality and performance dashboards.	Digital functionality not fully embedded across the pathway. Phase one go live planned for December 2026.		Continued investment and programmed prioritisation to support roll out of maternity EPR
7.0 Clinical Oversight & Escalation	Formalise consultant review arrangements, escalation thresholds, twice-daily triage huddles and structured senior oversight processes.	Senior oversight arrangements require agreement with consultant team to ensure that maternity triage is considered a priority when completing huddles/handover and board rounds.		Executive support for revised governance arrangements.
8,0. Health Inequalities Programme	Introduce ethnicity, language, deprivation, protected characteristics and access reporting to identify and reduce inequalities in care and outcomes.	Data not routinely captured, analysed or reported. Meeting arranged with BI data analyst to develop triage dashboard as part of the maternity digital record.		Business Intelligence and Population Health support.

9.0. Performance Dashboard & Governance	Implement a maternity triage dashboard including timeliness, delays, outcomes, experience, acuity, escalation and staffing metrics.	Formal reporting framework not established. Meeting arranged with BI data analyst to develop triage dashboard as part of the maternity digital record.		Information and Business Intelligence resource allocation.
10.0 Patient Information & Accessibility	Provide patient information in multiple languages, accessible formats, Easy Read versions and strengthen interpretation services.	Partially compliant with accessibility requirements. Work to develop and co-produce resources in top 10 languages. Consider pocket talk devices		Investment in translation resources and communication tools.
11.0 Patient Experience & Martha's Rule	Strengthening patient feedback systems, PREM readiness, awareness of escalation routes and compliance with Martha's Rule principles.	Feedback mechanisms require further development.		Support from Patient Experience and Quality teams.
11.1 Clinical Flow & Capacity Management	Develop a formal escalation framework for overcrowding, delayed assessment, ambulance arrivals, surge activity and capacity pressures.	No consistent operational escalation process are in place. Review ED activity and flow dashboard and implement system for maternity triage. This should be used as a tool for operational oversight by Trust patient flow teams.		Board support for flow and escalation policy implementation.
12.0 Audit & Assurance Programme	Establish quarterly audits against Maternity Triage Specification standards, BSOTS compliance, patient experience and documentation quality.	Assurance arrangements not fully established. Meeting arranged with BI data analyst to develop triage dashboard as part of the maternity digital record. Maternity Dashboard to be updated to include KPI's associated with triage.		Agreement of reporting requirements through Quality Committee.
13.0 Risk Management & Learning	Strengthening triangulation of incidents, complaints, claims, HSIB/MNSI learning and local risk management processes.	Risks identified but reporting and progress updates require further development		Executive oversight and support for risk reduction actions.
14.0 Workforce Wellbeing & Retention	Introduce workforce wellbeing, supervision, retention and recruitment initiatives to improve sustainability of the triage workforce.	Workforce pressures continue to impact resilience. Consider core staffing in triage to provide highly skilled team		Organisational workforce support.

15.0 Board Assurance & Regulatory Compliance	Establish a formal Board assurance framework demonstrating compliance with the Maternity Triage Specification, CQC expectations and LMNS quality requirements.	Partial Board assurance framework currently in place. Progress reporting via the Perinatal Oversight Report		Executive sponsorship and approval of formal reporting arrangements.

High Level Maternity Triage Specification Key Milestone Actions 2026/27

Milestone	Target	
Complete initial benchmarking against Maternity Triage Specification	Month 1	Complete
Complete gap analysis and prioritised improvement plan	Month 1	Complete
Submit assurance/self-assessment tool	Month 2	Awaiting tool on NHS Futures
Implement priority actions and evidence collection	Months 2-3.	Awaiting tool on NHS Futures
Undertake compliance review and re-benchmarking	Month 3	NHSE specification completed
Submit formal implementation progress report to Quality Committee	Month 3	Present to ETM 17.09.2026
Present assurance report, benchmarking outcomes and residual risks to Trust Board	Within 3 months of implementation	Benchmarking Tool, action plan and progress to be presented to Trust Board 07.10.2026

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2.
Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms
the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the
extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore*
'Not applicable' would be apply.
Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Report signed off by Trust Board (named Exec): Kevin Parker Evans Chief Nursing Officer

Trust Board sign off date: 10th September 2026

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Non-compliant	EV-01 TW26-014 Martha's Rule - Adults SOP EV-02 Attendance at National Webinar	Formal roll out of Martha's Rule in maternity and neonatal services has not yet commenced.	Identify maternity and neonatal Martha's Rule project leads. Establish MDT implementation group to include maternity, neonatal, CCOT and MNVP representation. Develop a Martha's Rule implementation plan and timeline.	National Webinar attended by MDT. Early planning is underway. Preliminary discussions have taken between the maternity and neonatal teams and Critical Care Outreach Team (CCOT) to review implementation across other Trust services and consider application within maternity and neonatal settings. Existing Trust escalation pathways provide a good foundation for implementation. Health Innovation Manchester has also offered support to Greater Manchester providers to rollout Martha's Rule. National Webinar is on the 24th September 2026. National funding agreed - awaiting.
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV-03 PQOM Reports EV-04 Picker Action Plan EV-05 Patient Experience and Engagement Report	A monthly cycle of collecting and analysing maternity and neonatal outcome, audit and experience data is established through existing governance arrangements. Further work is required to incorporate all available neonatal patient experience data from Fi-Care into integrated reporting and ensure all relevant sources of maternity and neonatal audit, outcome and experience intelligence are routinely included within the reporting cycle.	Incorporate neonatal FiCare/patient experience data within established perinatal quality reporting. Await the national roll-out of Mat-Neo PREM Review the range of maternity and neonatal clinical audits routinely reported to ensure comprehensive oversight of clinical quality.	The Perinatal Quality Oversight Report provides oversight of maternity and neonatal outcomes, clinical audit, patient experience, complaints, MNVP intelligence and targeted engagement activity. Feedback from women, families and neonatal parents is reported alongside patient commentary and health inequalities data, ensuring the voices and experiences of local communities are heard, scrutinised and acted upon through Board governance arrangements.
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV-06 MNVP Reports EV-07 Perinatal Improvement Plan EV-03 PQOM Report EV-08 LMNS Data Assurance Slides	Whilst outcome measures of key KPIs are reported through SPC charts and other quality metrics, further work is required to consistently demonstrate the measurable impact of all improvement activity within the Perinatal Improvement Plan.	Further develop the Perinatal Improvement Plan to include a measure of success and evidence of impact for each improvement project. Use the Perinatal Quality Oversight Report to provide Board assurance regarding progress, outcomes achieved and actions requiring escalation. Develop SPC-based maternity dashboards to strengthen outcome monitoring and trend analysis and strengthen Maternity Dashboard Report. Work with Business Intelligence colleagues to enhance maternity and neonatal outcome reporting capability.	The Perinatal Quality Oversight Report provides a triangulated view of maternity and neonatal outcomes, health inequalities, patient experience (including FFT and CQC maternity survey findings (including free text comments)), workforce, audit and safety intelligence. Actions arising from feedback, audits, incidents and engagement activity are monitored through the Perinatal Improvement Plan and governance forums. Health population data, including deprivation, ethnicity and vulnerability factors, is routinely collated and reported across multiple sources of safety intelligence to support identification of inequalities and ensure improvement activity is informed by the needs of the local population. The MNVP is represented within governance structures and undertakes regular engagement and listening activities to ensure the voices of women and families inform service improvement and Board assurance.

2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV-09 Health Inequalities Dashboard EV-10 E&E Improvement Plan EV-03 PQOM Report	Current reporting identifies variation in outcomes and experience by ethnicity, deprivation and vulnerability factors and demonstrates targeted interventions in response. Further work is required to develop and monitor outcome measures for targeted health inequalities initiatives, including the Enhanced Midwifery Team pilot, to demonstrate their effectiveness in reducing unwarranted variation and improving outcomes and experience for vulnerable women, babies and families.	Develop outcome measures for the Enhanced Midwifery Team pilot and other targeted health inequalities initiatives. Monitor and report the impact of targeted interventions through existing governance arrangements and the Perinatal Quality Oversight Report. Participate in the Perinatal Equality and Anti-Discrimination program.	The Perinatal Quality Oversight Report routinely analyses outcomes, experience and safety intelligence by ethnicity, deprivation and vulnerability factors. Health inequalities data is triangulated from multiple sources, including MNVP intelligence, Patient and Public Engagement Midwife activity, Birth Thoughts appointments, complaints, FFT responses and targeted engagement. Current reporting demonstrates representation from women living in areas of deprivation and minority ethnic communities and informs targeted interventions through services such as the Smokefree Pregnancy Team, Preterm Birth Service, Enhanced Midwifery Team and Equality, Equity and Inclusion workstreams.
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	EV-11 PQOM SOP EV-12 Trust Board Minutes	Strengthen evidence-base	Incorporate in Board ToR Incorporate in job plans	The Trust has established joint executive accountability for maternity and neonatal services through the Chief Nurse and Medical Director. These arrangements are supported by routine Board oversight and assurance processes, including Safety Champions meetings and review of the Perinatal Quality Oversight Report and escalation of maternity and neonatal quality, safety, workforce and performance matters.
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Compliant	EV-12 Trust Board Minutes	Strengthen evidence-base	Incorporate in job plans	The Director of Midwifery, Neonatal Leads and Clinical Directors are invited to attend Trust Board meetings whenever maternity or neonatal matters are discussed or maternity and neonatal papers are presented. In addition, they are core members of the bi-monthly Quality and Safety Committee, a formal sub-committee of the Trust Board, providing regular clinical leadership, assurance and oversight of quality, safety and governance across maternity and neonatal services.
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Non-compliant		Provision has not yet been confirmed to enable full multidisciplinary participation in the Perinatal Equity and Anti-Discrimination Programme (PEADP). Attendance and staff release arrangements for Intake 4 remain under development, and no dedicated funding has been identified to support backfill requirements.	Confirm multidisciplinary representation for PEADP Intake 4. Review workforce and backfill requirements to support staff attendance and programme participation. Develop a local implementation plan to ensure learning from the programme is disseminated across maternity and neonatal services. Monitor participation and programme delivery through established governance arrangements.	WWL has completed the Quadrumvirate Perinatal Leadership Programme and is currently preparing for participation in PEADP Intake 4 commencing September 2026. Workforce capacity and release arrangements are being considered to support multidisciplinary participation across maternity and neonatal services.
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Compliant	EV-13 Maternity and Neonatal Equalities Dashboard - NHS England Digital EV-14 Local Equalities Dataset EV-03 PQOM Report	Health inequalities data is routinely reviewed using locally developed datasets. Local reporting provides monthly oversight of key demographic and health inequalities measures across the maternity population. The principal limitation relates to the NHS England Maternity and Neonatal Equalities Dashboard, which remains under development and is subject to significant reporting lag, restricting its usefulness for timely monitoring of trends and the impact of interventions.	Maternity and Neonatal Equalities dashboard - NHS England Digital. Mitigation - Continue monthly review of local health inequalities data through established local governance arrangements. Utilise emerging functionality within the NHS England and regional inequalities dashboards as these develop.	Local maternity population and health inequalities data is reviewed routinely through established governance arrangements and reported through the Perinatal Quality Oversight Report. Reporting includes analysis of ethnicity, deprivation, age, BMI, smoking status, employment and vulnerability factors and is used to identify variation, inform targeted interventions and support Board assurance regarding health inequalities and equity of care. The Greater Manchester Equity and Equality Action Plan remains ongoing, with WWL represented through the Health Inequalities Specialist Midwife. In parallel, Greater Manchester Local Maternity and Neonatal Services (LMNS) is leading regional work to develop a more comprehensive North West Inequalities Dashboard to further strengthen monitoring of variation in outcomes, access and experience across different population groups. The Trust is curently developing K2 which will further support disaggregated data collection.
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	EV-03 PQOM Report (High Level Gap Analysis and Action Plan)	Implementation planning is not yet complete and is currently awaiting obstetric input to identify any remaining gaps and agree the required actions for implementation. Initial gap analysis has been completed, and review meetings have been arranged to finalise the action plan and implementation approach.	Finalise action plan with MDT input Roles and responsibilities and project leads must be clearly defined	Action plan will be available to submit to November Trust Board
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV-15 Maternity Dashboard Report EV-03 PQOM Report EV-16 CNST Bi-Annual Update Report	No gaps identified	No actions	Embedded monitoring arrangements demonstrate sustained compliance with the RCOG "Roles and Responsibilities of the Consultant Providing Acute Care" standard. Consultant attendance in defined acute care situations is consistently monitored and remains above the minimum 80% threshold required by Maternity Incentive Scheme (MIS) Year 8.
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	EV-17 Locum Database	No gaps identified	No actions	Process in place.

6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Compliant	EV-18 NWNODN Activity, Capacity and demand Report (ACD) EV-19 Mat-Neo Staffing Paper	No gaps identified	Annual workforce review to be undertaken.	The ACD report confirms that WWL meets the BAPM nurse staffing requirements. Work is ongoing to review the wider Allied Health Professional workforce to ensure alignment with BAPM workforce standards and recommendations. The service confirms that funding for the medical neonatal workforce is aligned to BAPM requirements (Tier 1, Tier 2 and Tier 3). The ability to staff the rota is affected by unavailability including maternity leave, vacancy and other unavailability. Active recruitment to fill vacancy is ongoing.
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Non-compliant	EV-20 Birthrate plus Report Jan 2026 EV-21 Bi-Annual Safe Staffing Report EV-22 Business Case	Birthrate plus identified a shortfall in Midwifery staffing. Business case and paper in progress and will be presented when total recruitment numbers agreed.	Perinatal Staffing Paper Secure funding approval for additional midwifery establishment identified through the Birthrate Plus review. Implement targeted recruitment to close the identified staffing gap.	Birthrate Plus review (January 2026) identified that the current midwifery establishment does not fully meet recommended staffing requirements (3.15 WTE shortfall). A business case is underway and an action plan to achieve Birth Rate plus requirements will be shared with Board.
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Compliant	EV-23 Anaesthetic Job Plan EV-24 Anaesthetic Rotas	No gaps identified	No actions	
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV-20 Birthrate Plus Report EV-21 Bi-Annual Safe Staffing Reports EV-03 PQOM Report	The Trust Board receives regular oversight of maternity and neonatal workforce, acuity, service pressures and escalation activity through integrated quality, safety and workforce reporting. This includes review of staffing levels, workforce sustainability, Birthrate Plus progress, vacancy and sickness data, red flag incidents, clinical risk escalations, service pressures and patient safety outcomes. The Board is therefore able to identify emerging risks, respond to periods of increased demand or reduced workforce availability, and seek assurance that mitigating actions are implemented and monitored.	Develop SPC-based maternity dashboards to strengthen outcome monitoring and trend analysis	Board reporting is supported by multidisciplinary governance arrangements that bring together maternity, neonatal and paediatric services, reducing the risk of siloed decision-making and enabling a coordinated response to changing clinical risk and operational pressures
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	EV-25 North West Maternity Escalation Policy & Operational Pressures Escalation Levels Framework EV-21 Bi-Annual Safe Staffing Reports EV-26 Training Needs Analysis (TNA) EV-20 Birth Rate plus Report 2026	Whilst processes are in place to manage the redeployment of specialist midwives during periods of escalation and operational pressure, there has not been a formal review by the Trust Board of internal resource deployment, including the impact of redeployment on specialist services, workforce resilience and continuity of care.	Utilise the Birthrate Plus Review and associated workforce recommendations to include maternity resource deployment, including specialist roles, service resilience and the impact of redeployment on care delivery in future iterations of the Perinatal Safe Staffing Report.	When specilaist midwives and managers are utilised in times of escalation this is undertaken using a risk-based approach to ensure safe re-deployment.
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Partially compliant	EV-27 Homebirth Review Paper (presented at ETM - sub-board Committee) EV-28 Homebirth AAA Report (to CEO and Chief Nurse)	Immediate improvement actions have been identified, implementation remains ongoing. Await national steer.	Mitigating action - Hybrid working across community and delivery suite areas commences pilot 19-10-2026 Re-visit options appraisal for Homebirth Service staffing model Await outcome of National Hombirth Task and Finish recommendations for national steer.	WWL has been part of the Regional Task and Finish group led by the Regional team. The Northwest Regional Home Birth Benchmarking Tool was completed and submitted to NHSE .
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Partially compliant	EV-27 Homebirth Review Paper EV-29 Risk Register Entry - ID 4358 EV-30 Homebirth Immediate Action Plan	Risk Register and associated actions not shared with Regional team at this time. Ongoing monitoring and escalations to NHS E as required.	Progress Risk and associated actions. Continue ongoing monitoring of Homebirth Service risks and implementation of mitigating actions, with escalation through the regional NHS E team as required	Scoping exercise to review homebirth operating procedures was undertaken, workstream themes identified and an action plan developed to mitigate any immediate risks whilst awaiting national steer.
8. Responding to incidents, complaints and concerns with humanity and candour						

8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	EV-31 TW-23-076 PSIRP (Perinatal Local Priorities - point 7) EV-03 PQOM Report EV-32 TW-10-054 Duty of Candour with attached SOP EV-33 Patient and Public Engagement Lead JD	A quarterly themed report is included in the PQOM Report.		Established robust processes in place that could be further enhanced with a dedicated quarterly PSIRF response report for presentation and discussion at Quality and Safety Committee.
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant	EV-34 Divisional Assurance slides EV-03 PQOM Report EV-35 Themed Complaint Report	Whilst complaint themes, learning actions and improvement plans are routinely reviewed and reported through divisional governance structures and Board reporting mechanisms, a consistent approach to measuring and evidencing the impact of actions taken in response to complaint themes is not yet fully established.	Implement routine monitoring and reporting of the impact of complaint-related improvement actions using outcome measures and SPC charts where applicable.	The trust demonstrates established processes for thematic review of complaints and concerns, with learning and actions routinely reported through divisional governance arrangements and the Perinatal Quality Oversight Report. Further work is required to strengthen the systematic monitoring and reporting of the impact of improvement actions to demonstrate measurable reductions in recurrent themes and provide enhanced Board assurance.
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	EV-33 Patient and Public Engagement Lead JD EV-32 TW-10-054 Duty of Candour with attached SOP EV-36 TW-23-076 PSIRP (FLO) EV-37 PMRT SOP EV-38 OBS-79 Birth Thoughts Guideline EV-39 TW-26-077 Postnatal Follow-up following Complex Birth SOP EV-40 CG25-024 Supporting Staff following Adverse Events Guideline EV-41 PSIRF Safety Day Training Slides	No gaps identified	No actions	
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Non-compliant		Triage Audit underway as servive specification tool received 12/08/26.	Complete Triage Service Specification Tool and develop action plan Present at ETM for Board sign off on 17-09-2026	
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Non-compliant		Not currently reported	Develop and implement an internal reporting solution to support direct submission of data and assurance information through Trust Board reporting processes.	Trust BI team will be asked to consider whether a platform can be configured to provide a single maternity, neonatal and child health assurance dashboard that supports both operational oversight and direct Board assurance reporting, without requiring manual collation of multiple reports.
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	EV-42 Triage Gap Analysis.	The National Maternity Triage Specification has been received and a detailed compliance review is underway. Further work is required to assess current arrangements against the national standard and identify any gaps requiring implementation.	Implement the National Maternity Triage Specification and embed associated reporting and assurance mechanisms through the K2 Maternity Information System.	The National Maternity Triage Specification is currently being reviewed against existing service arrangements. The implementation of the K2 Maternity Information System later this year will support compliance through electronic triage documentation, a real-time clinical status board and enhanced reporting functionality. Work is ongoing with Business Intelligence colleagues to ensure appropriate performance, quality and assurance reporting is available to support governance oversight and Board assurance.
10. Post death care						

10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV-43 Mortuary Board Assurance Report	No gaps identified	No actions	Submitted as required by Chief Nurse
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant	EV-43 Mortuary Board Assurance Report	No gaps identified	No actions	The Trust Board has received assurance regarding implementation of the recommendations arising from the Fuller Inquiry, including review of the 29 recommendations relevant to NHS organisations. Where recommendations are not yet fully implemented, time-bound action plans are in place and monitored through established governance arrangements. Regular Board assurance reports provide oversight of progress and compliance. Roles and responsibilities across the teams involved in mortuary care, including Estates, Safeguarding, Pathology, Bereavement, Mortuary and Corporate Services, are clearly defined, well understood and subject to regular review and testing. The Mortuary services team are now under Corporate Services in the remit of the Chief Nurse for oversight and assurance.

Title of report:	Midwifery Biannual Staffing review February 2026
Presented to:	Board of Directors
On:	17th June 2026
Presented by:	Kevin Parker Evans Chief Nursing Officer and DIPC
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	01942 773107 cathy.stanford@wwl.nhs.uk

Executive summary

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

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate Plus® organisation (or equivalent) should demonstrate this.
b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
c) The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.
All women in active labour receive one-to-one midwifery care.
d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the MIS year seven reporting period.

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

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

Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers. The BR+ Acuity tool supports this, which is a safe staffing tool for delivery suite and Maternity ward activity. The final Ockenden Review published in March 2022 details a series of immediate recommendations for all NHS hospital trusts in England to meet, with the aim of providing assurance of maternity safety within each provider trust's maternity services.

NICE (2015) published guidance on safer midwifery staffing and identifies red flags where further action is required to ensure safety of women and babies. This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations.

Achieving National Recommendations. Individual risks are detailed in the report body.

Financial implications

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

Legal implications

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

People implications

Patient Safety and Staff wellbeing considerations

Equality, diversity, and inclusion implications

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

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

None

Recommendation(s)

The Board are asked to review the findings of the report and consider that it demonstrates that an effective system of midwifery workforce planning and monitoring of safe staffing levels from Quarter 2 2025/2026 to Quarter 3 2025/2026 **(July- December 25) is** in place. This is a requirement of the NHSLA Maternity Incentive Scheme for Safety Action 5.

Maternity Safe Staffing for 2025/26

Report

In Q2 and Q3 period we have recruited **5.40 whole time equivalent (wte) Midwives**. In the same period there were **2.42 wte leavers**. The main period for recruitment within maternity services occurs predominately September to November each year following the third-year student midwives completing and qualifying.

Midwives	July	August	Sept	Oct	Nov	Dec
New Starters	1			4		
Leavers	1				1	1

Recruitment.

In September 2025, 8 Student Midwives who have undertaken their training programme here at WWL qualified and 2 were offered substantive wte posts and 4 fixed term posts to cover maternity leave. A further 6 will be qualifying between October and January and 4 posts are currently out to fixed term recruitment to cover maternity leave.

Although there are no substantive vacancies within the budgeted establishment, in this period there are 14 staff currently on Maternity Leave (12.28wte) and we are recruiting to fixed term posts to cover these but only offering to WWL student Midwives who have or are due to qualify.

Midwife to Birth Ratio

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

July	August	Sept	Oct	Nov	Dec
1:28	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**

Current Registered Midwife Vacancy Position (Staffing figures correct at 18.02.2026)

	Band 3/4	**Band 5/6**	**Band 7**	**Band 8a and above Total**
Clinical Vacancies	**1.66**		**0.42**	**0.0**
Projected vacancies in next 3 months	**0**	**0.56**	**0**	**0.0**
Supernumerary Ward manager change				**From March 2026**
Maternity Leave			**2.0**	
Total	**1.66**	**8.28**	**0.42**	**0.0**
Additional Birthrate+ recommendations				
Additional uplift to 25%		**wte**		
Total proposed vacancies inclusive of additional uplift to 25%.		**wte**		

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

Retention.

The Band 5 – 6 preceptorship program continues to be successful in maintaining our current staff with all progressing to Band 6 posts on completion of their preceptorship. 18.8 WTE remain on preceptorship programme. 9.42 WTE to progress to band 6 March 2026. 2 WTE to progress to band 6 May 2026.

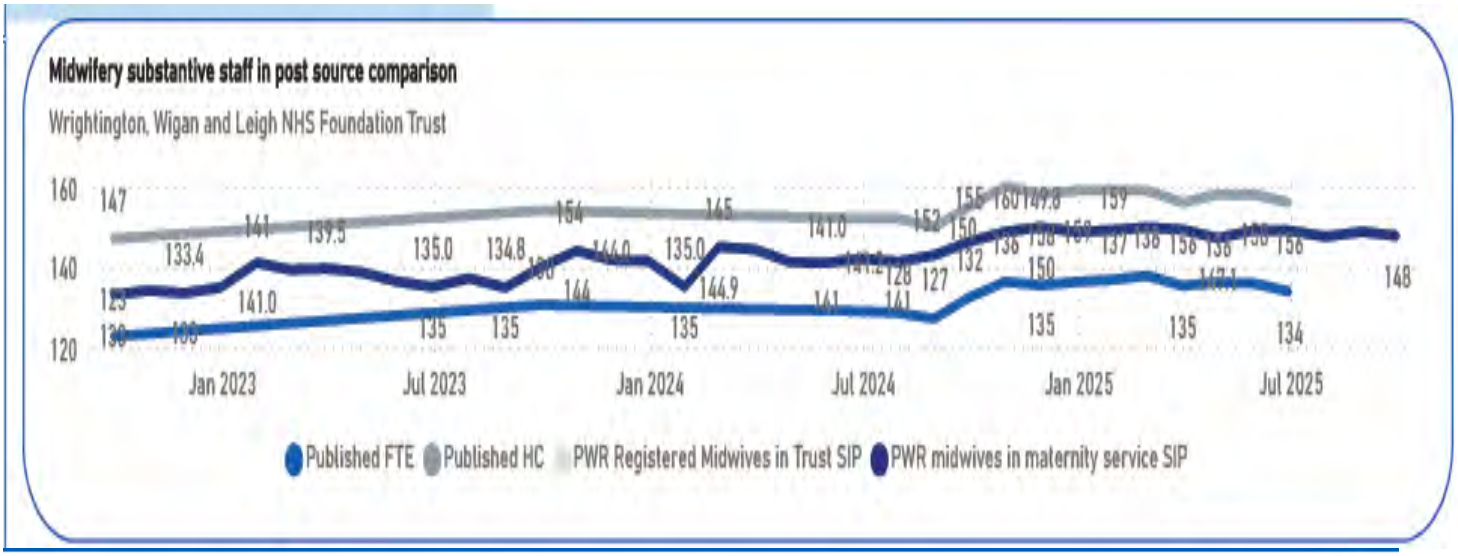
The recruitment and retention lead midwife funded by NHSE has undertaken a secondment with clinical informatics to support the implementation of the new electronic Maternity system, so this role is currently supported by an internal secondment (as this is external funding there is a requirement to backfill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

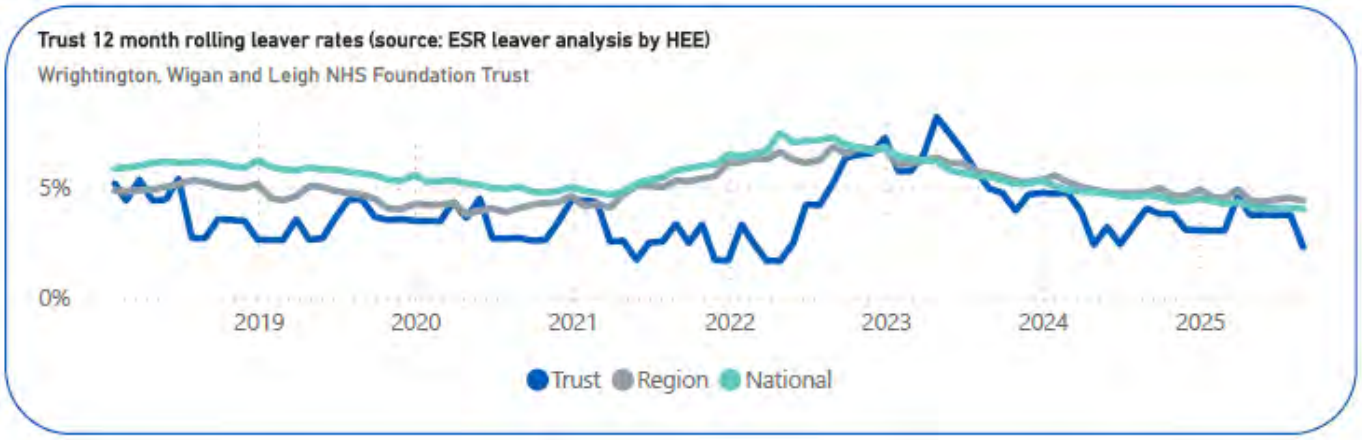
The purpose of the role is to focus on recruitment and retention, working with the preceptorship lead Midwife to provide a comprehensive preceptorship package, pastoral support throughout the recruitment process and to ensure ongoing support is available throughout the preceptorship period as newly qualified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

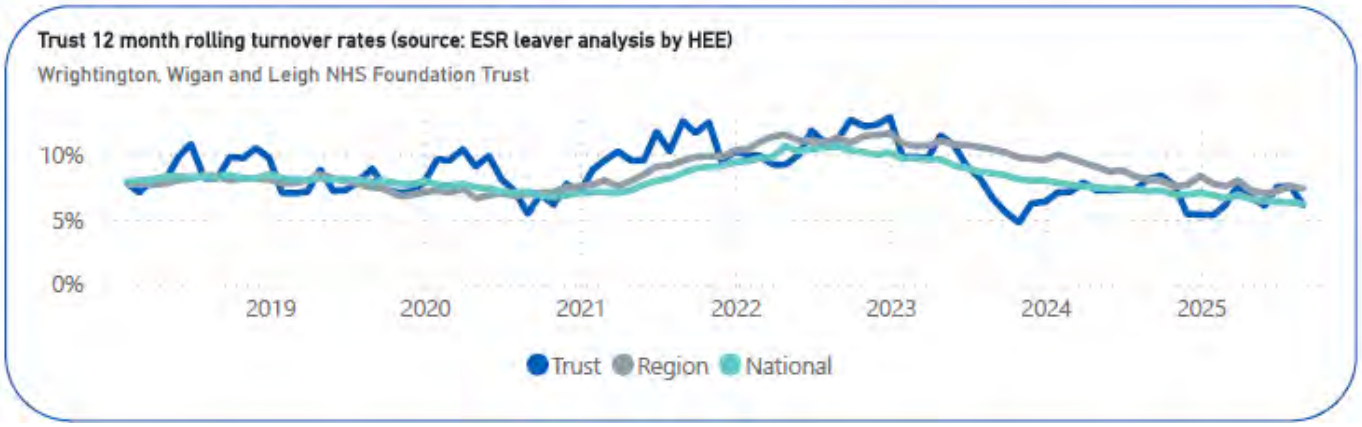
The RCM has raised awareness around the lack of experienced midwives and the challenges around their retention, therefore supportive development package for midwives progressing to Band 6 is in place as it has been recognised that the additional responsibilities can be a factor in high attrition rates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

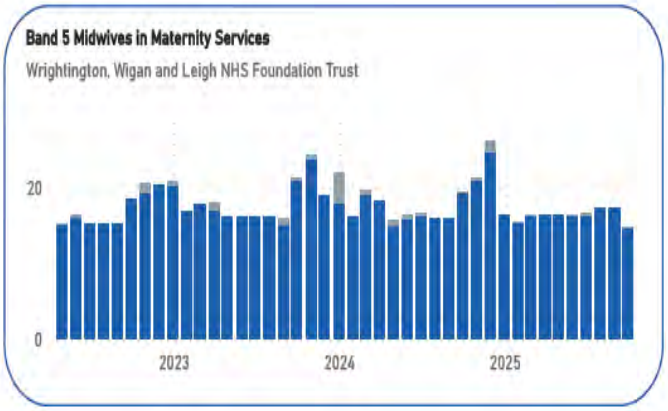
To ensure the retention of all grades inclusive of band 7 and above, development plans are in place to support their transition into the senior posts and to allow for succession planning.

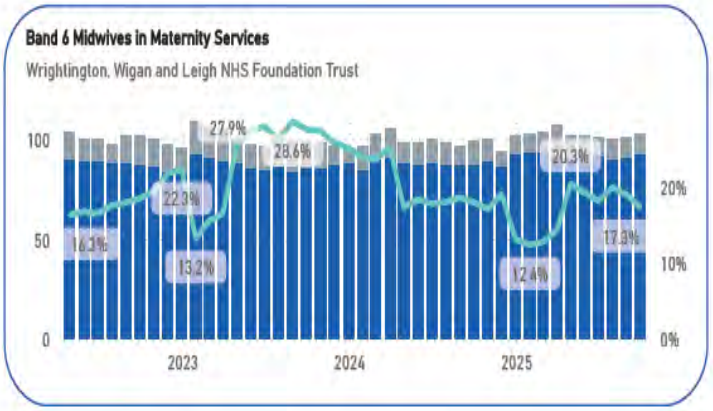
PWR Data

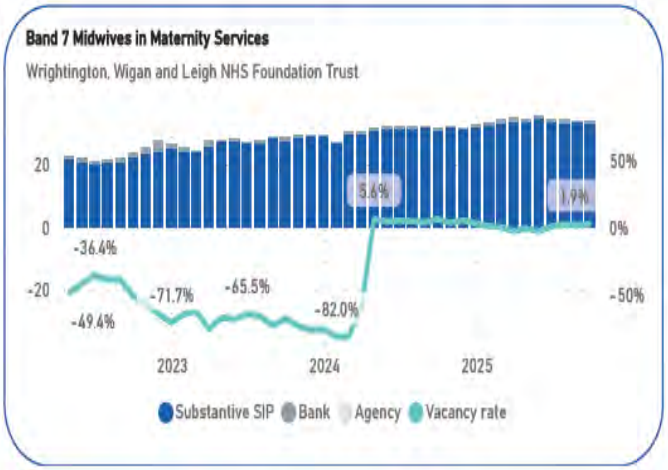


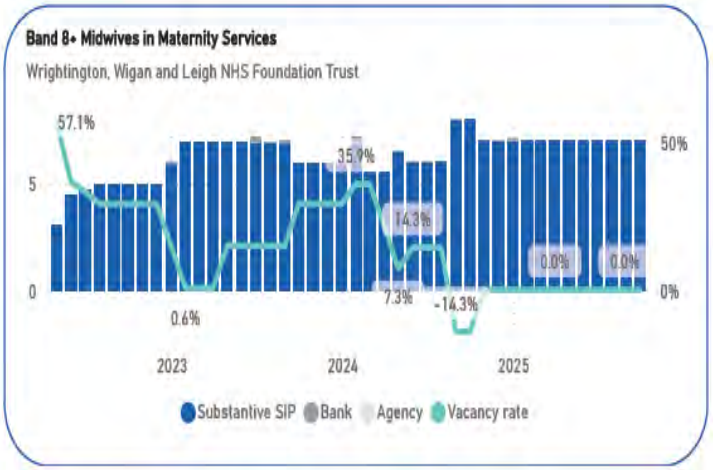


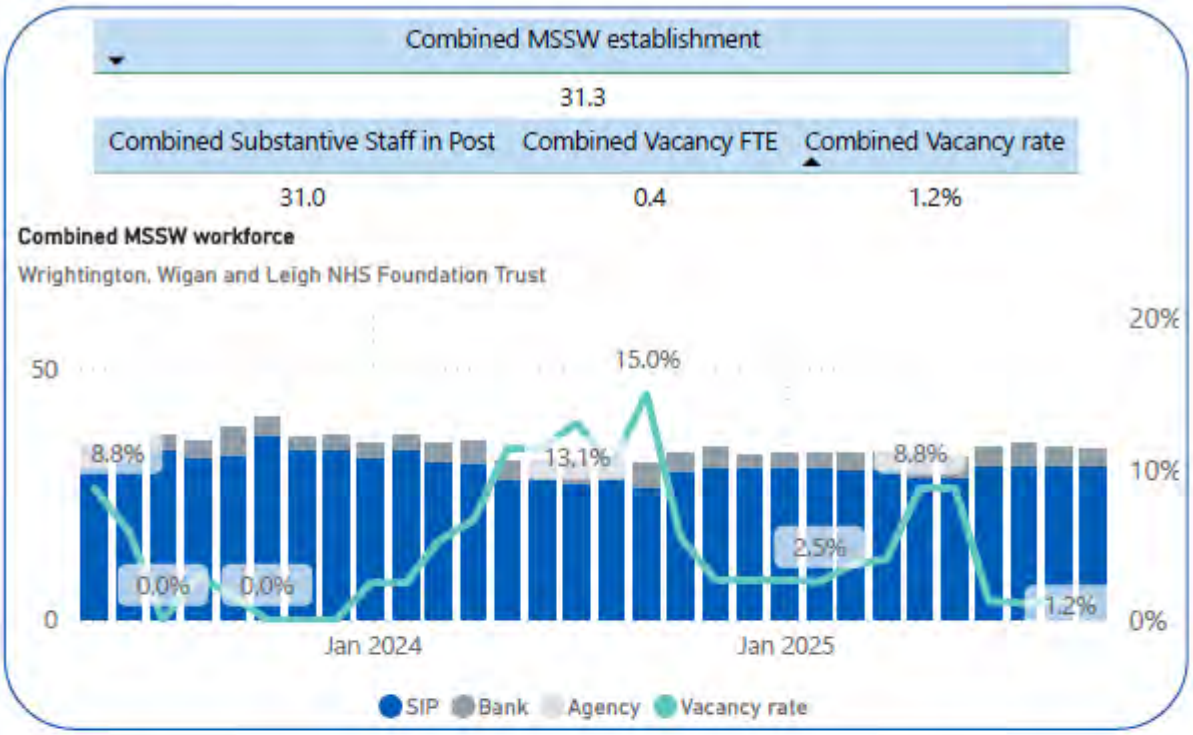


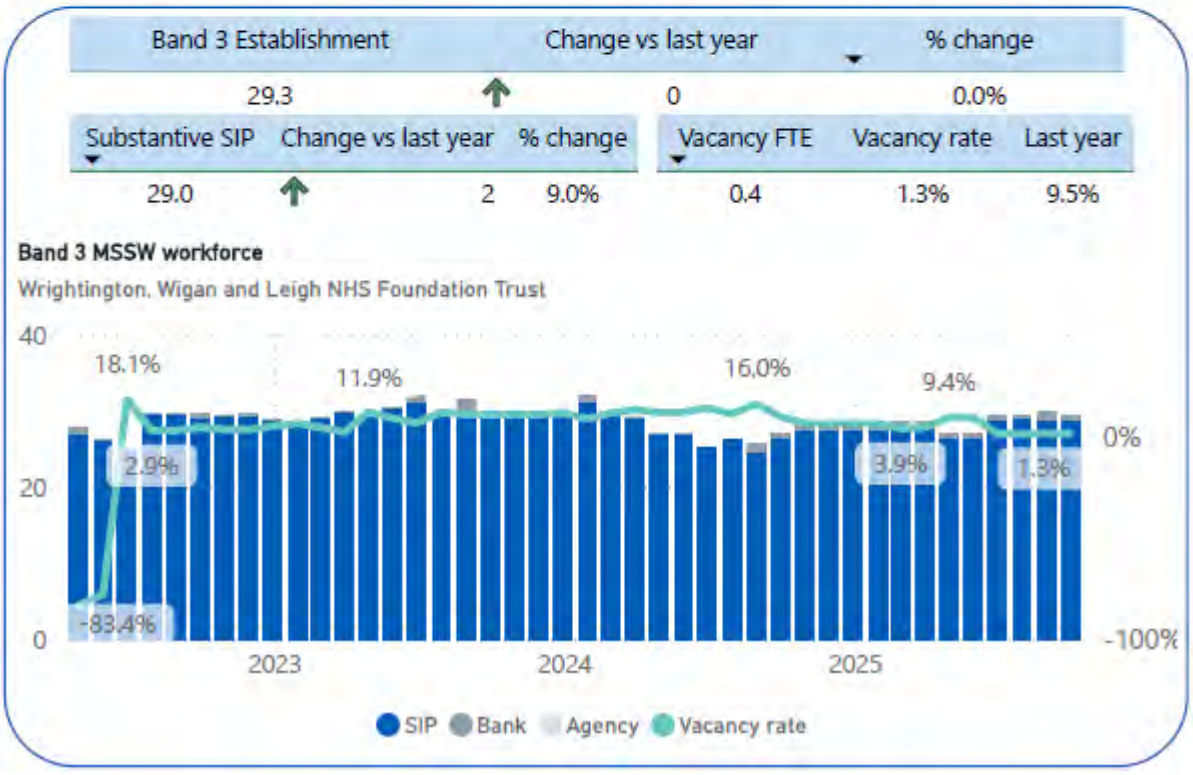

Band 5 Midwives in Maternity Services
Wrightington, Wigan and Leigh NHS Foundation Trust
20
0
2023
2024
2025


Band 6 Midwives in Maternity Services
Wrightington, Wigan and Leigh NHS Foundation Trust
100
50
0
20%
10%
0%
27.9%
28.6%
20.3%
22.3%
16.3%
13.2%
12.4%
17.3%
2023
2024
2025


Band 7 Midwives in Maternity Services
Wrightington, Wigan and Leigh NHS Foundation Trust
20
0
-20
50%
0%
-50%
5.6%
1.9%
-36.4%
-49.4%
-71.7%
-65.5%
-82.0%
2023
2024
2025
Substantive SIP
Bank
Agency
Vacancy rate


Band 8+ Midwives in Maternity Services
Wrightington, Wigan and Leigh NHS Foundation Trust
5
0
50%
0%
57.1%
35.9%
14.3%
0.0%
0.0%
0.6%
7.3%
-14.3%
2023
2024
2025
Substantive SIP
Bank
Agency
Vacancy rate

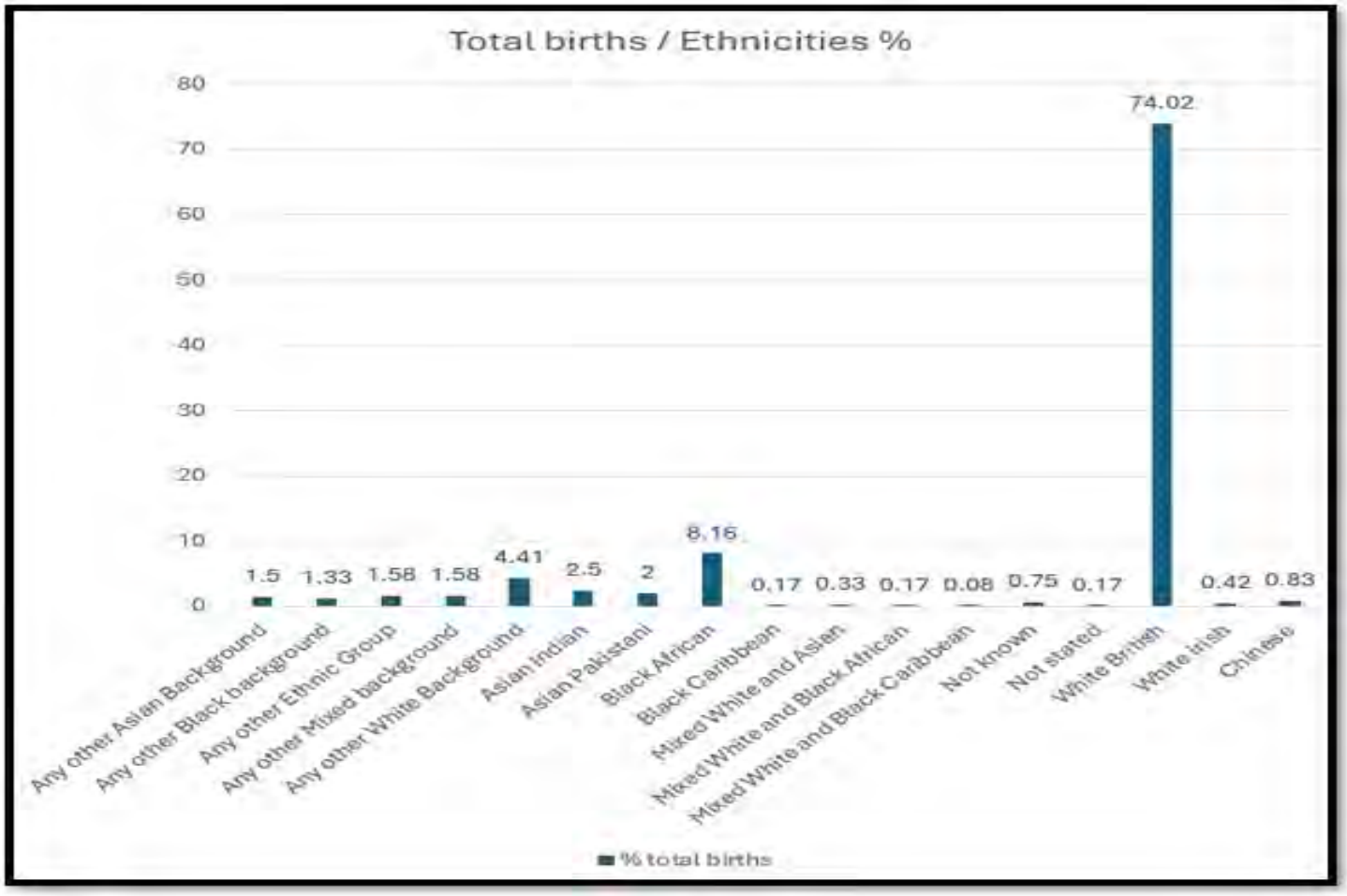




Enhanced Continuity Community Teams

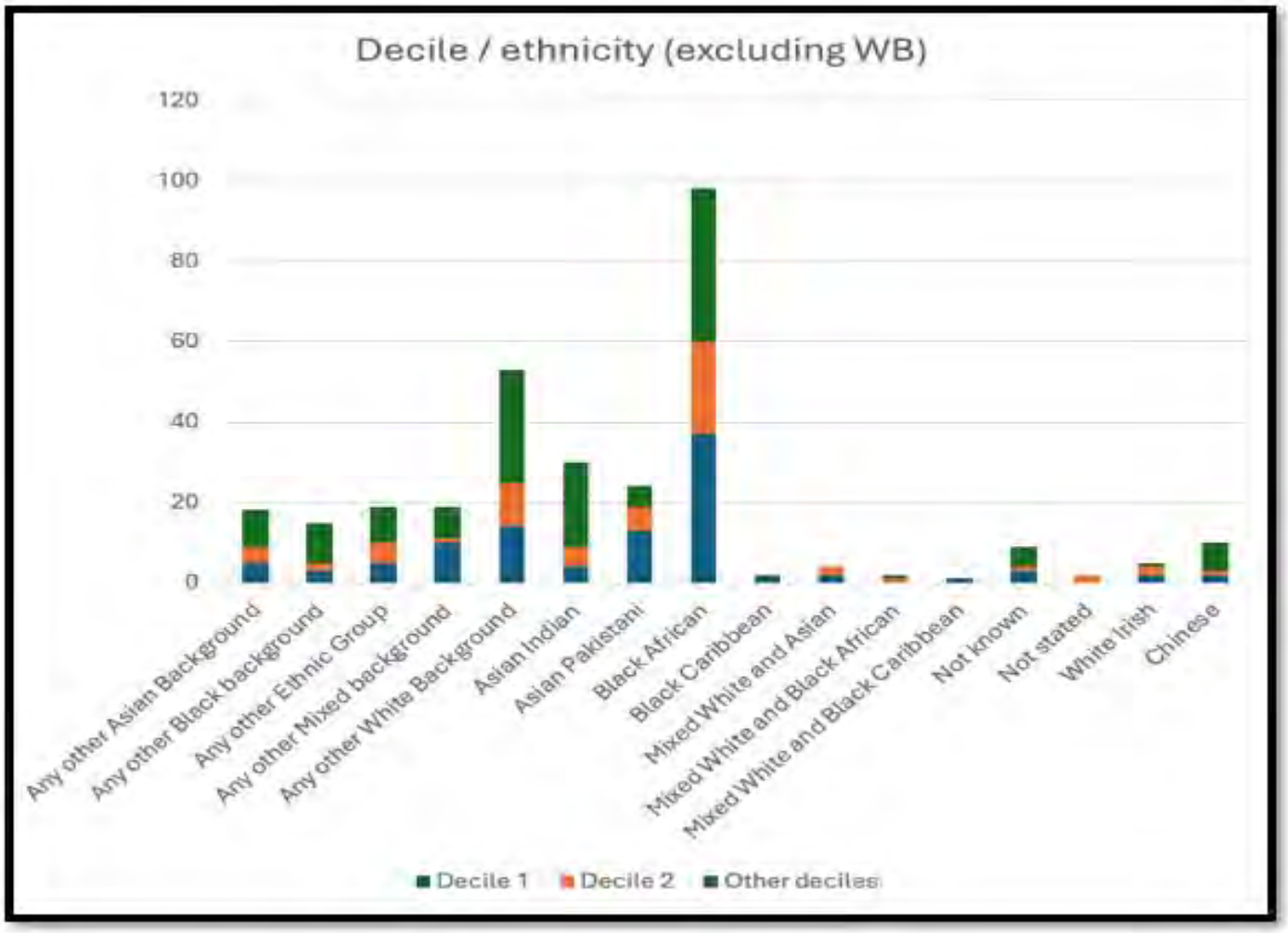
The roll out of enhanced continuity teams is linked to the 3 Year Delivery Plan for maternity and Neonatal Services to help improve outcomes for the most vulnerable mothers and babies. At present there are two enhanced Community Teams established which focus care on women at greatest risk of poor outcomes. Fern Team provide care to women and families from the most deprived neighbourhoods in deciles 1&2, as

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



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

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



Daisy Team.

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

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

Options for provision of enhanced care are currently being shared with Daisy team and the Wider Maternity Community Teams (this is covered within a separate report).

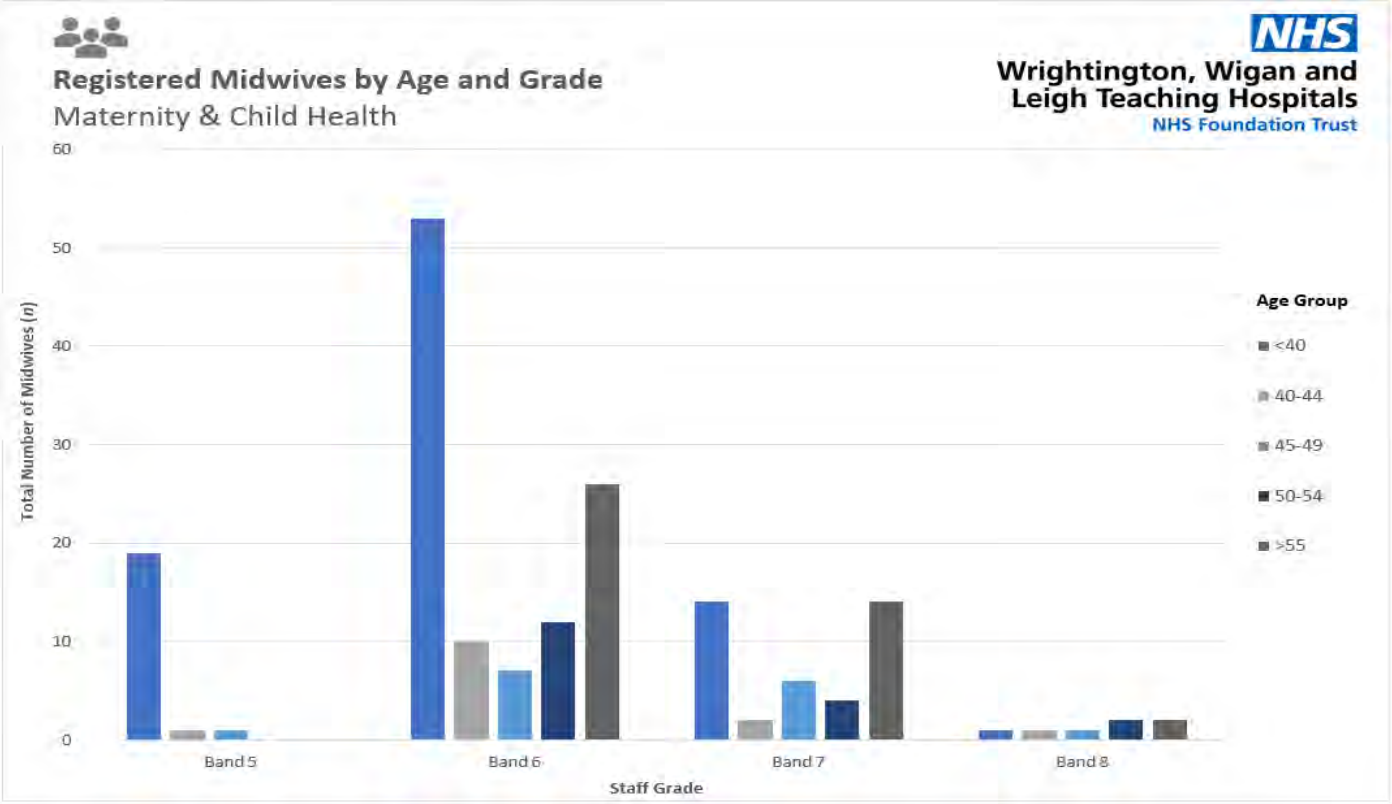
WWL are currently working with the local authority to agree KPI's linked to national, local, and regional objectives and working towards an integrated model of care which will include services from within the local authority and Health Visiting to provide a think Family Safeguarding approach to this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

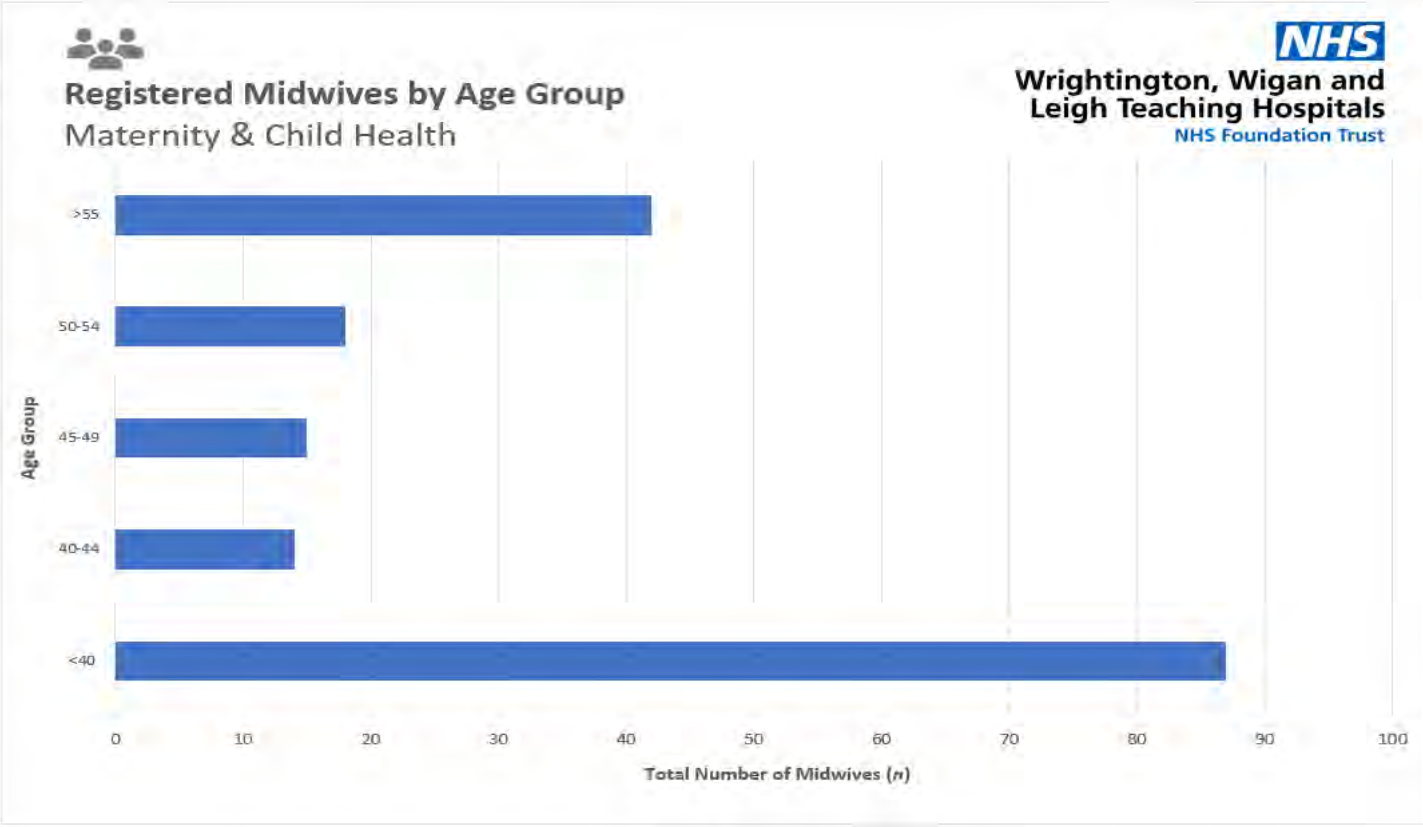
Immunisation Team.

The Respiratory Syncytial Virus (RSV) programme was rolled out for pregnant women and the staffing for this programme has been fully funded by NHSE with recurrent monies and the establishment has been adjusted to fully reflect this.

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

Workforce Age Profile
The age profile of the midwifery workforce has shifted within the last 6 months with the biggest group of registered midwives 76% being under 50. 57% of which are under 45 years old. Approximately 24% of the workforce is over 55, with this being more heavily weighted within the higher bands.





Sickness

Sickness within Maternity services has been high across all areas and is leading to significant pressures to provide safe staffing levels. Within the quarter the average sickness for Registered Midwives was approximately 8-9% and 9-10% for unregistered staff.

Significantly the top reason for all staff grades was anxiety/ depression/other psychiatric illness and of note the category other known causes not classified elsewhere is also used for mental health conditions to maintain confidentiality within smaller staff groups.

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

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

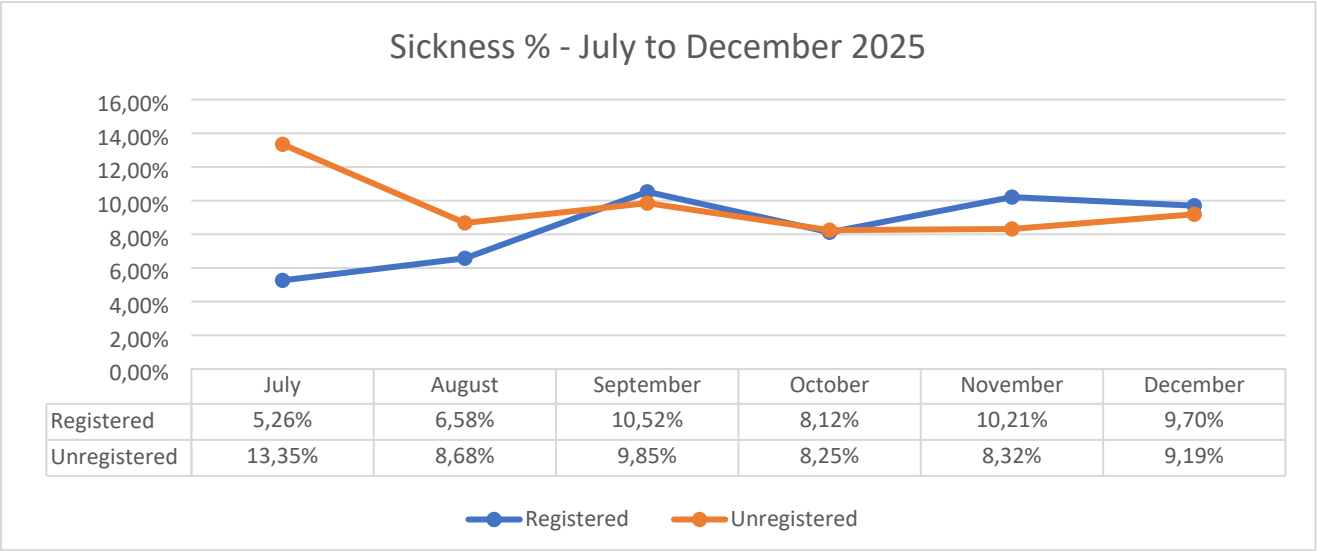
In addition to sickness the effect of increased Maternity Leave has had a significant impact on staffing levels.

Total Sickness %

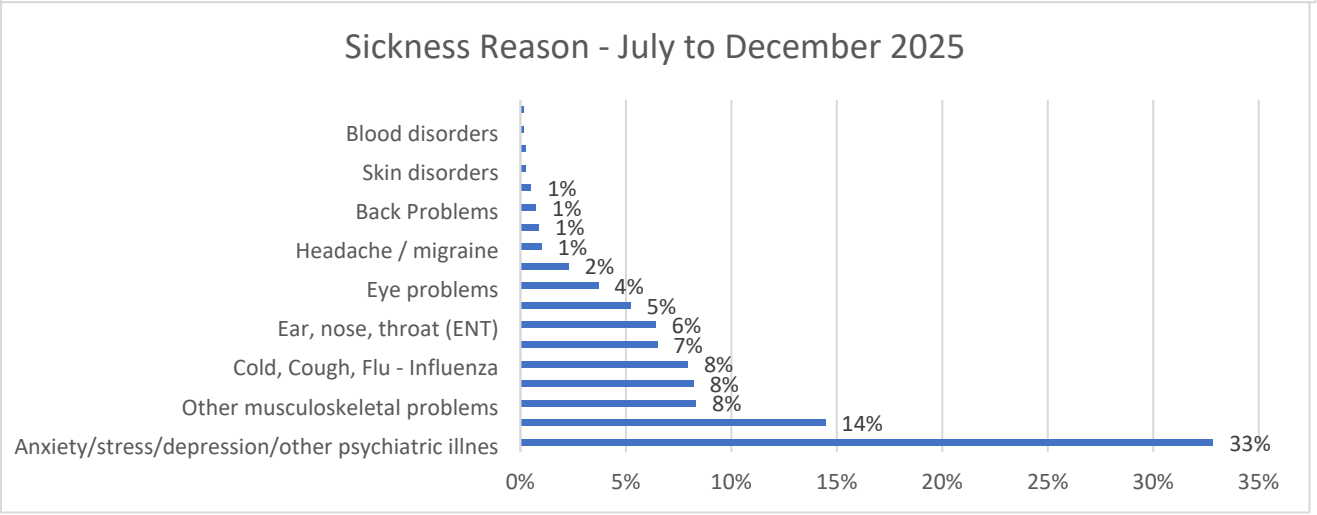
	July	August	Sept	October	Nov	Dec
Registered	5.26%	6.58%	10.52%	8.12%	10.21%	9.70%
Unregistered	13.35%	8.68%	9.85%	8.25%	8.32%	9.19%

Registered	July	Aug	Sept	Oct	Nov	Dec
WTE	138.66	136.22	136.45	136.68	137.87	132.56
Weekly Hours	5199.75	5108.25	5116.875	5125.5	5170.125	4971
Yearly Hours	270387	265629	266077.5	266526	268846.5	258492
Monthly Hours	22532.25	22135.75	22173.125	22210.5	22403.875	21541
Sickness Hours	1186.25	1455.75	2333.5	1803.75	2287.75	2089.5
%	**5.26%**	**6.58%**	**10.52%**	**8.12%**	**10.21%**	**9.70%**

Unregistered	July	Aug	Sept	Oct	Nov	Dec
WTE	31.26	32.17	31.73	31.45	31.15	31.37
Weekly Hours	1172.25	1206.38	1189.875	1179.38	1168.125	1176.375
Yearly Hours	60957	62731.5	61873.5	61327.5	60742.5	61171.5
Monthly Hours	5079.75	5227.63	5156.125	5110.63	5061.875	5097.625
Sickness Hours	678	453.5	508	421.5	421	468.5
%	**13.35%**	**8.68%**	**9.85%**	**8.25%**	**8.32%**	**9.19%**



	July	August	September	October	November	December
Registered	5,26%	6,58%	10,52%	8,12%	10,21%	9,70%
Unregistered	13,35%	8,68%	9,85%	8,25%	8,32%	9,19%



1:2:1 Care & Supernumerary Shift Coordinator (MIS Safety Action 5)

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

WWL utilises the Birthrate+ Acuity tool across the Maternity Floor. The twice daily Safety Huddle monitors, among other things, the provision of 1:1 care in labour and the supernumerary status of the Delivery Suite Co-ordinator.

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

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

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

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

- There must be a rostered planned and an actual supernumerary shift coordinator at the start of every shift to ensure oversight of all birth activity within the unit.
- All women in active labour receive one-to -one midwifery care.

- Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six-month period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising.

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

Red Flags

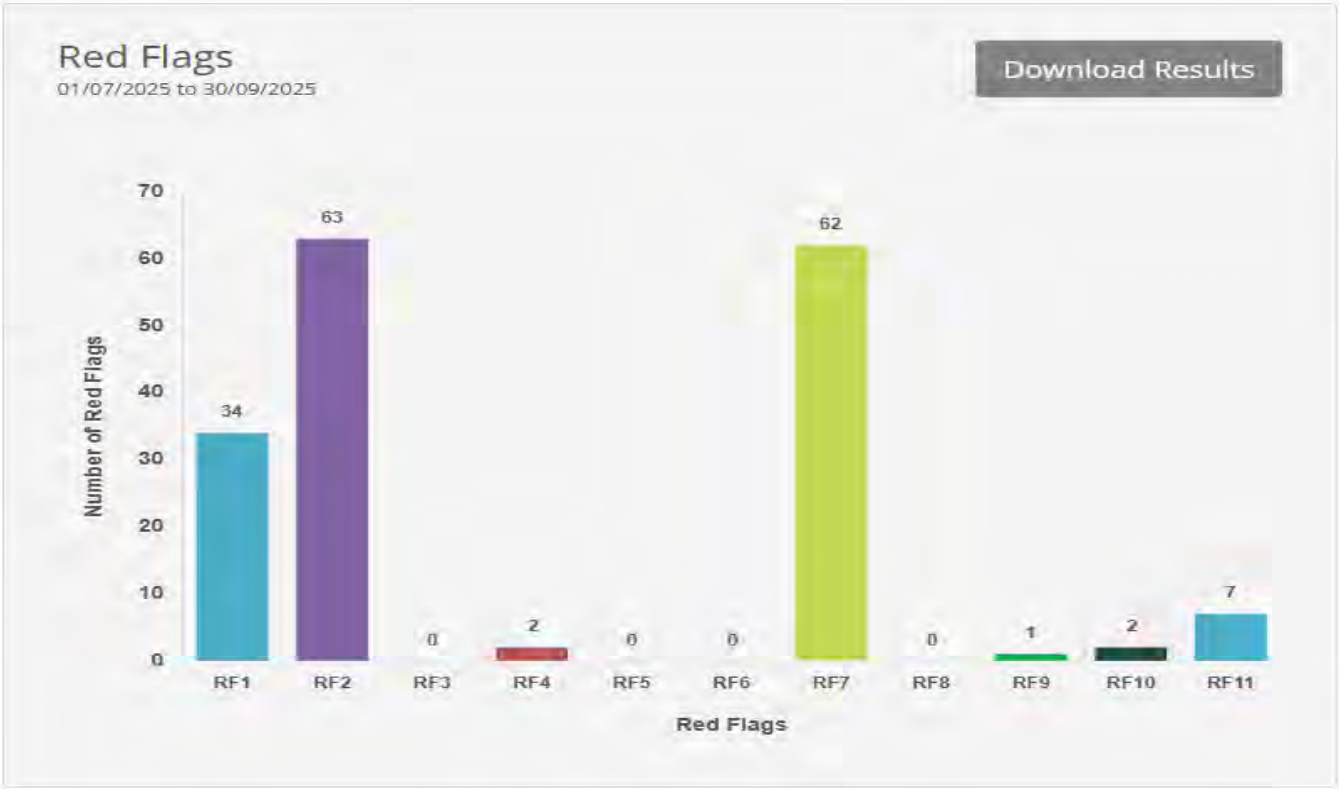
Midwifery red flags are reported Monthly in the Divisional Performance reviews, and Clinical Cabinet. Additionally, they are captured within the Quarterly Perinatal Quality Surveillance Reports which are submitted to Quality and Safety Committee, Safety Champions and Trust Board as well as Divisional and Directorate Governance Forums. These are reported via the Birthrate Plus+ Acuity tool and validated weekly.

In Q2 2025/2026 there were 171 red flags events reported, 68 were validated. This is a significant increase from Q1. Most staffing red flags in Q2 were due to missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) and a delay between admission and commencing the induction of labour process. The delays were contributed due to by maternity staffing shortages caused by short term sickness

- 7.44% registered
- 10.6% unregistered

Escalation was in line with Trust guidance and there was no harm reported.

In Q2 there were 3 maternity unit diverts, x2 due to no cover on the obstetric rota and one due to high acuity and shift leader not supernumerary. The unit diverted 3 women to neighbouring units. Letters of apology were sent to all 3 women.



Number of Red Flags recorded

01/07/2025 to 30/09/2025

Download Results

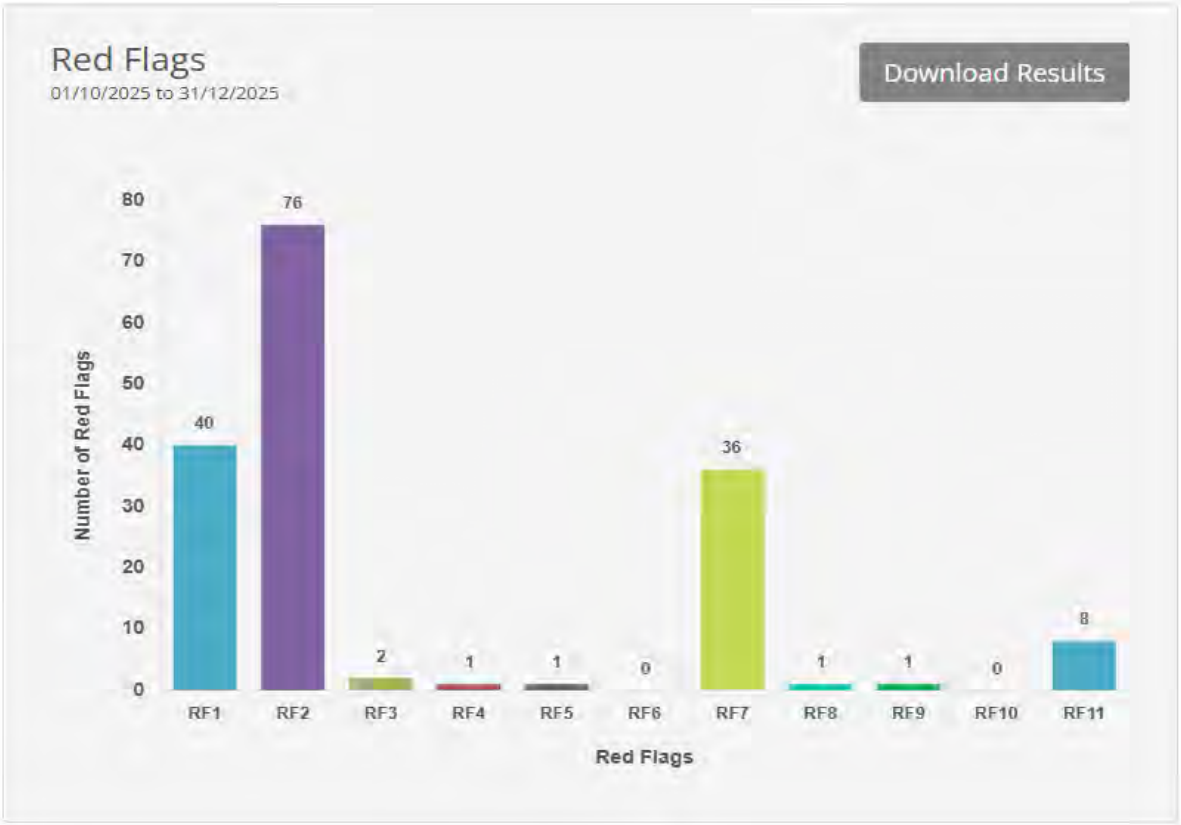
Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	34	20%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	63	37%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	2	1%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	62	36%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	1%
RF10	Coordinator unable to maintain supernumerary status - providing 1:1 care	2	1%
RF11	Coordinator unable to maintain supernumerary status - NOT providing 1:1 care	7	4%
TOTAL		171	

In Q3 2025/2026 there are 166 red flag events reported, 70 were validated, this was a 2.94% increase from Q2. Most of the staffing red flags in Q3 were due to missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). The delays were largely due to an increase in staffing shortages caused by short term sickness. Escalation was in line with Trust guidance and there was no harm reported.

- 10.6% registered sickness
- 8.59% unregistered sickness

In Q3 there was 1 maternity unit diverts, due to no cover on the obstetric rota. 0 women were transferred to neighbouring units.

Additional Birthrate Plus training was commissioned for managers and matrons to support the accurate recording of activity data. Sickness within the senior leadership team has contributed to inconsistencies in both data reporting and analysis. Work is ongoing to ensure that all data is captured accurately, duplicate entries are identified, and robust validation processes are consistently applied.



Number of Red Flags recorded

01/10/2025 to 31/12/2025

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	40	24%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	76	46%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	2	1%
RF4	Delay in providing pain relief	1	1%
RF5	Delay between presentation and triage	1	1%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	36	22%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	1	1%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	1%
RF10	Coordinator unable to maintain supernumerary status - providing 1:1 care	0	0%
RF11	Coordinator unable to maintain supernumerary status - NOT providing 1:1 care	8	5%
TOTAL		166	

Escalation policy

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

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

BirthRate Plus®

The Birthrate plus report has been received in February 2026 and these calculations have been utilised the support the paper

BirthRate Plus® recommends that management or specialist midwife roles should not be included in the clinical numbers. The recent report takes note that within WWL management and specialist roles the clinical specialist midwives have both an element of clinical and non-clinical within their role. Currently there are 19.60 wte Specialist Midwives of which 6.70 wte are allocated to the clinical total. The remaining 12.90 wte are included in the specialist wte.

It is a local decision of senior midwifery management as to the % contribution to the clinical staffing is allocated. The remaining % is included in the non-clinical roles to calculate required numbers

Birthrate Plus methodology.

A skill mix of 92.5% Registered staff /7.5% MSW's has been applied so that up to 10% of the clinical wte are suitably qualified MSWs (Band 3s), working in postnatal services in the ward and on community contribute to postnatal care. It is a local decision by the senior midwifery management team as to an appropriate skill mix for this area of care dependant on service need and demographic.

The clinical staffing has a deficit of 4.88wte with the current skill mix of 92.5% as registered staff and 7.5% as MSWs based on a traditional community model with full Case loading teams.

Applying 12% to the Birthrate Plus® clinical wte provides additional staff of 17.02wte for the above roles with it being a local decision as to which posts are required and appropriate hours allocated

Skill Mix

The total clinical WTE includes the contribution from appropriately trained Band 3 MSWs in hospital and community postnatal services. Currently the service applies a skill mix of 92.5% registered staff/7.5% Band 3 MSWs.

Maternity Senior Leader On-Call

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

This model is now unsustainable due to senior cover available and the increase in call outs due to sickness and acuity.

Across GM and nationally Midwifery Bleep holders are utilised to provide clinical oversight and support within their role, and they are included in the clinical calculation for consideration.

Should this be approved, there will be an additional requirement of 3.46 Band 7wte and they will be responsible for managing the flow and activity within the unit, including overnight and at weekends. (paper to be presented to ETM re SLT on call arrangements and case for change)

Currently there are 19.60wte Specialist Midwives in substantive funded posts of which 6.70wte (34.2%) is allocated to the clinical total. The remaining 12.90wte (65.8%) are included in the additional WTE plus the 7.00wte senior midwifery managers.

Clinical staffing requirements as identified by BR+ with Current 20% uplift	RMs	MSWs PN	Current Funded MW	Current Funded MSW
Intra-partum Services	**46.05**		37.66	5.38
Triage and Advice line	**10.75**		8.06	6.18
Maternity Ward (Antenatal & Postnatal inc TC	**28.20**	**	20.37	8.83
Outpatients (ANC)	**11.24**		7.42	4.06
Dau Assessment Unit	**1.79**		1.44	
Total for Hospital	**101.14 RM's and MSW's**			
Community WTE				
Community Teams	**27.72**	**	24.1	3
Enhanced Team	**12.60**	**	11.8	1

Total Clinical WTE	**141.83 RM's and MSW's**			
Additional roles	**Birthrate Plus**	**Current Funded**		
12%	16.52	19.90		
Total Clinical, Specialist & Management wte.	**154.20**	**156.85**		

****7.5% (no more than 10%) of MSW hours is to be applied against RM establishment as per professional judgement to provide support for postnatal care only.**

Current Clinical Funded Bands 3 – 7
Comparisons are made with the current funded establishment as per table below and includes any vacant posts not currently allocated to clinical areas.

RM's Band 5-7	Specialist Midwives contribution	PN MSW's	Current Total Clinical wte
119.99wte	6.70wte	10.26wte	**136.95wte**

MSW Funded

Additional Roles		Place of work
Band 3 MSWs	4.06	Antenatal Clinic
Band 3 MSWs	6.18	Triage (and Ultrasound Scanning)
Band 3 MSWs	5.38	Delivery Suite
Band 3 MSWs	5.70	Maternity Ward
Band 3 MSWs	3.0	Community Teams
Band 3 MSW's	2.0	Enhanced Team

Below shows the current funded establishment has a positive variance of 2.76wte allocated for the non-clinical roles. Note: The current wte for the non-clinical roles comprises 7.00wte of the senior management team and 12.90wte from the specialist midwives.

Current Funded wte	Birth Rate Plus wte	Wte Variance
19.90	17.14	+2.76

Comparison of Clinical Staffing

Current funded establishment bands 3-7	Birthrate Plus establishment bands 3-7	Variance Bands 3-7
136.95wte	142.86wte	-5.91wte

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

Recommendation: Increase Uplift from 20% to 25%

	Clinical wte	Additional wte	Total wte
20%	**141.83**	**17.02**	**158.85**
25%	**148.58**	**17.83**	**166.41**

Applying 25.0% uplift increases the total establishment by 7.56wte to 166.41wte and compared with the current WTE of 158.85wte the total shortfall is 9.56wte.

Training requirements for midwives have increased significantly following the introduction of:

- Maternity Incentive Scheme
- Saving Babies' Lives Care Bundle (Version 3)
- Core Competency Framework

Each midwife now requires **a minimum of 5 days annually** for mandatory training to remain compliant. This does **not** include:

- Trust-mandated eLearning
- Additional role-specific modules such as:
    - NIPE (Newborn and Infant Physical Examination)
    - Accredited Neonatal Life Support
    - Leadership
    - Critical Care

To meet these requirements and align with the **final Ockenden Report**, which recommends factoring in average sickness levels (previous 3 years), maternity leave, and annual leave (including Trust Birthday Leave), it is proposed that the current uplift of **20% be increased to 25%** in line with other GM trusts. This adjustment will:

- Incorporate training needs within the **3-Year Plan**
- Reduce reliance on temporary staffing, which will not decrease unless training requirements are supported
- Address recommendations previously agreed in principle but not actioned

Impact of Increase:

- **Uplift from 20% to 25% = +9.56 WTE**

MIS Year 8 Enhanced training requirements

Training expectations have been strengthened within the Year 8 Maternity incentive scheme and re-focused to align with the BAPM Neonatal Airway Safety Standard, Avoiding Brain-injury in Childbirth (ABC) implementation preparation, and national MDT learning themes. Two training compliance checkpoints are required each MIS year:

- **30 November** (mandatory), and
- **one other Trust-selected checkpoint**, declared in advance.

MIS Year 8 also integrates workforce expectations across midwifery, obstetrics, anaesthetics, neonatology, and perioperative teams (including trained anaesthetic assistants). **Trusts must demonstrate funded establishments aligned to BR+, neonatal nursing and BAPM standards**, alongside annual Caesarean birth capacity mapping and governance oversight of maternity and neonatal interdependencies.

Summary

Birthrate plus has identified that WWL maternity services have the required amount of specialist roles to support the service and the national agenda. It has considered the requirements to provide enhanced care to a cohort of women who are at risk of poor outcomes due to pre-existing health inequalities, complex social needs and high levels of safeguarding.

The senior leadership team is fully staffed and there are only very minimal vacancies within specialist and other managerial roles.

There are currently 2wte vacancies within the current clinical establishment, however there are a higher number than usual of maternity leave and sickness has been high for the last 6 months which have impacted the overall staffing levels.

Should the recommended 25% uplift be applied and the Bleep Holder roles be approved clinical vacancies will increase to:

- With Bleep Holders and uplift to 25% ... 9.56wte
- Without Bleep Holders… 6.10wte
- No uplift or bleep holders…3.15wte + current 2.0 wte vacancy …5.15wte

Board Requests

1. **Review the findings of the report**, including:
    - Current establishment
    - Existing vacancies
    - Compliance with **Maternity Incentive Scheme Safety Action 5**

2. **Receive a biannual staffing report** for maternity services

3. **Approve an additional uplift** to the baseline establishment to:
    - Support increased training needs
    - Comply with **Saving Babies' Lives** and **Maternity (Perinatal) Incentive Fund Year 7** and onward requirements

4. Note that the **final Ockenden Report** recommends incorporating sickness, maternity leave, and annual leave into uplift calculations.

5. Year 8 of the Maternity Incentive Scheme advises that Trusts should

Title of report:	Maternity and Neonatal 10-Point Plan Self-Assessment
Presented to:	Board of Directors
On:	07 October 2026
Item purpose:	Approval
Presented by:	Deputy Chief Nurse
Prepared by:	Director of Maternity and Child Health
Contact details:	T: 01942 773107 E: joanne.lambert@wwl.nhs.uk

Executive Summary

Purpose

The purpose of this paper is to seek Executive Team Meeting approval of the Maternity and Neonatal 10-Point Plan Self-Assessment prior to its submission to the NHS England Regional Team by the 25 September 2026.

Background

Following publication of the NHS England Maternity and Neonatal 10-Point Plan on 12 August 2026, and the subsequent release of the Maternity and Neonatal 10-Point Plan Assurance Tool on 28 August 2026, all providers are required to complete a self-assessment and submit supporting evidence via the Regional Future Platform. This has provided organisations with a compressed timeframe in which to review requirements, complete the assessment and collate supporting evidence.

The 10-Point Maternity and Neonatal Plan is in response to the findings of Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England and Donna Ockenden's Review of Maternity Services at Nottingham University Hospitals NHS Trust. Both reports identified significant concerns relating to safety, leadership, culture, governance, accountability and the experiences of women, babies and families, highlighting the need for sustained improvement across maternity and neonatal services nationally.

In response, NHS England introduced the Maternity and Neonatal 10-Point Plan, which sets out a series of immediate actions designed to strengthen safety, quality, organisational oversight and accountability. As part of the national assurance process, all providers are required to assess their position against each of the ten priority areas, supported by evidence which is subject to Board-level review and approval prior to submission.

Trust Position

The Trust has completed the self-assessment against all ten priority areas and collated supporting evidence. A cautious and evidence-based approach has been adopted, with full compliance assessed only where there is clear evidence that actions have been implemented and are embedded in practice. The accompanying narrative within the assurance tool provides a summary of progress against each priority area, including actions completed, work underway and any further activity required to achieve full compliance.

Where opportunities for further development have been identified, these have been incorporated into existing maternity and neonatal improvement plans and governance arrangements for ongoing monitoring. The self-assessment therefore provides a balanced and accurate reflection of the Trust's current level of assurance and its plans to address any outstanding requirements.

This submission represents the Trust's baseline assessment against the Maternity and Neonatal 10-Point Plan. A further Board-approved progress update is required by 31 December 2026, and additional reporting requirements may follow following publication of the National Maternity and Neonatal Action Plan later in 2026. All future submissions will be subject to Board review and approval through the Trust's established governance arrangements prior to submission.

Link to strategy and corporate objectives

The Maternity and Neonatal 10-Point Plan supports the Trust's strategic objectives for delivering safe, high-quality care, strengthening governance and assurance, and improving outcomes and experiences for women, babies and families.

Risks associated with this report and proposed mitigations

Failure to demonstrate compliance with the requirements of the 10-Point Plan may increase regulatory, quality and reputational risks; these are mitigated through ongoing improvement programmes, oversight via established governance arrangements, and Board scrutiny of progress.

Financial implications

There may be financial implications associated with delivering and sustaining the workstreams required to achieve and maintain full compliance with the Maternity and Neonatal 10-Point Plan; any resource, workforce or investment requirements identified through this work will be considered through the Trust's established financial planning and governance processes

Legal implications

The requirements of the 10-Point Plan support the Trust's obligations to provide safe and effective care and maintain appropriate governance and assurance arrangements.

People implications

Delivery of the 10-Point Plan requires continued engagement and collaboration across maternity, neonatal and corporate teams to strengthen leadership, culture, safety and accountability to include the Maternity and Neonatal Voice Partnership.

Equality, diversity and inclusion implications

Implementation of the 10-Point Plan supports the delivery of equitable, personalised and culturally responsive care and aligns with national ambitions to reduce inequalities in maternity and neonatal outcomes.

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

The self-assessment has been reviewed through the Trust's maternity and neonatal governance arrangements, prior to submission for Executive Team Meeting approval.

Recommendation(s)

The Board is asked to:

I. Review and approve the Maternity and Neonatal 10-Point Plan Self-Assessment prior to submission to the NHS England Regional Team.
II. Note the assurance provided through the self-assessment regarding the Trust's compliance with, and progress against, the national 10-Point Plan.
III. Support continued oversight of the associated improvement actions through existing governance arrangements
IV. Approve the Maternity and Neonatal 10-Point Plan Self-Assessment prior to Trust Board submission for information in October 2026

Appendix

NHS England Maternity and Neonatal 10 point plan

https://www.england.nhs.uk/long-read/maternity-and-neonatal-10-point-plan-assurance-process/

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2.
Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms
the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the
extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Report signed off by Trust Board (named Exec): Kevin Parker Evans Chief Nursing Officer

Trust Board sign off date: 10th September 2026

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Non-compliant	EV-01 TW26-014 Martha's Rule - Adults SOP EV-02 Attendance at National Webinar	Formal roll out of Martha's Rule in maternity and neonatal services has not yet commenced.	Identify maternity and neonatal Martha's Rule project leads. Establish MDT implementation group to include maternity, neonatal, CDOT and MNVP representation. Develop a Martha's Rule implementation plan and timeline.	National Webinar attended by MDT. Early planning is underway. Preliminary discussions have taken between the maternity and neonatal teams and Critical Care Outreach Team (CCOT) to review implementation across other Trust services and consider application within maternity and neonatal settings. Existing Trust escalation pathways provide a good foundation for implementation. Health Innovation Manchester has also offered support to Greater Manchester providers to rollout Martha's Rule. National Webinar is on the 24th September 2026. National funding agreed - awaiting.
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV-03 PQOM Reports EV-04 Picker Action Plan EV-05 Patient Experience and Engagement Report	A monthly cycle of collecting and analysing maternity and neonatal outcome, audit and experience data is established through existing governance arrangements. Further work is required to incorporate all available neonatal patient experience data from FI-Care into integrated reporting and ensure all relevant sources of maternity and neonatal audit, outcome and experience intelligence are routinely included within the reporting cycle.	Incorporate neonatal FiCare/patient experience data within established perinatal quality reporting. Await the national roll-out of Mat-Neo PREM Review the range of maternity and neonatal clinical audits routinely reported to ensure comprehensive oversight of clinical quality.	The Perinatal Quality Oversight Report provides oversight of maternity and neonatal outcomes, clinical audit, patient experience, complaints, MNVP intelligence and targeted engagement activity. Feedback from women, families and neonatal parents is reported alongside patient commentary and health inequalities data, ensuring the voices and experiences of local communities are heard, scrutinised and acted upon through Board governance arrangements.
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV-06 MNVP Reports EV-07 Perinatal Improvement Plan EV-03 PQOM Report EV-08 LMNS Data Assurance Slides	Whilst outcome measures of key KPIs are reported through SPC charts and other quality metrics, further work is required to consistently demonstrate the measurable impact of all improvement activity within the Perinatal Improvement Plan.	Further develop the Perinatal Improvement Plan to include a measure of success and evidence of impact for each improvement project. Use the Perinatal Quality Oversight Report to provide Board assurance regarding progress, outcomes achieved and actions requiring escalation. Develop SPC-based maternity dashboards to strengthen outcome monitoring and trend analysis and strengthen Maternity Dashboard Report. Work with Business Intelligence colleagues to enhance maternity and neonatal outcome reporting capability.	The Perinatal Quality Oversight Report provides a triangulated view of maternity and neonatal outcomes, health inequalities, patient experience (including FFT and CQC maternity survey findings (including free text comments)), workforce, audit and safety intelligence. Actions arising from feedback, audits, incidents and engagement activity are monitored through the Perinatal Improvement Plan and governance forums. Health population data, including deprivation, ethnicity and vulnerability factors, is routinely collated and reported across multiple sources of safety intelligence to support identification of inequalities and ensure improvement activity is informed by the needs of the local population. The MNVP is represented within governance structures and undertakes regular engagement and listening activities to ensure the voices of women and families inform service improvement and Board assurance.
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV-09 Health Inequalities Dashboard EV-10 E&E Improvement Plan EV-03 PQOM Report	Current reporting identifies variation in outcomes and experience by ethnicity, deprivation and vulnerability factors and demonstrates targeted interventions in response. Further work is required to develop and monitor outcome measures for targeted health inequalities initiatives, including the Enhanced Midwifery Team pilot, to demonstrate their effectiveness in reducing unwarranted variation and improving outcomes and experience for vulnerable women, babies and families.	Develop outcome measures for the Enhanced Midwifery Team pilot and other targeted health inequalities initiatives. Monitor and report the impact of targeted interventions through existing governance arrangements and the Perinatal Quality Oversight Report. Participate in the Perinatal Equality and Anti-Discrimination program.	The Perinatal Quality Oversight Report routinely analyses outcomes, experience and safety intelligence by ethnicity, deprivation and vulnerability factors. Health inequalities data is triangulated from multiple sources, including MNVP Intelligence, Patient and Public Engagement Midwife activity, Birth Thoughts appointments, complaints, FFT responses and targeted engagement. Current reporting demonstrates representation from women living in areas of deprivation and minority ethnic communities and informs targeted interventions through services such as the Smokefree Pregnancy Team, Preterm Birth Service, Enhanced Midwifery Team and Equality, Equity and Inclusion workstreams.
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	EV-11 PQOM SOP EV-12 Trust Board Minutes	Strengthen evidence-base	Incorporate in Board ToR Incorporate in job plans	The Trust has established joint executive accountability for maternity and neonatal services through the Chief Nurse and Medical Director. These arrangements are supported by routine Board oversight and assurance processes, including Safety Champions meetings and review of the Perinatal Quality Oversight Report and escalation of maternity and neonatal quality, safety, workforce and performance matters.
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Compliant	EV-12 Trust Board Minutes	Strengthen evidence-base	Incorporate in job plans	The Director of Midwifery, Neonatal Leads and Clinical Directors are invited to attend Trust Board meetings whenever maternity or neonatal matters are discussed or maternity and neonatal papers are presented. In addition, they are core members of the bi-monthly Quality and Safety Committee, a formal sub-committee of the Trust Board, providing regular clinical leadership, assurance and oversight of quality, safety and governance across maternity and neonatal services.
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Non-compliant		Provision has not yet been confirmed to enable full multidisciplinary participation in the Perinatal Equity and Anti-Discrimination Programme (PEADP). Attendance and staff release arrangements for intake 4 remain under development, and no dedicated funding has been identified to support backfill requirements.	Confirm multidisciplinary representation for PEADP Intake 4. Review workforce and backfill requirements to support staff attendance and programme participation. Develop a local implementation plan to ensure learning from the programme is disseminated across maternity and neonatal services. Monitor participation and programme delivery through established governance arrangements.	WWL has completed the Quadrumvirate Perinatal Leadership Programme and is currently preparing for participation in PEADP Intake 4 commencing September 2026. Workforce capacity and release arrangements are being considered to support multidisciplinary participation across maternity and neonatal services.
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Compliant	EV-13 Maternity and Neonatal Equalities Dashboard - NHS England Digital EV-14 Local Equalities Dataset EV-03 PQOM Report	Health inequalities data is routinely reviewed using locally developed datasets. Local reporting provides monthly oversight of key demographic and health inequalities measures across the maternity population. The principal limitation relates to the NHS England Maternity and Neonatal Equalities Dashboard, which remains under development and is subject to significant reporting lag, restricting its usefulness for timely monitoring of trends and the impact of interventions.	Maternity and Neonatal Equalities dashboard - NHS England Digital. Mitigation - Continue monthly review of local health inequalities data through established local governance arrangements. Utilise emerging functionality within the NHS England and regional inequalities dashboards as these develop.	Local maternity population and health inequalities data is reviewed routinely through established governance arrangements and reported through the Perinatal Quality Oversight Report. Reporting includes analysis of ethnicity, deprivation, age, BMI, smoking status, employment and vulnerability factors and is used to identify variation, inform targeted interventions and support Board assurance regarding health inequalities and equity of care. The Greater Manchester Equity and Equality Action Plan remains ongoing, with WWL represented through the Health Inequalities Specialist Midwife. In parallel, Greater Manchester Local Maternity and Neonatal Services (LMNS) is leading regional work to develop a more comprehensive North West inequalities Dashboard to further strengthen monitoring of variation in outcomes, access and experience across different population groups. The Trust is currently developing K2 which will further support disaggregated data collection.
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	EV-03 PQOM Report (High Level Gap Analysis and Action Plan)	Implementation planning is not yet complete and is currently awaiting obstetric input to identify any remaining gaps and agree the required actions for implementation. Initial gap analysis has been completed, and review meetings have been arranged to finalise the action plan and implementation approach.	Finalise action plan with MDT input Roles and responsibilities and project leads must be clearly defined	Action plan will be available to submit to November Trust Board
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 6, is there a minimum ≥50% consultant presence in defined acute care situations?	Compliant	EV-15 Maternity Dashboard Report EV-03 PQOM Report EV-16 CNST Bi-Annual Update Report	No gaps identified	No actions	Embedded monitoring arrangements demonstrate sustained compliance with the RCOG "Roles and Responsibilities of the Consultant Providing Acute Care" standard. Consultant attendance in defined acute care situations is consistently monitored and remains above the minimum 50% threshold required by Maternity Incentive Scheme (MIS) Year 6.
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(in line with MIS Year 6)*	Compliant	EV-17 Locum Database	No gaps identified	No actions	Process in place.

6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2025)? *(In line with MIS Year 8)*	Compliant	EV-18 NWNODN Activity, Capacity and demand Report (ACD) EV-19 Mat-Neo Staffing Paper	No gaps identified	Annual workforce review to be undertaken.	The ACD report confirms that WWL meets the BAPM nurse staffing requirements. Work is ongoing to review the wider Allied Health Professional workforce to ensure alignment with BAPM workforce standards and recommendations. The service confirms that funding for the medical neonatal workforce is aligned to BAPM requirements (Tier 1, Tier 2 and Tier 3). The ability to staff the rota is affected by unavailability including maternity leave, vacancy and other unavailability. Active recruitment to fill vacancy is ongoing.
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 6)*	Non-compliant	EV-20 Birthrate plus Report Jan 2026 EV-21 Bi-Annual Safe Staffing Report EV-22 Business Case	Birthrate plus identified a shortfall in Midwifery staffing. Business case and paper in progress and will be presented when total recruitment numbers agreed.	Perinatal Staffing Paper Secure funding approval for additional midwifery establishment identified through the Birthrate Plus review. Implement targeted recruitment to close the identified staffing gap.	Birthrate Plus review (January 2026) identified that the current midwifery establishment does not fully meet recommended staffing requirements (3.15 WTE shortfall). A business case is underway and an action plan to achieve Birth Rate plus requirements will be shared with Board.
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Compliant	EV-23 Anaesthetic Job Plan EV-24 Anaesthetic Rotas	No gaps identified	No actions	
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV-20 Birthrate Plus Report EV-21 Bi-Annual Safe Staffing Reports EV-03 PQOM Report	The Trust Board receives regular oversight of maternity and neonatal workforce, acuity, service pressures and escalation activity through integrated quality, safety and workforce reporting. This includes review of staffing levels, workforce sustainability, Birthrate Plus progress, vacancy and sickness data, red flag incidents, clinical risk escalations, service pressures and patient safety outcomes. The Board is therefore able to identify emerging risks, respond to periods of increased demand or reduced workforce availability, and seek assurance that mitigating actions are implemented and monitored.	Develop SPC-based maternity dashboards to strengthen outcome monitoring and trend analysis	Board reporting is supported by multidisciplinary governance arrangements that bring together maternity, neonatal and paediatric services, reducing the risk of siloed decision-making and enabling a coordinated response to changing clinical risk and operational pressures
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	EV-25 North West Maternity Escalation Policy & Operational Pressures Escalation Levels Framework EV-21 Bi-Annual Safe Staffing Reports EV-26 Training Needs Analysis (TNA) EV-20 Birth Rate plus Report 2026	Whilst processes are in place to manage the redeployment of specialist midwives during periods of escalation and operational pressure, there has not been a formal review by the Trust Board of internal resource deployment, including the impact of redeployment on specialist services, workforce resilience and continuity of care.	Utilise the Birthrate Plus Review and associated workforce recommendations to include maternity resource deployment, including specialist roles, service resilience and the impact of redeployment on care delivery in future iterations of the Perinatal Safe Staffing Report.	When specialist midwives and managers are utilised in times of escalation this is undertaken using a risk-based approach to ensure safe re-deployment.
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Partially compliant	EV-27 Homebirth Review Paper (presented at ETM - sub-board Committee) EV-28 Homebirth AAA Report (to CEO and Chief Nurse)	Immediate improvement actions have been identified. Implementation remains ongoing. Await national steer.	Mitigating action - Hybrid working across community and delivery suite areas commences pilot 19-10-2026 Re-visit options appraisal for Homebirth Service staffing model Await outcome of National Hombirth Task and Finish recommendations for national steer.	WWL has been part of the Regional Task and Finish group led by the Regional team. The Northwest Regional Home Birth Benchmarking Tool was completed and submitted to NHSE .
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Partially compliant	EV-27 Homebirth Review Paper EV-29 Risk Register Entry - ID 4358 EV-30 Homebirth Immediate Action Plan	Risk Register and associated actions not shared with Regional team at this time. Ongoing monitoring and escalations to NHS E as required.	Progress Risk and associated actions. Continue ongoing monitoring of Homebirth Service risks and implementation of mitigating actions, with escalation through the regional NHS E team as required	Scoping exercise to review homebirth operating procedures was undertaken, workstream themes identified and an action plan developed to mitigate any immediate risks whilst awaiting national steer.
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	EV-31 TW-23-076 PSIRP (Perinatal Local Priorities - point 7) EV-03 PQOM Report EV-32 TW-10-054 Duty of Candour with attached SOP EV-33 Patient and Public Engagement Lead JD	A quarterly themed report is included in the PQOM Report.		Established robust processes in place that could be further enhanced with a dedicated quarterly PSIRF response report for presentation and discussion at Quality and Safety Committee.
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant	EV-34 DMsional Assurance slides EV-03 PQOM Report EV-35 Themed Complaint Report	Whilst complaint themes, learning actions and improvement plans are routinely reviewed and reported through divisional governance structures and Board reporting mechanisms, a consistent approach to measuring and evidencing the impact of actions taken in response to complaint themes is not yet fully established.	Implement routine monitoring and reporting of the impact of complaint-related improvement actions using outcome measures and SPC charts where applicable.	The trust demonstrates established processes for thematic review of complaints and concerns, with learning and actions routinely reported through divisional governance arrangements and the Perinatal Quality Oversight Report. Further work is required to strengthen the systematic monitoring and reporting of the impact of improvement actions to demonstrate measurable reductions in recurrent themes and provide enhanced Board assurance.
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	EV-33 Patient and Public Engagement Lead JD EV-32 TW-10-054 Duty of Candour with attached SOP EV-36 TW-23-076 PSIRP (FLO) EV-37 PMRT SOP EV-38 OBG-79 Birth Thoughts Guideline EV-39 TW-26-077 Postnatal Follow-up following Complex Birth SOP EV-40 CG25-024 Supporting Staff following Adverse Events Guideline EV-41 PSIRF Safety Day Training Slides	No gaps identified	No actions	
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Non-compliant		Triage Audit underway as servive specification tool received 12/08/26.	Complete Triage Service Specification Tool and develop action plan Present at ETM for Board sign off on 17-09-2026	
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Non-compliant		Not currently reported	Develop and implement an internal reporting solution to support direct submission of data and assurance information through Trust Board reporting processes.	Trust BI team will be asked to consider whether a platform can be configured to provide a single maternity, neonatal and child health assurance dashboard that supports both operational oversight and direct Board assurance reporting, without requiring manual collation of multiple reports.
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	EV-42 Triage Gap Analysis.	The National Maternity Triage Specification has been received and a detailed compliance review is underway. Further work is required to assess current arrangements against the national standard and identify any gaps requiring implementation.	Implement the National Maternity Triage Specification and embed associated reporting and assurance mechanisms through the K2 Maternity Information System.	The National Maternity Triage Specification is currently being reviewed against existing service arrangements. The implementation of the K2 Maternity Information System later this year will support compliance through electronic triage documentation, a real-time clinical status board and enhanced reporting functionality. Work is ongoing with Business Intelligence colleagues to ensure appropriate performance, quality and assurance reporting is available to support governance oversight and Board assurance.
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2025?	Compliant	EV-43 Mortuary Board Assurance Report	No gaps identified	No actions	Submitted as required by Chief Nurse
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Compliant	EV-43 Mortuary Board Assurance Report	No gaps identified	No actions	The Trust Board has received assurance regarding implementation of the recommendations arising from the Fuller Inquiry, including review of the 29 recommendations relevant to NHS organisations. Where recommendations are not yet fully implemented, time-bound action plans are in place and monitored through established governance arrangements. Regular Board assurance reports provide oversight of progress and compliance. Roles and responsibilities across the teams involved in mortuary care, including Estates, Safeguarding, Pathology, Bereavement, Mortuary and Corporate Services, are clearly defined, well understood and subject to regular review and testing. The Mortuary services team are now under Corporate Services in the remit of the Chief Nurse for oversight and assurance.

Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:

Wrightington Wigan & Leigh NHS Truast

Please enter the **trust site** below:

Royal Albert Edward Infirmary

Guidance for completion

Purpose

This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

Principles for completion

The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

Dashboard

The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

Specification standard

The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

Benchmarking suggestions in line with the specification

This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

Benchmark rating

This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

There is a drop down menu incorporating the following:
Fully in place, evidenced and embedded
Partially in place, but inconsistent or not fully evidenced
Not in place, significant gaps or limited evidence
Not relevant to local pathway/context

Support required from Trust board to progress compliance

This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.

What happens if selecting:

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

There is automatic functionality built in that takes you to the Support required from trust board column.

Metrics

This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

Data captured per site

This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

There is a drop down menu incorporating the following:
Site captures this data
Site partially captures this data
Site doesn't capture this data

Support required from Trust board to progress the metric

What happens if selecting:
Site partially captures this data
Site doesn't capture this data
There is automatic functionality that takes you to the support required to progress this metric column

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

Estimated financial requirements to support compliance

Where assessed as **Partially in place, but inconsistent and not fully evidenced** or **Not in place, significant gaps or limited evidence**, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

Principles Menu

This functionality will enable you to navigate between the principles tabs more easily.

Maternity Triage Specification
Benchmarking Audit Tool Dashboard

Click below to link through to each principle

		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	18%	82%	0%	0%	0%	£0.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	40%	50%	10%	0%	0%	£0.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	0%	100%	0%	0%	0%	£0.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	33%	33%	0%	0%	£0.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	50%	38%	13%	0%	0%	£0.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	20%	80%	0%	0%	0%	£0.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	20%	40%	40%	0%	0%	£0.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	0%	42%	50%	8%	0%	£0.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	20%	40%	40%	0%	0%	£0.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	14%	43%	43%	0%	0%	£0.00

Principle 1: Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

Dashboard

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.	1. Local guidance agreed by stakeholders is in place ensuring consistent, clearly defined referral pathways for women presenting 24/7 in care areas outside of acute maternity services 2. The pathway defines where women should present based on gestation, symptoms, urgency and clinical need and this is shared with women, healthcare professionals and partner services. 3. The guidance in place covers early pregnancy, antenatal, intrapartum concerns and the postnatal period, up to 6 weeks and includes clearly definition of handover procedures between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support system-wide engagement with Primary Care, GP Federations and partner organisations to develop and ratify a single referral pathway across all services, ensuring consistent access and referral criteria. Current evidence - OBS 20 - A &E Northwest Community SOP - NWAS. Needed : Missing primary care referrals pathway eg. GP	
Provide clearly defined 24/7 access routes so women always know where to go with urgent concerns.	1. All access routes are clearly described including via telephone, walk-in and professional referral routes and that these are available and monitored 2. All information related to access routes is consistently applied to all areas of your organisation, including the Emergency Dept. 3. Clear information is provided to women identifying appropriate access routes for all gestations of pregnancy and postnatal period	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support investment in additional wayfinding and signage, including within ED and key access points across the Trust, to improve visibility of maternity triage access routes. Currently have signs on Level 1, 2 and 3. Signs needed in A&E and more signage as one sign on level 1 and along corridors as just single signage per floor. Webpage to be updated to include wider information for service users.	
Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs; share this with women, staff and partner services including primary care, ambulance services and NHS 111, supporting seamless care from early pregnancy to six weeks postnatal.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below No support required.	
Ensure inclusive access arrangements so all women can use maternity triage safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration; pathways should be clear and accessible to women with no prior system knowledge.	1. A documented policy exists to ensure equitable access to maternity triage for ALL women. 2. Professional interpretation and translation services are available and routinely used within maternity triage services. 3. Information about how to access maternity triage is available in multiple formats, including easy read, large print, audio, digital and translated versions. 4. Reasonable adjustments for women with physical, sensory, learning, cognitive or communication disabilities have been made 5. Triage pathways have been reviewed, and where necessary, amended to identify and reduce barriers related to race, ethnicity, culture, socioeconomic deprivation and inclusion health needs 6. Pathways in place identifying different access routes for women without digital access and literacy and women who have no known GP registration status, immigration status or previous engagement with maternity services. Clear self referral and direct access routes exist without requiring women to navigate complex healthcare systems 7. Information is designed to be understandable for women with no prior knowledge of maternity services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Review of patient information resources to ensure availability in multiple languages, formats and accessibility standards Patient information available accesible via QR code on ALL handheld notes. Need to establish if available in all languages.3. Patient information leaflet to be available in multiple formats. Consider Pocket Talk Device.	
Maintain access routes such as telephone, walk-in and community referral, with an open-door policy for anyone attending with concerns or needing urgent care; initial assessment should be equitable regardless of route of access or previous attendance.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Fully in place, embedded and evidenced	No further action required	

Provide accessible and consistent guidance and signposting for staff and service users, with onward referral and coordinated handover responsibility resting with healthcare professionals in the presenting service. Providing support for women to navigate between services.	1. The service has clearly defined pathways and guidance to support staff and service users in accessing the appropriate service 2. Information and signposting has been provided to staff and service users 3. Guidance is provided in all accessible formats required for your service. 4. Clear handover procedures are in place for effective handover of care between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support provision of accessible patient information in alternative formats and languages to ensure equitable access for all service users Patient information leaflet in use - need to consider other languages/formats	
Define referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.	1. Agreed referral criteria are in place across local maternity services, including community midwifery, antenatal clinics, maternity triage and day assessment services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Development and implementation of a Day Assessment Unit SOP	
Establish communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.	1. Documented communication pathways exist between maternity triage and key partner services - including those listed within the specification standard.	Fully in place, embedded and evidenced	No further action required Strengthen engagement with Primary Care partners to formalise communication and referral pathways into maternity services.	
Plan ongoing care, including sufficient bed capacity to support timely and safe admission for women requiring inpatient care from maternity triage services.	1. Defined pathways are in place to support the ongoing management and care of women following maternity triage assessment. 2. Clear criteria are established for admission, observation, transfer, discharge and follow up care following triage assessment. 3. The service has a process to assess, monitor and manage maternity bed capacity to support timely admission from triage. 4. The service has provision in place for women requiring admission to be transferred to appropriate inpatient setting without avoidable delay. 5. Formal escalation processes exist when bed capacity is constrained, including operational and clinical escalation arrangements.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Strengthen Escalation Action cards to be included in Triage SOP.	
Share information and discharge summaries in a timely way with relevant care partners, including primary care and community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.	1. A formal process exists for sharing discharge information and outcomes following triage attendance, tailored to the individual need. 2. A formal process exists for sharing discharge summaries/assessments and clinical outcomes to relevant care providers and to the women.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support digital development to enable standardised discharge communication and information sharing with community maternity services and Primary Care.K2 being implemented- process to be agreed for electronic discharge summary	
Provide a postnatal pathway to six weeks postnatal, including guidance on care of the baby where required; where the baby does not need separate neonatal or paediatric care, avoid separating baby from mother wherever possible.	1. A clearly defined pathways exists for women accessing maternity services from birth to 6 weeks postnatal. 2. The pathway describes ongoing assessment, follow-up, escalation and support requirements throughout the postnatal period 3. Guidance is available to support assessment and care of the baby where this is relevant to the reason for attendance. 4. Processes are in place to support the needs of both the woman and baby during postnatal assessment and care. 5. Clear referral process are in place for babies requiring neonatal or paediatric review and ongoing care. 6. Guidance is in place to reflect a family centred approach to minimise separation of mother and baby.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Neonatal care not provided in Triage. If neonate well and mum admitted mum and baby remain together. Pathway via Paediatric A&E and Ward	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Rate of triage presentations per 1,000 births. Why: Helps services understand demand and plan capacity.	Site captures this data	Please outline what support you require from your trust board below	£0.00

	Site captures this data	Continue oversight through maternity performance and quality dashboards.
Metric: Frequency of unplanned maternity triage service closures per month. Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.	Site captures this data	Please outline what support you require from your trust board below
Metric: Ethnicity, deprivation and language data for each woman presenting, including English as a first language and need for interpretation services. Why: Identifies groups more likely to face access barriers or worse outcomes, supporting targeted action to reduce inequalities.	Site doesn't capture this data	Please outline what support you require from your trust board below Support Health Inequalities workstreams to improve data collection, reporting and targeted service improvement
Metric: Proportion of women who attend without prior telephone triage. Why: Helps services understand use of different access routes and confirm open-door policies are working as intended.	Site captures this data	Please outline what support you require from your trust board below Support inclusion within routine maternity audit and quality dashboard reporting.

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Principle 2: Recognition as urgent care

Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Maternity triage services must be recognised across the whole system as a safety-critical environment and the primary access point for urgent and emergency care and advice for pregnant women, and those up to six weeks postnatal, experiencing unexpected or urgent concerns or problems.	1. Maternity triage is formally recognised within organisational policies and governance structures as a safety-critical clinical environment. 2. Maternity triage is recognised as the primary access point for urgent and emergency maternity advice, assessment and care. 3. Pathways are in place clearly identifying maternity triage as the preferred point of access for women with urgent pregnancy, labour or postnatal concerns up to six weeks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support formal recognition of maternity triage within Trust governance structures and oversight of patient tracking via EPR.	
Design maternity triage to provide rapid assessment and care, ensuring every woman receives initial triage assessment within 15 minutes of arrival regardless of time of day or service pressures.	1. A Local standard is in place requiring all women attending maternity triage receives an initial assessment within 15 minutes of arrival. 2. The service has systems in place to monitor compliance to the 15 minutes from arrival assessment. 3. The service has systems in place to monitor compliance of the 15 minutes assessment regardless of route of presentation, clinical condition, time of day, day of week or service pressures. 4. Clear guidance exists defining the minimum requirements for the initial triage assessment 5. Workforce contingency plans are in place to achieve the 15 minutes assessment, including at times of peak demand. 6. Escalation processes are in place for when timely assessment is threatened due to increased acuity.	Fully in place, embedded and evidenced	No further action required No further action required. Ongoing assurance through audit and performance reporting.	
Ensure maternity triage is accessible to all women presenting with unscheduled pregnancy, labour or postpartum concerns without requiring an appointment or referral.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Fully in place, embedded and evidenced	No further action required	
Embed a culture that validates and responds to women's concerns, reinforcing that seeking care was the right decision and that accessing triage is appropriate whenever women have concerns.	1. The service promotes a culture where women's concerns are listened to, taken seriously and responded to appropriately 2. The service actively promotes staff consistently reassuring women that seeking advice or assessment was appropriate, regardless of the outcome of assessment. 3. Women can report through patient experience options experience of maternity triage services. 4. . Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information platforms. The same information also needs to be available for those using	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Patient Engagement and Experience midwife in post, Friends and Family Tests. Calls are recorded and audited weekly.	
Provide information on expected waiting times based on risk categorisation on arrival, including real-time updates where feasible.	1. The service has defined waiting time expectations aligned to their local triage risk categorisation. 2. Systems are in place to ensure women are informed and updated regarding delays and waiting times where feasible.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Waiting times Poster	
Operate as a safety net with an open-door approach: women can attend in-person maternity triage without prior contact; attendance is accepted without	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral.		No further action required	

judgement; concerns are assessed promptly and without assumptions, including latent labour and apparently non-urgent issues.	2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Fully in place, embedded and evidenced		
Keep maternity triage distinct from scheduled or day assessment activity and, where possible, physically separate.	1. Through operational policy maternity triage operates as a distinct service for unscheduled pregnancy, labour and postnatal concerns. 2. Maternity triage is operationally separate from scheduled outpatient, antenatal clinic and day assessment activity. 3. Maternity triage is provided in a dedicated area that is physically separate from scheduled services, wherever feasible.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support estate development and capacity planning to provide dedicated maternity triage accommodation separate from Day Assessment Unit activity in line with national standards.	
Define maternity triage through a Standard Operating Procedure that clearly distinguishes it from day assessment, including scope, exclusions and navigation between services; scheduled reviews, tests and treatments should be managed separately by separate staff in a separate location.	1. A documented and approved Standard Operating Procedure (SOP) defines the purpose, scope and function of maternity triage. 2. The SOP describes the presentations, conditions and circumstances appropriate for maternity triage. 3. The SOP describes activities excluded from maternity triage, including scheduled reviews, planned assessments, routine monitoring, tests and treatments.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Develop Day Assessment SOP	
Clearly signpost maternity triage throughout the hospital with information and maps available electronically and/or in paper form.	1. Maternity triage is clearly signposted throughout the hospital from all main entrances, emergency departments, outpatient areas and maternity services. 2. Signage is visible, consistent and easy to understand. 3. Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information platforms. The same information also needs to be available for those using paper hand held notes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support investment in additional wayfinding signage, maps and digital information across all hospital entrances, corridors and the Emergency Department	
Recognise maternity triage as a core part of the urgent and emergency care system, working with ambulance and emergency services on escalation, conveyance decisions, structured handover and assessment in the safest setting.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support development of formal agreements with Emergency Department, NWAS, NHS 111 and Primary Care partners to ensure consistent pathways, escalation processes and place of care decisions.	
Participate in a system-wide network that supports neighbouring Trusts during periods of high demand to enhance safety across the wider geography.	1. The trust actively participates in system wide maternity networks to support safety across neighbouring trusts. 2. Formal mutual support agreements are in place with neighbouring trusts. 3. Clear triggers are defined for when system wide support should be requested or offered.	Fully in place, embedded and evidenced	No further action required No further action required. Continue participation in regional escalation and mutual aid arrangement.	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps identify common urgent issues and monitor whether triage is being used appropriately as the first point of urgent care.	Site captures this data	Please outline what support you require from your trust board below Data collected Triage specific dashbaord required.	£0.00

Principle 3: Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Align the clinical model with RCOG Good Practice guidance and ensure every attending woman is assigned a clinical priority based on physical, mental and social wellbeing.	1.The maternity triage clinical model is aligned with current RCOG Good Practice Guidance and relevant national maternity standards.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Require separate private location for telephone triage, require maternity specific training for BSOTS	
Ensure triage assessment and clinical prioritisation are carried out by staff trained in the specific triage method.	1. The service can evidence initial triage assessments and clinical prioritisation are undertaken only by staff who have completed training in the local maternity triage method. 2. A documented competency framework exists for staff undertaking maternity triage assessment and prioritisation. 3. The service can evidence staff complete a structured induction and training programme before independently undertaking triage assessments.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support protected training time and workforce arrangements to ensure staff allocated to maternity triage are trained, competent and have completed the required maternity triage competency framework before undertaking independent assessment and prioritisation. Agree core model for safe staffing	
Aim to adopt the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), as recommended by RCOG Good Practice Paper No. 17.	1. The service had adopted, or has a documented implementation plan to adopt, the Birmingham Symptom Specific Obstetric Triage System or an equivalent evidence based maternity triage methodology.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Modified BSOTS model, including compliance with triage timescales, prioritisation standards, outcomes and workforce competency, with oversight through the Trust governance framework.	
If not using BSOTS, ensure any adaptation or alternative model is evidence-based, clinically evaluated or piloted, demonstrates equivalent outcomes through audit, and is formally agreed by the Trust Board.	1. Where BSOTS is not used, the Trust has adopted an alternative maternity triage model that is supported by evidence, local evaluation and has undergone testing prior to implementation. 2. The service can demonstrate through audit and performance monitoring that the model achieves outcome equivalent to, or better than, established triage standards 3. The alternative triage model has received formal approval through governance structures and the trust board.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Modified BSOTS model, including compliance with triage timescales, prioritisation standards, outcomes and workforce competency, with oversight through the Trust governance framework.	
Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women and ensuring timely, appropriate care based on clinical need.	1. The maternity triage model explicitly incorporates principles of equity and supports fair, consistent assessment and prioritisation for all women. 2. Staff undertaking maternity triage roles receive training on unconscious bias, cultural competence and equitable care. 3. Staff training includes awareness of know maternal inequalities and variation in outcome for different population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support development and delivery of training aligned to the Trust Health Inequalities Strategy, focusing on cultural competence, unconscious bias and maternity inequalities to support equitable triage assessment and escalation.Specific staff training for triage staff required and included inthe TNA SOP	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women triaged in each category of urgency. Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.	Site captures this data	Please outline what support you require from your trust board below No further action required. Continue oversight through routine audit and performance reporting.	£0.00
Metric: Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency.	Site captures this data	Please outline what support you require from your trust board below	

Why: Measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.	Site captures this data	Triage Dashboard required
Metric: Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded. Why: Monitors the impact of delays on women's care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.	Site Partially captures this data	Please outline what support you require from your trust board below Support digital and audit developments to enable systematic capture and reporting of outcomes associated with delays in care
Metric: Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care. Why: Helps understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.	Site captures this data	Please outline what support you require from your trust board below No further action required. Continue monitoring through governance and audit arrangements.

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Principle 4: Clear information for women

Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Provide clear, consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns.	1. Women are provided with clear information on how to contact maternity services throughout pregnancy and up to six weeks postnatal. 2. Information clearly describes when women should seek advice, assessment or urgent care 3. The service has a single point of contact for maternity advice and triage is promoted consistently across the service.	Fully in place, embedded and evidenced	No further action required	
Offer information and advice in accessible formats, including plain language, easy-read materials, and culturally appropriate messaging. Information should clearly explain how to access care and reassure women of their entitlement to support.	1. Information about maternity triage and access to care is available in accessible formats, including plain language, easy-read and translated materials. 2. Information is designed to meet the needs of women with varying levels of health literacy, communication needs and accessibility requirements. 3. Information is culturally appropriate and reflects the needs of the local population 4. The service ensures women are given clear information on how to access maternity services, including telephone triage, face-to-face triage and urgent care pathways.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support the development and translation of maternity triage information into a range of accessible formats, including easy-read, translated and digital resources, to meet the needs of the local population and reduce health inequalitiesPatient leaflet required in additional formats	
Provide timely access to effective interpretation services where needed; do not rely on family members or accompanying individuals to interpret; allow adequate time for accurate information exchange and decision-making while reducing communication-related bias and assumptions.	1. The service provides access to professional interpretation services for women who require language support. 2. There is guidance in place enabling access to interpretation services 24/7 with strengthened messaging regarding not relying on family members, friends or accompanying individuals to provide interpretation. 3. Triage assessments and decisions are based on accurate information exchange and not compromised by language barriers. 4. Staff are trained to understand communication related bias, assumptions and risks associated with language barriers.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support investment in additional interpretation resources and equipment to ensure timely access to professional interpretation services within maternity triage 24/7, including dedicated interpreter devices within the triage environment. Additional telephone interpreter on wheels required for maternity triage - currently only 1 available across the maternity floor. Requires Pocket talk	
Provide consistent and personalised discharge information, including asking women if they are happy to be discharged, checking understanding of next steps, and clearly outlining when and how to re-attend or seek further advice if symptoms or concerns change.	1. A standardised discharge process is in place tailored to the woman's individual clinical needs, concerns and circumstances. 2. A standardised discharge process includes actively seeking that the woman is happy to be discharged and that decision making has been informed and in partnership. 3. A standardised discharge process outlining information about follow-up arrangements, investigations, appointments and ongoing care needs.	Fully in place, embedded and evidenced	No further action required	
Ensure effective signposting and discharge information through direct referral to the appropriate service, avoiding directing women elsewhere without coordinated handover or support.	1. A guideline exists for women requiring ongoing care from another service are directly referred by the maternity triage staff and not asked to self refer. 2. Clear handover processes are in place when care is transferred between services, and women are supported to understand their care plan and next steps.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support the development of formalised referral and handover pathways between maternity triage, primary care, emergency care and specialist services to ensure women are directly referred and supported to access ongoing care without unnecessary barriers	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps services understand why women seek	Site captures this data	Please outline what support you require from your trust board below Support continued use of maternity triage attendance data to inform patient information resources, service planning and targeted improvement initiatives	**£0.00**

Why. Helps services understand why women seek care and ensure information provided addresses common concerns, improving early help-seeking.		improvement initiatives.

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Principle 5: Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.	1. A single, dedicated telephone number is available for maternity triage and advice services. 2. Telephone maternity triage service is available 24 hours a day, 7 days a week. 3. The contact number is well publicised and routinely shared with women, families, primary care, ambulance services, NHS111 and partner organisations. 4. Telephone triage is undertaken by clinically active midwives with responsibility for maternity triage assessment and advice. 5. Guidance is in place to support staffing arrangements to ensure telephone triage functions are delivered safely, including not diverting to labour ward due to unknown response times.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support workforce planning and establishment review to ensure sustainable staffing for a dedicated telephone triage function 24/7 specifically overnight 2.69 WTE	
Encourage telephone triage use where appropriate but never make it the only route to care.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A dedicated telephone triage service is available. 3. Communication is tailored to encourage women to contact telephone triage with clarity that telephone is not the only option available and they can access maternity triage via any route beneficial to them 4. Information provided to women consistently reinforces that telephone triage compliments not replaces direct care.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below nd establishment review to ensure sustainable staffing for a dedicated telephone triage function 24/7 sp	
Ensure all women have open access to face-to-face maternity triage; where a woman remains anxious or concerned after telephone triage, invite them to attend for in-person assessment.	1. All women and staff understand there is direct access to face to face maternity triage assessment regardless of previous telephone contact. 2. Women and staff are aware that if the woman remains anxious it is appropriate to encourage face to face attendance.	Fully in place, embedded and evidenced	No further action required	
Operate telephone triage from a protected, quiet, confidential space away from the main clinical area and clinical office space; the midwife's sole responsibility during this time should be telephone triage.	1. Telephone triage is delivered from a dedicated space specifically designed to support safe, effective telephone triage. 2. The telephone triage area is sufficiently designed that it is located in a quiet area and in an environment that protects confidentiality. 3. The telephone triage area is located away from busy and noisy clinical areas and in a dedicated space, not a shared office environment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support workforce planning and establishment review to ensure sustainable staffing for a dedicated telephone triage function 24/7.	
Do not defer in-person attendance to manage service workload; give women clear information about clinical urgency of attending and operate a low threshold for attendance because telephone assessment is difficult and subjective.	1. Guidance is place to support the decision making around face to face attendance and based on the woman's need not service capacity. 2. The service has processes in place to ensure attendance to face to face is not discouraged or delayed based on awareness of service capacity and/or staffing pressures. 3. Processes are in place to ensure telephone triage promotes a low threshold for face to face review.	Fully in place, embedded and evidenced	No further action required	
Do not allow telephone triage to provide definitive diagnosis, determine clinical priority before in-person assessment, make appointments for in-person triage, or manage or limit the number or timing of women attending.	1. The service has a documented policy in place defining the purpose and limitations of telephone triage. 2. There is a guideline in place acknowledging that telephone triage is used to assess concerns, provide advice and determine next steps, but not provide a diagnosis. 3. There is guidance in place ensuring telephone triage does not replace formal prioritisation of clinical need. 4. Telephone triage is not used to schedule appointments for maternity triage assessment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Guideline currently being updated	
Maintain clear pathways so suspected threatened	1. The service has a documented pathway for the assessment of suspected		No further action required	

preterm or extreme preterm birth is signposted to in-person maternity triage without delay, where this is the safest and most appropriate setting.	preterm labour and extreme preterm birth. 2. The service has a process to ensure all women with suspected preterm or extremely preterm birth are directed to face to face maternity triage without delay. 3. Referral criteria is in place to action this. 4. There are agreed pathways and communication in place with primary care, NHS111, emergency departments and community midwifery services for suspected preterm and extremely preterm birth.	Fully in place, embedded and evidenced	
Document all calls in real time using a standardised template within the woman's electronic patient record where available; audio-record calls with consent to support accuracy and safety; document requests for hospital attendance including urgency and expected timeframe.	1. All telephone triage contacts are documented contemporaneously during or immediately after contact. 2. A standardised telephone triage template is used for all calls. Including documentation supporting request for attendance and anticipated time frame. 3. Where available, telephone triage assessments are recorded in the woman's Electronic Patient Record.	Fully in place, embedded and evidenced	No further action required

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	**Total estimated cost to implement this principle**
Metric: Rate of calls to telephone triage per 1,000 births. Why: Helps services understand demand for telephone triage and plan staffing and resources effectively.	Site captures this data	Please outline what support you require from your trust board below No further action required. Continue monitoring through maternity performance dashboards.	**£0.00**
Metric: Proportion of women who call telephone triage but do not attend in person. Why: Monitors the effectiveness of telephone triage in identifying urgent care needs and whether barriers may be preventing attendance when needed.	Site doesn't capture this data	Please outline what support you require from your trust board below	
Metric: Proportion of dropped or unanswered calls to telephone triage. Why: Identifies service capacity issues and supports timely access for urgent concerns, reducing risk of harm.	Site captures this data	Please outline what support you require from your trust board below Support ongoing workforce and capacity planning to ensure telephone triage services remain responsive and meet demand safely.	

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Principle 6: Service user voice and experience

Women's feedback must shape service design, improvement and experience.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Develop a deeper understanding of their local populations, including social, cultural, and geographical contexts. To do this, maternity services should proactively engage and seek feedback from service users on their experiences of triage services and care, including telephone triage.	1.The service has processes in place to understand the social, cultural and geographical characteristics of the local population accessing maternity triage services. 2.The service routinely seeks feedback from women and families regarding their experiences of maternity triage, including telephone triage and face-to-face services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support development of a maternity triage patient experience programme, including targeted engagement with diverse communities and underserved groups, to better understand barriers to access and experience	
Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.	1.The service has a documented approach for routinely gathering feedback from women and families who use maternity triage services. 2.Patient experience data are reviewed at regular intervals through local governance and quality meetings. 3.The service routinely analyses data to identify themes, trends, risks and opportunities for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support implementation of routine maternity triage feedback mechanisms, including real-time feedback, surveys and engagement through MNVP, with regular review through governance structures	
Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality.	1. The service has a documented approach for routinely gathering, analysing and acting on feedback from women and families using maternity triage services. 2. The service provides opportunity to provide feedback during or immediately following their care experience. 3. Feedback mechanisms are accessible and designed to capture the experiences of diverse population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support development of a maternity triage quality dashboard and "You Said, We Did" approach to demonstrate service improvements resulting from patient feedback.	
Clearly inform women how to raise concerns or seek further review if dissatisfied with triage review outcomes, including local escalation routes and relevant safety processes, and awareness of Martha's Rule as implemented across maternity services.	1. The service has a documented approach on how women receive clear information on how to raise concerns about their care, assessment or triage outcome. 2. The service has a well documented approach on how women can request further clinical review. 3. There are clear pathways for women to raise concern about ongoing clinical review and care. This should also include progressing implementation of Marthas Rule.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support review and enhancement of patient information resources to ensure women are aware of escalation routes, second clinical reviews, complaints processes and Martha's Rule	
Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM) when available.	1. The service has adopted or plans to adopt the national Patient Reported Experience Measure (PREM) when available	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support implementation of the national Maternity and Neonatal PREM when available and ensure maternity triage feedback is included within Trust patient experience reporting arrangement. Friends and family feedback - triage	
Value qualitative lived experience alongside quantitative data, recognising that small numbers of serious concerns can reveal system issues not visible in aggregated metrics.	1. The service formally recognises qualitative feedback as a key source of intelligence alongside quantitative data. 2. The service regularly gathers and uses intelligence through qualitative data capture.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support development of processes that enable qualitative feedback, patient stories and lived experience to be routinely reviewed alongside performance, audit and safety data.	
Work with local Maternity and Neonatal Voices Partnership (MNVP) to co-produce improvements and embed service user voice in decision-making	1. The service has an active and ongoing partnership with local Maternity and Neonatal Voices Partnership (MNVP)		No further action required	

and service design; close the feedback loop through “you said, we did” updates.		Fully in place, embedded and evidenced	No further action required. Continue partnership working and co-production through existing MNVP arrangements.

Metrics	Data captured per site	Support required from Trust Boards to progress the metric
Metric: Qualitative and quantitative data on the experience of women using maternity triage services, collected through existing local feedback methods and transitioning to the national maternity and neonatal Patient Reported Experience Measure when available. Why: Helps services understand women’s experience, including whether they feel informed, respected and involved in their care, and target actions to improve experience.	Site doesn’t capture this data	Please outline what support you require from your trust board below Support implementation of a maternity triage experience measurement framework, including collection of qualitative and quantitative feedback and transition to NEOPREM reporting when available
Metric: Frequency and diversity of feedback collected, including review by ethnicity to confirm feedback reflects the service population. Why: Ensures timely, representative feedback is available to support continuous improvement based on service user experience.	Site doesn’t capture this data	Please outline what support you require from your trust board below Support development of reporting mechanisms that monitor feedback by ethnicity, deprivation and protected characteristics to ensure representative engagement and reduce inequalities
Metric: Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. Why: Monitors whether identified issues lead to timely, measurable improvement actions, supporting continuous service improvement and accountability.	Site captures this data	Please outline what support you require from your trust board below Governance processes monitor actions arising from patient feedback, complaints, incidents and audits, including demonstrable impact of service improvements.

Total estimated cost to implement this principle

£0.00

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Principle 7: Facilities and estates

Triage needs safe, visible, fit-for-purpose space designed for urgent care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
The triage service, where possible, should be co-located with the central delivery suite or labour ward (or be positioned as close as possible to it), to support timely escalation and care and minimise transfer risks.	1.The maternity triage service is co-located with, or situated in close proximity to, the labour ward/central delivery suite wherever possible. 2.Where co-location is not possible, a formal risk assessment has been undertaken and mitigating actions implemented to ensure that delays in escalation, transfer and treatment for women requiring urgent or emergency care are minimised.	Fully in place, embedded and evidenced	No further action required	
Provide a suitably sized seated waiting area that is easily visible to clinical staff.	1. A designated waiting area is provided for women accessing maternity triage services	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support review of maternity triage estate capacity to ensure waiting areas are sufficient to accommodate activity levels whilst maintaining patient safety, visibility and dignity.	
Include a reception area where staff are notified of women's arrival and women can access help quickly if they require more urgent attention.	1. Maternity triage includes a clearly identified reception for women attending the service. 2. Processes are in place to ensure clinical staff are promptly notified when a woman arrives at the service. 3. Women have a clear and immediate means of alerting staff if they require more urgent attention.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support estate redesign to provide a dedicated reception and arrival point with clear mechanisms for alerting staff to urgent clinical need.	
Maintain dedicated space protected for initial triage so a midwife can assess promptly and safely while maintaining privacy; ensure the space has appropriate equipment.	1. A dedicated space is available and protected for initial maternity triage assessment. 2. The assessment area is equipped with all equipment required to undertake maternity triage assessment.	Fully in place, embedded and evidenced	No further action required	
Ensure appropriate facilities for timely ongoing care, with sufficient space for healthcare staff, women and families while safeguarding privacy and confidentiality.	1. The maternity triage service has sufficient clinical space to support ongoing assessment, treatment, monitoring and observation. 2. The clinical environment facilities are designed to protect privacy during discussions, examinations, investigations and treatment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support maternity estate development to provide sufficient clinical capacity, assessment rooms and monitoring spaces that protect privacy, dignity and confidentiality.	
Include a well-equipped office space within the clinical area to support clear confidential handover and centralised oversight of workload.	1. A dedicated office space is located within or immediately adjacent to the maternity triage clinical area. 2. The office space supports confidentiality and oversight of worload.	Fully in place, embedded and evidenced	No further action required	
Ensure access to essential diagnostics including electronic fetal monitoring, blood tests, urine samples and ultrasound.	1. Maternity triage has timely access to diagnostic investigation equipment.	Partially in place, but inconsistent or not fully	Please outline what support you require from your trust board below	

		inconsistent or not fully evidenced	Require K2 data ports and CTG	
Meet accessibility standards including accessible WCs and clear signage in line with Health Building Note 09-02; provide quiet or private areas where possible, clear waiting process explanations, and systems showing women have been seen and are awaiting care.	1. The maternity triage environment meets relevant accessibility standards, including HBN 09-02. 2. Accessible WC arrangements are available and clearly signposted. 3. Signposting is clear and consistent 4. Women receive clear information explaining waiting processes and clinical prioritisation	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support environmental improvements to ensure compliance with accessibility standards, improve wayfinding and provide clearer information regarding waiting processes and prioritisation.Needs Toilet faciliates	
Be physically separate from scheduled or day assessment activity to maintain focus on urgent and unscheduled care.	1. Maternity trriage is provided in a dedicated area specifically designed for urgent and unscheduled care. 2. Maternity triage is physically separate from dat assessment, antenatal clinic and other scheduled care areas.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support long-term maternity estate planning to provide a dedicated maternity triage area is not physically separate from Day Assessment Unit activity and scheduled care.	
Design the physical environment to promote women's sense of safety and comfort.	1. The maternity triage area is designed to promote a sense of safety, comfort and reassurance for women and their families.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support refurbishment and environmental improvements that create a welcoming, safe and therapeutic environment for women and their families.	
Support maternity triage with modern interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.	1. Maternity triage is supported by a digital system that facilitates assessment, documentation, prioritisation and care coordination. 2. Clinical assessments, triage decisions, escalations and actions are documented in a timely way.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support implementation of K2 and associated digital developments to enable real-time documentation, escalation, information sharing and maternity triage workflow management.	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Clinical area where the woman was admitted following triage, where relevant, for example Antenatal Ward, Labour Ward or Intensive Treatment Unit. Why: Supports estates planning by showing demand for specific areas and informing capacity requirements, inpatient flow and service user	Site captures this data	Please outline what support you require from your trust board below No further action required. Ongoing assurance through estates reviews, governance oversight and service monitoring.	£0.00

Principle 8: Staffing

Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Use dynamic staffing models informed by local activity data and aligned to the triage system used; consider unit size and activity levels so sufficient trained personnel are available.	1. The maternity triage service uses a staffing model informed by local activity and acuity information. 2. Staffing levels align to the maternity triage system in use.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support implementation of recommendations and establishment review to align maternity triage staffing levels with demand, acuity and 24/7 service requirements and telephone at night	
Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG Good Practice Paper No. 17 minimum standards, with capacity and escalation pathways at all times including nights and weekends; review staffing models regularly against local attendance data.	1. Dedicated maternity triage midwifery and obstetric staffing is provided in line with the RCOG Good Practice Paper No. 17. 2. Appropriate medical staffing is available to support timely assessment, review and escalation of clinical concerns 3. Staffing arrangements cover 24 hours 7 days a week 4. Staffing models are reviewed regularly utilising data relating to acuity, peak activity periods and service demand.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support review of obstetric staffing arrangements to provide timely senior medical input to maternity triage and ensure workforce models align with national guidance.Dr not dedicated 24/7.	
Ensure dedicated triage staffing is structurally independent of labour ward midwifery staffing; treat redeployment from triage to other maternity areas as a formal escalation event and document, review and monitor through governance processes.	1. Maternity triage has dedicated staffing establishment that is separate from labour ward staffing requirements. 2. A formal process defines circumstances in which triage staff may be redeployed and identifies associated escalation requirements and recorded as a formal escalation event. 3. Redeployment events and triage staffing pressures are reviewed regularly through maternity governance processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support formal governance arrangements to monitor maternity triage staffing, redeployment events and escalation occurrences through routine maternity governance reporting.Not reviewed regualrly through maternity governance processes	
Where possible, have a minimum of one midwife responsible for initial triage assessment and at least one other midwife carrying out subsequent care, informed by local demand, service need and RCOG birth-rate modelling.	1. Staffing arrangements support separation of initial assessment and ongoing care requirements.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support investment in additional funded midwifery posts to achieve recommended maternity triage staffing levels and separation of assessment and ongoing care functions across day and night shifts.budget for an additional midwife during the day time and and additional midwife during the night time to increase staffing to meet the national standards..	
Ensure initial triage assessment and telephone triage are undertaken by appropriately trained and experienced staff with clinical judgement to advise, assess urgency, escalate concerns and initiate urgent interventions.	1. Initial maternity triage assessment and telephone triage are undertaken only by staff who have completed training in the locally adopted maternity triage methodology.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support development and implementation of a formal maternity triage training programme with protected training time and competency assessment for all staff working in triage.	
Define competency requirements for triage functions so staff are well supported and supervised.	1. A documented competency framework defines the knowledge, skills and behaviours required for all maternity triage roles	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below All staff have been given the Maternity upskilling package produce by the LMNS. Support adoption and implementation of a formal maternity triage competency framework, building on the LMNS maternity upskilling package, with compliance monitored through governance processes.TNA requires update	
Ensure staff working in triage receive appropriate training including rapid assessment, with clear competency frameworks and governance, and maintain regular experience in this setting.	1. All staff undertaking maternity triage complete a structured training programme appropriate to their role and responsibilities.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support protected training capacity and workforce planning to ensure staff can undertake training, maintain competence and gain regular triage experience via TNA	

			maintain competence and gain regular triage experience via TNA	
Define escalation protocols and thresholds for peak activity and escalating midwifery and medical staffing when capacity is exceeded; base thresholds on attendance numbers and clinical urgency categories, embed in policies/governance and support with real-time activity monitoring.	1. A documented escalation framework exists for maternity triage, defining actions required during periods of increased activity, capacity pressures or workforce shortages.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support development and approval of a formal maternity triage escalation framework linked to activity, acuity, capacity and staffing pressures.	
Where staffing is adjusted in response to critical workload and demand, make decisions carefully and promptly, balancing acuity and safety across the wider maternity service to maintain minimum safe staffing levels.	1. A documented policy defines how staffing adjustments are made during periods of critical workload, demand or capacity pressure, including wellbeing off staff needing to have regular breaks.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support development of a workforce escalation policy that defines staffing responses during surge activity whilst maintaining safe staffing levels and staff wellbeing.	
Include locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds to ensure timely senior input when required.	1. The maternity triage service has locally agreed criteria defining when senior midwifery, obstetric or consultant review is required in maternity triage. 2. Clear processes are in place for consultant attendance beyond the twice daily ward rounds.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Triage is not currently formally included in the daily ward round. Support development of agreed consultant review criteria and inclusion of maternity triage within senior obstetric oversight arrangements.	
Ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of triage activity and escalation, with clear communication to neonatal teams where required; review triage activity during consultant-led labour ward rounds twice daily, seven days a week.	1. The maternity service has locally agreed criteria to ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. 2. Processes exist to ensure timely communication with neonatal teams where required. 3. Processes are in place to ensure triage activity is reviewed during consultant led labour ward rounds twice daily, seven days a week.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support incorporation of maternity triage activity, acuity and capacity review into consultant-led labour ward rounds and daily operational reviews.	
Restrict midwifery-led unit triage-type activity to low-risk term labour assessment; promptly transfer women who present with concerns requiring triage care to the appropriate obstetric unit with a designated maternity triage service.	1. Local policy clearly defines the role of Midwifery Led Units (MLUs) in assessing unscheduled attendances. 2. Clear guidance exists defining triage type activity within MLUs including inclusion and exclusion criteria. 3. A clear documented pathway exists to facilitate prompt transfer of women requiring maternity triage assessment to the designated obstetric unit.	Not relevant to local pathway/context	No further action required	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women assessed, including initial triage and medical clinical review, within expected timeframes based on the category of urgency. Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.	Site captures this data	Please outline what support you require from your trust board below Continue oversight through maternity performance, quality and safety reporting.	£0.00
Metric: Frequency of staff being redeployed from maternity triage to other maternity care areas within the unit. Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.	Site doesn't capture this data	Please outline what support you require from your trust board below Support development of monitoring and reporting processes for maternity triage redeployment events, with routine review through maternity governance structures.	

Principle 9: Equity and equality

Services must use data and targeted action to identify and reduce inequalities.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Acknowledge and understand inequalities experienced by service users as a crucial first step.	1. The service formally recognises health inequalities and their impact on access, experience, safety and outcomes within maternity triage services.	Fully in place, embedded and evidenced	No further action required	
Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.	1. The service uses population health intelligence to understand the needs of the local maternity population, including demographic, clinical, cultural and socioeconomical factors.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Teams to access population health intelligence and use this to inform maternity triage service development and targeted interventions.Needs to be considered as part of the K2	
Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements; map inequalities, for example by postcode, to visualise need and guide targeted interventions.	1. The service routinely analyses demographic data to understand variation in access, experience and outcomes across different population groups. 2. Findings from demographic and outcome data analysis informs the design of targeted interventions and improvement strategies to reduce inequalities and improve outcomes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support development of routine maternity triage inequalities reporting, including analysis by ethnicity, deprivation, language and geography, with oversight through maternity governance and quality committees.Inequalites considered as part of governance reviews.	
Work with local improvement initiatives and community-led organisations so lived experience meaningfully informs service improvements.	1. The service actively participates in local, regional and national improvement initiatives focussed on maternity safety, experience, equity and outcomes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support engagement with community organisations, voluntary sector partners and health inequality programmes to ensure lived experience informs service design and improvement.	
Ensure all staff involved in maternity triage undertake training supporting culturally safe care, including cultural competence, cultural safety, cultural intelligence and unconscious bias.	1. Staff have received training to understand and respond appropriately to diverse cultural beliefs, values, traditions and preferences that may influence care.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support delivery of mandatory training on cultural competence, cultural safety, health inequalities and unconscious bias for all staff undertaking maternity triage assessments.	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Note: Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.	Site doesn't capture this data	Please outline what support you require from your trust board below Support improvements in maternity data systems to enable routine collection, reporting and analysis of ethnicity, deprivation, language and other protected characteristic data.	£0.00
Metric: Equity and equality data should be captured		Please outline what support you require from your trust board below	

as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language. Why: Helps identify variation and potential inequality in access, experience and outcomes.	Site doesn't capture this data	Support development of health inequalities dashboards and population health reporting to identify variation in access, experience and outcomes and inform targeted quality improvement initiatives.

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Principle 10: Data and measurement

Data must drive oversight, learning from incidents and continuous improvement.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Collect and review all data outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample; at minimum include attendance patterns, peak times and waiting times and examine inequalities for initial triage.	1. The service routinely collects and reviews all metrics identified in the measurement strategy, where feasible. 2. Processes are in place to ensure data are accurate, complete, timely and representative of maternity triage activity.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where a metric cannot be captured, identify improvements needed to enable future capture, including timescales and whether the process is manual or automated.	1. The service has assessed all metrics within the maternity triage specification measurement strategy and identified those that cannot be currently captured. 2. Improvement plans are in place for all metrics that cannot currently be captured.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Continue to support implementation of identified improvement plans for metrics that cannot currently be captured, including digital developments through K2 and routine governance oversight of progress against agreed timescales.	
Review data at appropriate intervals—daily, weekly, monthly and quarterly—to identify trends, patterns and improvement areas.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support development of a formal maternity triage performance dashboard and reporting framework with agreed daily, weekly, monthly and quarterly review processes.Current collects monthly data	
Establish processes for teams to frequently review data, reflect on insights or changes, and respond to support continuous improvement.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support implementation of regular maternity triage review meetings, quality improvement processes and governance reporting to ensure data informs service development and patient safety improvements.	
Embed maternity triage within robust governance arrangements, including routine safety event review through the Patient Safety Incident Response Framework (PSIRF).	1. Maternity triage is explicitly included within the organisations maternity governance framework with defined leadership, accountability and reporting arrangements. 2. Maternity triage incidents and safety events are managed in line with the Trust's Patient Safety Incident Response Framework (PSIRF) policy and processes.	Fully in place, embedded and evidenced	No further action required	
Include demographic variables such as ethnicity, language, deprivation and disability, as outlined in the measurement strategy, to understand local population needs and address inequalities in access and outcomes.	1. The service routinely collects demographic data for women accessing maternity triage in line with the measurement strategy. 2. The service can identify groups experiencing differences in access, timeliness, experience, escalation and outcomes. 3. Equity and demographic data are routinely reviewed through governance structures with clear accountability for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support development of maternity triage inequalities reporting and dashboard functionality to enable routine analysis of access, experience and outcomes by protected characteristics and deprivation.	
Be transparent with women about why data is collected and how it will be used to improve care, especially in communities with lower trust in the	1. Women are provided with clear information about what data are collected, why they are collected and how they support care delivery and service improvement	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Support development of patient information resources explaining how maternity triage data are used to improve services, reduce inequalities and support safer care	

healthcare system.	improvement		improve services, reduce inequalities and support safer care.	

Dashboard

Principles menu

Previous | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Next

Total estimated cost to implement this principle

£0.00

Title of report:	Thirlwall Inquiry Report and Recommendations: Immediate Actions and Board Assurance
Presented to:	Board of Directors
On:	7 October 2026
Item purpose:	Information
Presented by:	Chief Nursing Officer / Executive Lead for Maternity and Neonatal Services
Prepared by:	Chief Nursing Officer
Contact details:	Kevin.Parker-Evans@wwl.nhs.uk

Executive summary

The final report of the Thirlwall Inquiry[1] describes grave failures to act promptly on concerns, safeguard babies and listen to staff and families. NHS England's letter of 21 September 2026 to provider Trusts (included at Appendix 1) states that the learning is relevant to every NHS trust and integrated care board, not only organisations providing neonatal services. It requires every Trust and ICB Board to review the report at its next available public meeting, consider whether similar events could occur locally, and obtain assurance that effective safeguards, escalation routes and a culture of professional curiosity are in place.

Immediate provider actions outlined in the letter include:

- communicating by 28 September 2026 that the Sudden and Unexpected Death in Children (SUDIC) process applies to every unexpected death, or collapse leading to death, of a person under 18, including within neonatal units. This was completed on 28 September
- improving bereavement care in line with the National Bereavement Care Pathway
- ensuring neonatal insulin storage and access controls meet GIRFT requirements by 31 March 2027
- installing CCTV focused on insulin storage by 30 November 2026, with recordings retained for at least 28 days
- confirming that staff and Board members have appropriate safeguarding training and know how to raise and escalate concerns.

The Board is asked to receive the report, test whether comparable failures could occur within the Trust, review the current assurance position and agree strengthened oversight through a time-bound action plan (to be completed in due course). Any material gaps or risks should be escalated urgently to the NHS England regional team. The principal areas for assurance are leadership and

[1] Thirlwall Inquiry report - GOV.UK

culture, Freedom to Speak Up, clinical governance, mortality and safeguarding processes, medicines security, bereavement support, support for neonatal staff, and how the Trust communicates assurance to parents and families.

Link to strategy and corporate objectives
The required response supports the Trust's core objectives for safe, high-quality and compassionate care; effective leadership and governance; an open and learning culture; safeguarding children; and working with patients, families and partners. It also aligns with the national Maternity and Neonatal Care 10-Point Plan and the expectations of the Insightful Provider Board guidance.

Risks associated with this report and proposed mitigations

- **Patient safety and safeguarding:** delayed recognition or escalation of unusual harm could expose babies and children to avoidable risk. Mitigation: confirm SUDIC, safeguarding, mortality review and escalation arrangements; test their use through audit and case review.
- **Culture and leadership:** staff may not feel able to speak up or challenge. Mitigation: triangulate staff survey, Freedom to Speak Up, incident and people data; strengthen feedback and executive oversight.
- **Medicines security:** inadequate insulin controls could permit misuse or unexplained access. Mitigation: deliver the GIRFT controls and CCTV requirements to the national deadlines, with monitored actions.
- **Bereavement and family confidence:** inconsistent support or communication may compound harm and reduce trust. Mitigation: benchmark against the National Bereavement Care Pathway and provide clear assurance and support to families.
- **Compliance and reputation:** failure to evidence timely action may result in regulatory intervention and loss of confidence. Mitigation: maintain a Board-owned action plan, report exceptions and escalate material risks to the regional team.

Financial implications
There may be capital and revenue costs associated with CCTV installation and secure data retention, improvements to insulin storage and access controls, safeguarding training, bereavement pathway implementation, staff support and independent assurance. Costs will be quantified through the action plan and managed through established business-case, procurement, information governance and financial-control processes. No unfunded commitment should be inferred from this paper.

Legal implications
The Trust must continue to meet its statutory and regulatory duties relating to patient safety, safeguarding children, candour, mortality review, information governance, data protection, employment and health and safety. Camera deployment requires a documented lawful basis, data protection impact assessment, proportionate positioning and access controls, retention arrangements and clear communication with staff and families. Legal and information governance advice should be obtained as implementation plans develop.

People implications
All staff need clear SUDIC escalation routes, confidence that concerns will be heard and acted upon, and safeguarding training appropriate to their role. Leaders must model professional curiosity and constructive challenge. The Trust should review psychological support for staff working with very sick babies and those affected by the Inquiry's findings, while ensuring that accountability arrangements are fair, transparent and consistent with a learning culture.

Equality, diversity and inclusion implications
Actions should be designed and monitored to avoid unequal access, experience or outcomes. Particular consideration should be given to communication needs, language and health literacy, disability and reasonable adjustments, digital exclusion where remote monitoring is introduced, cultural and religious needs in bereavement care, and differential confidence in raising concerns. An equality impact assessment should accompany material service or policy changes, supported by engagement with families and staff.

Which other groups have reviewed this report prior to its submission to the committee/board?
Discussion has taken place at the Executive Team Meeting. It is anticipated that future Board oversight of the action plan would be delegated to the Quality and Safety Committee.

Recommendation(s)

The Board is asked to:
1. Receive and discuss the Thirlwall Inquiry report and NHS England letter dated 21 September 2026.
2. Consider explicitly whether similar events could occur within the Trust and state whether it is assured that current controls protect babies and children in every care setting.
4. Approve development of a single, time-bound action plan covering safeguarding, speaking up, mortality review, bereavement care, insulin security, CCTV, staff support and family communication, with named executive owners, acknowledgement of potential capital investment required and evidence of completion.
5. Require confirmation that neonatal insulin access and storage arrangements will meet GIRFT requirements by 31 March 2027 and that CCTV focused on insulin storage will be operational by 30 November 2026 with recordings retained for at least 28 days.
6. Agree regular assurance reporting through the Quality and Safety Committee and prompt escalation of any material residual risks to the NHS England regional team.

Report

This paper summarises the implications of the final Thirlwall Inquiry report and sets out the immediate actions specified in the NHS England letter of 21 September 2026. It is intended to support an evidence-based public Board discussion and a clear record of the assurance received, gaps identified and actions agreed.

1. Background and national context

The Inquiry found devastating failures by individuals and systems to respond quickly enough to concerns and safeguard babies, together with cultural and governance conditions that impeded challenge and decisive action. NHS England emphasises that the findings require consideration by every Trust and ICB Board. The central test is not limited to neonatal services: it is whether the organisation can recognise unusual patterns, listen to staff and families, join up information, escalate concerns without fear, and act with sufficient urgency.

The Government has indicated that it will consider the recommendations in full and has commenced work on national actions including remote baby monitoring, strengthened insulin and medical examiner guidance, review of national safeguarding guidance and training, regulation of NHS managers through a barring scheme, and continued rollout of the National Bereavement Care Pathway.

2. Requirements in the NHS England letter

Public Board review: review the Inquiry report at the next available public Board meeting (7 October 2026); consider whether similar events could occur locally and seek assurance that babies and children are protected in every setting. Boards should test whether professional curiosity, speaking up and constructive challenge are genuinely supported. Risks to this culture must be discussed urgently with the regional team.

SUDIC: for Trusts with a neonatal unit, urgently communicate to relevant staff and the Board that the SUDIC process applies to every unexpected death, or collapse leading to death, of an infant or child under 18 where no pre-existing medical cause is apparent, irrespective of place of death and including neonatal units. The letter set a deadline of 28 September 2026 which was met. SUDIC reporting operates alongside the Trust’s internal reporting arrangements.

Bereavement care: take immediate action to improve support for bereaved families in line with the National Bereavement Care Pathway for stillbirth and neonatal death and the NHS Medium Term Planning Framework.

Insulin controls: ensure every neonatal unit meets GIRFT access-control and storage requirements by 31 March 2027. Pending biometric access, install CCTV focused on insulin storage fridges, cupboards or units by 30 November 2026, with recordings retained for at least 28 days.

Safeguarding: ensure all staff and Board members are compliant with safeguarding training at the appropriate level, understand where and how to raise and escalate concerns, and can demonstrate that safeguarding babies and children receives appropriate organisational prominence.

Health and wellbeing: consider how to reassure and support parents whose babies are receiving neonatal care and review psychological support for staff working in these services.

3. Assurance the Board should seek

The Board should receive concise evidence against the following questions:

- Are unusual patterns, repeated concerns and weak signals identified across incidents, mortality, complaints, workforce, speaking-up and safeguarding data?
- Are concerns promptly escalated across professional and organisational boundaries, with clear responsibility for decision-making and external referral?
- Do staff know the SUDIC process and can the Trust evidence compliant application, including interface with police, coroner, medical examiner, safeguarding partners and internal incident processes?
- Are neonatal medicines securely stored, access-controlled, monitored and auditable, with unexplained access or discrepancies investigated promptly?
- Is safeguarding training complete and effective for all relevant staff and Board members, rather than treated as a compliance exercise alone?
- Do staff and families receive timely feedback after raising concerns, and is there evidence that challenge is welcomed and acted upon?
- Is bereavement support consistent, personalised and culturally appropriate, and are staff supported following traumatic events?
- Does the Board receive sufficiently granular and triangulated information to identify deteriorating safety, cultural or governance risks?

4. Proposed Trust response and governance

A single corporate action plan should consolidate the Trust's response, avoid fragmented assurance and identify a named executive owner, delivery lead, due date, evidence source, current rating and residual risk for each action. The plan should distinguish actions already complete from those requiring validation or further work.

Immediate evidence should include confirmation of the SUDIC communication; current compliance with role-appropriate safeguarding training; neonatal insulin storage and access arrangements; the CCTV implementation plan and information governance approvals; alignment with the National Bereavement Care Pathway; Freedom to Speak Up and escalation arrangements; relevant mortality, incident and safeguarding audits; and support available to staff and families.

The Executive Team should oversee delivery, with thematic scrutiny through the relevant quality and safety, safeguarding, people, audit/risk and finance forums. Quality and Safety Committee should be designated to maintain an integrated view and report to the Board. Exceptions, missed deadlines and material residual risks should be escalated promptly, including to the NHS England regional team where required.

5. Conclusion

The Thirlwall Inquiry requires a whole-organisation response rooted in patient safety, safeguarding, openness and accountability. Board consideration should create a clear and auditable record of the evidence reviewed, the level of assurance reached, any gaps or risks identified and the actions commissioned. The Trust should not wait for the Government's full response before completing the immediate actions specified by NHS England.

Appendix 1 – NHSE Letter to NHS Trusts 21 September 2026

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

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

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's report is a sobering moment for all of us working in the NHS. From the devasting failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

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This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on new guidance on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children** (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

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expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death**.** This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

- **Insulin**: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the Insightful Provider Board guide is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

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The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow**.** It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,





Duncan Burton

Chief Nursing Officer for England

Sarah-Jane Marsh

NHS England Chief Operating Officer

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Title of report:	Provider Capability Self-Assessment
Presented to:	Board of Directors
On:	7 October 2026
Item purpose:	Ratification
Presented by:	Director of Corporate Governance
Prepared by:	Director of Corporate Governance
Contact details:	Katharine.dowson@wwl.nhs.uk

Executive summary

The Trust is required to submit an annual self-assessment of its leadership capability and governance arrangements. Introduced by NHS England in 2025, the framework requires providers to assess whether they have the structures, leadership and governance needed to understand and respond to performance and risk.

Following a review at a recent Board workshop, the Trust has submitted a draft green-amber assessment, subject to agreement by the Board. In 2025, one domain was rated green-amber; this year, two domains are assessed as green-amber.

Following submission by the Trust, the Greater Manchester Integrated Care Board (ICB) will review this, taking into account third-party assurance from a variety of sources, before passing it to NHS England for endorsement.

Appendix 1 is the proposed high-level submission. Appendix 2 provides the more detailed consideration of the evidence against each statement.

This self-assessment is not an assessment of organisational performance in isolation. It considers whether the Trust has the leadership, capability and governance arrangements to identify material performance and quality concerns, take appropriate action and oversee improvement. The covering report does not reproduce all of the evidence through which the Board assures itself. It summarises the principal matters informing the Board's judgement, the action and assurance arrangements in place, and the areas where further evidence of delivery or sustained improvement is required. More detailed supporting evidence is provided in Appendix 2 and through the established reports received by the Board and its committees.

The Board's assessment has been made in the context of the recent CQC report (September 2026) and the Section 29A warning notice (July 2026). The Trust has accepted the concerns identified and has established improvement plans addressing the required actions, including plans relating to sepsis and mental health care. The Board and its committees have received assurance on the establishment and early implementation of these plans. However, the Board recognises the distinction between having credible plans, delivering the planned actions and demonstrating sustained improvement in patient experience and outcomes. Further assurance will therefore continue to be required as the plans progress. In addition, the Trust has its already established transformation plans in place which continue to be progressed such as the Better Lives in conjunction with local partners such as Wigan Council.

In reaching the proposed ratings, the Board completed the evidence worksheet at Appendix 2, its current performance, regulatory findings, improvement plans and the assurance received through Board and committee reporting. The ratings reflect the Board's judgement of the Trust's leadership and governance capability to recognise and respond to concerns; they do not imply that all required standards are currently being achieved or that all improvement benefits have yet been demonstrated.

The Board intends to focus its next workshop in November on the Trust's transformation plans, to ensure the Board is fully aware of the clear milestones, targets, measures of patient benefit, the accountable lead and the route for reporting progress to the Board. This workshop will strengthen, consolidate and test the arrangements in place.

Link to strategy and corporate objectives

This is related to Trust governance and compliance with NHS England requirements for an annual submission.

Risks associated with this report and proposed mitigations

The assessment will be reviewed and verified by the ICB and NHS England national teams against performance data and a wide range of third-party assurance information, such as the NHS Oversight Framework. The ICB and NHS England national teams will each consider whether the assessment aligns with their view of the Trust's leadership and governance arrangements. If the overall assessment drops below green-amber, then the Trust would not be able to apply for Advanced Foundation Trust (AFT) or Integrated Health Organisation status in the future, as green or green-amber status is one of the requirements in the AFT guidance.

Financial implications

No direct financial implications are identified; however, Domain 6 highlights an area for further Board oversight in relation to financial plans and their impact on care and outcomes.

Legal implications

No direct legal implications are identified.

People implications

A negative assessment could affect staff morale and confidence in the Trust's leadership and governance arrangements.

Equality, diversity and inclusion implications

Domain 4, Access and Delivery of Services, explicitly references the Board's awareness of health inequalities and the actions in place to address them.

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

The Executive Management Team met and reviewed the self-assessment initially, and the Board considered it in detail at the September Board workshop.

Background

The Board has reviewed and contributed to the evidence sheet at Appendix 2 and considers that the Trust is rated green across four domains and green-amber across two domains. This is a slight deterioration from 2025 when one domain was marked as green-amber.

In reaching its judgement on the four domains rated green, the Board reviewed the supporting evidence, current performance, identified risks and the assurance received through Board and committee reporting, and concluded that the Trust has effective leadership and governance arrangements in place, while recognising that continued oversight remains necessary.

Domain Number	Domain Description	Rating
1	Strategy, Leadership and Planning	Green
2	Quality of Care	Green
3	People and Culture	Green
4	Access and Delivery of Services	Green / Amber
5	Productivity and Value for Money	Green
6	Financial Performance and Oversight	Green / Amber

A green-amber rating indicates that the Trust has broadly effective leadership and governance arrangements but that one or more areas require further development, enhanced oversight or additional evidence of delivery. It may apply where material concerns are being actively managed through credible plans and established assurance routes, but where the required actions have not yet been completed or sustained improvement has not yet been demonstrated. The rating does not mean that current performance concerns have no effect on quality, access or patient outcomes.

Domain 2 – Quality of Care

Criterion 6 is assessed as green-amber because required standards are not yet being met consistently. However, the Trust's Board and management are monitoring this closely and have plans in place to address the areas of concern. These include the concerns identified in the CQC report and Section 29A warning notice. The proposed overall green rating for Quality of Care reflects

the Board's judgement that the Trust has established governance arrangements to identify quality concerns, assign executive accountability, implement improvement action and scrutinise progress through the relevant committees and the Board.

The work to address the CQC concerns is being led by the Chief Nursing Officer and Chief Medical Officer. It is monitored regularly through Executive Team meetings, with progress reported to the Board and the Council of Governors. All remedial work was completed by the end of September, with the exception of some additional estates work, which will be completed once the required equipment is received.

6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics).

Assurance remains outstanding on whether improvement is sustained, for example sepsis figures and whether this results in better patient experience and outcomes. This will be reported back through Quality and Safety Committee by the Chief Medical Officer and Chief Nursing Officer. The Board is therefore asked to consider whether the overall green rating remains appropriate in the light of the identified performance gaps, early evidence of delivery and the assurance still required.

Domain 4 – Access and Delivery of Services

Domain 4 is rated green-amber because the Trust can identify inequalities in access and waiting times, but the actions, measurable population health targets and associated trajectories are not yet fully developed or agreed with system partners. This differs from the 2025 assessment because the Board has applied greater scrutiny to whether identified inequalities are being translated into measurable action and demonstrable improvement. Progress will be overseen through the People Committee, with the agreed targets and implementation plan returning to the Board by April 2027.

The Board recognises that further work is required under this domain, particularly in relation to the self-assessment criteria 13 and 14:

13. The trust can identify and address inequalities in access to/waiting times for NHS services across its patients.
14. Appropriate population health targets have been agreed with the integrated care board.

The Trust can identify where there are health inequalities, as evidenced in the annual Health Inequalities Report and the Integrated Performance Report, which now includes health inequalities as a measure. Further Board-led work is required to determine how these inequalities will be addressed effectively, including the setting of targets and plans.

The Trust has identified local population health priorities, but the associated population health targets remain in development.

Domain 6 – Financial Performance and Oversight

Domain 6 is rated green-amber because financial risks and recovery plans are subject to established oversight, but the Board requires stronger evidence that efficiency and transformation plans are being systematically tested for their effects on quality, access, patient outcomes and staff. The

assessment distinguishes between forecast benefits and benefits already demonstrated. This differs from the 2025 assessment because the Board has identified a need for more explicit and integrated assurance on the quality and operational effects of financial recovery plans.

17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes.

There is robust management of financial risk, as evidenced through reports from the Trust's internal and external auditors. However, the Board considers that it could provide greater challenge to financial plans to ensure that they do not adversely affect patient care and outcomes. Improvement against this statement will focus on evidence, reported through Board and committee meetings, that the effects of financial measures on patients, quality, access, outcomes and staff have been assessed. This work is being led by the Chief Finance Officer and reported to the Finance and Performance Committee and onward to the Board.

The Board will review compliance in these areas at an appropriate interval and by April 2027 at the latest.

The Board has agreed the ratings for this submission at the earlier workshop and the evidence which sits alongside the submission. Additional improvement areas identified through the assessment are:

- Monitoring of staff diversity across the organisation to ensure it is representative of the local population – work is underway to review the Equality, Diversity and Inclusion Strategy and publish a new framework. As part of this, there will be a published plan to improve diversity within management roles, as well as to improve the experience of all staff working at the Trust. This work is being led by the Chief People Officer.
- Consideration of digital leadership and experience at Board level. This work is being led by the Chief Executive and Chair with the Director for Corporate Governance.

Recommendation(s)

The Board is asked to:

- consider whether the proposed domain and overall ratings represent a true and balanced assessment of the Trust's current leadership and governance capability
- endorse the submission of the Provider Capability Self-Assessment to the ICB made on 2 October, subject to any amendments agreed at the meeting;
- note the material concerns, improvement actions, residual risks and assurance still outstanding
- require progress against the significant improvement plans to be reported through the identified committees and returned to the Board at the stated assurance points.

Appendix 1 – Provider Capability 2026 Submission
Appendix 2 – Provider Capability Self-Assessment worksheet

Provider Capability - Self-Assessment Template - Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*While the Trust can identify health inequalities further work is required to address health inequalities and embed this throughout its work. Population health targets have been agreed with locality partners but work remains ongoing with the ICB.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Partially confirmed**	*Governance frameworks are robust however improvement is required on ensuring full review of quality and people risks when seeking to address financial targets and in discussions at the Board.*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	

Signed on behalf of the board of directors

	Signature
Name	Dame Professor Robina Shah
Date	onsdag 7. oktober 2026

Domain	Self Assessment Criteria	Description	Evidence	Indicative Evidence or lines of enquiry	Capability Rating	Areas for Improvement
	Domain 1 - Strategy, Leadership and Planning					
1 Strategy, Leadership and Planning	1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	Objectives and internal priorities are set in consultation with the ICB and local partners	Progress with Unity Healthier Wigan Board Board and Committee papers Wigan Youth Zone Primary/Secondary Care Agreement and engagement	*•Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?*	**Green**	
		Acting as an anchor institution	Wigan Education and Skills Partnership Borough Partners Engagement with Edge Hill University Rotational nursing and community partners.	*•Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?*		
		10-year strategy for the Trust in place	Trust Strategy 2020–2030 reviewed during 2026 and relaunched. Four areas: Patients, People, Performance and Partnership	*•Can the board recognise when change is required and to adapt arrangements as the organisation evolves?*		
		Board Assurance Framework	Updated annually and reviewed at every Board and committee meeting No enforcement action in place from NHSE Trust continues to comply with terms of Provider Licence	*•Does the board understand the key risks to delivering the strategy and ensure these are appropriately assessed and mitigated?* *•Is the trust currently complying with the conditions of its licence?*		
	2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England	Trust is meeting all statutory requirements. Not part of the Performance Improvement Programme	Annual Report & Accounts National Oversight Framework ranking	*•Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?*	**Green**	
		National Performance Recovery	Trust has plans in place to meet all national recovery programmes, and the Board is fully sighted on these, e.g. removal of corridor care, 65-week waits, Referral to Treatment times and removal of deficit funding. Any variance from the plan is escalated to the Board/Committees	*•Is it co-operating with the requirements of any national performance improvement or recovery programmes?*		
	3. The board has the skills, capacity and experience to lead the organisation.	Board Membership and Development	Non-Executive Director vacancies are currently undergoing recruitment; all Executive Directors are permanent appointments Annual programme of workshops to allow time for development of deeper knowledge in key areas and Board development.	*•Are all board positions filled and, if not, are there plans in place to address vacancies?*	**Green**	Formalised Board development plan for the year ahead
		Clear lines of accountability to Execs and Board	Structure diagrams Committee Terms of Reference reflect specific portfolios NED champions in place eg Maternity	*•What proportion of board members are in interim/acting roles?*		
		Succession Planning	Succession planning and skills-mix discussions at the Remuneration and Nomination Committees	*•Is an appropriate board succession plan in place?*		
		Appraisal processes in line with NHSE guidance	Appraisal policy and documents Submissions to NHS England	*•Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?*		

4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served	Representation in key partnership collaborations eg Better Lives with Wigan Council and ICB partners	Bolton Collaboration Board papers – Board-to-Board meetings Healthier Wigan Partnership papers Participation in discussions regarding the Better Care Fund with partners		Green	
	Recruitment collaboration with Bolton and Salford	Better Lives Programme working with local authority partners to improve outcomes for patients, encourage the shift to community from acute and align financial pathways. Mutual Aid support for Northern Care Alliance			
	Engagement in the Trust Provider Collaborative, including membership of the executive lead group, e.g. Chief Operating Officers	Trust Provider Collaborative papers Annual Report and Accounts	*•Can the board evidence that it is working effectively with the wider system, not just focused on the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and left shifts to community care where appropriate and agreed?*		Further development of engagement as a full Board with system and other partners to review challenges and successes (Board-to-Board meetings, etc).
	Alignment of Financial Plans	Annual Planning process across GM ICB	*•Do the Trust's operating and financial plans align with those of its commissioning ICB or ICBs, in particular regarding activity and capital expenditure?*		
	Primary Care interface	LMC, Primary and Secondary Care Interface Group and GP Board meetings. Agreement in place with primary colleagues.			
	Digital Strategy in place	Cyber Strategy in place Board and Committee minutes The Better Connected digital transformation programme includes a range of digitisation projects, including assisted voice technology for outpatient clinics. Performance is overseen by the Finance & Performance Committee.	*•Is there sufficient digital literacy at board level and is digital a core element of discussions regarding planning, delivery, assurance and risk?*		
5. The trust has an effective cyber security strategy and uses digital technology to support improvement	Board Assurance Framework	On Corporate Risk Register Data Protection and Security Toolkit Annual Audit - meets requirements - basis of cyber security strategy and planning	*• Is cyber risk included on Board Assurance Frameworks and/or corporate risk registers?*	Green	
	Strategy Document	Digital is a cross-cutting theme Digital transformation is discussed at Board and Board Committee meetings – meeting minutes There is a digital transformation programme in place. Examples discussed at Board include maternity systems	*• Can the board articulate how digital is an enabler across the organisation's operations – quality, productivity, access and safety – and supports the governance and culture of the organisation*		
	Board Skills	A Non-Executive Director with a digital transformation background is being appointed	*• Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?*		Trust is an outlier in GM as has no Chief Digital Information Officer at executive level

	Domain 2 - Quality of Care					
2. Quality of Care	6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics)	Effective flows of information to Board on quality of care	Board and Committee minutes Integrated Performance Report – complaints and patient safety incidents alongside a wide range of quality metrics Internal Audit review of PSIRF The Trust has plans in place to meet all national recovery programmes, and the Board is fully sighted on these, e.g. removal of corridor care, 65-week waits, RTT and removal of deficit funding. Any variance from the plan is escalated to the Board/Committees	*The trust can demonstrate and assure itself that internal procedures:* *- ensure required standards are achieved (internal and external)* *- investigate and develop strategies to address substandard performance* *- plan and manage continuous improvement* *- identify, share and ensure delivery of best practice* *- identify and manage risks to quality of care*	**Amber**	Trust cannot currently *ensure* that required standards are met although improvement plans are in place. Evidence of sustained improvemetn eg sepsis to be reviewed by Board.
					Green	
	7. The Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Board engagement on quality of care	Fundamentals of Care Academy launch with advocacy as a central theme Quality and Safety Committee minutes Board commitment to creating a Just Culture environment	*There is board-level engagement on improving quality of care across the organisation*	**Green**	
		Performance Reporting and Walkabouts	Regular NED walkabouts and Listening into Action events ensure Board members have the opportunity to visit clinical and non-clinical areas and meet staff Integrated Performance Report Quality Account ASPIRE Programme of ward accreditation	*Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients.*		
			Annual Report and Accounts Finance Reports and Committee Minutes/Papers Quality Impact Appraisal process	*Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community.*		
			Annual Internal Audit Programme	*Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are*		
		Training and Appraisals	The Integrated Performance Report includes staff training and appraisal rates, discussed at every Quality and Safety Committee meeting Appraisal forms reviewed this year to increase compliance figures The Mandatory and Statutory Training Programme incorporates national requirements plus additional local priorities	*Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.*		
	8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.	Effective flow of information on patient experience and safety to the Board and Committees	Board and Committee papers/minutes	*•Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?*	**Green**	
		Patient stories at Board and Committees Quality and safety escalation processes for patients	Committee minutes Defined processes	*•Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities?*		
		Lived Experience Partners Panel – delivers direct feedback to the Board through patient stories.	Integrated Performance Report Board and Committee minutes Listening into Action visits/NED walkabouts Quality Account ASPIRE Programme of ward accreditation	*•Is the board satisfied that it receives timely information on quality that is focused on the right matters?*		
			Friends and Family Test reporting Part of National Oversight Framework Reporting	*•Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this?*		
			Lived Experience Panel PLACE inspections Patient voice and patient support groups The new Fundamentals of Care Academy has the patient voice at its centre	*•How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?*		
			Clinical voice in Board through executive and non-executive appointments	*•Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns?*		
		Complaint numbers and response times presented to the Board and Committees	Internal Audit Report: Complaints Procedure 2025 Integrated Performance Report Otis Room development in ED in response to a patient complaint	*•Is the board satisfied that the trust has a clear system both to receive complaints from patients and to escalate serious and/or recurring complaints to the relevant executive decision-makers?*		

	Domain 3 - People and Culture					
3. People and Culture	9. Staff feedback is used to improve the quality of care provided by the trust and monitor and improve staff experience.	Staff Side fully involved in People Committee	People Committee ToR, papers and minutes	*•Does the board look at all relevant staff information (including trainee information) to monitor the experience of working at the trust and identify areas for*	**Green**	
		Monitoring of, and actions arising from, pulse checks, the Staff Survey and other sources	Board and People Committee papers and minutes Freedom to Speak Up Reports to Board	*•Does the board engage with staff forums to continually consider how quality of care can be improved and how cultural/staff-experience issues can be addressed?*		
		Direct staff feedback (staff story to Board/committees)	Board and Committee minutes	*•Are staff surveys and other information (such as the NHS Staff Standards) routinely reported to the board and issues discussed? Are agreed actions followed up?*		
			WRES and WDES annual reports to the Board	*•Does the board monitor staff diversity across the organisation to ensure it is representative of the local population?*		Work underway to describe this more effectively through a ED&I framework and new policy
	10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	Review of Skills	Service Reviews across all clinical areas in progress	*•Does the trust regularly review skills at all levels across the organisation?*	**Green**	
		Reporting of training metrics and actions	Board and Committee papers/minutes Integrated Performance Report People Committee metrics and minutes	*•Does the board see and, if necessary, act on levels of compliance with mandatory training?*		
		Human Factors Training	WWL Learning Platform with all mandatory and recommended development including human factors	*•Have all staff completed relevant training and does the board see a log of avoidable staff-initiated events?*		
	11. Staff can express concerns in an open and constructive environment	Freedom to Speak Up service externally provided, regularly reports and has direct access to Board	Board and People Committee papers and minutes; regular FTSU reports FTSU processes have been strengthened during the year and re-contracted to improve reporting. Participation in the FTSU network is through the Partnership Forum. Freedom to Speak Up Policy Freedom to Speak Up Annual Report FTSU Champions	*•Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?*	**Green**	
		Complaints Oversight	Every complaint is signed off by the CEO or Deputy CEO and reviewed by the Chief Nurse or Medical Director	*•Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?*		
		Trust has examples of doing things differently based on staff feedback with programmes of cultural work focused on maternity, theatres and resident doctors.	A resident doctor presentation at Board resulted in the establishment of an executive-led working group Global Majority Workforce Passport Scheme Sexual Safety work to improve governance processes	*•Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?*		
			Incident reporting metrics reviewed at Committee Staff survey metrics reviewed at Board/Committees and action plan in place	*•Is there a safe reporting culture throughout the organisation? How does the board know?*		
		Staff Survey Results	Reported to the Board/Committees/Council of Governors Staff Survey Action Plan	*•Is the trust an outlier on staff surveys across peers?*		

	Domain 4 - Access and Delivery of Services					
4. Access and Delivery of Services	12. Plans are in place to improve performance against the relevant access and waiting time standards.	Reporting of national standards through Integrated Performance Report and NOF Reporting	Better Lives Programme/Progress with Unity Healthier Wigan Board papers and minutes Board and Committee papers GM Elective Care	*Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary?*	**Green**	
		Reporting and escalation to Board	Board papers and minutes Single Point of Access work Transformation programmes, e.g. Cancer and Capital Investment, directly linked to areas not meeting standards, e.g. A&E access times	*Where waiting-time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement?*		
	13. The trust can identify and address inequalities in access to/waiting times for NHS services across its patients.	Board discussions on data and information on inequalities Engagement across the Trust	Board papers and agendas with a health inequalities reflection Every Board and Committee paper has a health inequalities reflection section, as do triple AAA assurance reports New IPR metrics linked to health inequalities introduced in 2026 Staff briefing sessions on inequalities at Team Brief	*Can the board track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population, and are plans in place to address any variation?*	**Green** **Amber**	A Board session on health inequalities data, and an action plan in response, is to be programmed for the next 12 months to improve work to address health inequalities
	14. Appropriate population health targets have been agreed with the integrated care board.	Population health is a key factor/focus for the Trust. Aims and approach agreed with the ICB Population health targets agreed locally (Wigan Partnership) for children, maternity and end-of-life care	Better Lives Programme Healthier Wigan Board papers and minutes Board and Committee papers Integrated Performance Report Review of patient letters to address health inequalities Work to reduce DNAs Staff briefings on health inequalities work	*•Is there a clear link between specific population health measures and the internal operations of the trust?* *•Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?*	**Green** **Amber**	A Board session on health inequalities data, and an action plan in response, is to be programmed for the next 12 months to improve work to address health inequalities Greater Trust representation on the local Health and Wellbeing Board is to be requested
	Domain 5 - Productivity and Value for Money					
5. Productivity and Value for Money	15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Board has good visibility of metrics and plans to improve, together with delivery	Board and Committee minutes Integrated Performance Report NCCI reporting at Board and Committee level, with the use of Model Health System data embedded Implied productivity metrics are included in Divisional Assurance Packs and reported to the Finance Improvement Group. These are used to focus on activity delivery and cost improvement Packs distributed to divisions, including NCCI and SLR information	*• Does the Board use all available and relevant benchmarking data, as updated from time to time by NHS England, to:* *- review its performance against peers* *- identify and understand any unwarranted variations* *- put programmes in place to reduce unwarranted negative variation*	**Green**	
		The NOF framework includes efficiency metrics	Reported to the Finance & Performance Committee and through to the Board as part of the AAA report			
		The Model Health System is used to inform business-case decision-making	Board, Committee and Wider Leadership Team papers, with discussions recorded in minutes	*Is there a track record of delivery of planned productivity improvements?*		

	Domain 6 - Financial Performance and Oversight					
6. Financial Performance and Oversight	16. The trust has a robust financial governance framework and appropriate contract management arrangements.	Clear systems of control and reporting requirements	Standing Financial Instructions Schedule of Matters Reserved for the Board 'Clean' Head of Internal Audit opinion and external audit opinion on the statutory accounts Audit Committee Terms of Reference	*•Does the trust have a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data?*	**Green**	
		No contract disputes	Regular contract discussions with the ICB Signed-off plan	*•Have there been any contract disputes over the past 12 months and, if so, have these been addressed?*		
		Alignment of financial systems with staffing	External Auditors' Report Cost Improvement Programme Financial reporting	*•Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out?*	**Green**	
		Agency/Bank	Bank/agency usage has declined over the last 24 months but remains a challenge. Where usage has increased, this is due to increased patient numbers.	*Has the Trust had to rely on more agency/bank than planned?*		
	17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	Testing of financial plans	Divisional Assurance Meetings Board and Committee Minutes evidence of challenge	*Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care?*	**Amber**	Improve the addressing of quality and people risks when signing off the financial plan and ensure that the plan is met. To be reviewed in 6 months.
		Impact on quality and staff	Quality Impact Assessment process Ongoing investment in quality as required	*Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing?*	**Green**	
			Integrated Performance Report Financial Recovery Plan	*Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?*		
	18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	System-wide discussions	Annual planning process with the ICB	*Is the board contributing to system-wide discussions on allocation of resources?*	**Green**	
		Alignment of the financial plan with partners	Worked closely with the local authority in the past to help the Trust achieve its plan Work is ongoing to align financial systems for future mutual benefit, but more work is required.	*Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?*		

Report Title	Annual Effectiveness and Terms of Reference (ToR) Review
Presented to:	Board of Directors
On	7 October 2026
Item Purpose	To approve
Presented By	Nina Guymer, Head of Corporate Governance
Prepared by:	Nina Guymer, Head of Corporate Governance
Contact Details	Teams

Key Messages

- The annual reviews provide assurance that the **Board's committees are operating effectively overall** and are substantially **fulfilling the responsibilities delegated** through their Terms of Reference.
- Across committees, respondents reported **positive committee cultures, constructive challenge, open debate, effective chairing and an appropriate balance of skills and experience**.
- Committees responded flexibly to emerging issues alongside their agreed workplans. The reviews also identified some deferred items and areas where scheduling could be more closely adhered to.
- The principal **opportunities are to sharpen the focus on strategic risks, controls and assurance; improve conciseness of committee papers; strengthen external assurance; demonstrate impact; improve action follow-through; and clarify committee governance interfaces** (in terms of groups reporting into the committees).
- The findings indicate no significant concerns about overall committee effectiveness. They provide a basis for targeted and consistent improvement supported by the Board and committee Chairs.
- The Committees are acting within the powers delegated by the Board and considering appropriate areas.

Risks associated with this report and proposed mitigations

- At times, unclear assurance requirements, reporting routes or governance interfaces could result in duplication, gaps in oversight or excessive operational detail, reducing the time available for strategic scrutiny
- No risks, financial, legal, people ED&I or health equalities implications have been identified from the content of this report.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Support committees to implement the actions arising from each committee's individual effectiveness review.
- Ask Committee Chairs to report progress through routine assurance reporting to the Board.
- Review progress and the impact of changes through the next annual effectiveness review cycle.

1. Key achievements for the Committee this year were:
    - Provided effective challenge and escalation where assurance gaps were identified.
    - Maintained robust oversight of financial governance, annual accounts and stewardship arrangements.
    - Strengthened assurance around cyber security, information governance and counter-fraud arrangements.
    - Supported effective corporate governance and Board assurance through policy approvals, oversight of statutory reporting requirements, and scrutiny of workforce, quality, patient safety, research and improvement priorities across the organisation

Introduction

2. The Board needs to be confident that effective corporate governance arrangements are in place in its Committees to provide assurance and to ensure that those powers delegated to Committees are being exercised appropriately.

3. Committees should have accurate and robust terms of reference (ToR) and provide assurance that the duties identified within these are either being appropriately carried out each year or a rationale for deferral has been provided. This will be achieved through:
    - self-assessments of Committee performance against the identified remit and any performance measures
    - annual consideration of the ToR (including its purpose and role) to ensure they remain relevant and up to date, and highlighting of any proposed changes
    - identification of items for consideration for the following year

Structure of the Review

4. The review process has been coordinated by the Committee administrator with the support of Chairs and Committee members in order to provide assurance to the Board that it is discharging its duties effectively.

5. Reviews have enabled the Committee to understand whether the items received were relevant to the purpose and role of the Committee, whether it should be recommended that these areas of business should not be received in future, or identify where there are new areas the Committee has reviewed in year that should be added to the ToR.

Outputs

How the Board Can Support Its Committees	
Board expectation	**How this supports effectiveness**
Reinforce the assurance role	Expect agenda items to focus on risks, controls, assurance gaps, mitigating actions and required decisions.
Support proportionate reporting	Promote concise summaries and reporting by exception where this can reduce volume without weakening assurance.
Set consistent expectations for papers	Require clear identification of risks, controls, assurance sources, gaps and requested actions.

How the Board Can Support Its Committees	
Board expectation	**How this supports effectiveness**
Strengthen assurance mapping	Improve visibility of relevant internal audit, external audit, regulatory, peer-review and benchmarking evidence across committee boundaries.
Require clearer evidence of impact	Seek completed actions, outcomes achieved and examples of improvement arising from committee scrutiny.
Clarify governance interfaces	Confirm responsibilities and escalation routes where committees and supporting groups overlap.
Support effective chairing and participation	Preserve open debate and constructive challenge while keeping discussion strategic and assurance focused.
Monitor improvement actions	Use routine Chair reporting to provide proportionate updates on implementation and impact.

Summary of findings across Committees from the 2026 effectiveness reviews		
Committee	**Improvement priorities**	**What the Committee will implement / work on**
Audit Committee	• End-of-meeting reflection • Strategic focus on risk systems and controls • Visibility of impact • Visibility of Chair and Board reporting	• Use a consistent closing reflection • Keep risk discussion at system and control level • Record improvements resulting from scrutiny or assurance gaps • Keep members informed about wider Chair engagement and Board assurance
Finance and Performance Committee	• End-of-meeting reflection • Digital and sustainability assurance • Paper quality • Visibility of outcomes	• Use a consistent closing reflection • Review sufficiency of digital and sustainability assurance • Strengthen paper quality and assurance focus • Make improvements arising from scrutiny more explicit
People Committee	• Assurance and control reporting • Information requirements • Impact and outcomes • Paper quality • Meeting effectiveness	• Map workforce assurance sources, controls and gaps • Increase visibility of relevant external scrutiny • Align reporting to remit and strategic objectives • Report completed actions, improvements and outcomes • Use assurance-focused paper guidance and templates • Manage agenda's effectively to prioritise items

Summary of findings across Committees from the 2026 effectiveness reviews		
Committee	**Improvement priorities**	**What the Committee will implement / work on**
Quality and Safety Committee	• Volume and focus of reporting • Impact and outcomes • External assurance and benchmarking • Governance interfaces	• Use concise summaries and exception reporting • Review whether all reports need routine presentation • Show actions, learning and improvements from scrutiny • Increase external review, benchmarking and regulatory intelligence • Clarify the relationship with supporting groups
Research Committee	• Assurance focus and strategic priorities • Impact and action follow-through • External assurance and partnership input • Membership and stakeholder engagement • Expanded remit	• Refocus agendas on risks, controls, assurance and strategic delivery • Track actions and demonstrate outcomes • Increase external assurance and academic partner input where appropriate • Review skills, expertise and stakeholder perspectives • Update the Terms of Reference and workplan to includer education and training. Membership list amended and university representatives included.

Recommendation

To note that the Committees are working within their Terms of Reference and within the delegated powers from the Board and all have identified areas for improvement.
To approve the terms of reference for each Committee.

Appendix 1 – Terms of Reference
Appendix 2 – Cycles of Business

Finance and Performance Committee

TERMS OF REFERENCE

1. Authority/Constitution

1.1 The Finance and Performance Committee ("the Committee") is constituted as a standing committee of the Foundation Trust's Board of Directors ("the Board"). The Committee is authorised by the Board to act within its Terms of Reference. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

1.2 The Committee has the authority to oversee and take decisions relating to the organisation's activities in order to achieve its strategic objectives, within the scope of these Terms of Reference.

1.3 The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

1.4 The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise, if it considers this expedient to the exercise of its functions.

1.5 The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its Terms of Reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any such groups will report directly to the Committee, which will oversee their work.

2. Purpose

2.1 The purpose of the Committee is to enable the Board to obtain assurance that the Trust is financially sustainable, delivers its operational performance objectives and makes effective, efficient and value-based use of its resources and, in particular, that the governance arrangements, systems and controls relating to finance, performance, capital, productivity and transformation are effective and support delivery of the Trust's strategic objectives.

3. Membership

3.1 The Committee shall be comprised of the following voting members:

- Three Non-Executive Directors, one of whom shall be Chair;
- Chief Finance Officer

- Chief Operating Officer
- Deputy Chief Executive

3.3 The following are required to attend in a non-voting capacity:
- Director of Corporate Governance or Deputy

3.4 The Committee may invite or co-opt other staff, external advisers or subject matter experts to attend meetings where their expertise is required to support the Committee's consideration of specific matters. Such attendees will participate at the discretion of the Chair and will normally attend only for the relevant agenda item(s).

3.5 An open invitation exists for all members of the Board of Directors to attend the Committee.

4. Quorum

4.1 The Committee will be deemed quorate on the attendance of two Non-Executive Directors and one Executive Director.

4.2 In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

4.3 Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to contribute effectively to the Committee's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members unless they are formally acting up in accordance with the Trust's Constitution.

5. Requirements of Membership

5.1 Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded, monitored and reported annually.

5.2 Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or connected persons are incompatible or in competition with the interests of the organisation. Committee members are required to exercise judgement and declare such interests where there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests maintained by the Company Secretary.

6. Duties

6.1 Finance

6.1.1 Review and endorse the Trust's annual financial plan prior to presentation to the Board for approval.

6.1.2 Monitor in-year financial performance against the agreed plan at divisional and organisational level.

6.1.3 Review and monitor the strategic five-year capital programme, annual capital budgets and three-year sustainability plan, and recommend these to the Board for approval.

6.1.4 Review the Trust's cash position and related treasury management policies, including the 12-month rolling cash-flow forecast and investment portfolio.

6.1.5 Consider and recommend a borrowing strategy to the Board where such a strategy is required.

6.1.6 Review external financing arrangements or vehicles, including borrowing, joint ventures and private finance arrangements.

6.1.7 Monitor delivery of the Cost Improvement Programme, including the recurrent nature and sustainability of savings.

6.1.8 Monitor the detailed monthly income and expenditure position and assess the robustness of risk assessments underpinning financial forecasts.

6.1.9 Receive assurance regarding procurement performance and matters relevant to the Trust's financial and operational performance.

6.2 Performance

6.2.1 Review the performance elements of the Trust's integrated performance reporting and seek assurance regarding delivery of key performance standards.

6.2.2 Receive performance data disaggregated by ethnicity and deprivation where relevant and seek assurance that the data is used to reduce health inequalities.

6.2.3 Consider the adequacy of forecasting models used in relation to operational performance.

6.2.4 Consider proposals for investment in or divestment from services within the Committee's delegated authority.

6.2.5 Monitor delivery against the Digital Strategy and associated investment plans.

6.2.6 Monitor delivery against the Green Plan.

6.2.7 Monitor operational performance against planned trajectories and seek assurance regarding the effectiveness and timeliness of corrective action.

6.2.8 Seek assurance that systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support operational management and Board assurance.

6.2.9 Receive assurance regarding estates and facilities performance and matters relevant to the Trust's financial and operational performance.

6.2.10 Seek assurance on the Trust's transformation programme and delivery of agreed outcomes and targets set for each element.

6.3 Risk and Assurance

6.3.1 Review the Board Assurance Framework risks and corporate risks within the Committee's remit and seek assurance regarding the adequacy and effectiveness of mitigating actions.

6.3.2 Escalate significant risks, gaps in control or gaps in assurance to the Board as required.

6.3.3 Provide information to the Audit Committee, on request, to support its oversight of the Trust's system of governance, risk management and internal control.

6.4 Business Cases

On the recommendation of the Wider Leadership Team and/or Executive Team, the Committee shall:

6.4.1 Review and support the approval of business cases in line with the Trust's Standing Financial Instructions, considering these in line with the Trust's strategic direction, priorities and affordability.

6.4.2 Seek assurance regarding the effectiveness of approved investments through post-investment appraisal.

7. Data Privacy

7.1 The Committee is committed to protecting and respecting data privacy and will have regard to applicable data protection legislation, including the UK General Data Protection Regulation and the Data Protection Act 2018.

8. Equality, Diversity & Inclusion

8.1 In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by creating an environment that is inclusive for the workforce, patients and service users, including those with protected characteristics and vulnerable members of the community.

9. Reporting

9.1 The Committee will provide information to any Board Committee where requested, or where delegated and deemed appropriate, to assist that Committee in ensuring good structures, processes and outcomes across all areas of governance.

9.2 The Committee will be accountable to the Board of Directors. The Board will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

9.3 Reports, including regular assurance reports, will be received from the following sub-groups established to support the Committee in fulfilling its duties. The Committee will approve the Terms of Reference for each group during the year:

- Financial Improvement Group
- Digital Strategy Oversight Group
- Global Training Education Steering Group
- Greener WWL Steering Group.

10. Administration of Meetings

10.1 Meetings shall be held every two months, with additional meetings held on an exceptional basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of six meetings per year.

10.2 The Company Secretary will make arrangements to ensure that the Committee is supported administratively. Duties will include development and monitoring of a workplan, agenda setting, taking minutes, preparing an assurance report for the Board of Directors and providing appropriate support to the Chair and Committee members.

10.3 Agendas and papers will be circulated at least four working days in advance of the meeting.

10.4 Minutes and an updated action log will be circulated to members for comment as soon as is reasonably practicable.

10.5 An annual workplan will be agreed and reviewed at least twice per year by the Committee to ensure that it is meeting the duties described in these Terms of Reference.

11. Review

11.1 The Terms of Reference shall be reviewed annually and approved by the Board. The next review date shall be March 2027.

11.2 The Committee will undertake an annual review of its performance against its workplan and the Trust's strategic objectives in order to evaluate the achievement of its duties.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Research, Education and Training Committee
TERMS OF REFERENCE

1. Authority/Constitution

1.1. The Research Committee ("the Committee") is constituted as a standing committee of the Foundation Trust's Board of Directors ("the Board"). The Committee is authorised by the Board to act within its terms of reference. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

1.2. The Committee has the authority to oversee and take decisions relating to the organisation's activities in order to achieve its strategic objectives, within the scope of these terms of reference.

1.3. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

1.4. The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise, if it considers this expedient to the exercise of its functions.

1.5. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

2. Purpose

2.1.1 The purpose of the Committee is to provide the Board with assurance that the Trust has a strategic direction for research, innovation, medical education and non-mandatory training and that risks to strategic delivery in these areas and the Trust's reputation have been identified and mitigated.

3. Membership

3.1 The Committee shall be comprised of the following voting members:

- Three Non-Executive Directors, one of whom will be the Committee Chair
- Medical Director
- Director of Strategy and Planning
- ~~Chief Nurse~~
- Chief People Officer

- Director of Communications and Stakeholder Engagement

3.2 The following are required to attend in a non-voting capacity:

- Clinical Director for Research and Development
- Corporate Director of Nursing - Education, Workforce & Standards
- Director of Medical Education
- Director or Deputy Director of Corporate Governance
- Divisional Research Champion (on 1 in 4 rotational basis)
- ~~University/Higher Education Representation~~
- Edge Hill University Representative
- Finance representative
- Greater Manchester University Representative
- Head of Research and Development
- University of Manchester Medical Education and Training Representative

3.2 An open invitation exists for all members of the Board of Directors to attend the Committee.

3.3 The Committee may be attended by any other person who has been invited to attend a meeting by the Committee, so as to assist in deliberations for specific items.

4. Quorum

4.1 The Committee will be deemed quorate on the attendance of three voting members, to include at least one Non-Executive Director and one Executive Director.

4.2 In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

4.3 Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

4.4 Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

5. Requirements of Membership

5.1 Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored and reported annually.

5.2 Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interest of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

6. Duties

6.2 In order to fulfil its role and obtain the necessary assurance, the Committee will:

- Inform the development and provide assurance against the following strategies, associated policies, implementation plans and annual reports. It will ensure that these are aligned with the Trust's Strategy, its strategic objectives, national good practice and guidance and planned improvements in patient care, workforce capability and organisational development:
    - Research Strategic Plan
    - People and Culture Strategy (training and education elements)
    - Research Assurance Framework
    - Annual Clinical Audit Report

- Ensure that governance and assurance systems operate effectively and underpin programme delivery to include the areas associated with the above strategies and annual reports.

- Identify and support the synergies between research, innovation, training, medical education and innovation to ensure they are strategically aligned and sustainable

- Endorse and promote a culture of ambition, supporting innovative practice across the Trust

- Provide strategic oversight of the application to become a university hospital and once successful ensure that the Trust maintains the appropriate focus and approach to retain and benefit from this accreditation.

6.2 The Committee's general duties in the above areas will be to:

- Provide assurance to the Board on compliance with associated legislation, national reporting and regulatory requirements and best practice

- Support research and innovation being embedded at every level of the organisation through establishing the conditions for increasing participation in clinical trials.

- Oversee the promotion of a patient-focused and ambitious culture for research and innovation within the Trust

- Monitor the efficient and safe delivery of research activity, capability and participation including how evidence is translated into practice and oversight of projects to ensure they meet national and Trust objectives

- Seek assurance on the quality of research and innovation projects, training and medical educational provision, in order to enhance the reputation of the Trust as a centre of excellence

- Consider emerging local, national and international initiatives that may provide opportunities through innovative working including through academic partnerships or networks

- Develop and support a strategic approach to education and professional training that is multi-disciplinary and suitably ambitious to support the aim to become a university hospital trust and develop an outstanding offer for staff in line with the NHS Staff Standards.

- Ensure through the use of third party assurance such as the GMC survey and internal engagement with staff groups, that the experience for staff receiving clinical training at the Trust is of a high standard and that the Trust achieves a positive reputation for the delivery of education and training

- Consider and review relevant metrics that align to the NHS Oversight Framework, support the development of appropriate performance measures such as key performance indicators (KPIs), and associated analysis, reporting and escalation frameworks to inform the organisation to support continual improvement.

- Monitor the delivery of any corrective action plans in areas where acceptable assurance is not yet in place

- To assure the Board that, where there is a research, innovation education or training risk that may jeopardise the Trust's ability to deliver its strategic objectives, or which have significant reputational, patient or cost impact, that these are being managed in a controlled and timely manner to mitigate the risks.

- To monitor finances across all areas in the scope of the Committee including grant income to ensure resources are being utilised appropriately and strategically.

7. Data Privacy

7.1.1 The Committee is committed to protecting and respecting data privacy. The RIME Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

8. Equality, Diversity & Inclusion

8.1.1 In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

9. Reporting

9.1 The Committee will provide information to any Board Committee where requested, or delegated where deemed appropriate, to assist the Committee in ensuring good structures, processes and outcomes across all areas of Governance.

9.2 The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

9.3 Reports including regular assurance reports will be received from the following sub-groups which have been established by the Committee to support it in fulfilling its duties. The Committee will approve the terms of reference for each of these groups during the year:

- Institutional Review Group
- Research Finance Investment Group
- Education Governance Group *(currently reporting to People Group)*

10. Administration of Meetings

10.1 Meetings shall be held quarterly with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of four meetings per year.

10.2 The Company Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting, writing an assurance report for the Board of Directors and providing appropriate support to the Chair and Committee members.

10.3 Agendas and papers will be circulated at least four working days in advance of the meeting.

10.4 Minutes and an updated action log will be circulated to members for comment as soon as is reasonably practicable.

10.5 An annual workplan will be agreed which will be reviewed at least twice per year by the Committee to ensure it is meeting its duties as described in this Terms of Reference.

11. Review

11.1 The Terms of Reference shall be reviewed annually and approved by the Board. The next review date shall be March 2027.

11.2 The Committee will undertake an annual review of its performance against its work plan and the Trust's strategic objectives in order the evaluate the achievement of its duties.

Quality and Safety Committee
TERMS OF REFERENCE

1. Authority/Constitution

1.1. The Quality and Safety Committee ("the Committee") is constituted as a standing committee of the Foundation Trust's Board of Directors ("the Board"). The Committee is authorised by the Board to act within its Terms of Reference. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

1.2. The Committee has the authority to oversee and take decisions relating to the organisation's activities in order to achieve its strategic objectives, within the scope of these Terms of Reference.

1.3. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

1.4. The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise, if it considers this expedient to the exercise of its functions.

1.5. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its Terms of Reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

2. Purpose

2.1 The purpose of the Committee is to obtain assurance that the Trust provides high standards of patient care through its quality and safety assurance structures, processes and controls. Its areas of oversight are patient safety, safeguarding, patient and public engagement, clinical risk management, health and safety and compliance with legal, regulatory and other obligations relating to quality

3. Membership

3.1 The Committee shall be comprised of the following voting members:

- Four Non-Executive Directors, one of whom shall be Chair;
- Chief Nurse
- Chief Medical Officer

3.2 The following are required to attend in a non-voting capacity:

- Associate Director of Governance and Patient Safety
- Divisional Director of Midwifery and Neonates
- Clinical representatives from both the Start Well and Planned Care division and Live Well and Urgent Care division being both:
    - Divisional Directors of Nursing and Allied Health Professionals and
    - Divisional Medical Directors

3.3 The Committee may invite or co-opt other staff, external advisers or subject matter experts to attend meetings where their expertise is required to support the Committee's consideration of specific matters. Such attendees will participate at the discretion of the Chair and will normally attend only for the relevant agenda item(s).

3.4 An open invitation exists for all members of the Board of Directors to attend the Committee.

4. Quorum

4.1 The Committee will be deemed quorate on the attendance of three voting members, to include at least two Non-Executive Directors and one Executive Director.

4.2 In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

4.3 Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

5 Requirements of Membership

5.1 Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored and reported annually.

5.2 Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interest of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

6. Duties

6.1 To inform the development, and provide assurance against the following strategies, associated policies, implementation plans and annual reports. It will ensure that these are aligned with the Trust's Strategy, its strategic objectives, national good practice and guidance and planned improvements in patient care, workforce capability and organisational development:

- Quality Strategy
- Quality Account
- Clinical Audit Annual Report
- Infection Prevention and Control Annual Report
- Infection Prevention and Control Board Assurance Framework
- Safeguarding Annual Report
- Learning from Deaths Annual Report
- Organ Donation Annual Report
- Maternity Annual Mortality Report
- Complaints Annual Report

Quality Measures

6.2 To receive reports on quality and safety performance measures including those measures on the Integrated Performance Report and the NHS Oversight Framework;

6.3 To exercise oversight of the outcomes of Quality Impact Assessments processes, to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

6.4 As requested by the Board, or determined by the Committee, to monitor the implementation of improvement plans in respect of quality of care and patient safety and assess assurance that implementation is successfully resolving the underlying causes.

7. Compliance And Regulation Duties

7.1 To assess available assurance that the Trust is appropriately responding to external reports, reviews, investigations, internal audits or strategies relevant to patient care and experience.

8. Clinical Governance and Risk Management Duties

8.1 To review assurance reports on quality and safety areas including those mandated to be received by the Board this will include but will not be limited to mortality, infection prevention and control, safeguarding and maternity according to the agreed workplan for the Committee

8.2 Assess assurance regarding the effectiveness of processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

8.3 To receive regular reports on the clinical quality accreditation programme , to assess its effectiveness

8.4 To review the Board Assurance Framework (Patients) and corporate risks escalated by the Risk Management Group in accordance with the Trust's risk management strategy and to seek assurances regarding mitigating actions.

9. Safety Culture Duties

9.1 To review the theme and trends related to incident management (including incidents involving staff and patients), inquests and litigation; and assess assurance that the Trust is learning and improving as a result

9.2 To assess assurance that appropriate feedback mechanisms are in place for those reporting incidents and that a culture of openness and transparency in respect to incident reporting is encouraged;

9.3 To assess available assurances on the implementation of the Patient Safety Incident Response Framework

10. Patient Experience Duties

10.1 To consider reports on all formal and informal patient feedback, both positive and negative, and to consider available assurance that the Trust is taking appropriate and timely action in respect of matters of concern.

10.2 To review the themes, trends and monitor improvements relating to complaints and concerns; and assess assurance that the Trust learning and improving as a result of the information.

11. Clinical Audit and Effectiveness Duties

11.1 To be assured that learning from the clinical audit programme is shared and provides the basis for evidence-based practice leading to improvement in patient care.

11.2 To ensure that care is based on evidence of best practice/national guidance and recommendations from national audits and external bodies such as the National Confidential Enquiry into Patient Outcomes and Death are responded to.

12. Data Privacy

12.1 The Committee is committed to protecting and respecting data privacy. The RIME Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

13. Equality, Diversity & Inclusion

13.1 In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

14. Reporting

14.1 The Committee will provide information to any Board Committee where requested, or delegated where deemed appropriate, to assist the Committee in ensuring good structures, processes and outcomes across all areas of Governance.

14.2 The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

14.3 Reports including regular assurance reports will be received from the following sub-groups which have been established by the Committee to support it in fulfilling its duties. The Committee will approve the Terms of Reference for each of these groups during the year:

- Patient Experience and Engagement Group
- Strategic Quality Assurance Group
- Fundamentals of Care Academy Group?

15. Administration of Meetings

15.1 Meetings shall be held every two months with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of six meetings per year.

15.2 The Company Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting, writing an assurance report for the Board of Directors and providing appropriate support to the Chair and Committee members.

15.3 Agendas and papers will be circulated at least four working days in advance of the meeting.

15.4 Minutes and an updated action log will be circulated to members for comment as soon as is reasonably practicable.

15.5 An annual workplan will be agreed which will be reviewed at least twice per year by the Committee to ensure it is meeting its duties as described in these Terms of Reference.

16. Review

16.1 The Terms of Reference shall be reviewed annually and approved by the Board. The next review date shall be March 2027.

16.2 The Committee will undertake an annual review of its performance against its work plan and the Trust's strategic objectives in order the evaluate the achievement of its duties.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

People Committee
TERMS OF REFERENCE

1. Authority/Constitution

1.1. The People Committee ("the Committee") is constituted as a standing committee of the Foundation Trust's Board of Directors ("the Board"). The Committee is authorised by the Board to act within its Terms of Reference. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

1.2. The Committee has the authority to oversee and take decisions relating to the organisation's activities in order to achieve its strategic objectives, within the scope of these Terms of Reference.

1.3. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

1.4. The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise, if it considers this expedient to the exercise of its functions.

1.5. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its Terms of Reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

2. Purpose

2.1 The purpose of the Committee is to obtain assurance that the Trust has effective people, culture and workforce arrangements in place to support the delivery of its strategic objectives. Its areas of oversight are workforce strategy and planning, organisational culture, equality, diversity and inclusion, employee engagement and wellbeing, leadership and talent development, and compliance with national workforce priorities, statutory requirements and other people-related obligations.

3. Membership

3.1 The Committee shall be comprised of the following voting members:

- Four Non-Executive Directors, one of whom shall be Chair;
- Chief People Officer
- Chief Nurse

- Chief Medical Officer

3.2 The following are required to attend in a non-voting capacity:

- Deputy Chief People Officer
- Staff Side Chair

3.3 The Committee may invite or co-opt other staff, external advisers or subject matter experts to attend meetings where their expertise is required to support the Committee's consideration of specific matters. Such attendees will participate at the discretion of the Chair and will normally attend only for the relevant agenda item(s).

3.4 An open invitation exists for all members of the Board of Directors to attend the Committee.

4. Quorum

4.1 The Committee will be deemed quorate on the attendance of three voting members, to include at least two Non-Executive Directors and one Executive Director.

4.2 In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

4.3 Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

5 Requirements of Membership

5.1 Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored and reported annually.

5.2 Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interest of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

6 Duties

6.1 To monitor the implementation and relevance of the WWL People and Culture Strategy.

6.2 To receive assurance that WWL has thorough and robust implementation plans in response to the NHS Staff Survey, in line with the NHS People Promise.

6.3 To monitor the implementation and relevance of the WWL Equality Diversity and Inclusion Strategy, and to provide assurance of improvements and compliance against key statutory and NHS specific workforce equality, diversity and inclusion requirements.

6.4 To receive assurance that a culture of speaking up, psychological safety, civility and learning is embedded throughout the Trust.

6.5 To provide assurance to the Board of Directors on workforce and organisational development issues; taking account of local and national agendas.

6.6 To monitor and provide assurance to the Board of the specific workforce and organisational development risks identified within the Board Assurance Framework or Corporate Risk Register and people related corporate objectives.

6.7 To receive assurance that the Trust's People and Culture Strategy and workforce plans remain aligned with national, regional and local workforce priorities, strategies, statutory requirements and NHS England workforce standards.

6.8 To support talent management and the expansion of management and leadership opportunities.

6.9 To encourage innovation and the development of alternative workforce and service delivery models.

6.10 To receive assurance that the strategies it monitors and the workstream which it oversees make use of digital and sustainable solutions to support efficiency, in line with WWL's Digital Strategy and Green Plan.

6.11 To monitor delivery progress of national and mandated standards falling within its remit.

7. Data Privacy

7.1 The Committee is committed to protecting and respecting data privacy. The RIME Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

8. Equality, Diversity & Inclusion

8.1 In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by

the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

9. Reporting

9.1 The Committee will provide information to any Board Committee where requested, or delegated where deemed appropriate, to assist the Committee in ensuring good structures, processes and outcomes across all areas of Governance.

9.2 The Committee will be accountable to the Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

9.3 Reports including regular assurance reports will be received from the following sub-groups which have been established by the Committee to support it in fulfilling its duties. The Committee will approve the Terms of Reference for each of these groups during the year:

- Local Negotiating Committee
- Educational Governance Group
- Partnership Forum
- Equality, Diversity and Inclusion Strategy Group
- Occupational Safety and Health Group

10. Administration of Meetings

10.1 Meetings shall be held every two months with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of six meetings per year.

10.2 The Company Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting, writing an assurance report for the Board of Directors and providing appropriate support to the Chair and Committee members.

10.3 Agendas and papers will be circulated at least four working days in advance of the meeting.

10.4 Minutes and an updated action log will be circulated to members for comment as soon as is reasonably practicable.

10.5 An annual workplan will be agreed which will be reviewed at least twice per year by the Committee to ensure it is meeting its duties as described in these Terms of Reference.

11. Review

11.1 The Terms of Reference shall be reviewed annually and approved by the Board. The next review date shall be March 2027.

11.2 The Committee will undertake an annual review of its performance against its work plan and the Trust's strategic objectives in order the evaluate the achievement of its duties.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Audit Committee
TERMS OF REFERENCE

1. Authority/Constitution

1.1 The Audit Committee ("the Committee") is constituted as a standing committee of the Foundation Trust's Board of Directors ("the Board"). The Committee is authorised by the Board to act within its Terms of Reference. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

1.2 The Committee has the authority to oversee and take decisions relating to the organisation's activities in order to achieve its strategic objectives, within the scope of these Terms of Reference.

1.3 The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

1.4 The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise, if it considers this expedient to the exercise of its functions.

1.5 The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its Terms of Reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any such groups will report directly to the Committee, which will oversee their work.

2 Purpose

2.1 The purpose of the Committee is to provide the Board with independent and objective assurance on the integrity of financial reporting and the effectiveness of the Trust's governance, risk management and internal control arrangements, including oversight of internal audit, external audit and counter fraud.

3. Membership

3.1 The Committee shall be comprised of the following voting members:

- Three independent Non-Executive Directors, one of whom shall be Chair. The Committee shall ensure that it has sufficient skills to discharge its responsibilities and at least one member should have recent and relevant financial experience.
- The Chair of the Foundation Trust shall not chair or be a member of the Committee.
- The Vice Chair and Senior Independent Director should not both be members of the Committee and neither shall chair the Committee.

3.4 The following are required to attend in a non-voting capacity:

- Chief Finance Officer
- Medical Director
- Head of Risk
- Director of Corporate Governance
- The Trust's appointed internal and external auditors
- Local Counter Fraud Specialist

3.5 The Local Counter Fraud Specialist should attend a minimum of two Committee meetings each year.

3.6 The Accounting Officer should attend annually to discuss the assurance process supporting the Annual Governance Statement and when the Committee considers the Annual Report and Accounts.

3.7 Other Executive Directors and staff shall be invited by the Committee Chair to attend meetings at which the Committee will consider areas of risk, operational matters or internal audit reports with no or limited assurance relating to their responsibilities.

3.8 The Committee may invite or co-opt other staff, external advisers or subject matter experts to attend meetings where their expertise is required to support the Committee's consideration of specific matters. Such attendees will participate at the discretion of the Chair and will normally attend only for the relevant agenda item(s).

3.9 The Committee Chair may approve the attendance of observers, particularly members of staff where attendance at assurance committee meetings is recommended as part of their development plan.

4. Quorum

4.1 The Committee will be deemed quorate on the attendance of two Non-Executive Directors.

4.2 In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

4.3 There is no provision for alternates to represent voting members at meetings of the Committee unless they are formally acting up to cover a prolonged absence, in accordance with the Trust's Constitution.

5. Requirements of Membership

5.1 Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded, monitored and reported annually.

5.2 Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or "connected persons" are incompatible or in competition with the interests of the organisation. Committee members are required to exercise judgement and declare such interests where there is a risk of

implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests maintained by the Company Secretary.

6. Duties

Governance, Risk Management and Internal Control

6.1 To assess the adequacy and effectiveness of the Trust's systems of governance, risk management and internal control across all clinical and non-clinical activities, including the arrangements supporting achievement of the Trust's objectives and the maturity of the Trust's control environment.

6.2 To review and approve the Annual Report and Annual Governance Statement on behalf of the Board before they are laid before Parliament, in order to determine their completeness, objectivity, integrity and accuracy. This will include a comment on the fitness for purpose of the overall assurance framework, the completeness and embeddedness of risk management, the effectiveness of governance arrangements and the appropriateness of evidence supporting regulatory compliance.

6.3 To review the Trust's risk management framework, including the risk management strategy, Board Assurance Framework, principal risks, control disclosures and underlying assurance processes, and to seek assurance that these remain complete, embedded and effective.

6.4 To utilise the work of internal audit, external audit, other assurance functions, executive management and relevant assurance committees to evaluate the effectiveness of overarching systems of governance, risk management and internal control.

6.5 To review policies, arrangements and the culture of compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the Code of Governance for NHS provider trusts, the NHS Provider Licence and the Fit and Proper Persons requirements.

6.6 To satisfy itself that the Trust's policy, systems and processes for managing conflicts of interest, gifts and hospitality and bribery are effective, including receiving reports relating to non-compliance.

Counter Fraud

6.7 To satisfy itself that the Trust has adequate arrangements in place for the prevention of fraud, bribery and corruption that meet NHS Counter Fraud Authority standards and the requirement to prevent fraud in the Economic Crime and Corporate Transparency Act 2023 by having adequate counter-fraud measures in place. To review the outcomes of work in these areas and any related policies and procedures and to support the Trust to build an anti-fraud culture.

6.8 To review, approve and monitor the Local Counter Fraud Specialist's work plans, receive regular updates on counter fraud activity, monitor implementation of action plans and consider NHS Counter Fraud Authority quality assessment reports.

Internal Audit

6.9 To satisfy itself that there is an effective internal audit function that meets the applicable public sector internal audit standards and provides appropriate independent assurance to the Committee, Accounting Officer and Board.

6.10 To review and approve the internal audit strategy and plan, ensuring that they are aligned with the Trust's assurance needs and risk framework and include reviews of data quality.

6.11 To consider the major findings of internal audit work, management's response and the implications for the Trust, and to monitor progress in implementing recommendations.

6.12 To oversee the effective operation of internal audit, including its resourcing, coordination with external audit, compliance with relevant standards, independence and standing within the Trust.

6.13 To consider the provision and cost of the internal audit service and any questions of resignation or dismissal relating to internal audit staff.

External Audit

6.14 To review and monitor the effectiveness of the external audit process, taking account of relevant UK professional and regulatory requirements and ensure the annual report includes how the effectiveness of external audit was assessed, the approach to appointment or reappointment, tenure and retendering and, where non-audit services are provided how auditor independence and objectivity are safeguarded.

6.15 To assess the external auditor's work and fees annually and, based on that assessment, make recommendations to the Council of Governors regarding appointment, reappointment or removal. The assessment will include the auditor's independence, objectivity and effectiveness.

6.16 To support the Council of Governors in agreeing criteria for appointing, reappointing and removing external auditors by providing information on performance, quality, value, timeliness and fees, and by making relevant recommendations.

6.17 To ensure that, where a recommendation is not adopted by the Council of Governors, the matter and the reasons are included in the Annual Report.

6.18 To oversee the appointment of an auditor at the end of each agreed contract to support value for money, with consecutive contracts involving the same audit partner running for no more than twenty years in total, and to make a recommendation to the Council of Governors.

6.19 To review all external audit reports, including the report to those charged with governance and any work undertaken outside the annual audit plan, together with management responses and monitor implementation of recommendations.

6.20 To review and approve the policy governing the engagement of the external auditor to provide non-audit services, taking account of relevant ethical guidance.

Financial Reporting

6.21 To monitor the integrity of the Trust's financial statements throughout the year and any other formal announcements relating to financial performance, including significant financial reporting judgements.

6.22 To review the annual statutory accounts and financial statements to determine their completeness, objectivity, integrity and accuracy. The Trust's Annual Report will

describe the Committee's work, including significant financial statement issues and how they were addressed.

6.23 To review all relevant disclosures through the year including changes in and compliance with accounting policies, practices and estimation techniques, unadjusted misstatements, significant judgements and audit adjustments, letters of representation, explanations for significant variances and any unresolved reservations or disagreements between external audit and management.

6.24 To review accounting and reporting systems used for reporting to the Board, including arrangements for budgetary control.

6.25 To review the Trust's accounting policies annually, seek assurance on the process for making key accounting judgements and make recommendations to the Board, including in relation to Standing Financial Instructions, significant departures from them and the Scheme of Reservation and Delegation.

Raising Concerns

6.26 To review the effectiveness of arrangements that allow staff and contractors to raise concerns in confidence about possible improprieties in any area of the organisation, including financial, clinical, safety and workforce matters, and to seek assurance that concerns are investigated proportionately, independently and in accordance with relevant policies.

Information Governance and Cyber Security

6.27 To receive the results of the annual Data Security and Protection Toolkit audit and assurance on plans to address identified issues and to ensure that the Trust is following national guidance and following a recognised national accreditation programme for cyber security (Cyber Essentials).

6.28 To receive assurance reports on the effectiveness of IT management arrangements, lessons learned from the crystallisation of cyber security risks, liaison with regulators and support provided to affected parties following significant security breaches.

6.29 To ensure that the Trust has robust business continuity and recovery plans in place to respond to any cyber attack and that the risks relating to cyber security are brought appropriately to the Board's attention through the Board Assurance Framework and risk management controls.

6.30 To receive an annual report from the Senior Information Risk Officer on systems of control and key performance indicators for information governance, including data protection and freedom of information compliance.

6.31 To receive reports of externally reportable data protection breaches and a review of lessons learnt and action taken to prevent these from reoccuring.

Other Matters

6.32 To review performance indicators relevant to the Committee's remit.

6.33 To examine any other matter referred by the Board and initiate investigations as determined by the Committee.

6.34 To review the work of other Trust committees insofar as it relates to the Committee's assurance function.

6.35 To consider the outcomes of significant reviews undertaken by regulators, inspectors, professional bodies or other organisations where these relate to the Committee's remit.

7. Data Privacy

7.1 The Committee is committed to protecting and respecting data privacy. The Committee will have regard to UK data protection legislation and will demonstrate, where applicable, compliance with the UK General Data Protection Regulation and the Data Protection Act 2018.

8. Equality, Diversity & Inclusion

8.1 In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by creating an environment that is inclusive for the workforce, patients and service users, including people with protected characteristics and vulnerable members of the community.

9. Reporting

9.1 The Committee will provide information to any Board Committee where requested, or where delegated and appropriate, to assist that Committee in ensuring sound structures, processes and outcomes across all areas of governance.

9.2 The Committee will be accountable to the Board of Directors. The Board will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting of the Committee.

9.3 The Committee shall routinely receive the minutes of the Finance and Performance Committee, People Committee, Quality and Safety Committee and Research, Education and Training Committee.

9.4 The Committee will receive reports, including regular assurance reports, from the following sub-groups established to support it in fulfilling its duties. The Committee will approve the Terms of Reference for each group during the year:

- Caldicott Group
- Risk Management Group
- Senior Information Risk Officer Meeting

10. Administration of Meetings

10.1 Meetings shall be held at least four times per year, with additional meetings convened as necessary.

10.2 At least once a year, the Committee shall meet with the Local Counter Fraud Specialist and internal and external auditors without management present.

10.3 The Head of Internal Audit, the representative of external audit and the Local Counter Fraud Specialist shall have a right of direct access to the Chair of the Committee.

10.4 The Company Secretary or their nominated deputy shall act as secretary to the Committee and will make arrangements to ensure that the Committee is supported administratively. Duties will include development and monitoring of a workplan, agenda setting, taking minutes, preparing an assurance report for the Board and providing appropriate support to the Chair and Committee members.

10.5 Agendas and papers will be circulated at least four working days in advance of the meeting.

10.6 Minutes and an updated action log will be circulated to members for comment as soon as is reasonably practicable.

10.7 An annual workplan will be agreed and reviewed at least twice per year by the Committee to ensure it is meeting the duties described in these Terms of Reference.

11. Review

11.1 The Terms of Reference shall be reviewed annually and approved by the Board. The next review date shall be March 2027.

11.2 The Committee will undertake an annual review of its performance against its workplan and the Trust's strategic objectives in order to evaluate achievement of its duties. The report will describe how the Committee has fulfilled its Terms of Reference

Board of Directors
Workplan 2026/27

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Item	Public/private	Presenter	Author	Commissioner/ Approver	Type	Purpose	Format	Time	Feb	Apr	Jun	Aug	Oct	Dec
Introductory items														
Chair and quorum	Both	Chair	N/A	Chair	S	Information	Verbal	1	x	x	x	x	x	x
Apologies for absence	Both	Chair	N/A	Chair	S	Information	Verbal	1	x	x	x	x	x	x
Declarations of interest	Both	Chair	N/A	Chair	S	Assurance	Verbal	1	x	x	x	x	x	x
Directors register of interests	Public	NA	Nina Guymer	NA	S	Information	Document	1	x	x	x	x	x	x
Story - Patient/ Research/ Staff	Public	CNO/DCEO/Chief People Officer	TBC	CPO/CNO/Head of Research	S	Information	Presentation	5	x	x	x	x	x	x
Minutes	Both	Chair	N/A	Chair	S	Decision	Document	5	x	x	x	x	x	x
Action log	Both	Chair	N/A	Chair	S	Assurance	Document	5	x	x	x	x	x	x
Chair's report (and stakeholder update)	Public	Chair	Robina Shah	Chair	S	Information	Document	10	x	x	x	x	x	x
Chief Executive's report	Both	Chief Executive	Comms Team	Chief Executive	S	Information	Document	15	x	x	x	x	x	x
Strategy														
Strategy 2031	Public	Deputy Chief Executive	Richard Mundon	Deputy Chief Executive	S	Assurance	Document	20				x		
Corporate objectives	Public	Deputy Chief Executive	Chris Clark	Deputy Chief Executive	S	Approval	Document	5		x				
Review of corporate objectives progress	Public	Deputy Chief Executive	Chris Clark	Deputy Chief Executive	S	Assurance	Document	15						x
Board assurance framework	Public	Chief Executive	John Harrop	Chief Executive	S	Assurance	Document	15	x	x	x	x	x	x

Partnerships report	Public	Deputy Chief Executive	Richard Mundon	Deputy Chief Executive	S	Information	Document	10		x			x	
University teaching hospital update	Public	Chief Medical Officer	Sanjay Arya	Chief Medical Officer	S	Assurance	Document	10		x			x	x
Digital strategy update	Public	Deputy Chief Executive	Richard Mundon	Deputy Chief Executive	S	Assurance	Document	15						x
People and culture strategy update	Public	Chief People Officer	Tracy Narot	Chief People Officer	S	Assurance	Document	5						x
Quality and safety														
Maternity Mortality Annual Report	Public	Divisional Dir of Midwifery	Jo Lambert	Chief Nursing Officer	S	Assurance	Document	10						x
Perinatal quality oversight report (quarterly)	Public	Divisional Dir of Midwifery	Jo Lambert	Chief Nursing Officer	S	Assurance	Document					x		x
Biannual maternity staffing report	Public	Divisional Dir of Midwifery	Jo Lambert	Chief Nursing Officer	S	Assurance	Document						x	x
CNST submission	Public	Chief Nursing Officer	Cathy Stanford	Chief Nursing Officer	S	Assurance	Document		x					
Guardian of Safe Working Hours report	Public	Chief Medical Officer	Abigail Callender-Iddon	Chief Medical Officer	S	Information	Document	10	x		x	x		x
Learning from deaths report	Public	Chief Medical Officer	Martin Farrier	Chief Medical Officer	S	Information	Document	15		x	x	x		x
Safe nursing staffing biannual review	Public	Chief Nursing Officer	Mem Van Beek	Chief Nursing Officer	S	Assurance	Document	10	x			x		
Complaints annual report	Public	Chief Nursing Officer	PALS Team	Chief Nursing Officer	S	Assurance	Document	15				x		
7-day services report	Public	Chief Medical Officer	Alison Unsworth	Chief Medical Officer	S	Approval	Document	5		x				
Health and Safety annual report	Assoc Dir of Governance & Patient Safety	Chief Nurse	Ehsan Haqqani	Chief Nurse	S	Assurance	Document	10	x					
EPRR report & core standards self assessment	Public	Chief Ops Officer	Mark Taylor	Chief Ops Officer	S	Approval	Document	5		x			x	
Performance														
Committee chairs' AAA reports	Public	Committee chairs	Non-Executives	Committee Chairs	S	Assurance	Document	20	x	x	x	x	x	x

Integrated performance report (and quarterly NOF where applicable)	Public	MD/Chief People Officer/COO/CN	DAA Team	Deputy Chief Executive	S	Assurance	Document	20	x	x	x	x	x	x
Finance report	Public	Chief Finance Officer	Heather Shelton	Chief Finance Officer	S	Assurance	Document	10	x	x	x	x	x	x
Capital update	Public	CFO/DoS	Tabitha Gardner/ Richard Mundon	Chief Finance Officer	S	Assurance	Document	15						x
Capital plan	Public	CFO/DoS	Tabitha Gardner/ Richard Mundon	Chief Finance Officer	S	Approval	Document	15		x				
Annual planning submission	Public	Deputy Chief Executive	Chris Clark	Deputy Chief Executive	S	Approval	Document	20	x	x				x
NHS provider capability assessment	Public	Director of Corp Gov	Katharine Dowson	Director of Corp Gov	S	Approval	Document	10						x
Annual sustainability report	Public	Deputy Chief Executive	Josh Balmer	Deputy Chief Executive	S	Assurance	Document	10	x					
People														
Staff survey report	Public	Chief People Officer	Rachel Gleave	Chief People Officer	S	Assurance	Document	15		x				
Resident doctors' 10-point plan update	Public	Chief People Officer	Charlotte Wright	Chief People Officer	S	Assurance	Document	15		x			x	
Freedom to Speak Up Guardian's report	Public	FSTU Guardian	Rachel Gleave	Chief People Officer	S	Assurance	Document	10		x			x	
Modern Slavery and Human Trafficking statement	Public	Director of Corp Gov	Katharine Dowson	Director of Corp Gov	S	Approval	Document	5				x		
Equality, diversity, inclusion & health inequalities														
EDI annual report	Public	Chief People Officer	Angelique Hartwig	Chief People Officer	S	Assurance	Document	15	x					
Workforce Race Equality Standard	Public	Chief People Officer	Angelique Hartwig	Chief People Officer	S	Approval	Document	10					x	
Workforce Disability Equality Standard	Public	Chief People Officer	Angelique Hartwig	Chief People Officer	S	Approval	Document	10					x	
Gender pay gap report	Public	Chief People Officer	Angelique Hartwig	Chief People Officer	S	Approval	Document	10		x				
Items following committee review														

Safeguarding annual report	Public	Chief Nursing Officer	Carlene Baines	Chief Nursing Officer		Assurance	Document	15	x					
Revalidation report	Public	Chief Medical Officer	Kathryn Heffernan	Chief Medical Officer		Approval	Document	10					x	
Equality Delivery System (EDS) 2	Public	Chief People Officer	Angelique Hartwig & Debbie Jones	Chief People Officer		Approval	Document	15			x			
Well led														
Review of board and committee effectiveness	Public	Director of Corp Gov	Nina Guymer	Director of Corp Gov	S	Discussion	Document	15		x			x	
Review of committee terms of reference	Public	Director of Corp Gov	Nina Guymer	Director of Corp Gov	S	Approval	Document	5		x			x	
Review of master workplan	Public	Director of Corp Gov	Nina Guymer	Director of Corp Gov	S	Approval	Document	5		x			x	
Use of the common seal report	Public	Director of Corp Gov	Nina Guymer	Director of Corp Gov	S	Information	Document	1		x				
NHS England self-certifications	Public	Director of Corp Gov	Katharine Dowson	Director of Corp Gov	S	Approval	Document	10		x				
Charity annual report and accounts	Public	Chief Finance Officer	Shirley Martland	Chief Finance Officer	S	Approval	Document	5						x
Review Standing Financial Instructions	Public	Chief Finance Officer	Shirley Martland	Chief Finance Officer	S	Approval	Document	5					x	
Fit and proper persons report	Public	Director of Corp Gov	Nina Guymer	Director of Corp Gov	S	Assurance	Document	5				x		
Annual report from the Audit Committee	Public	Audit Chair	Nina Guymer	Audit Chair	S	Assurance	Document	10		x				
Review of Board Diversity Policy	Public	Director of Corp Gov	Katharine Dowson			Approval	Document	5					x	
Conclusion														
Board assurance framework: reflections	Both	Chief Executive	John Harrop	Director of Corp Gov	S	Discussion	Document	5	x	x	x	x	x	x
Consent agenda														
Committee members are asked to review the papers on the consent agenda to check that they are content that there will be no opportunity to discuss these at the meeting. Please notify Company.Secretary@wwl.nhs.uk as soon as possible and in any event, at least two days prior to the meeting, with queries on any paper within the consent agenda or concerns which may warrant the paper being moved to the substantive agenda for fuller discussion.														

Private meeting														
Introductory items														
Chair and quorum	Both	Chair	N/A	N/A	S	Information	Verbal	1	x	x	x	x	x	x
Apolgies for absence	Both	Chair	N/A	N/A	S	Information	Verbal	1	x	x	x	x	x	x
Declarations of interest	Both	Chair	N/A	N/A	S	Assurance	Verbal	1	x	x	x	x	x	x
Minutes	Both	Chair	N/A	N/A	S	Decision	Document	5	x	x	x	x	x	x
Action log	Both	Chair	N/A	N/A	S	Assurance	Document	5	x	x	x	x	x	x
Chair's report	Private	Chair	Robina Shah	Chair		Information	Verbal		x	x	x	x	x	x
Chief Executive's report	Both	Chief Executive	N/A	Chief Executive		Information	Verbal		x	x	x	x	x	x
Other items														
National cost collection	Private	Chief Finance Officer	Finance Team	Chief Finance Officer	S	Approval	Document				x			
Data Protection Officer's annual report	Private	Chief Executive	Ged English-Gallantry	Chief Executive	S	Assurance	Document		x		x			x
Senior Information Risk Officer's annual report	Private	Deputy Chief Executive	Gerrard English-Gallentry	Deputy Chief Executive	C	Assurance	Document			x			x*	x
Med. exclusions/restrictions Q report	Private	Chief Medical Officer	Charlotte Wright	Chief Medical Officer	C	Assurance	Document		x		x	x		x
Conclusion														
Summary of decisions and actions	Private	Chair	Verbal	N/A	S	Information	Verbal	2	x	x	x	x	x	x
Equality and health inequalities reflections	Private	Chair	Verbal	N/A	S	Discussion	Verbal	2	x	x	x	x	x	x

Meeting evaluation •Was the agenda correctly focused •Were the papers appropriate? •Was the discussion appropriate?	Private	Chair	Verbal	N/A	S	Discussion	Verbal	2	x	x	x	x	x	x
Consent agenda														
Committee members are asked to review the papers on the consent agenda to check that they are content that there will be no opportunity to discuss these at the meeting. Please notify Company.Secretary@wwl.nhs.uk as soon as possible and in any event, at least two days prior to the meeting, with queries on any paper within the consent agenda or concerns which may warrant the paper being moved to the substantive agenda for fuller discussion.														
Internal audit plan	Private	Audit Chair	Jonathan Haury	Chief Finance Officer	C	Approval	Document			x				
Minutes of Board Committees	Private	N/A	Head of Corp Gov & Dep Co Sec	Head of Corp Gov & Dep Co Sec	C	Information	Document	0	x	x	x	x	x	x
Date, time and venue of next meeting:														
Ad hoc items scheduled														

Title of report:	Fit and Proper Persons Policy
Presented to:	Board of Directors
On:	7 October 2026
Item purpose:	Approval
Presented by:	Director of Corporate Governance
Prepared by:	Director of Corporate Governance
Contact details:	corporate.governance@wwl.nhs.uk

Executive summary

This report seeks approval of the Trust's new Fit and Proper Persons Policy, which sets out the arrangements for ensuring that all Board members and other relevant senior postholders meet the statutory Fit and Proper Persons requirements. The policy has been developed following an internal audit recommendation and replaces the previous Standard Operating Procedure linked to the Recruitment and Selection Policy. It reflects the requirements of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the NHS England Fit and Proper Person Test Framework.

The policy clarifies the responsibilities of the Chair, Senior Independent Director, Chief Executive, People Services and the Director of Corporate Governance in relation to appointment checks, annual reviews, ongoing fitness, record keeping, reporting and escalation of concerns. It also sets out the process for managing circumstances where an individual may not meet, or may no longer meet, the Fit and Proper Persons requirements.

Approval of the policy will strengthen the Trust's governance arrangements by ensuring a clear, consistent and auditable process for demonstrating compliance, supporting Board assurance, regulatory accountability and public confidence in the leadership of the organisation.

Link to strategy and corporate objectives

This policy supports the Trust's corporate objectives by strengthening the governance arrangements that ensure Board members are fit and proper to lead the organisation and discharge their responsibilities effectively. The policy also supports regulatory compliance, transparency, accountability and effective stewardship by ensuring that the Trust can evidence compliance with statutory requirements and the NHS England Fit and Proper Person Test Framework.

Risks associated with this report and proposed mitigations
Incomplete or inconsistent checks could weaken Board assurance that all Directors, including interim or acting-up postholders, are fit and proper to hold office. This could also damage confidence among patients, staff, governors, regulators and partners.

If evidence of checks, Chair sign-off, annual declarations, references, and audit trails are incomplete or not retained consistently, the Trust may be unable to demonstrate compliance during internal audit, CQC review, or NHS England assurance processes.

Financial implications
If an appointment, removal, or “unfit” outcome is challenged, the Trust may incur legal costs, HR case management costs, or employment tribunal-related costs. Failure to comply could lead to regulatory intervention, reputational damage, remedial action plans, or additional assurance requirements, all of which may carry financial consequences.

Legal implications
If the Trust does not fully implement the policy, it may fail to meet Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This could lead to Care Quality Commission scrutiny, regulatory challenge, or reputational damage.

People implications
Decisions about appointment, continued fitness, or removal from office may be challenged if processes are not applied fairly, consistently, transparently, and with appropriate evidence

Equality, diversity and inclusion implications
Checks relating to health, criminal records, employment history, social media, or professional fitness could have unintended discriminatory impacts if reasonable adjustments, context, proportionality, and equality duties are not properly considered.

Which other groups have reviewed this report prior to its submission to the committee/board?
None

Recommendation
To approve the Fit and Proper Persons Policy.

Appendix 1 – Fit and Proper Persons Policy

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

POLICY NAME:	**Fit and Proper Persons Policy**
POLICY ID NUMBER:	**New Policy**
VERSION NUMBER:	**1**
APPROVING GROUP:	**Board of Directors**
DATE THIS VERSION APPROVED:	**7 October 2026**
RATIFYING GROUP	**PARG (Policy Approval and Ratification Group)**
DATE THIS VERSION RATIFIED:	
AUTHOR(S) (JOB TITLE)	**Director of Corporate Governance**

DIVISION/DIRECTORATE:	**Corporate**
LINKS TO ANY OTHER POLICIES/PROCEDURES:	
CONSULTED WITH:	**Board of Directors** **People Services**

DATES PREVIOUS VERSION(S) APPROVED	**Version:**	**Date:**
NEXT REVIEW DATE:	**31 October 2029**	
MANAGER RESPONSIBLE FOR REVIEW **(Must be Authors Line Manager)**	**Chief Executive**	



VERSION CONTROL

Version	Date	Amendment
1	October 2026	New Policy replacing previous SOP

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ANNUAL REVIEW AND ONGOING FITNESS	10
MANAGING AN UNFIT OUTCOME	12
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RAISING CONCERNS	14
HUMAN RIGHTS ACT	14
INCLUSION AND DIVERSITY STATEMENT	14
MONITORING AND REVIEW	14
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EQUALITY IMPACT ASSESSMENT	31

APPENDICES		PAGE NUMBER
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App B	Summary of Director's Fit and Proper Persons Checks	18
App C	Annual Submission Reporting Template to NHS England	19
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POLICY ON A PAGE

PURPOSE AND SCOPE

Applies to Executive Directors, Non-Executive Directors, Associate Non-Executive Directors, interim, temporary and relevant acting-up arrangements, including those with significant influence over Board decisions.

Ensures all individuals in scope are fit and proper to hold Board-level responsibility and do not present an unacceptable risk to the Trust, patients, staff or the public

APPOINTMENT CHECKLIST

Candidates complete the Fit and Proper Persons self-attestation and are subject to pre-employment checks, including identity, right to work, qualifications, employment history, occupational health, DBS where applicable, professional registration and relevant register checks.

Appointments remain conditional until satisfactory checks are completed.

REVIEW AND DECISION

People Services and Corporate Governance coordinate evidence and records. The Chair, Chief Executive or Senior Independent Director reviews the outcome, depending on the role being assessed.

Formal appointment decisions must be recorded through the relevant Committee, Board or Council of Governors route.

ANNUAL ASSURANCE

All individuals in scope complete annual declarations and ongoing checks. The Corporate Governance Team retains evidence, updates records and supports the Chair's annual assurance statement.

Annual outcomes are reported to the Board, Council of Governors and relevant NHS England Regional Director as required.

CONCERNS AND ESCALATIONS

Directors must immediately disclose any change that may affect their fitness. Concerns are reviewed proportionately and may require investigation, regulatory referral, withdrawal of appointment, removal processes or dispute resolution.

Relevant records must be maintained securely, including ESR entries, local files, board member references and supporting evidence.

1. POLICY STATEMENT

1.1. This policy details how the Trust will meet the requirements placed on NHS providers to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 5: Fit and Proper Persons Requirement (FPPR) which sets out how to ensure that those individuals covered by its scope are fit and proper to carry out their role.

1.2. The purpose of the FPPR is to:

- ensure that NHS providers are not managed or controlled by individuals who present an unacceptable risk either to the organisation or people receiving the service provided by the Trust
- ensure that directors are fit and proper to assume responsibility for the overall quality and safety of care delivered

1.3. The aim of the processes outlined in this policy is to ensure that all members of the Board of Directors, have been subject to the relevant Fit and Proper Persons checks on appointment and thereafter on an annual basis.

1.4. It is the ultimate responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all relevant post holders (as defined in section 2) meet the test.

1.5. This policy applies to all individuals appointed to the Board of Directors (both Executive Directors and Non-Executive Directors and Associate Non-Executive Directors), including permanent positions, interim positions and any relevant acting up arrangements irrespective of their voting rights and individuals whom, though not a member of the Board have significant influence on board decisions.

1.6. An individual falls under the requirement of the Regulated Activity Regulations regardless of whether they undertake the role on a permanent or interim basis.

2. KEY PRINCIPLES

2.1 Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 Regulations) places a duty on NHS providers not to appoint an individual or allow an individual to continue to be, an Executive Director or equivalent or a Non-Executive Director under given circumstances. This means that individuals covered by the FPPR should not be appointed / continue to hold office unless they meet the following criteria. The individual:

- must be of good character
- must have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed
- must be able, by reason of health, after reasonable adjustments, to perform the tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed

- has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity
- must be able to supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Commission (CQC) (see Appendix G).

2.2 When assessing a person being 'of good character' NHS providers are required to take account of Schedule 4 of the 2014 Regulations, namely:

- whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and;
- whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

2.3 The CQC's definition of good character is not the objective test of having no criminal convictions but instead rests upon a judgement as to whether the person's character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion for Boards in reaching a decision and allows for the fact that people can and do change over time. In such circumstances, responsibility for a decision on good character would lie with the Chair.

2.4 The 2014 regulations list categories of persons who are prevented from holding office and for whom there is no discretion where the person is:

- an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
- the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
- has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under any enactment.

3. RESPONSIBILITIES

3.1 The Chair has responsibility for:

- overseeing the outcome of Fit and Proper Person Tests where the individual is a Non-Executive Director, or the Chief Executive. If the outcome is the

removal of a Non-Executive Director, this will need to be referred to the Council of Governors.

- with the support of the Director of Corporate Governance, undertaking investigations into any concerns raised about individuals who are subject to this policy, including where the individual has notified the Chair that they may no longer comply with Fit and Proper Persons requirements.
- submitting a declaration to the Board of Directors and the relevant NHS Regional Director on an annual basis providing assurance that all individuals subject to this policy meet the Fit and Proper Persons requirements.
- ensuring that there is a completed reference for any director who is considered under the Fit and Proper Persons Framework who leaves the Board for whatever reason, whether or not a reference has been requested.
- concluding on assessments for the whole Board (executive and non-executive, permanent or temporary, voting or non-voting).

3.2 The Senior Independent Director (a Non-Executive Director) has responsibility for;

- overseeing the outcome of Fit and Proper Person Test where the individual is the Chair and ensuring that the Chair is meeting the requirements of the FPPT. Where the SID and Deputy chair are the same individual, another Non-Executive Director should be appointed to review the chair's Fit and Proper Person Test on a rotational basis.
- with the support of the Director of Corporate Governance, undertaking investigations into any concerns raised about the Chair, including where the Chair has notified the Senior Independent Director that they may no longer comply with Fit and Proper Persons requirements. If the outcome is the removal of the Chair, this will need to be referred to the Council of Governors

3.3 The Chief Executive has responsibility for:

- overseeing the outcome of Fit and Proper Person Tests where the individual is a direct report of the Chief Executive, a member of the Executive Team or is acting up into such a post
- with the support of the Director of Corporate Governance, undertaking investigations into any concerns raised about one of the above individuals, including where the individual has notified the Chief Executive that they may no longer comply with Fit and Proper Persons requirements.

3.4 The People Services Team, under the supervision of the Chief People Officer, has responsibility for:

- undertaking all pre-employment checks for directors under the 2014 Regulations. These checks are undertaken for all permanent and interim positions as well as acting up arrangements;
- accessing and entering the Fit and Proper Person Checks onto Electronic Staff Record (ESR)
- entering the Board reference onto ESR
- liaising with the recruiting manager and sending a copy of the following documents to the Director of Corporate Governance to retain:
  - Fit and Proper Persons Requirement Personal Disclosure Form
  - Fit and Proper Person Test Checklist – New Applicants Checklist

- signed and dated copies of documents to support all checks.

3.5 The Director of Corporate Governance has responsibility for:

- undertaking all annual checks for under the 2014 Regulations. These checks are undertaken for all permanent and interim positions as well as acting up arrangements
- advising the Chair and Board of Directors on the process necessary to ensure the Trust has robust systems in place which comply with Regulation 5 of the 2014 Regulations (together with any guidance issued by the CQC)
- ensuring that any Fit and Proper Persons Tests undertaken comply with the process detailed in this policy, bringing non-compliance to the attention of the Chair, Senior Independent Director or Chief Executive (as relevant)
- maintaining files for all Directors. The file will contain copies of the recruitment documents as detailed in Table 1 together with documentary evidence of completion of subsequent annual checks (see section 7)
- where an investigation is required, acting as the secretary to the chair of the investigation panel (i.e. the Chair, Senior Independent Director or Chief Executive as mandated in paragraphs 4.1 to 4.3 above) and appointing / liaising with legal advisors in respect of the advice for the chair of the panel, the arrangements for the panel to meet, the collation of any evidence requested and liaison with the individual under investigation)
- testing elements of Fit and Proper Person test assessment and recording outcome and evidence for chair to review and conclude
- submitting the signed copy of the annual Fit and Proper Persons Test (Appendix C) by the chair to the relevant Regional Director.

3.6 Directors are responsible for:

- continuing to meet the requirements of being a Fit and Proper Person by signing the declaration form provided upon appointment and thereafter on an annual basis.
- immediately bringing to the attention of the relevant person (see below) any circumstances where they may not continue to meet the requirements of being a Fit and Proper Person:
  - if a Non-Executive Director - to the Chair of the Trust
  - if the Chair – to the Senior Independent Director and the Chief Executive
  - if an Executive Director - to the Chief Executive.
- not refusing to give their consent, on request, to the pre-employment checks described in Appendix B.
- for maintaining their Disclosure & Barring Service (DBS) checks and providing all information necessary to complete the Fit and Proper Persons Test, the annual signed self-declarations /DBS check to assist the Trust in undertaking an investigation (if required) in a timely manner.

4. NEW APPOINTMENTS

4.1 Where a post is subject to the Fit and Proper Persons Test (as listed in paragraph 2.1) candidates will be notified as part of the Trust's normal recruitment processes. In addition to the other requirements of the NHS Safer Employment Check Standards and the Trust's Recruitment and Selection Standard Operating Procedure, candidates will be required to complete the Fit and Proper Persons Self-Attestation Form (see Appendix A). Any offer of employment will be subject to satisfactory completion of the Fit and Proper Persons Test.

4.2 The Fit and Proper Persons Test for a new starter upon appointment will comprise of the following (including checking their Declaration Form against the information reviewed below):

Table 1 - Fit and Proper Persons Test for a New Starter

Element to test	Process
Good character	Pre-employment checks – see Recruitment and Selection Policy and supporting procedures (e.g. references, identity checks, right to work, qualifications checked)
Physically and mentally fit	Occupational health screening process
Necessary qualifications	Certificates and professional registration checks - see Recruitment and Selection Policy and supporting procedures Self-declaration – see Appendix A
Skills and experience	Interview / assessment centre - see Recruitment and Selection Policy and supporting procedures Self-declaration – see Appendix A Criminal convictions Disclosure and Barring Service
Employment history	Application form / CV - see Recruitment and Selection Policy and supporting procedures
Bankruptcy / insolvency	Searches of relevant insolvency and bankruptcy register - see Recruitment and Selection Policy and supporting procedures Self-declaration – see Appendix A
Investigations / struck off / Barring Lists	Searches of relevant professional registers and Companies House - see Recruitment and Selection Policy and supporting procedures Self-declaration – see Appendix A
Fitness to practice (including safeguarding / misconduct / mismanagement)	Professional registration - Recruitment and Selection Policy Clinical Staff Registration, Nurse, Midwifery and Nursing Associate Revalidation Checks Policy Self-declaration – see Appendix A
Eligibility to hold office	Searches of disqualified director register Self-declaration – see Appendix A

4.3 If a person meets the Fit and Proper Persons Test, then along with the satisfactory completion of the other required pre-employment checks, an offer of employment may be confirmed. If it is unlikely the person will meet the Fit and Proper Person Tests, please refer to section 7 below.

4.4 A member of the People Services Team will ensure that the Fit and Proper Person Test Checks Summary (Appendix B) is completed once the recruitment checks have been completed.

4.5 Following this, hard copies of the recruitment documents and the checklist will be given to the Chair to review and sign off confirming assurance that the checks are complete and that the post holder meets the requirements.

4.6 Electronic copies of the checks will be retained on the Trust's electronic personal files by the Corporate Governance Team.

4.7 Where a senior level post or interim is sourced by an agency or executive search company, the agency will be made aware of the Trust's Fit and Proper Person Test process and must confirm that they have undertaken the necessary checks, and share these with the Trust, or agree that these will be completed by the Trust.

4.8 Joint appointments across different NHS organisations

4.8.1 For joint appointments across different NHS organisations, the full Fit and Proper Person Test would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the Chair of the other contracting NHS organisation to ensure that the director is fit and proper to perform both roles.

4.8.2 The host/employing NHS organisation will then provide a 'letter of confirmation' (Appendix F) to the other contracting NHS organisation to confirm that the director in question has met the requirements of the Fit and Proper Person Test.

4.8.3 The Chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the Fit and Proper Person test assessment of the director.

4.8.4 For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a Chair or Non-Executive Director) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the Fit and Proper Person Test.

4.8.5 If the Fit and Proper Person assessment at one organisation finds an individual not to be a Fit and Proper Person, the Chair should update their counterpart of any other NHS organisation(s) where the individual has a director-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not a Fit and Proper Person at the other organisation.

5. FORMAL CONFIRMATION OF APPOINTMENTS

5.1 All appointments including interim appointments will be required to be approved by:

- the Remuneration Committee in respect of Executive Director appointments
- the Nominations Committee and Council of Governors in respect of Non-Executive Director appointments.

5.2 In line with the Trust's Scheme of Delegation, all decisions on appointments will need to take account of the Trust's obligations under the 2014 Regulations. The decision must be formally recorded in the minutes taken at the meeting.

5.3 Where the Trust deems that an applicant can be appointed, despite not meeting the characteristics outlined in Schedule 4, Part 2 of the Regulations (Good Character), the reasons will be recorded in the minutes of the relevant meeting (i.e. Remuneration Committee, Nominations Committee, Council of Governors, Recruitment Panel).

5.4 Where the Trust considers that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence(s) to undertake the role within a specified timescale, any such discussions or recommendations will be recorded in the minutes of the relevant Committee. The expected competencies and the timescales for achievement will be agreed by the Committee and communicated to the individual. The Committee will then monitor progress at agreed intervals.

5.5 If the candidate has a physical or mental health disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to. Any prospective candidate will need to complete the 'Fit and Proper Person' Self-Attestation Form at Appendix A. In the event the prospective candidate identifies any physical or mental health concerns (and subject to further information being obtained from the candidate, if necessary) their appointment will be subject to clearance by Occupational Health as part of the pre-appointment process. Any discussion or decision as to whether a candidate is appointable on grounds of health will be recorded in the minutes of the relevant Committee.

6. ANNUAL REVIEW AND ONGOING FITNESS

6.1 The Trust is responsible for ensuring the continued 'fitness' of those persons to whom the Fit and Proper Persons Test applies (as detailed in paragraph 2.1). The Trust shall discharge this responsibility through an annual review process which will be aligned with appraisal dates to ensure that outcomes are available for reference at individual appraisals. Documentation will comprise of the following:

- completion of an annual self-attestation, the 'Fit and Proper Persons Self- Attestation Form' (Appendix A), by the persons covered by this policy
    - record of completed annual checks against the disqualified directors register, the bankruptcy and insolvency register, employment tribunal judgments, social media channels, the removed charity trustees register and relevant professional registers.
    - record of the last dated DBS check/update which must have been issued in the last three years. The level of the DBS check (basic, standard, or enhanced with barred lists) will be agreed with the recruiting manager and may vary across director roles.
    - The date of the last formal annual appraisal process by the relevant line manager will be recorded in line with the competency self-assessment as provided in the NHS England Leadership Competency Framework[1].

[1] https://www.england.nhs.uk/long-read/nhs-leadership-competency-framework-for-board-members/

6.2 The schedule for the annual checks, together with coordinating responsibility, is as follows:

Table 2

Check	Coordinated By	Timing
F&PP Self-Declaration Form	Corporate Governance Team	April
Insolvency, Bankruptcy & Disqualified Director Registers, Social Media Checks, Removed Charity Trustees, and Employment Tribunal Judgments	Corporate Governance Team	April
Annual Criminal Record Self-Declaration	People Services Team	April
Annual Appraisals in line with the Leadership Competency Framework domains	Director of Corporate Governance through liaison with Chair, Chief Executive and Senior Independent Director	April - September

6.3 Documentary evidence of the completion of annual checks will be retained in the files maintained by the Director of Corporate Governance. Where checks are undertaken using an electronic system, Insolvency Register checks for example, a 'screenshot' of the outcome of the check should be taken to provide documentary evidence of check completion.

6.4 For the purposes of clarity, annual checks will be undertaken for all individuals subject to this policy at the times set out in the schedule above, regardless of appointment date. For example, checks carried out for an individual appointed in November will be repeated in the following March/April of the following year.

6.5 All individuals covered by this policy are required to highlight to the Trust as soon as possible any reasons or changes in their circumstances that may mean they no longer meet the 2014 Regulations. This requirement is also detailed in the contract of employment for the posts covered by the 2014 Regulations.

6.6 The Director of Corporate Governance will ensure compliance through an annual audit of files and this will take place during Q1 of each financial year. The Corporate Governance Team will undertake the audit and report the findings.

6.7 Once the audit has been finalised, the Chair will make an annual statement of compliance on the Fit and Proper Persons Regulations in Q1 to the Board and Council of Governors.

6.8 In line with best practice the Trust will ask the internal auditor to undertake a review of the processes and systems of control for Fit and Proper Persons at least every three years.

6.9 the Fit and Proper Persons status of members of the Board of Directors is subject to review on appointment and on an annual and ongoing basis. The outcome of these reviews will be subject to:

- An annual report to the Council of Governors
- An annual report to the Board of Directors
- In respect to the Board of Directors, a signed attestation compliance by the chair to be submitted to the relevant regional director annually.

7 Managing an Unfit Outcome

7.1 At Appointment

If during pre-employment screening it emerges that the individual appears unlikely to meet the requirements of the Fit and Proper Person Test, then consideration should be given to withdrawing the offer of appointment/employment. The Chief People Officer, in conjunction with the recruiting manager, in discussion may consider if requests for further information from the individual are needed so as to make a fully informed decision**. I**f the individual fails to meet the Fit and Proper Persons Test requirements, the offer of appointment/employment should be withdrawn.

7.2 At Annual Review

7.2.1 Where concerns are raised relating to an individual being fit and proper to carry out their role, the Chair will address this in the most appropriate, relevant and proportionate way on a case by case basis. Where it is necessary to investigate or take action, the appropriate Trust policies and procedures will be utilised. For Non-Executive Directors, the Council of Governors' Nominations and Remuneration Committee will be notified.

7.2.2 Where an individual who is registered with a professional regulator (HCPC, GMC etc.) no longer meets the Fit and Proper Persons requirement, the Trust must inform the regulator and also take action to ensure the position is held by a person meeting the requirements. Professional regulators may remove an individual from a register for breaches of codes of conduct.

7.2.3 Directors may be personally subject to legal proceedings and, where the court finds proven serious misconduct of a type prescribed in legislation, may be found guilty of that misconduct. Directors must declare this to the Trust as their employer.

7.3 Failure to Complete the Checks

7.3.1 If, during the annual review process, aspects of the checks have not been completed or it has been found that the Trust has not complied with this policy, consideration should be given – based upon a risk assessment – as to whether or not the individual conducting the checks should be subject to any form of disciplinary action.

7.3.2 In these circumstances, the Chief People Officer will bring this matter to the attention of the Chair, Senior Independent Director or Chief Executive and the Director of Corporate Governance, who will agree the necessary actions. This will include ensuring all checks have been completed as required. The matter and outcome should be reported to the individual concerned, the Audit Committee, and

as part of the annual report to the Board of Directors and/or the Council of Governors.

7.3 Dispute Resolution

7.4.1 Where a director identifies an issue with data/information held about them in relation to the Fit and Proper Person Test, they may request a review of the checks which should be conducted in accordance with this policy in the first instance by the Chief Executive or Chair.

7.4.2 Where this does not lead to a satisfactory resolution for the director, the following options are available:

- For the Chair a second request for review can be made to the Senior Independent Director or Deputy Chair who would establish a process proportionate to the matter being considered; for example, establishing a panel with at least one independent member.
- For all other directors the options could include:
  - referring the matter to the Information Commissioner's Office
  - submitting a grievance (for executive director roles only)
  - taking the matter to an employment tribunal (for executive director roles only)
  - instigating civil proceedings.

7.4.3 NHS organisations may wish to take their own legal advice or seek advice from NHS England.

8. Personal Data

8.1 Personal data relating to the Fit and Proper Person Test assessment will be retained in local record systems and on the NHS Electronic Staff Record. This data will be retained beyond the individual leaving the Trust in line with local policies on the retention of HR data.

8.2 An annual submission form (Appendix C) will be generated for Chair sign off and submitted to the NHS England Regional Director, where the NHS England Fit and Proper Person test central team will collate records from NHSE regions.

8.3 Each director who is subject to the Fit and Proper Persons Framework will be provided with a privacy notice (Appendix E) describing how their data will be retained.

9. Fit and Proper Persons Reference Request

9.1 NHS organisations will need to request references (Appendix D), and store information relating to these references so that it is available for future checks; and use it to support the full Fit and Proper Person test assessment on initial appointment.

9.2 NHS organisations should maintain complete and accurate references at the point where the director departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and retained references should be kept locally on Electronic Staff Record**.**

9.3 References will apply as part of the Fit and Proper Person test assessment when there are new appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

- New appointments that have been promoted within an NHS organisation.
- Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
- Individuals who join an NHS organisation in an applicable role of for the first time from an organisation that is outside of the NHS.
- Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

10. Raising Concerns

10.1 Any member of staff who has concerns relating to a Director's ability to comply with the Fit and Proper Persons requirement should raise these concerns with the Director of Corporate Governance. Alternatively, individuals may follow the guidance set out in the Trust's Freedom to Speak Up Policy. In the case of referrals via the Freedom to Speak Up route, the Freedom to Speak Up Guardian should advise the Director of Corporate Governance accordingly whilst maintaining appropriate levels of confidentiality.

11. CONSULTATION

In developing this policy, the Trust has taken account of the 2014 Regulations, the 2023 NHS England Fit and Proper Person Test Framework for Board Members, guidance issued by the CQC, and discussions with professional bodies, including NHS Employers.

12. HUMAN RIGHTS ACT

Implications of the Human Rights Act have been considered in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

13. INCLUSION AND DIVERSITY

The document has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as we are aware, there is no impact on any protected characteristics.

14. MONITORING AND REVIEW

- This document will be reviewed every 3 years or as and when changes or legislation which affects the document are introduced.
- Where issues of concern are raised, an ad hoc report to either the Council of Governors or the Board of Directors (as appropriate) on the outcome of the review into the concern that had been raised.
- Where necessary, reports on non-compliance with this policy will be presented to the Audit Committee.

Table 3 - Monitoring Compliance

Appendix A FIT AND PROPER PERSON SELF-ATTESTATION
Fit and Proper Person Test annual/new starter self-attestation

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Fit and Proper Persons tests undertaken for newly appointed Directors	Director of Corporate Governance	Audit of personal files to ensure the pre-employment checks (including FPPT together with the leadership competency framework self-assessment) have been undertaken for all new Director appointees.	On appointment	Trust Chair / Chief Executive
Annual Fit and Proper Persons test declarations completed by existing Directors.	Director of Corporate Governance	Audit of personal files to ensure the annual fit and proper persons declarations and annual leadership competency self-assessment have been completed by existing Directors.	Annually	Trust Chair / Chief Executive

15. ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g., large print, Braille, and audio cd.
For more details, please contact translation.services@wwl.nhs.uk

I declare that I am a fit and proper person to carry out my role. I:

am of good character

have the qualifications, competence, skills and experience which are necessary for me to carry out my duties.

where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals.

am capable by reason of health of properly performing tasks which are intrinsic to the position.

am not prohibited from holding office (eg directors disqualification order)

within the last five years:

I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more.

been un-discharged bankrupt nor have been subject to bankruptcy restrictions or have made arrangement/compositions with creditors and has not discharged.

nor is on any 'barred' list.

have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the Chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of Director of Corporate Governance:	
Date of signature of Director of Corporate Governance:	
For Chair to complete	
Signature of Chair to confirm receipt:	
Date of signature of Chair:	

Appendix B Fit and Proper Persons Test Checks Summary

Director's fit and proper

person checks

Name of director:
Role:

Check undertaken	Result
Register of disqualified directors:	
Bankruptcy and insolvency register:	
Register of disqualified and removed charity trustees:	
General search of public information via internet search engine:	
Additional checks for posts where professional qualification is required to undertake the role or is otherwise held:	
Professional registration check:	
Check against fitness to practice register:	

Checks undertaken by:			
Signed:		**Date:**	
Checks reviewed by:			

APPENDIX C- Annual NHS Fit and Proper Persons Submission Reporting Template

Annual NHS Fit and Proper Person Test submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: Fit and Proper Person Test outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'No' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: Fit and Proper Person Test reviews / inspections

Use this section to record any reviews or inspections of the Fit and Proper Person Test process, including Care Quality Commission, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Care Quality Commission				
Other, e.g. internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [NAME OF TRUST] [YEAR]				
For the Senior Independent Director/Deputy Chair to complete:				
Fit and Proper Person Test for the Chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
For the chair to complete:				

Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the Fit and Proper Person Test being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
As Chair of [organisation], I declare that the Fit and Proper Person Test submission is complete, and the conclusion drawn is based on testing as detailed in the Fit and Proper Person Test framework.		
Chair signature:		
Chair signature:		
For the regional director to complete:		
Name:		
Signature:		
Date:		

Appendix D: Director's Fit and Proper Persons Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely
[Recruitment officer's name]

Board Member Reference request for NHS Applicants: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.	
1. Name of the applicant (1)	
2. National Insurance number or date of birth	
3. Please confirm employment start and termination dates in each previous role *A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)* *B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)*	

Job Title: From: To: Job Title From: To: Job Title: From: To: Job Title: From: To:
4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:

6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*

7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:

8. Confirmation of reason for leaving:

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)

Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation**	Yes □	No □

• **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		

If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:

14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable.
(Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)

Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix E: Template FPPT Privacy Notice

[organisation name] is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the FPPT.

The FPPT in ESR is commissioned by NHS England.

Contact: [name in organisation who leads on this, e.g. SIRO]
Address: [for the person or team above]
Phone Number [for the person or team above]
E-mail: [for the person or team above]

The type of personal information we collect is in relation to the FPPT for board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. Name, position title (unless this changes).
2. Employment history – This would include detail of all job titles, organisation, departments, dates, and role descriptions.
3. References.
4. Job description and person specification in their previous role.
5. Date of medical clearance.
6. Qualifications.
7. Record of training and development in application/CV.
8. Training and development in the last year.
9. Appraisal incorporating the leadership competency framework has been completed.
10. Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.
11. DBS status.
12. Registration/revalidation status where required.
13. Insolvency check.
14. A search of the Companies House register to ensure that no board member is disqualified as a director.
15. A search of the Charity Commission's register of removed trustees.
16. A check with the CQC, NHS England and relevant professional bodies where appropriate.
17. Social media check.
18. Employment tribunal judgement check.
19. Exit reference completed (where applicable).
20. Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements.

[If applicable] We may also receive personal information indirectly, from the following sources in the following scenarios:

- References when we have made a conditional offer to you.
- Publicly accessible registers and websites for our FPPT.
- Professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations.
- Regulatory bodies, e.g. CQC and NHS England.

We use the information that you have given us to:

- conclude whether or not you are fit and proper to carry out the role of board director
- inform the regulators of our assessment outcome.

We may share this information with NHS England, CQC, future employers (particularly where they themselves are subject to the FPP requirements), and professional bodies.

Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:

- We need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our policies and procedures [insert].

Your data protection rights

Under data protection law, you have rights including:

- Your right of access – You have the right to ask us for copies of your personal information.
- Your right to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
- Your right to erasure – You have the right to ask us to erase your personal information in certain circumstances.
- Your right to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances.
- Your right to object to processing – You have the right to object to the processing of your personal information in certain circumstances.
- Your right to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.
- You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at [insert email address, phone number and or postal address] if you wish to make a request.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at [Insert your organisation's contact details for data protection queries]. You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO's address

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Helpline number: 0303 123 1113 ICO website: https://www.ico.org.uk

Appendix F: Letter of Confirmation

The following wording is given as an example. It may not be applicable in every case and may consequently need addition or amendment. For example, a confirmation at the time of initial appointment may be different to the annual core testing.

[**LEAD EMPLOYING ORGANISATION**[2] **LETTERHEAD**] [**DATE**]

Dear [**CHAIR NAME**[3]],

Fit and Proper Person Test

This confirmation letter is provided in connection with [**name of board member, job title of board member, organisations that the joint board member post covers**] for [**year of test, eg 2023/24**] as at [**date of conclusion of annual**[4] **FPPT for the individual**] for the purpose of the Fit and Proper Person Test.

As Chair of [**lead employer**], I confirm that I have carried out the Fit and Proper Person Test for [**name of board member**].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [**name of board member**] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [**name of board member**] is fit and proper as at [**date of conclusion of test**], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely,

…….. (signature)

…….. (Chair of lead employer organisation)

Date……..

I confirm that I have received the outcome for the FPPT for [**name of board member**] and that I have provided any necessary information for you to reach this conclusion.

…….. (signature)

…….. (Chair of lead employer organisation)

Date…….

[2] This is the organisation which holds the contract/employs the board member who works jointly across more than one organisation.
[3] This is the name of the chair of the other organisation that the joint board appointment is made with.
[4] It should be noted that while there will be an annual assessment of being fit and proper, it is a pervasive and ongoing process at all times. Any relevant matter related to the board member being fit and proper should be reported as soon as it arises.

Appendix G CQC Regulations

1. The CQC has the right to require the provision of information set out in Schedule 3 of the 2014 Regulations and such other information as is kept by the organisation that is relevant to the individual as follows:

a) Proof of identity including a recent photograph

b) Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(38), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(39);

c) Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults;

d) Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to:
   - health or social care, or,
   - children or vulnerable adults;

e) Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended;

f) In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform;

g) A full employment history, together with a satisfactory written explanation of any gaps in employment;

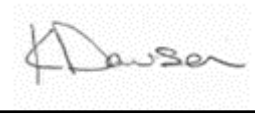
h) Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity;

i) For the purposes of this Schedule:

   i. The appointed day' means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;
   ii. 'Satisfactory' means satisfactory in the opinion of the CQC;
   iii. Suitability information relating to children or vulnerable adults' means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

Equality Impact Assessment Form - POLICY / GUIDELINES
STAGE 1 - INITIAL ASSESSMENT

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	**Sex** (assigned at birth) (male / female)	**Age** (18 years+)	**Race / Ethnicity**	**Disability** (hearing / visual / physical / LD / Neuro diverse / mental health)	**Religion / Belief**	**Sexual Orientation** (LGBTQIA+)	**Gender Re-Assignment** (trans / non-binary / gender fluid)	**Marriage / Civil Partnership**	**Pregnancy & Maternity**	**Carers**	**Other Group**	**List Negative / Positive Impacts Below**
Does the policy have the potential to affect individuals or communities differently in a negative way?	N	N	N	N	N	N	N	N	N	N	N	No negative differential impact has been identified. The policy applies consistently to all individuals in scope and includes reasonable adjustments where health or disability considerations arise.
Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The policy supports fair, transparent and consistent appointment, annual review, reasonable adjustment, escalation and assurance processes for all board-level roles. It promotes good governance, patient safety and equitable decision-making.
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	N	N	N	N	N	N	N	N	N	N	N	No further information is required at Stage 1. The policy should continue to be monitored through annual file audit, reporting to the Board/Council of Governors and review of any concerns, disputes or reasonable adjustment issues raised during implementation.

Job Title	Director of Corporate Governance	**Signed**		**Date**	23 September 2026

IF 'YES and NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via WWL Intranet - Equality Impact Assessments

Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an Equality Impact Assessment. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation

Appendix H
POLICY MONITORING AND REVIEW ARRANGEMENTS

Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
Please complete relevant to how you will monitor the policy						

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	9 September 2026
Chair:	Francine Thorpe

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

ALERT

Patient Flow, Capacity and Urgent Care Pressures

There were several interrelated reports concerning patient flow, prolonged waits, emergency department pressures and corridor care. Whilst substantial improvement activity is underway, risks remain associated with capacity pressures, delivery of interdependent improvement plans and the potential impact on patient safety and experience.

The Emergency Waiting Room Thematic Analysis in particular identified weaknesses in waiting room safety systems and the potential for harm associated with prolonged waits. Assurance was received regarding the quality of the review and the robustness of the resulting action plan and the Committee will maintain continued oversight of delivery of the nine recommendations to ensure sustained improvement.

Delivery of a number of Corridor Care actions remains outstanding and continued oversight is required to ensure progress is maintained.

Medicines & Healthcare products Regulatory Agency

Despite previous assurances that significant actions were required following the MHRA inspection, the latest update reported no substantive change in position. Members were not assured that sufficient progress is being made by the Northern Care Alliance to address outstanding actions and want to understand the implications of further delay (patient safety, regulatory or operational risks). An update has been requested for the next meeting, with revised timescales

ASSURE

Maternity and Neonatal Services

t Maternity and neonatal services remain safe, with stable outcomes, no maternity signals since November 2025, no maternal deaths and continued progress against Maternity Incentive Scheme requirements. Governance arrangements remain effective and work is underway to strengthen Board reporting and oversight. Workforce capacity remains the principal risk, with a Birthrate Plus review identifying a shortfall of 3.15 WTE midwives.

Patient Safety

The Patient Safety Incident Response Framework continues to operate effectively. providing oversight of investigations, thematic reviews and organisational learning. Continued work is

underway to strengthen the alignment between incident learning, quality improvement activity and workforce development.

C. difficile Improvement
The recent increase in C. difficile cases has been comprehensively reviewed, with no evidence of an outbreak identified. Comparative performance remains favourable against peer organisations and a targeted improvement plan is in place addressing antimicrobial stewardship, timely isolation, treatment and infection prevention measures.

Sepsis Improvement
Significant improvement achieved across key sepsis indicators and associated outcome measures over the previous 12 months. Continued focus will be maintained on sustaining performance improvements and embedding changes within routine practice.

CQC Section 29A Warning Notice
Improvement actions remain on track and are subject to robust executive oversight. Delivery remains aligned to wider urgent and emergency care improvement programmes.

ADVISE

National Oversight Framework
The Trust remains in Segment 3 of the National Oversight Framework, with Effectiveness and Experience of Care and People and Workforce remaining in Segment 4. Whilst improvement activity is expected to positively impact future performance, the Committee noted the need for continued focus on patient experience, workforce measures and reducing the number of patients who do not meet criteria to reside.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Workforce capacity in maternity remains a principal risk for the service.

HEALTH INEQUALITIES REFLECTIONS

- Maternity reporting highlighted work to improve outcomes for vulnerable and disadvantaged groups
- Smoking cessation, vaping and household smoking exposure during pregnancy were also considered, with further work planned to strengthen understanding of local population needs
- Discussions relating to patient flow, prolonged waits and corridor care recognised the disproportionate impact on frail and vulnerable patients

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	30 September 2026
Chair:	Julie Gill

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

ALERT
Breach of elective performance standards There continues to be a number of patients waiting over 52 weeks in addition to patients waiting over 65 weeks, and this has an impact on patient safety and satisfaction, as well as the associated financial impact arising from under-delivery of planned elective activity. **Finance recovery and CIP** The financial position is deteriorating, with a significant risk to delivery of the financial plan, and concerns regarding the pace of recurrent CIP and transformation benefits delivery noted. Assumptions underpinning the recovery plan have become more fragile, particularly with regard to transformation, and there was discussion regarding potential external scrutiny and intervention.
ASSURE
Digital Strategy Assurance was given regarding progress in implementing the including maintenance of DSPT compliance, delivery of the Better-Connected programme, deployment of Federated Data Platform products and development of automation and AI initiatives. Prioritisation arrangements for digital developments are subject to a structured governance process incorporating operational, clinical and risk considerations. Some more positive performance and the progress has been achieved in community services and in the neuro developmental pathway for children and young people. **Corporate transformation** Governance arrangements are in place to oversee delivery of the full portfolio of transformation programmes and monitor achievement of intended benefits. Whilst programmes have been assigned to the People and Quality & Safety committees, this Committee need to maintain an oversight of the aggregate impact of transformation activity across the organisation. **Backlog maintenance** The Committee approved submission of the Premises Assurance Model on the Board's behalf - backlog maintenance levels remain stable and that actions are in place to address significant-risk backlog items within the estate. **Financial recovery** A recovery plan is in place, supported by enhanced controls, accelerated turnaround support and increased executive oversight. Members robustly considered the financial sustainability risk score and agreed to retain it recognising the mitigations in place.

ADVISE

Turnaround support - **Start Well and Planned Care division**
External support has been commissioned to accelerate delivery of the Trust recovery plans - members were assured regarding governance arrangements, ongoing executive oversight and monitoring of benefits realisation.

Cash position
The Trust is not currently forecast to require cash support during 2026/27 but that cash support may be required during the early part of 2027/28 and that a Cash Management Group has been established to strengthen oversight and monitoring of the Trust's cash position.

Business cases endorsed for the Board's approval:

- Virtualisation Infrastructure refresh business case - with assurance that the investment is required to replace end-of-life infrastructure supporting core clinical and digital services.
- Network Infrastructure refresh to maintain digital resilience
- Diagnostic Hub cost variation business case for onward submission - with assurance regarding the strategic benefits of the scheme, the rationale for the cost increase and the management of the associated capital implications.

Greater Manchester Procurement
The collaborative model will not proceed in its current form due to challenges in achieving collective agreement. Alternative partnership and collaboration opportunities will continue to be explored and noted that a further report will be presented to Board in October.

Urgent care
There are continued pressures impacting urgent care performance, including the impact of increased demand and flow constraints; positive improvements being realised through front-door transformation initiatives, including urgent treatment centre streaming, urgent community response, CAT and frailty services; and that delivery of the Better Lives transformation programme remains critical to achieving improvements in urgent care performance and readiness for winter.

Elective recovery
Delivery of the elective recovery programme, including turnaround support and transformation activity, remains critical to improving performance and achieving financial recovery objectives. The total number of patients on the RTT waiting list remains materially above the plan at 46324 when the planned position is 40343.

Corridor care
Delivery of the remaining actions at pace is essential ahead of winter and that the Committee will continue to monitor progress through future reports.

Corporate transformation
Oversight of transformation programmes should be strengthened, including clearer reporting of delivery milestones, benefits realisation and the cumulative financial impact across all programmes. A tracker will be shared with the Committee each month, with the option of holding an additional Committee meeting available should the information give members sufficient cause for concern.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

A new risk relating to cyber security and digital resilience was added to the board assurance framework, with elements of the risk controls and board education around this to be strengthened moving forwards.

HEALTH INEQUALITIES REFLECTIONS

The Committee considered equality, diversity and inclusion implications of long waits and access challenges for vulnerable patient groups and the importance of ensuring these considerations remain visible within recovery planning and reporting.

Agenda item:

Committee report

Report from:	People Committee
Date of meeting:	15 September 2026
Chair:	Mr M Wilkinson

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

ALERT

Board Assurance Framework
Freedom to Speak Up reporting arrangements do not currently provide the level of assurance expected by the Committee. Work is underway to strengthen reporting and oversight arrangements by the Committee and also the Board.

People Dashboard
Sickness absence remains above target and appraisal compliance remains below the Trust target and worsening. Improvement activity is underway, however the Committee agreed these areas require continued Board visibility.

Professional Standards Concerns
Strengthened governance and oversight arrangements are resulting in increased visibility and reporting of professional standards concerns. This may initially lead to an increase in matters managed through formal processes as organisational controls and scrutiny mature.

ASSURE

Learning Review: Sexual Misconduct Cases

- The Committee received the findings of the independent review and took assurance that significant actions have already been implemented to strengthen governance, oversight and management of sexual misconduct concerns.
- Organisational learning is being embedded and strengthened arrangements are already influencing case management and decision-making.

Resident Doctors 10-Point Plan

- Robust governance arrangements remain in place, with the majority of assurance standards now rated compliant and improvement activity continuing in the remaining areas.

NHS England Workforce Race Equality Standard (WRES) and Disability Standard (WDES)

- The Committee received assurance regarding the arrangements in place to oversee workforce equality improvements and support delivery of the associated action plan.

ADVISE

Chief People Officer Update

The Committee agreed to advise the Board of:

- Strong participation in the national Band 5 job evaluation review.
- The establishment of the Executive-led Non-Medical Staff Conduct, Capability and Professional Practice Panel.
- The direct submission of the Greater Manchester Recruitment Hub business case to Board instead of the People Committee due to decision making timescales.
- The forthcoming NHS England Board Succession Planning submission due by 31 December 2026.

People Dashboard

Work is underway to review the People Dashboard and strengthen alignment with the revised Board Assurance Framework. The Committee will also monitor the impact of implementation of the Greater Manchester Recruitment Hub on workforce performance metrics including 'time to hire' where we are currently seeing performance deterioration

Lord John Mann Review

Work is underway to respond to the review findings and a deeper review of workforce equality and inclusion matters will be undertaken later in the year. The Committee would propose to the Board that it approves anti-racism statements.

Equality, Diversity and Inclusion

The Committee reflected on the need to strengthen future scrutiny of workforce equality indicators, health inequalities and lived experience data and agreed this should be highlighted to the Board.

Delayed updates to note:

- The GM Recruitment Hub update was not considered by People Committee due to programme timescales and the need to take the business case directly to Board (once it is ready).
- The GMC Survey was deferred as key leads were unavailable and further external review/feedback from the Deanery was still pending. The Committee was advised that there was no detriment from this delay
- A Guardian of Safe Working Hours deep dive was discussed following a discussion at teh Board's previously meeting and it was agreed that this would be provided in November.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Due to the interim arrangements in place the Committee has not received the scheduled report from the Freedom to Speak Up Guardian since April 2026. This is a risk for the Board in ensuring the effectiveness of this service. A report is being sought for the Board meeting in October ahead of a new contract being agreed.

HEALTH INEQUALITIES REFLECTIONS

- Workforce equality considerations featured throughout the meeting, including the WRES, WDES and Lord John Mann Review reports.
- Members recognised that the revised People BAF now explicitly incorporates the Trust's role as an Anchor Institution and contribution to addressing health inequalities.

- The Committee reflected on the opportunity to strengthen future scrutiny of workforce equality indicators and lived experience data.
- Members also discussed how diverse workforce voices could be brought into future Committee discussions to strengthen assurance and challenge.

Committee report

Report from:	Audit Committee
Date of meeting:	22 September 2026
Chair:	Simon Holden

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

ALERT

- The Trust continues to experience a small number of reportable information breaches, including unauthorised access to health records, which remain a concern.
- An audit of compliance with the Working Time Directive has received Limited Assurance from MIAA, an action plan is in place to remedy with further review by the People Committee.
- There is still an outstanding high risk audit recommendation from 2025/26 on medical job planning, although work is in progress to remedy.
- There are 2 high risks (15+) on the risk register relating to patients (namely point of care testing and ante natal drug access) where risk scores have remained high for over 6 months and there are outstanding actions which are now overdue. These risks were discussed at the RMG in September and actions are being progressed through the Divisional Risk Groups.

ASSURE

- The Audit Committee received the standing financial instructions (SFIs), as part of their annual review, and supported the inclusion of a new section (12.10 to 12.17) on redundancy, severance & other exit payments. These updated SFIs are recommended to the full Board for approval.
- The review of waiting list management (excluding cancer care) by MIAA has received moderate assurance.
- The review of the Cyber Assessment Framework (CAF) aligned with the Data Security & Protection Toolkit, assessed the risk as low with high confidence in the controls with no recommendations. This is a significant achievement and unusual for providers, although the Trust does need to guard against complacency as this remains a high-risk area.
- The Committee received an update from the counter fraud service on the proactive, & reactive, work currently ongoing
- The Committee also reviewed, and approved, the trust wide risk assessment of counter fraud, and specifically the measures in place relating to the “failure to prevent fraud” offence.
- The annual report from the Senior Information Risk Owner, outlining the ongoing work on information governance & cyber security, was received. A challenge regarding increasing numbers of Subject Access Requests was noted.
- The Committee received/agreed the Audit Committee annual effectiveness review and agreed the terms of reference subject to approval by the Board.

ADVISE
• As identified through the MIAA internal audit on waiting lists, there is a low risk of patients whereby patients on the e referral system could lose their “slot” if they have not proactively booked with Trust within a 180-day period. A remedy to this situation is being sought through the recommendations in the waiting list validation internal audit report. • Losses & special payments, for April to August (5 months) have reduced in both value & volume, although GDPR claims are consistently being received. • There were 22 financail waivers for the April to August period totalling £1.1m, with none being retrospective or unsupported (noting 2 waivers combined totalled £0.5m, with further action suggested). • Digital, digital security & AI have all been a thread running through this quarter’s Audit Committee and this highlights both their increasing importance, but also the increasing risk.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• Nothing in addition.

Committee report

Report from:	Research Committee
Date of meeting:	1 September 2026
Chair:	Professor Dame Robina Shah

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

ALERT

Workforce Capacity and Protected Research Time

Ongoing workforce and clinical capacity pressures that continue to limit opportunities for staff to participate in research activity. Work is underway to strengthen arrangements for protected research time, including an executive decision to support research through programmed activity for doctors. Capacity constraints however remain a risk to sustaining and expanding research activity across the organisation, with 32 out of 45 commercial expressions of interest turned down in Q1 due to clinical capacity limits and a lack of available doctors to lead them.

Education and Training Governance

Further governance development is required to support the proposed inclusion of education and training responsibilities within the Committee's remit. Consideration is needed regarding reporting arrangements, assurance mechanisms and alignment with other committees to ensure effective oversight. Further work to be conducted on Terms of Reference before being recommended for approval to the Board of Directors.

Institutional Review Group (IRG)

A critical gap in the lower-level assurance chain - IRG has suffered from recurring quorum failures. internal capacity constraints are directly causing the Trust to decline commercial research opportunities, as seen in Q1 where 32 out of 45 commercial expressions of interest were turned down due to clinical capacity limits and a lack of available doctors to lead them.

ASSURE

Research Champion's presentation

The Committee was assured regarding the strength of the Trust's research culture, driven by the expansion of the workforce to 66 active Research Champions and 100 staff members engaged in the Research Incubator

Research Activity, Strategy and Culture

Strength of the Trust's research culture, engagement across professional groups and ongoing progress in developing the refreshed Research Strategy were evidenced through papers and discussions. Continued growth in research participation and strong multidisciplinary engagement demonstrated, whilst recognising the importance of evidencing research impact and implementation into practice.

Research Assurance and Reporting

Agreed future reporting should evolve to provide a stronger balance between performance data, insight and narrative. Mechanisms exist to monitor research performance, but further refinement of assurance reporting required to increase focus on impact, strategic priorities and emerging risks. Headline recruitment totals currently create a risk of false reassurance, as Q1 performance is heavily reliant on a few high-volume studies (e.g., Surgery over-performing while Medicine and Dermatology lag). Reporting will be refined to better track specialty breadth and active PIs.

Clinical Audit

Effective clinical audit arrangements in place with a significant volume of audit activity undertaken. The AMaT platform was noted as a robust tool for tracking clinical improvements and examples of where audit findings had led to improvements in practice, patient safety and clinical outcomes were given.

National Oversight Framework

The Committee was assured that mechanisms are being established to track the new National Oversight Framework metric requiring 80% of clinical trials to recruit their first participant within 90 days – there is a need to track this using exact numbers and failure causes, not just general percentages

ADVISE

Research Strategy Refresh

Greater emphasis required on: demonstrating the impact of research on patient care and outcomes; knowledge mobilisation and implementation of research findings into practice; patient and public involvement, particularly engagement with groups whose voices are less frequently heard and alignment with the Trust's wider strategic objectives and University Hospital ambitions.

University Hospital Application

Recommended that the mid-November submission date must be revised to a more realistic timeframe. Given that the overall application is only 65% complete—with severe material evidence gaps remaining in Research Activity/Impact (15%) and University Partnership working (45%) – the Committee decided that the submission should only proceed when the Trust is entirely confident it can fully evidence all required criteria.

Committee Effectiveness Review

Results indicate that the Committee is strong in engagement, enthusiasm and discussion, but needs to mature further as an assurance committee, with greater focus on strategic oversight, risks, action follow-up and assurance reporting. The Committee requires an explicit BAF mandate. Rather than simply noting the corporate BAF as a whole, a map of the specific strategic risks the Committee is delegated to assure on behalf of the Board (such as corporate risk PR8/CO8) must directly drive the future Committee workplan. Principle of bringing clinical education and training oversight into the Committee's remit supported, whilst emphasising the need to maintain a strong focus on research.

Some concerns regarding attendance noted. Attendance, engagement and assurance pathways will be reviewed as part of review of Terms of Reference to ensure robust governance and escalation processes.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

On review of the draft report, it was requested that future reporting explicitly separate achievements from live risks and control gaps, ensuring the IRG attendance challenges and external staff funding arrangements are accurately captured

HEALTH INEQUALITIES REFLECTIONS
The Committee supported the proposed inclusion within the refreshed Research Strategy of a stronger focus on resident-centred research, neighbourhood health needs and community engagement. Members highlighted the importance of ensuring that research activity reflects population need and that more inclusive approaches are developed to engage communities whose voices are currently underrepresented in research and service development activities.

Title of report:	M05 26/27 Integrated Performance Report
Presented to:	Board of Directors
On:	07th October 2026
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 M5 August 26, 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 26/27. 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.

At Month 5, the Trust continues to demonstrate resilience and some strong quality outcomes, but the overall position is increasingly constrained by the interaction between operational demand, workforce capacity and financial recovery. Mortality remains within expected levels, pressure-ulcer rates have maintained reductions, and complaints timeliness has improved to 93.76%; however, maternity indicators and healthcare-associated infections require continued oversight.

Urgent and emergency care pressures are affecting the whole hospital pathway. Four-hour performance reduced to 72.2%, while 12-hour waits increased to 17.3%, driven by rising demand, evening and overnight capacity gaps, and delays in patient flow. These pressures increase reliance on corridor care and create potential risks to patient experience, safety and staff wellbeing. The Index of Disparity also indicates that long A&E waits disproportionately affect older patients, reinforcing the importance of admission-avoidance initiatives such as the Call Before Convey and Care Home pilot.

Similar capacity constraints are affecting planned care. Although the proportion of patients waiting under 18 weeks has improved, there are 52 patients who have been waiting over 65 weeks, overall waiting list size is increasing, cancer 31- and 62-day standards are below target, and elements of diagnostic compliance remain challenged. Theatre staffing, diagnostic delays, histopathology turnaround and MDT capacity are common dependencies across elective and cancer recovery.

Workforce performance is therefore both a risk in its own right and a key constraint on recovery. Concerns regarding appraisal compliance, sickness levels, high turnover rate and time to hire

timeframes; at the same time, a further 245.7 WTE reduction is required by March 2027. This creates a significant delivery tension: workforce reductions and variable-pay controls must be achieved without worsening clinical capacity, staff wellbeing or service performance.

Gram-negative bloodstream infections require strengthened attention: E. coli increased to nine cases and Klebsiella to four, with rolling 12-month positions above their respective annual thresholds. Limited microbiology and infection-prevention capacity is constraining detailed analysis and the development of robust post-infection reviews.

Financial delivery is the principal strategic risk and is closely linked to these operational challenges. The Trust reported a £7.4 million deficit, £3.9 million adverse to plan, with elective income, recurrent cost improvement and reductions in bank and agency expenditure behind trajectory; cash reduced to £18.6 million. Delayed elective recovery restricts income, while urgent-care pressure and workforce gaps increase premium staffing and reduce productivity, creating a reinforcing cycle between operational and financial underperformance.

The immediate priority is to convert existing improvement activity into measurable, recurrent benefit. This requires coordinated delivery of ED escalation arrangements, length-of-stay reductions, the Acute Medical Offer, elective and cancer recovery plans, workforce retention and absence actions, and recurrent savings schemes. Board oversight will focus on whether these actions collectively improve flow and productivity while protecting quality, reducing inequalities and maintaining safe staffing.

The Integrated Performance Report (IPR) provides an important retrospective view of organisational performance. Over the coming months, we intend to supplement this with a concise forward-looking report describing the most significant improvement activity underway to address the key issues highlighted within the IPR. This will draw on a combination of Trust-wide transformation programmes, National Oversight Framework (NOF) improvement plans and divisional recovery activity, providing the Board with greater visibility of how the organisation is responding to areas of challenge rather than simply reporting performance outcomes. The intention is not to duplicate existing programme reporting arrangements, but to provide a clear line of sight between the issues highlighted in the IPR and the improvement actions being prioritised by the Trust.

Whilst this will require further design work, this month we have included a small number of illustrative examples from the Trust's major transformation programmes that directly support the priorities and challenges identified within the IPR.

The Better Lives programme continues to focus on improving patient flow and reducing pressure across urgent and emergency care pathways. Current priorities include implementation of the Acute Medical Offer (ensuring patients receive timely assessment in the right place, by the most appropriate clinician), further development of admission avoidance pathways such as Call Before Convey and the Enhanced Care Home offer and continued focus on reducing length of stay through improved flow processes and discharge arrangements. These initiatives are intended to support improvements in four-hour and twelve-hour performance, reduce corridor care and create opportunities to reduce the costs associated with operating additional capacity across the hospital.

The Better Access outpatient redesign programme is focused on reducing avoidable demand and making better use of existing capacity. Priority work includes implementation of a Single Point of Access model across outpatient specialties, with ten specialties expected to go live in October. This will help ensure that patients receive the right care and advice first time, whilst reducing unnecessary outpatient attendances. The programme is also focused on improving clinic utilisation and increasing adoption of Patient Initiated Follow Up pathways, supported by the rollout of digital and AI-enabled solutions. Collectively these initiatives are intended to support elective recovery, reduce unnecessary follow-up activity and improve access for patients waiting for care. They also support the Trust's financial recovery by increasing activity delivered through core capacity, reducing reliance on waiting list initiative activity and improving outpatient productivity.

Alongside this, the Better Pathways cancer transformation programme continues to focus on pathway redesign within Breast, Colorectal and Upper GI services. Recent work has strengthened patient tracking arrangements, improved pathway oversight and initiated redesign of triage, booking and step-down processes, supported by the development of enhanced digital reporting tools. This work is intended to improve compliance with cancer waiting time standards and address known constraints within diagnostics, pathology and treatment pathways.

Further development of this section will be undertaken over the coming months to ensure future Board reports provide a more systematic and integrated view of the improvement work being undertaken across the organisation in response to the performance challenges highlighted within the IPR.

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?

ETM 24.9.26.

Recommendation(s)

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

Report

Please see the attached M05 26/27 IPR report.

Appendices
None.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

M05 26/27 Integrated Performance Report

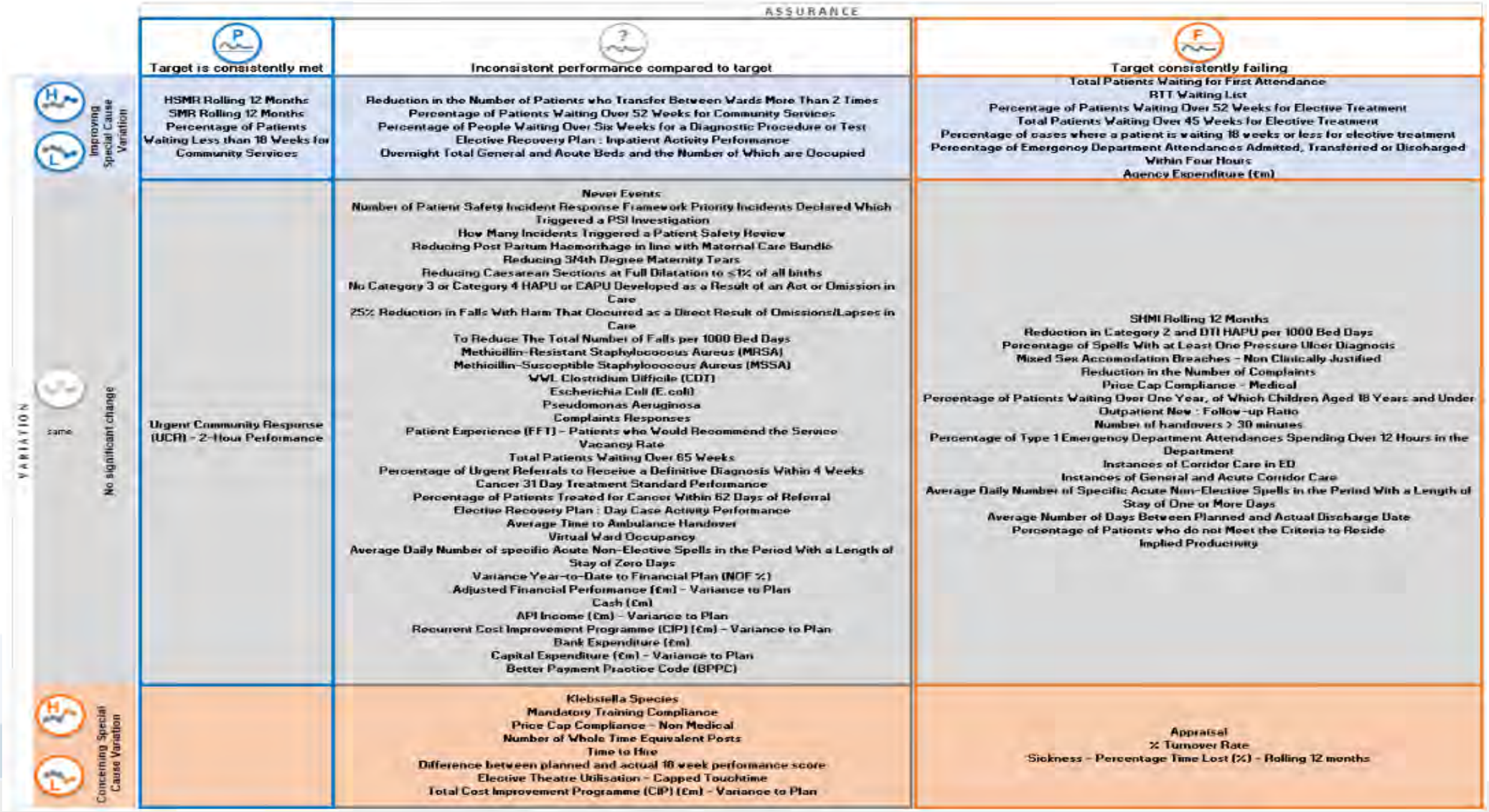
Meeting presented to:

Board of Directors : 7/10/26

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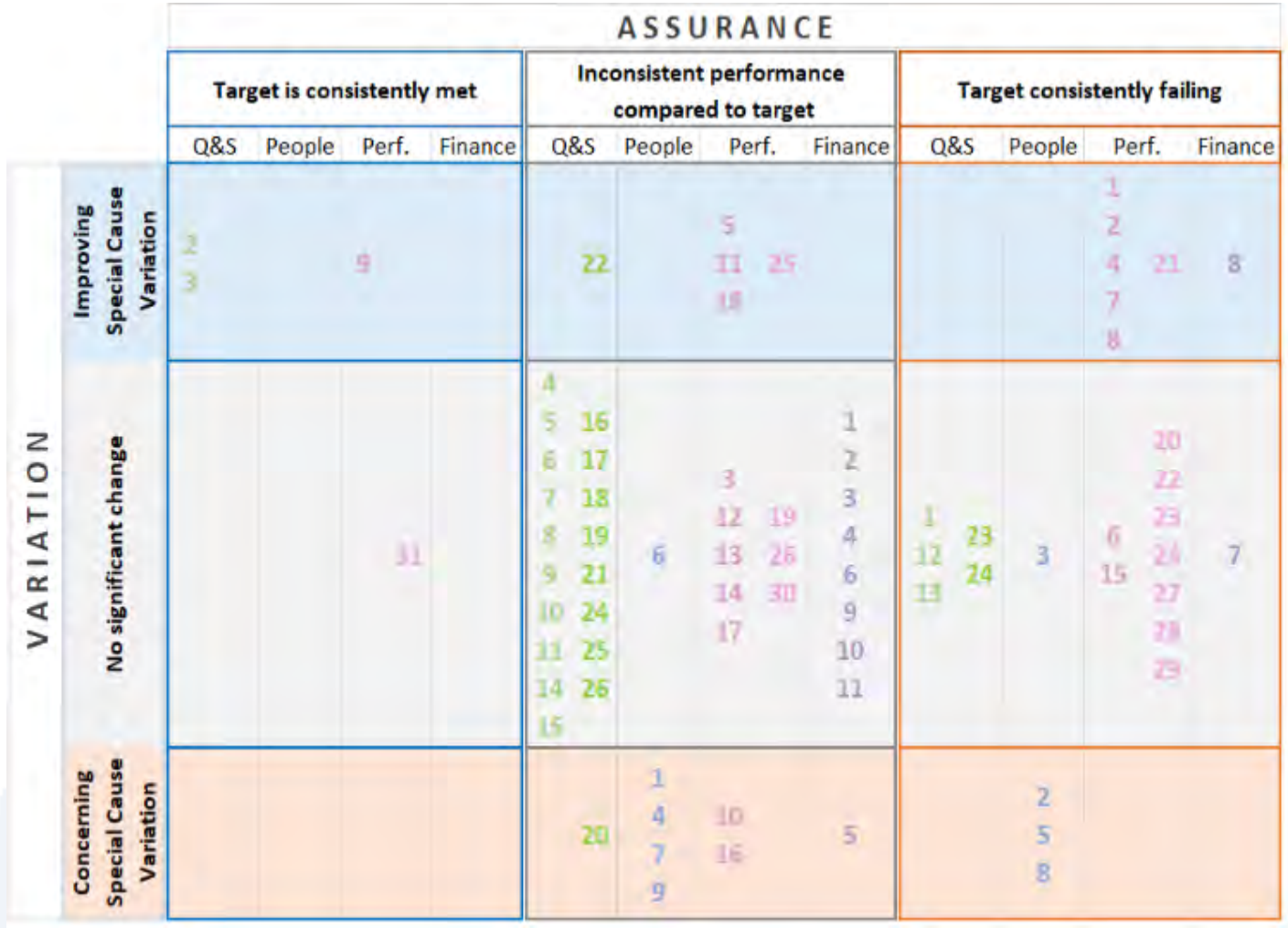
- Integrated Performance Report Summary Matrix
- Integrated Performance Report Overview Matrix
- Statistical Process Control (SPC) introduction
- DQ Framework Overview
- Index of Disparity overview
- Index of Disparity update
- M05 Trust Holistic Commentary
- Quality & Safety Overview 1 of 2
- Quality & Safety Insight Report 1 of 2
- Quality & Safety Overview 2 of 2
- Quality & Safety Insight Report 2 of 2
- Quality & Safety Commentary
- People Overview
- People Insight Report
- People Commentary
- Elective Care -Performance Overview
- Elective Care - Performance Insight report
- Elective Care - Performance Commentary
- Urgent Care -Performance Overview
- Urgent Care - Performance Insight report
- Urgent Care - Performance Commentary
- Finance Overview
- Finance Insight Report
- Finance Commentary

Trust Matrix : M05 26/27



VARIATION	ASSURANCE: Target is consistently met	ASSURANCE: Inconsistent performance compared to target	ASSURANCE: Target consistently failing
Improving Special Cause Variation	HSMR Rolling 12 Months SMR Rolling 12 Months Percentage of Patients Waiting Less than 18 Weeks for Community Services	Reduction in the Number of Patients who Transfer Between Wards More Than 2 Times Percentage of Patients Waiting Over 52 Weeks for Community Services Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test Elective Recovery Plan : Inpatient Activity Performance Overnight Total General and Acute Beds and the Number of Which are Occupied	Total Patients Waiting for First Attendance RTT Waiting List Percentage of Patients Waiting Over 52 Weeks for Elective Treatment Total Patients Waiting Over 45 Weeks for Elective Treatment Percentage of cases where a patient is waiting 18 weeks or less for elective treatment Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours Agency Expenditure (£m)
No significant change (same)	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 Reducing Post Partum Haemorrhage in line with Maternal Care Bundle Reducing 3/4th Degree Maternity Tears Reducing Caesarean Sections at Full Dilatation to ≤1% of all births 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/Lapses in Care To Reduce The Total Number of Falls per 1000 Bed Days Methicillin-Resistant Staphylococcus Aureus (MRSA) Methicillin-Susceptible Staphylococcus Aureus (MSSA) WVL Clostridium Difficile (CDT) Escherichia Coli (E.coli) Pseudomonas Aeruginosa Complaints Responses Patient Experience (FFT) – Patients who Would Recommend the Service Vacancy Rate Total Patients Waiting Over 65 Weeks Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks Cancer 31 Day Treatment Standard Performance Percentage of Patients Treated for Cancer Within 62 Days of Referral Elective Recovery Plan : Day Case Activity Performance Average Time to Ambulance Handover Virtual Ward Occupancy Average Daily 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 2) Adjusted Financial Performance (£m) - Variance to Plan Cash (£m) API Income (£m) - Variance to Plan Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan Bank Expenditure (£m) Capital Expenditure (£m) - Variance to Plan Better Payment Practice Code (BPPC)	SHMI Rolling 12 Months Reduction in Category 2 and DTI HAPU per 1000 Bed Days Percentage of Spells With at Least One Pressure Ulcer Diagnosis Mixed Sex Accommodation Breaches - Non Clinically Justified Reduction in the Number of Complaints Price Cap Compliance - Medical Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under Outpatient New : Follow-up Ratio Number of handovers > 30 minutes Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department Instances of Corridor Care in ED Instances of General and Acute Corridor Care Average Daily Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days Average Number of Days Between Planned and Actual Discharge Date Percentage of Patients who do not Meet the Criteria to Reside Implied Productivity
Concerning Special Cause Variation		Klebsiella Species Mandatory Training Compliance Price Cap Compliance - Non Medical Number of Whole Time Equivalent Posts Time to Hire Difference between planned and actual 18 week performance score Elective Theatre Utilisation - Capped Touchtime Total Cost Improvement Programme (CIP) (£m) - Variance to Plan	Appraisal % Turnover Rate Sickness - Percentage Time Lost (%) - Rolling 12 months

Trust Matrix: M05 26/27



	Q&S-1
1	SHMI Rolling 12 Months
2	HSMR Rolling 12 Months
3	SMR Rolling 12 Months
4	Never Events
5	Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation
6	How Many Incidents Triggered a Patient Safety Review
7	Reducing Post Partum Haemorrhage in line with Maternal Care Bundle
8	Reducing 3/4th Degree Maternity Tears
9	Reducing Caesarean Sections at Full Dilatation to ≤1% of all births
10	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care
11	Reduction in Category 2 and DTI CAPU per 1000 DN Contacts
12	Reduction in Category 2 and DTI HAPU per 1000 Bed Days
13	Percentage of spells with at least one pressure ulcer diagnosis (L89)
14	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care
15	To reduce the total number of falls per 1000 bed days
	Q&S-2
16	Methicillin-Resistant Staphylococcus Aureus (MRSA)
17	Methicillin-Susceptible Staphylococcus Aureus (MSSA)
18	WWL Clostridium Difficile (CDT)
19	Escherichia Coli (E.coli)
20	Klebsiella Species
21	Pseudomonas Aeruginosa
22	Reduction in the Number of Patients who Transfer Between Wards More Than 2 Times
23	Mixed Sex Accomodation Breaches - Non Clinically Justified
24	Reduction in the Number of Complaints
25	Complaints Responses
26	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

	Start Well & Planned Care
1	Total Patients Waiting for First Attendance
2	RTT Waiting List
3	Total Patients Waiting Over 65 Weeks
4	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment
5	Percentage of Patients Waiting Over 52 Weeks for Community Services
6	Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under
7	Total Patients Waiting Over 45 Weeks for Elective Treatment
8	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment
9	Percentage of Patients Waiting Over 18 Weeks for Community Services
10	Difference between planned and actual 18 week performance score
11	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test
12	Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks
13	Cancer 31 Day Treatment Standard Performance
14	Percentage of Patients Treated for Cancer Within 62 Days of Referral
15	Outpatient New : Follow-up Ratio
16	Elective Theatre Utilisation - Capped Touchtime
17	Elective Recovery Plan : Day Case Activity Performance
18	Elective Recovery Plan : Inpatient Activity Performance
	Live Well & Urgent Care
19	Average Time to Ambulance Handover
20	Number of handovers > 30 minutes
21	Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours
22	Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department
23	Instances of corridor care in ED
24	Instances of general and acute corridor care
25	Overnight Total General and Acute Beds and the Number of Which are Occupied
26	Virtual Ward Occupancy
27	Average Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days
28	Average Number of Days Between Planned and Actual Discharge Date
29	Percentage of Patients who do not Meet the Criteria to Reside
30	Average Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days
31	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	Implied Productivity
8	Agency Expenditure (£m)
9	Bank Expenditure (£m)
10	Capital Expenditure (£m) - Variance to Plan
11	Better Payment Practice Code (BPPC)

Using Statistical Process Control (SPC) Charts

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

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

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

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

NHS England's SPC Icons



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	

The Index of Disparity

What is the Index of Disparity (IoD)?

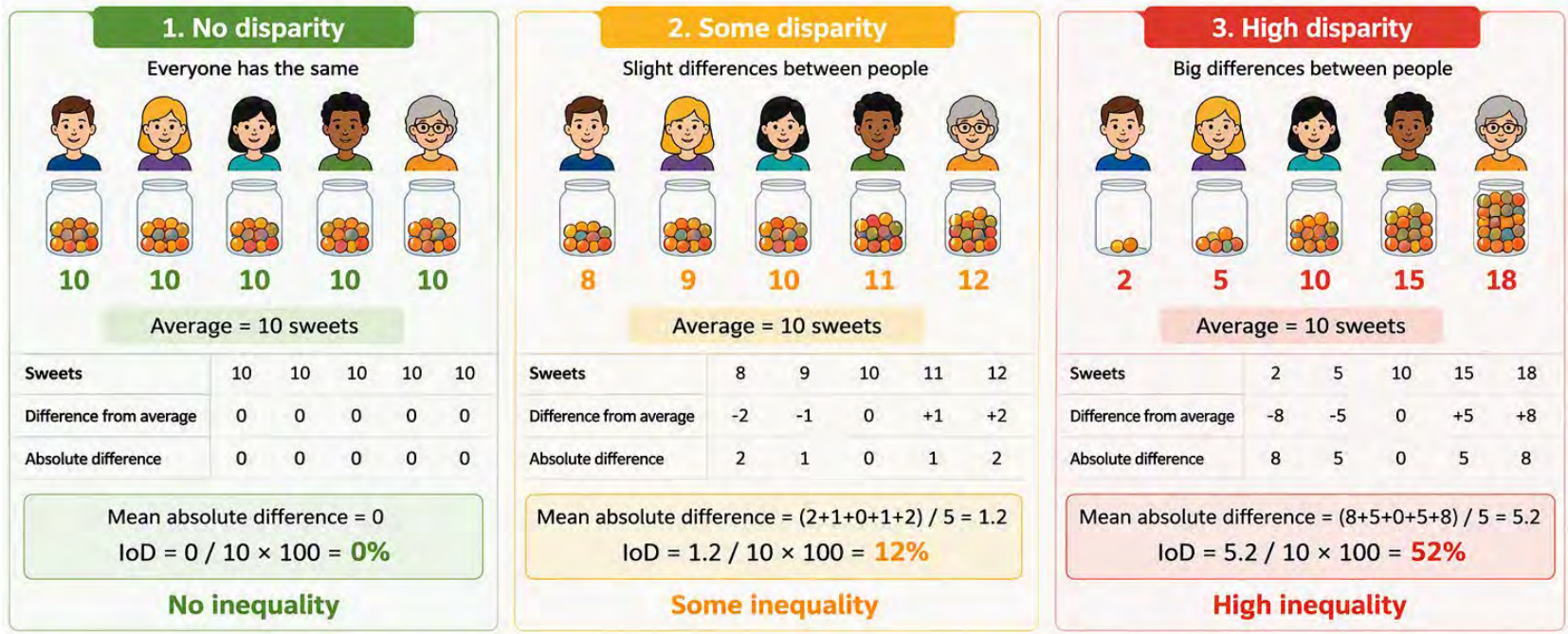
The Index of Disparity (IoD) is a summary measure used to quantify relative inequality across multiple groups for a given indicator. It measures how much each demographic group (IMD quintiles, age groups, ethnicity groups or sex) differs from the overall average performance. A higher score indicates greater inequality between groups, while a lower score indicates less inequality.

To illustrate how the Index of Disparity works, imagine five people each have a bag of sweets. If the average number of sweets is 10, the Index of Disparity measures how far each person's number of sweets differs from the average.

If all five people have 10 sweets, this would indicate no inequality and the Index of Disparity would be **0%.**

However, if some people have more than 10 sweets and others have fewer, the disparity increases. The greater the differences from the average (in this case 10 sweets), the higher the Index of Disparity.

As a new methodology within the Trust, the IoD should be interpreted carefully while we build understanding of its application, usability and limitations. Results should be considered alongside supporting intelligence and local context and used to inform further investigation where appropriate.



Key points

- IoD looks at the average difference from the average.
- It does not matter if some are above or below the average – only how far away they are.
- The higher the IoD percentage, the greater the inequality.

The formula

$$\text{Index of Disparity (IoD)} = \frac{\text{Sum of absolute differences}}{\text{Number of people} \times \text{Average}} \times 100$$

where Average = (Total sweets) / (Number of people)

Why incorporate IoD to the IPR?

Incorporating the IoD where possible into the IPR allows us to interrogate the possibility of demographic disparities, or healthcare inequalities, influencing the performance of our indicators. Some indicators will be more impacted by the demographics of our patients than others, and surfacing this allows us to interrogate and take appropriate actions to tackle any inequalities that may exist across our services. By reviewing the IoD over time, we can monitor trends and progress.

The Index of Disparity:

This quarter's update focuses on the KPIs in the Live Well and Urgent Care section of the report. The schedule for updates on IoD in 26/27 can be seen below

Index of Disparity Update Schedule	Reporting Quarter	Reported in
Live Well & Urgent Care Performance	2026/27 Q1	Aug-26
Start Well & Planned Care Performance	2026/27 Q2	Nov-26
Quality & Safety KPIs	2026/27 Q3	Feb-27
General IoD Update & Areas of Interest	2026/27 Q4	May-27

The table below outlines the Index of Disparity for these indicators whilst also displaying the disparity for the four contributing groups. It also highlights the largest overall contributor for each KPI. The overall Index of Disparity can be seen adjacent to the performance numbers on slide 21.

You can see that age tends to be the largest contributing factor to IoD for the Live Well & Urgent Care Metrics. IMD Quintile & Sex, have relatively little disparity across all the KPIs. Urgent Community Response shows Ethnicity as the largest contributor, and generally Ethnicity shows a lot of variation across the different metrics. However, it is important to note that this can easily be influenced by small sample sizes.

The indicator with the largest IoD is A&E 12-Hours, which shows an IoD of **30.8%** or (0.31), and an age disparity of **74.1%**. Whilst this may be somewhat expected due to the cohort of patients that often populate this metric.

Urgent Community Response has the least disparity across the indicators, shows a relatively small IoD of **3%.**

			Contributing Demographics				
Metric Name	Latest Quarter	Total IoD	IMD Quintile (Deprivation)	Age	Ethnicity	Sex	Largest Contributor
Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within	2026/27 Q1	**4.5%**	1.1%	12.8%	3.7%	0.5%	Age (12.8%)
Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the	2026/27 Q1	**30.8%**	3.5%	74.1%	45.2%	0.1%	Age (74.1%)
Average Time to Ambulance Handover	2026/27 Q1	**7.2%**	2.0%	15.2%	9.9%	1.9%	Age (15.2%)
Average Daily Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of	2026/27 Q1	**6.7%**	2.2%	15.7%	7.4%	1.7%	Age (15.7%)
Number of Handovers > 30 Minutes	2026/27 Q1	**12.2%**	2.2%	27.0%	18.0%	1.7%	Age (27.0%)
Average Daily Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days	2026/27 Q1	**7.6%**	2.4%	18.5%	5.7%	3.7%	Age (18.5%)
Urgent Community Response (UCR) – 2-Hour Performance	2026/27 Q1	**3.0%**	1.3%	2.6%	7.3%	0.8%	Ethnicity (7.3%)

Executive Board Narrative: M05 26/27

At Month 5, the Trust continues to demonstrate resilience and some strong quality outcomes, but the overall position is increasingly constrained by the interaction between operational demand, workforce capacity and financial recovery. Mortality remains within expected levels, pressure-ulcer rates have maintained reductions, and complaints timeliness has improved to 93.76%; however, maternity indicators and healthcare-associated infections require continued oversight.

Urgent and emergency care pressures are affecting the whole hospital pathway. Four-hour performance reduced to 72.2%, while 12-hour waits increased to 17.3%, driven by rising demand, evening and overnight capacity gaps, and delays in patient flow. These pressures increase reliance on corridor care and create potential risks to patient experience, safety and staff wellbeing. The Index of Disparity also indicates that long A&E waits disproportionately affect older patients, reinforcing the importance of admission-avoidance initiatives such as the Call Before Convey and Care Home pilot.

Similar capacity constraints are affecting planned care. Although the proportion of patients waiting under 18 weeks has improved, there are 52 patients who have been waiting over 65 weeks, overall waiting list size is increasing, cancer 31- and 62-day standards are below target, and elements of diagnostic compliance remain challenged. Theatre staffing, diagnostic delays, histopathology turnaround and MDT capacity are common dependencies across elective and cancer recovery.

Workforce performance is therefore both a risk in its own right and a key constraint on recovery. Concerns regarding appraisal compliance, sickness levels, high turnover rate and time to hire timeframes; at the same time, a further 245.7 WTE reduction is required by March 2027. This creates a significant delivery tension: workforce reductions and variable-pay controls must be achieved without worsening clinical capacity, staff wellbeing or service performance.

Gram-negative bloodstream infections require strengthened attention: E. coli increased to nine cases and Klebsiella to four, with rolling 12-month positions above their respective annual thresholds. Limited microbiology and infection-prevention capacity is constraining detailed analysis and the development of robust post-infection reviews.

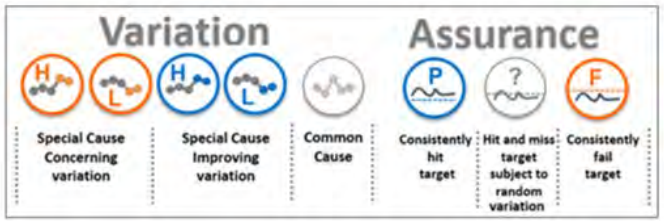
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The immediate priority is to convert existing improvement activity into measurable, recurrent benefit. This requires coordinated delivery of ED escalation arrangements, length-of-stay reductions, the Acute Medical Offer, elective and cancer recovery plans, workforce retention and absence actions, and recurrent savings schemes. Board oversight will focus on whether these actions collectively improve flow and productivity while protecting quality, reducing inequalities and maintaining safe staffing.

Quality & Safety Overview 1 of 2: M05 26/27

	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	Apr 26	Yes	103.9	100.0		F	103.6	102.1	105.1	S	T	P
2	HSMR Rolling 12 Months	Jun 26	No	89.2	100.0	L	P	91.7	89.2	94.2	S	T	P
3	SMR Rolling 12 Months	Jun 26	No	87.7	100.0	L	P	88.7	86.4	91.0	S	T	P
4	Never Events	Aug 26	No	0	0		?	0	-1	1	S	T	P
5	Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation	Aug 26	No	0	4		?	2	-3	6	S	T	P
6	How Many Incidents Triggered a Patient Safety Review	Aug 26	No	15	18		?	24	2	45	S	T	P
7	Reducing Post Partum Haemorrhage in line with Maternal Care Bundle	Aug 26	No	151.83	100.00		?	102.40	46.34	158.46	S	T	P
8	Reducing 3/4th Degree Maternity Tears	Aug 26	No	5.32%	2.60%		?	2.95%	-1.08%	6.99%	S	T	P
9	Reducing Caesarean Sections at Full Dilatation to ≤1% of all births	Aug 26	No	2.62%	1.00%		?	2.51%	-1.60%	6.61%	S	T	P
10	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care	Aug 26	No	2	0		?	3	-1	7	S	T	P
11	Reduction in Category 2 and DTI CAPU per 1000 DN Contacts	Under Construction											
12	Reduction in Category 2 and DTI HAPU per 1000 Bed Days	Aug 26		3.92	2.25		F	4.60	2.32	6.88	S	T	P
13	Percentage of Spells With at Least One Pressure Ulcer Diagnosis	Aug 26	Yes	1.1%	0.9%		F	1.5%	0.9%	2.0%	S	T	P
14	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care	Aug 26	No	1	1		?	1	-2	4	S	T	P
15	To Reduce The Total Number of Falls per 1000 Bed Days	Aug 26	No	7.84	6.10		?	6.82	4.04	9.61	S	T	P

Summary icons key:



*Please note : NOF denotes the National Oversight Framework

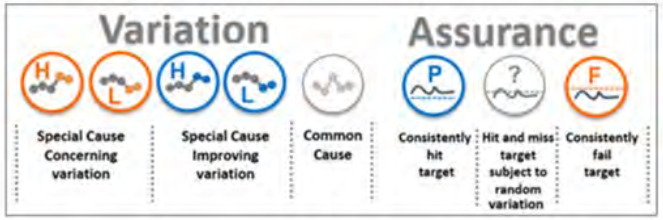
** Percentage of spells with at least one pressure ulcer diagnosis reported 1 month in arrears

Quality & Safety Overview 2 of 2: M05 26/27

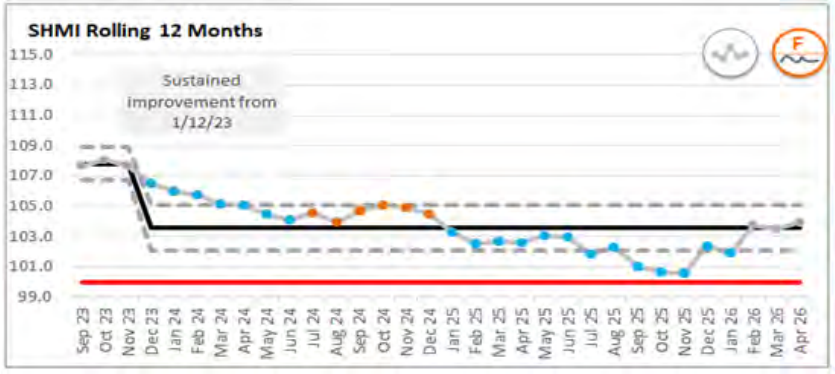
	KPI	Latest month	Metric included in NOF *	Measure	Threshold	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Timely & Complete	Process & System
16	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Aug 26	Yes	0	0			0	0	1	S	T	P
17	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Aug 26	No	2	0			1	-1	4	S	T	P
18	WWL Clostridium Difficile (CDT)	Aug 26	Rate	4	5			6	-3	15	S	T	P
19	Escherichia Coli (E.coli)	Aug 26	Rate	9	3			4	-2	10	S	T	P
20	Klebsiella Species	Aug 26	No	4	1	H		1	-1	4	S	T	P
21	Pseudomonas Aeruginosa	Aug 26	No	0	0			0	-1	2	S	T	P
22	Reduction in the Number of Patients who Transfer Between Wards More Than 2 Times	Aug 26	No	71	106	L		118	71	166	S	T	P
23	Mixed Sex Accomodation Breaches - Non Clinically Justified	Aug 26	No	15	0		F	20	5	34	S	T	P
24	Reduction in the Number of Complaints	Aug 26	No	77	40		F	69	41	97	S	T	P
25	Complaints Responses	Aug 26	No	93.8%	90.0%			73.1%	50.9%	95.3%	S	T	P
26	Patient Experience (FFT) - Patients who Would Recommend the Service	Aug 26	No	81.7%	90.0%			87.1%	81.2%	93.0%	S	T	P

*Please note : NOF denotes the National Oversight Framework

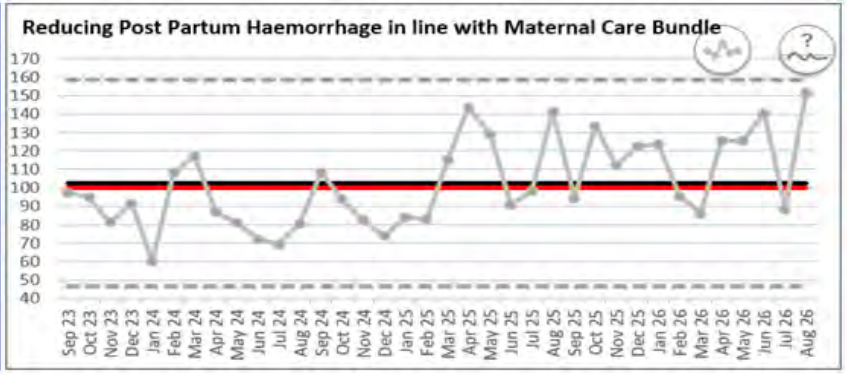
Summary icons key:



Quality & Safety Insight Report 1 of 2: M05 26/27



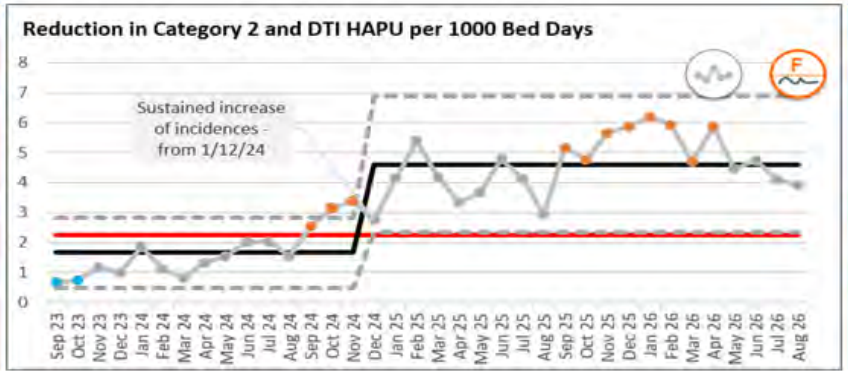
Apr-26
103.94
Variance Type
Common Cause Variation
Threshold
100.0
Target achievement
Metric is consistantly missing the target/ threshold



Aug-26
151.83
Variance Type
Common Cause Variation
Threshold
100
Target achievement
Inconsistent performance compared to threshold/ target



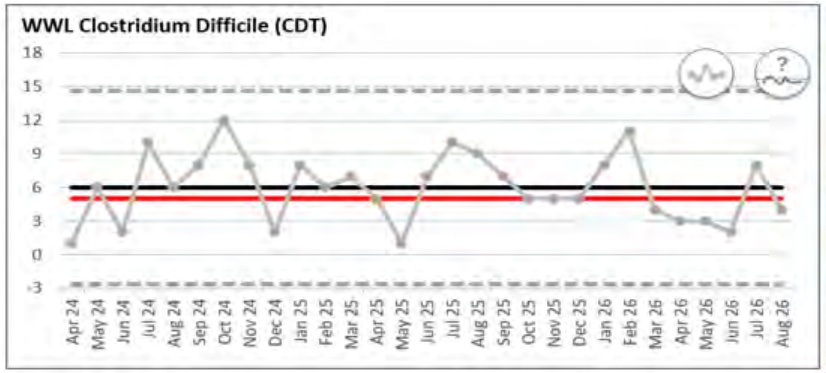
Aug-26
5.32%
Variance Type
Common Cause Variation
Threshold
2.6%
Target achievement
Inconsistent performance compared to threshold/ target



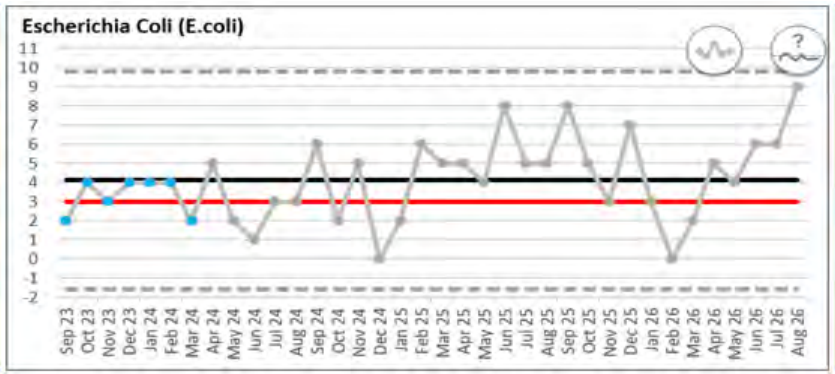
Aug-26
3.92
Variance Type
Common Cause Variation
Threshold
2.25
Target achievement
Metric is consistantly missing the target/ threshold

Summary:	Actions:	Assurance:
1 . SHMI : We remain well within the expected range for SHMI and better than the expected range for HSMR. **2. Post Partum Haemorrhage:** Performance remains inconsistent against the target of 100. August 2026 deteriorated to 151.8 following a period of sustained variation. **3. Reducing 3/4th Degree Maternity Tears:** Recent improvement demonstrated, with performance below the 2.6% threshold for most of 2026. A rise in August is noted and will continue to be monitored. **4. Pressure Ulcers – category 2 and above per 1000 bed days:** We continue to report a sustained reduction since April 26 a total reduction of 33%..	**1. SHMI:** Monthly and quarterly mortality review groups continue. Improvement plans are monitored to ensure that patients are appropriately managed. Continue to work with system partners to ensure appropriate discharge placements for patients. **2. Post Partum Haemorrhage:** PPH audit underway to identify contributory factors and opportunities for improvement. Findings expected by the end of Q2. **3. Reducing 3/4th Degree Maternity Tears**: OASI work ongoing via the Perinatal Pelvic Health Midwife covering both prevention and after-care. **4. Pressure Ulcers – category 2 and above:**. We have carried out our introductory launch across WWL for our Fundamentals of Care Academy with great success – over 130 staff attended across the Trust with representation from various workforce groups. Official Launch is the 17th September and will include a re-set and refresh of our PU strategy. We have set ourselves a 20% reduction from 24/25 levels. Moisture lesion / category 1 panels will be stood up and led by our Ward Leaders, with a clear focus on prevention.	**1. SHMI :** 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. We have seen improvements in sepsis pathways management in relation to blood cultures collection within the first hour and senior clinical review **2. Post Partum Haemorrhage:** Cases continue to be monitored through maternity governance processes, with audit outcomes informing further actions as required. North-West Regional guidance with evidence-based changes in practice ratified August. **3. Reducing 3/4th Degree Maternity Tears**, longer-term performance remains unpredictable due to earlier variability and breaches above the threshold. Targeted improvements continue via training, audit, case-review and service improvements. **4. Pressure Ulcers – category 2 and above:** We have changed the metric to calculate a rate per 1000 bed days to enable comparison with other Trusts. A reduction of 33% since April is seen overall and have now reduced our corporate risk register score from 16 to 12.

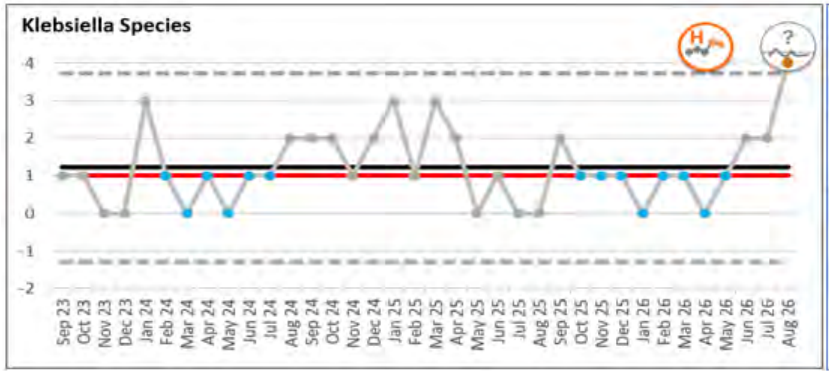
Quality & Safety Insight Report 2 of 2: M05 26/27



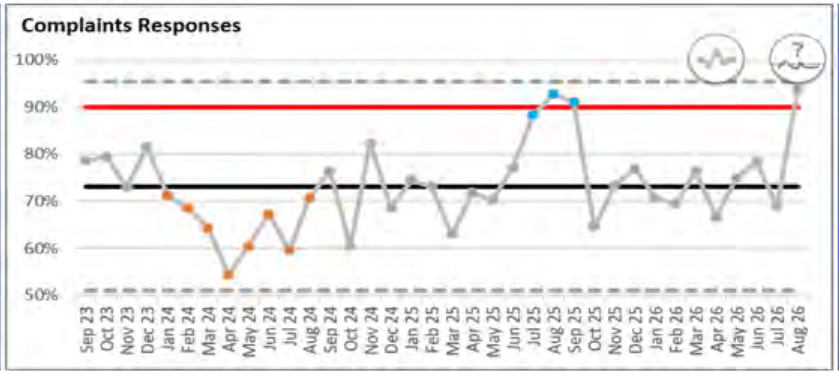
Aug-26
4
Variance Type
Common Cause Variation
Threshold
5
Target achievement
Inconsistent performance compared to threshold/ target



Aug-26
9
Variance Type
Common Cause Variation
Threshold
3
Target achievement
Inconsistent performance compared to threshold/ target



Aug-26
4
Variance Type
Special cause concerning variation points
Threshold
1
Target achievement
Inconsistent performance compared to threshold/ target



Aug-26
93.75%
Variance Type
Common Cause Variation
Threshold
90%
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. Clostridioides Difficile (CDT): The number decreased to 4 cases in August 2026 from 8 cases in July. Total of 20 cases at 31.08.2026. The NHSE Threshold for 2026/ 2027 is 62 cases. 2. **E-Coli:** The E.coli count increased to 9 cases in August 2026 from 6 cases in July. The NHSE Threshold for 2026/ 2027 is 33 cases. There are challenges with microbiologist and IPC capacity to gather the required information and review cases. **3. Klebsiella:** Although the cases have increased to 4 during August 26, these numbers are still small in comparison to population levels. **4. Complaints Responses:** We are proud to report our response rate is the best we have ever reported achieving 93.76%, this has been achieved through focussed improvement workstream across both divisions. This has exceeded our 90% performance timeframe.	**1. Clostridioides Difficile (CDT):** The CDI Review Process continues to identify learning, good practice, and areas for action. 17 of the 20 cases have been reviewed and the Learning, Action and Improvement Plans, and Good Practice have been shared with the Divisions and care areas. A CDI position updated was shared with Quality and Safety Committee in September 2026. 2. & 3.Surveillance of **E.coli and Klebsiella** continues, with identification and analysis of themes and trends, with an aim to develop a robust post infection review process. Explore the capacity of the IPC and microbiology services to enable an enhanced focus on the gram-negative blood stream agenda. **4. Complaints Responses:** Learning from complaints and managing the increasing volume of complaints is overseen by the Patient Relations Team, which includes the divisional process for formal complaints. A focussed improvement piece of work has been implemented and will continue. Whilst we have seen a remarkable improvement in our complaint responses achieving 93.75%, we will continue the standardised approach to the processes embedded; ensuring sustainability is achieved. An agreed measure is that although the Trust adopts a 60-day response timeframe, divisional teams will finalise responses within a 50-day timeframe to facilitate and enable executive sign off	**1. Clostridioides Difficile (CDT):** All CDT case reviews will be completed for Year 2026/ 2027 (Total of 17 cases reviewed at 31.08.2026). **2. & 3 E-Coli and Klebsiella:** Reporting and surveillance continues for all Mandatory reportable HCAI organisms. More in-depth analysis of the gram-negative blood stream infections is required but this is dependent on microbiology and IPC capacity. 4. **Complaints Responses**: Monthly meetings are held with governance teams for oversight of late responses. We have seen a significant reduction in late responses.

Quality & Safety Narrative: M05 26/27

During M5, positive outcomes for patient quality and safety continue, despite operational and site pressures. There is evidence of good outcomes in care, demonstrated through multiple discharge points happening through the day for pathway 0 patients , & increased discharges before 5pm. We have seen a sustained reduction in the number of patients who are frequently moved, therefore reducing opportunities for harm to occur. We have also seen improvements in sepsis pathways management.

The latest HSMR position is 89.2, significantly below the 100 threshold and much better than many similar sized GM hospitals. The latest 12-month SHMI standardised position is 103.9 for the latest rolling 12 months to April 26, is still well 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.

The Trust did not escalate any incidents for a Patient Safety Incident Investigation but did review 15 incidents using patient safety reviews. This was just under the threshold we have set and there were no identified themes or trends within these patient safety reviews.

Full-dilatation caesarean sections increased to 2.62% in M5. Performance shows common cause variation, and improvement is not yet sustained or reliable. Decisions at full dilatation must continue to prioritise maternal and neonatal safety however retrospective case review could identify potentially avoidable factors and unwarranted variation, informing targeted improvement and ongoing governance oversight. Maternity OASI (severe tear) rates increased to 5.32% in M5, above the 2.6% threshold, following a period of sustained improvement. Although discouraging initial review shows no themes or trends and the figure is still within common cause variation. Overall, the downward trend continues but historical variation means sustained performance will remain under review with ongoing improvement work within the PSIRF. PPH ≥1L -2.5L performance remains above the threshold of 100 per 1000 births , with M5 recording 151.8 per 1,000 births. While month-to-month variation is consistent with expected system performance, achievement against the target remains inconsistent. The overall trend shows sustained performance above the threshold in recent months. Findings from the next audit undertaken by the PPH Working Group will be presented in M7 within the PSIRF to support ongoing improvement and assurance.

We continue to report a sustained reduction since April 26 in the rate of Hospital Acquired Pressure Ulcers, category 2 and above pressure ulcers per 1000 bed days – a total reduction of 33%. We officially launch our Fundamentals of Care Academy on the 17th September and have already formally introduced Fundamentals across WWL with great success. We have also reduced our Corporate risk scoring from 16 to 12, reflecting the sustained improvements seen across WWL over the last five months. The ownership at ward level will further support the reductions on category 2 pressures ulcers and above. We have in addition strengthened governance around specific Trust Wide themes to ensure active improvements are the focus; set against key performance indicators.

Healthcare associated infections (HCAI) have remained variable in month. Reporting and surveillance continues for all Mandatory reportable HCAI organisms; the CDI Review Process continues to identify learning, good practice, and areas for action; the updated CDI position was shared with Quality and Safety Committee in September 2026. E. coli cases increased from six to nine cases, the highest number reported this period, while Klebsiella cases rose to four but remain low relative to the population. Surveillance continues; however, limited microbiology and IPC capacity is constraining detailed analysis and the development of robust post-infection reviews.

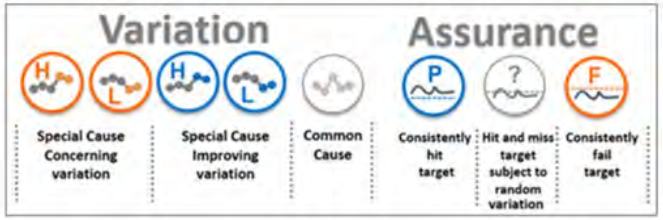
Complaints response times have improved significantly; we are proudly reporting a response rate of 93.76% and have exceeded the 90% performance timeframe.

The Trust has changed Friends and Family (FFT) supplier; we have experienced delays in the implementation of the new system, which has impacted our M5 submission. Performance relates mainly to ED patients, with small numbers for inpatients and outpatients; weekly meetings are in place with the supplier to expediate the implementation across remaining areas at WWL. The new FFT portal will allow our clinical teams to dissect their data within the new divisional structures and analyse themes and trends to support quality improvement.

People Overview : M05 26/27

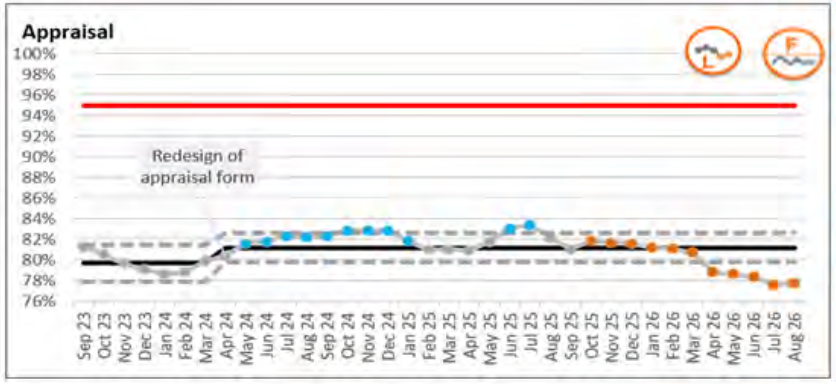
	KPI	Latest month	Metric included in NOF *	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
1	Mandatory Training Compliance	Aug 26	No	94.2%	95.0%	L	?	94.4%	93.2%	95.6%	S	T	P
2	Appraisal	Aug 26	No	77.7%	95.0%	L	F	81.2%	79.8%	82.6%	S	T	P
3	Price Cap Compliance - Medical	Aug 26	No	0.0%	30.0%		F	0.5%	-0.6%	1.7%	S	T	P
4	Price Cap Compliance - Non Medical	Aug 26	No	80.3%	90.0%	L	?	95.9%	82.1%	109.6%	S	T	P
5	% Turnover Rate	Aug 26	No	9.3%	8.5%	H	F	8.9%	8.5%	9.3%	S	T	P
6	Vacancy Rate	Aug 26	No	4.9%	5.0%		?	5.5%	4.4%	6.6%	S	T	P
7	Number of Whole Time Equivalent Posts	Aug 26	No	44.62	0.00	H	?	-83.30	-199.12	32.52	S	T	P
8	Sickness - Percentage Time Lost (%) - Rolling 12 months	Aug 26	Yes	6.2%	5.0%	H	F	5.7%	5.6%	5.8%	S	T	P
9	Time to Hire	Aug 26	No	81.0	65.0	H	?	60.8	48.1	73.4	S	T	P

Summary icons key:

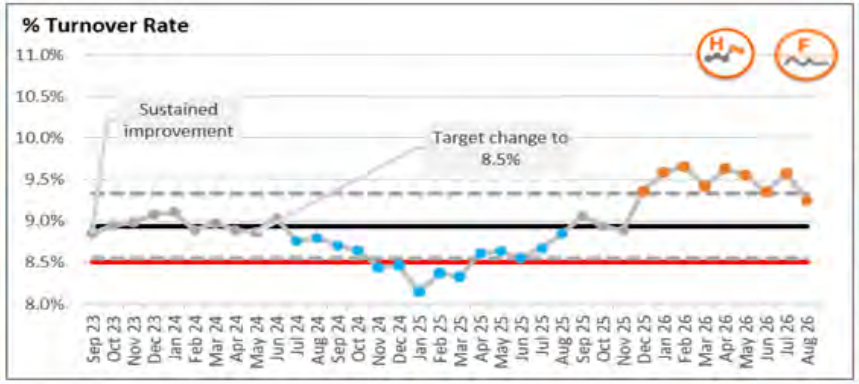


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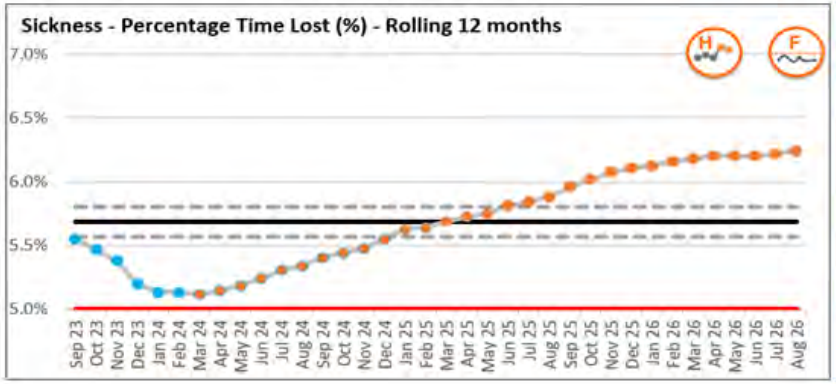
People Insight Report : M05 26/27



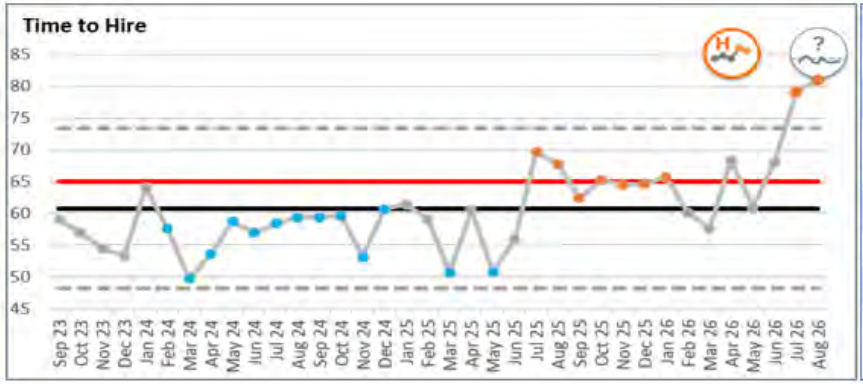
Aug-26
77.70%
Variance Type
Special cause concerning variation
Target
95.0%
Target achievement
Metric is consistently missing the threshold/ target



Aug-26
9.25%
Variance Type
Special cause concerning variation
Target
8.5%
Target achievement
Metric is consistently missing the threshold/ target



Aug-26
6.24%
Variance Type
Special cause improving variation
Target
5.0%
Target achievement
Metric is consistently missing the threshold/ target



Aug-26
81
Variance Type
Special cause improving variation
Target
65
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. Appraisal: Increased marginally from 77.6% to 77.7%, but continues to remain significantly below the 95% target. **2. Turnover**: Reduced from 9.6% to 9.25%, but remains above the 8.5% target. Turnover amongst staff with less than 12 months' service reduced from 19.5% to 18.5%. **3. Sickness:** Rolling 12-month sickness increased from 6.2% to 6.3%, remaining above the 5% target. In-month sickness also increased from 6.1% to 6.2%.. **4. Time to Hire:** Increased from 79.1 days to 81 days, remaining above the 65-day target.	**1.Appraisal:** Continued focus from divisions to improve appraisal compliance, with targeted action in lower-performing areas. National Staff Survey and People Promise activity will also continue to support improvements in the quality and effectiveness of appraisal conversations. **2. Turnover:** Continued focus on retaining staff in areas with higher turnover, using divisional and staff-group data to identify hotspots and agree targeted actions. Exit feedback and local retention plans will continue to be reviewed to better understand and address key reasons for leaving.. **3. Sickness:** Continued delivery of the absence reduction plan, with focus on early intervention, compassionate management of long-term absence, manager capability and targeted wellbeing support to prevent and reduce absence.. **4. Time to Hire:** Recruitment will review vacancies exceeding the 65-day standard to identify delays across shortlisting, interview decisions, pre-employment checks and manager responses, with targeted action where recurring delays are identified.	**1.Appraisal:** Divisional appraisal performance is reviewed through Divisional Performance Meetings, with the People Dashboard presented to the Wider Leadership Team and further oversight through People Committee. **2. Turnover:** Turnover performance and hotspot analysis are reviewed through Divisional Performance Meetings and People Committee. Progress against divisional retention actions will continue to be monitored through the People Dashboard. **3. Sickness:** Delivery of the absence reduction plan continues to be monitored through the monthly Task & Finish Group, with oversight of absence levels and associated actions through Divisional Performance Meetings, Wider Leadership Team and People Committee. **4. Time to Hire:** Time to hire performance will continue to be monitored through recruitment performance reporting, with vacancies exceeding the 65-day standard reviewed to identify recurring delays and areas requiring escalation.

People Narrative : M05 26/27

Appraisals – Appraisal compliance increased marginally from 77.6% in July to 77.7% in August, but remains significantly below the Trust target of 95%. Performance continues to demonstrate sustained underperformance. Oversight continues through Divisional Performance Meetings, with divisions asked to address areas of lower compliance. National Staff Survey actions linked to the People Promise 'We are Always Learning' will continue to focus on improving the quality and effectiveness of appraisal conversations alongside overall compliance.

Turnover – The Trust's rolling turnover rate reduced from 9.6% in July to 9.25% in August, but remains above the 8.5% target. Turnover amongst staff with less than 12 months' service also reduced from 19.5% to 18.5%. The most frequently recorded reasons for leaving included dismissal, work-life balance, relocation and retirement. Divisional retention activity and National Staff Survey actions will continue to focus on identified workforce and service hotspots.

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Total workforce – Total workforce usage increased by 16.8 WTE in August to 6,819.4 WTE, comprising 6,446.8 WTE substantive, 344.0 WTE bank and 28.5 WTE agency. The August position is 44.1 WTE below the planned MTP position of 6,863.5 WTE. However, a further 245.7 WTE reduction is required to reach the March 2027 MTP target of approximately 6,573.7 WTE. Grip and control arrangements remain in place, with divisions continuing to develop and deliver workforce plans that support the required reduction whilst addressing recruitment, retention and workforce supply challenges.

Sickness – Rolling 12-month sickness increased from 6.2% in July to 6. 3% in August, remaining above the Trust target of 5%. In-month sickness also increased from 6.1% to 6.2%, with short-term sickness at 2.4% and long-term sickness at 3.8%. Anxiety and stress remains the most frequently recorded absence reason. Delivery of the absence reduction plan continues, including manager training, early intervention, compassionate case management and targeted wellbeing support informed by triangulation of sickness and staff survey data.

Time to Hire – Time to hire increased from 79.1 days in July to 81 days in August, remaining above the 65-day target. Recruitment will continue to review vacancies exceeding the standard to identify delays in shortlisting, interview decisions, pre-employment checks and manager responses, with targeted action taken where recurring delays are identified.

Mandatory Training – Mandatory training compliance improved from 93.9% in July to 94.2% in August, continuing the recent upward trend and narrowing the gap to the 95% target. Compliance will continue to be reviewed through divisional governance arrangements, with targeted follow-up in areas reporting lower performance.

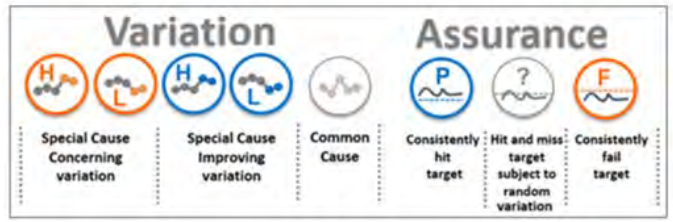
Performance Overview – Start Well & Planned Care : M05 26/27

	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	Aug 26	No	28191	26707			30638	27217	34058	S	T	P
2	RTT Waiting List	Aug 26	No	46324	40343			48155	46617	49693	S	T	P
3	Total Patients Waiting Over 65 Weeks	Aug 26	No	52	0			39	-5	83	S	T	P
4	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment	Aug 26	Yes	2.4%	2.0%			2.8%	2.3%	3.3%	S	T	P
5	Percentage of Patients Waiting Over 52 Weeks for Community Services	Aug 26	Yes	0.0%	0.0%			0.1%	0.0%	0.2%	S	T	P
6	Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under	Aug 26	No	0.4%	0.0%			0.5%	0.3%	0.6%	S	T	P
7	Total Patients Waiting Over 45 Weeks for Elective Treatment	Aug 26	No	2694	837			3066	2608	3524	S	T	P
8	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Aug 26	Yes	60.5%	60.6%			58.5%	56.5%	60.5%	S	T	P
9	Percentage of Patients Waiting Less than 18 Weeks for Community Services	Aug 26	Yes	88.3%	80.0%			86.6%	83.6%	89.6%	S	T	P
10	Difference between planned and actual 18 week performance score	Aug 26	Yes	-2.41%	1.00%			0.62%	-1.90%	3.14%	S	T	P
11	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test	Aug 26	Yes	17.5%	18.5%			24.2%	15.7%	32.6%	S	T	P
12	Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks	Jul 26	Yes	82.8%	80.0%			79.9%	72.8%	87.0%	S	T	P
13	Cancer 31 Day Treatment Standard Performance	Jul 26	No	89.0%	94.0%			90.6%	81.7%	99.5%	S	T	P
14	Percentage of Patients Treated for Cancer Within 62 Days of Referral	Jul 26	Yes	76.5%	80.0%			74.2%	60.7%	87.7%	S	T	P
15	Outpatient New : Follow-up Ratio	Aug 26	No	2.2	2.0			2.2	2.1	2.4	S	T	P
16	Elective Theatre Utilisation - Capped Touchtime	Aug 26	No	80.4%	85.0%			82.7%	79.3%	86.2%	S	T	P
17	Elective Recovery Plan : Day Case Activity Performance	Aug 26	No	89.0%	100.0%			95.6%	86.0%	105.3%	S	T	P
18	Elective Recovery Plan : Inpatient Activity Performance	Aug 26	No	132.2%	100.0%			101.7%	78.4%	125.1%	S	T	P

*Please note : NOF denotes the National Oversight Framework

** Cancer Target Metrics are reported 1 month in arrears

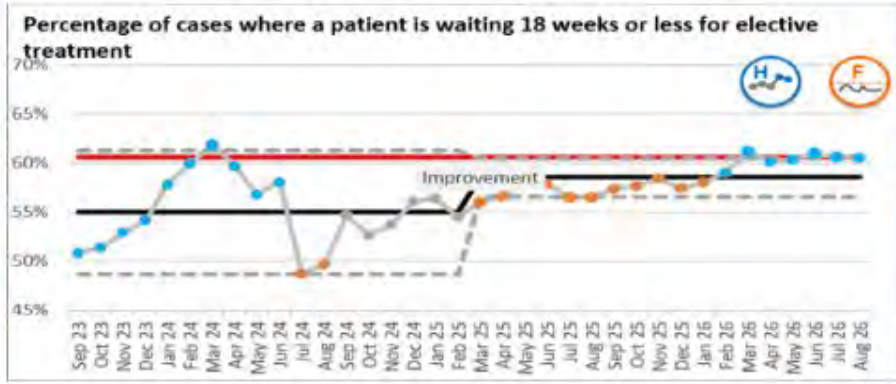
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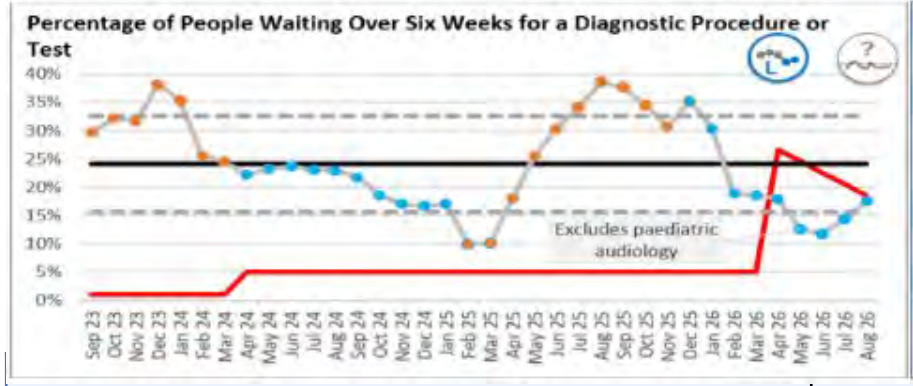
Performance Insight Report - Start Well & Planned Care : M05 26/27



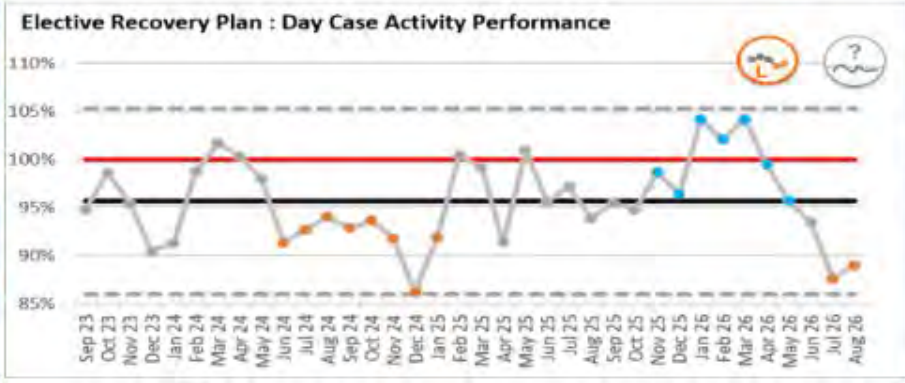
Aug-26
52
Variance Type
Commmon cause variation
Target
0
Target achievement
Inconsistent performance compared to threshold/ target



Aug-26
60.50%
Variance Type
Special cause improving variation
Target
60.6%
Target achievement
Metric is consistently missing the threshold/ target



Aug-26
17.51%
Variance Type
Special cause improving variation
Target
18.5%
Target achievement
Inconsistent performance compared to threshold/ target



Aug-26
88.98%
Variance Type
Special cause concerning variation
Target
100%
Target achievement
Inconsistent performance compared to threshold/ target

1. RTT 65WW: 65-week waiters have reduced slightly again from 70 to 52 but further work is required to achieve 0 by the end of September.
2. 18-week RTT performance: Performance is demonstrating an improving position on baseline, from 60.3% in May to 60.9% in June and then 60.6% in July.
3. DM01 6 Week Waits: Increase in 6-week breaches has arisen due to a temporal reduction in MR capacity due to a flood and water ingress to an MR scanner at Wrightington Hospital.
4. ERP Day Case Activity Performance: July and August have seen underdelivery of day case activity vs plan, however this is offset by a significant overdelivery of elective activity.

1. RTT 65WW: Long-waiters for General Surgery, ENT, and T&O.
2. 18-week RTT performance: Specialty action plans are in place to support the delivery of the18-week position. Ongoing focus on productivity and validation continue with positive effect
3. DM01 6 Week Waits: Scanner has been restored to full capacity and additional sessions are being booked to reduce breach position
4. ERP Day Case Activity Performance: Specialties will closely scrutinise theatre casemix to ensure all available theatre time is utilised.

1. RTT 65WW: Long-waiters are being monitored fortnightly in the Elective Performance meeting. The Trust continues to aspire to having 0 65 week waiters by the end of September.
2. 18-week RTT performance: Performance is monitored fortnightly in the Elective Performance meeting reporting to ETM and F&P
3. DM01 6 Week Waits: Performance is monitored through weekly trackers and reviewed in monthly Diagnostic Assurance Meeting. Trajectory to recovery estimates that recovery will be achieved in November if no other factors reduce capacity levels.
4. ERP Day Case Activity Performance: Performance is widely scrutinised and reported through Divisional Assurance Meeting packs.

Performance Narrative - Start Well & Planned Care : M05 26/27

RTT Waiting List: The August 2026 month end position shows 45,765 incomplete pathways which is considerably over the planned RTT position of 40,343. 60.5% of patients are waiting under 18 weeks but again this is behind the planned position. There is an increasing number of patients waiting over 52 weeks with 2.4% of these patients waiting over 52 weeks and 52 patients for over 65 weeks across a limited number of specialties against a planned position of 0. All long waiters are subject to targeted specialty level actions and close operational oversight. Independent sector activity continues to be utilised to support the Trust to reduce long waits to zero by September month-end.

Cancer Performance: Cancer performance presents a mixed position. The 28-day Faster Diagnosis Standard is the strongest area, achieving 82.8% against the 80% target, supported by breast, skin and lung pathways. Gynaecology remains challenged, while Lower GI faces emerging diagnostic and straight-to-test endoscopy risks. The 31-day and the 62-day standards are below target Although theatre capacity has been restored, staffing shortages and short-notice list cancellations continue to constrain treatment delivery, creating unavoidable deferrals despite cancer activity being prioritised. Lower GI is the principal source of breaches, with further pressures across Gynaecology, Upper GI, Urology, Head and Neck, and Haematology. Theatre constraints, diagnostic delays, histopathology turnaround, workforce capacity and MDT coordination remain the main systemic risks. Recovery is being supported through stronger patient tracking list management, operational oversight, pathway redesign, improved pathology escalation and additional treatment capacity secured with The Christie.

Radiology: Radiology performance was mixed, with overall DM01 compliance deteriorating to 89.44%, below the 95% standard and down from 94.8% previously. Activity plan achieved for CT , while MRI, NOUS and DEXA were below plan in month. Year-to-date activity nevertheless remained above plan for MRI, CT and NOUS.
The diagnostic backlog was concentrated in NOUS and MRI. Performance pressures were driven by annual-leave capacity constraints, and reduced scanning capacity due to a leak contained within the MR unit. CT breaches were primarily CTCA-related, although CT activity remained above plan. A new digital solution, xWave, for receiving GP imaging referrals has been implemented in August and throughout September. This should improve waiting-list accuracy and provide real time data. Phase two is planned for non-medical referrers by the end of Q3 and this will provide us up to data waiting list data for all imaging examinations. NHSP for additional hours has now been implemented on the 1st September in all areas. Low pick up of shifts will potentially impact capacity until recruitment is completed.

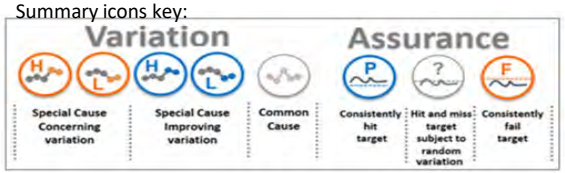
Performance Overview – Live Well & Urgent Care : M05 26/27

	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	Index of Disparity (IoD)
19	Average Time to Ambulance Handover	Aug 26	No	00:28:10	00:22:10		?	00:28:22	00:21:00	00:35:43	S	T	P	0.07
20	Number of handovers > 30 minutes	Aug 26	No	39.6%	5.0%		F	39.0%	23.3%	54.7%	S	T	P	0.12
21	Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours	Aug 26	Yes	72.2%	76.0%	H	F	71.1%	66.0%	76.3%	S	T	P	0.05
22	Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department	Aug 26	Yes	17.3%	2.0%		F	18.1%	13.2%	23.0%	S	T	P	0.31
23	Instances of Corridor Care in ED	Aug 26	No	187	0		F	330	84	576				N/A
24	Instances of General and Acute Corridor Care	Aug 26	No	337	0		F	350	138	563				N/A
25	Overnight Total General and Acute Beds and the Number of Which are Occupied	Aug 26	No	86.1%	96.0%	L	?	92.0%	87.4%	96.7%	S	T	P	N/A
26	Virtual Ward Occupancy	Aug 26	No	61.5%	80.0%		?	73.4%	49.3%	97.5%	S	T	P	N/A
27	Average Daily Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days	Aug 26	No	62	48		P	62	56	68	S	T	P	0.08
28	Average Number of Days Between Planned and Actual Discharge Date	Aug 26	Yes	0.9	0.5		F	0.9	0.6	1.2	S	T	P	N/A
29	Percentage of Patients who do not Meet the Criteria to Reside	Aug 26	No	25.7%	12.5%		P	24.4%	19.4%	29.4%	S	T	P	N/A
30	Average Daily Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days	Aug 26	No	48	52		P	47	34	61	S	T	P	0.07
31	Urgent Community Response (UCR) - 2-Hour Performance	Jul 26	No	85.8%	70.0%		P	83.1%	77.1%	89.2%	S	T	P	0.03

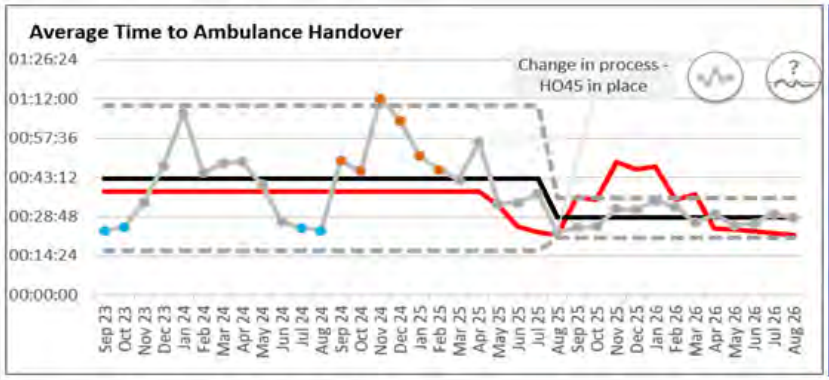
*Please note : NOF denotes the National Oversight Framework

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

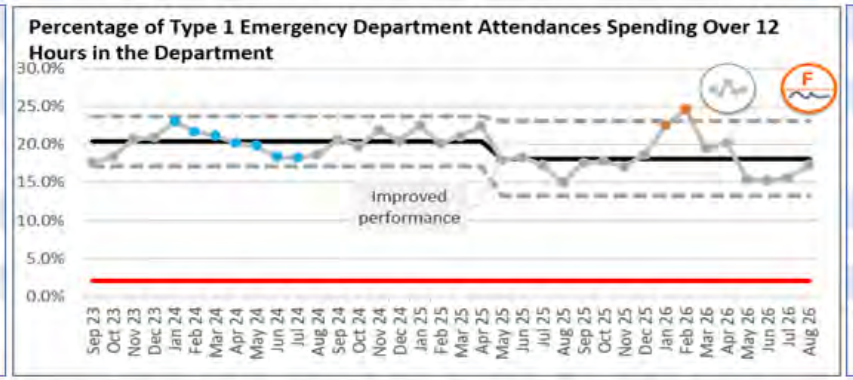
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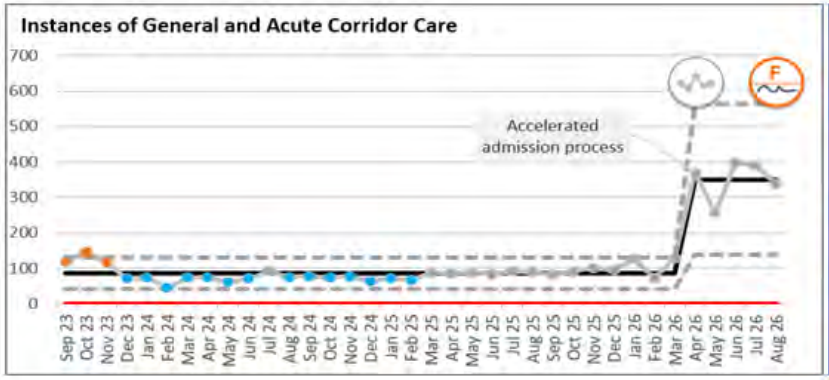
Performance Insight Report - Live Well & Urgent Care : M05 26/27



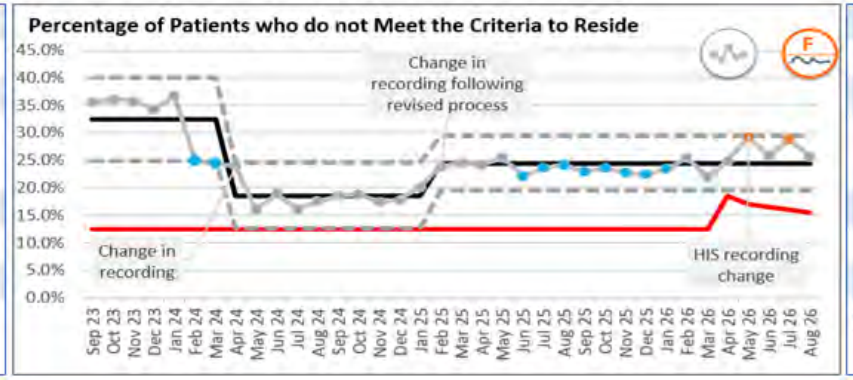
Aug-26
00:28:10
Variance Type
Commmon cause variation
Target
00:22:10
Target achievement
Inconsistent performance compared to threshold/ target



Aug-26
17.27%
Variance Type
Commmon cause variation
Target
2.0%
Target achievement
Metric is consistently missing the threshold/ target



Aug-26
337
Variance Type
Commmon cause variation
Target
0
Target achievement
Metric is consistently missing the threshold/ target



Aug-26
25.65%
Variance Type
Commmon cause variation
Target
12.5%
Target achievement
Metric is consistently missing the threshold/ target

Summary:	Actions:	Assurance:
1. Time to Ambulance Handovers: Ambulance handover times remain above the target of 22:10 primarily due to flow and capacity constraints in the Emergency Department. **2. A&E 12 Hour Waits:** Marked deterioration in 12-hour performance however remains below the mean – primarily due to a deterioration in flow and capacity in ED. **3. G&A Corridor Care:** Increased occupancy in the ED due to longer waits for admission have led to the need to escalate patients onto the corridor to maintain cubicle capacity for incoming unstable patients. **4. No Criteria to Reside Patients:** There has been a reduction in the number of patients not meeting the criteria to reside although accurate data collection remains a concern.	**1. Time to Ambulance Handovers:** ED Escalation and Surge triggers currently being launched with training underway. Due to go live in October and will support response to ambulance surge and department occupancy. ED time to be seen is a critical factor in maintaining occupancy – a task and finish group for evening and overnight performance is underway. **2. A&E 12 Hour Waits:** Bed Days dashboard developed to incorporate 5% LoS reduction target for each ward. To be monitored and embedded into existing governance and transformation processes. **3. G&A Corridor Care:** Actions for 1 and 2 above will help to address department occupancy. The ED Quality and Safety plan continues to be embedded with a focus on maintaining patient care and experience at times of escalation, particularly on the corridor. **4. No Criteria to Reside Patients:** Focus continues on the long length of stay patients with overall ward length of stay being monitored. NCTR patients are also reviewed by the twice weekly multi-agency escalation calls.	**1. Time to Ambulance Handovers:** NWAS relationship meetings continue where performance is reviewed and processes amended **2. A&E 12 Hour Waits:** 12- hour continues to be below the mean with key actions in place as part of the BetterLives programme to recover to target. **3. G&A Corridor Care:** As part of the BetterLives programme the AMO continues to be developed with testing scheduled for October. **4. No Criteria to Reside Patients:** Grand rounds well embedded as BAU focussing on reducing NCTR delays. Pathway 0 discharges are increasing which suggests fewer patients being badged as needing discharge support. The organisational redesign is also bringing together IDT and TOCH to deliver operational efficiencies

Performance Narrative - Live Well & Urgent Care : M05 26/27

August saw sustained pressure across the urgent and emergency care pathway, with high demand, workforce challenges and ongoing flow constraints impacting performance throughout the month. Overall, 4-hour performance reduced from 75.4% in July to 72.2% in August, reflecting pressures across both the Emergency Department and wider hospital system. Despite this deterioration, performance remains significantly improved compared to the position prior to the March Sprint, with a number of recovery actions now embedded into daily operations. RAEI performance has remained above regional averages, with Type 3 performance continuing above 95%.

An ongoing and increasingly concerning challenge during August was the deterioration in waits to be seen during the late afternoon, evening and overnight period. The pattern of increasing ED attendances, particularly in the period of 4pm – 12am, overlaid with increased occupancy of patients waiting for admission have resulted in a mis-balance in capacity and demand resulting in prolonged waits to initial assessment and treatment. August also coincided with the annual junior doctor changeover, creating a temporary reduction in clinical productivity as new staff completed induction and became familiar with local pathways and processes. In response, the department are undertaking a detailed review of demand patterns and are adjusting shift patterns accordingly. Clinical processes and departmental productivity are also being monitored and managed through the evening and overnight task and finish group. Furthermore, training has commenced on the new ED Escalation and Surge Triggers, which are due to be implemented in October. This SOP is expected to provide structure and consistency to the clinical and operational approach to responding to demand in ED.

The impact of hospital flow has been evident in the deterioration of the 12-hour wait position which rose to 17.3% in August. Since mid-August there has been a slow and steady reduction in the number of patients with no criteria to reside and a corresponding increase in the patients with a criteria to reside. The long length of stay meetings continue to focus on the criteria to reside patients with actions in place to ensure that plans from the MDT are enacted. A dashboard has been further developed to introduce greater grip and control at ward level on length of stay, with a target 5% reduction. Furthermore, considerable efforts have been made to eliminate medical outliers which is now a sustained position. Evidence shows that patients placed out of their specialty bed base are more likely to experience a prolonged stay and ultimately poorer outcomes. Through early August, this resulted in empty beds across the Surgical wards being carried into the weekend, ultimately reducing long waits for surgery in ED over the weekend.

August also saw significant progress in the development of the Acute Medical Offer, bringing together emergency and acute medical services into a more integrated front-door model. Design work has focused on earlier senior decision making, improved utilisation of same day emergency care and reducing unnecessary admissions. This work is a key initiative to address increased demand through the Winter period with the aim to commence testing in October.

A key area of progress during August has been the Call Before Convey and Care Home pilot, targeting the increase in >65-year-olds presenting to the ED. Developed jointly with NWAS and Care Homes, the pilot enables senior geriatrician review before conveyance decisions are made, ensuring patients are directed to the most appropriate service at the earliest opportunity. The initiative is supporting a more proactive approach to admission avoidance, particularly for frail patients and care home residents, while strengthening integration between community, ambulance and acute services. Early learning has been positive to support expansion of the pilot during its initial phase, with detailed benefits realisation work now underway.

Whilst operational pressures remained high throughout August, the division continued to make progress across a range of improvement programmes and targeted interventions aimed at improving patient flow, reducing avoidable admissions and supporting sustainable recovery across the urgent and emergency care pathway.

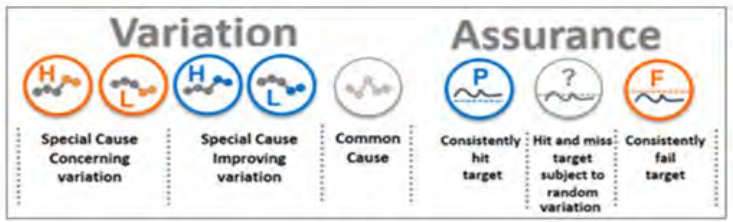
Performance Overview - Finance : M05 26/27

	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 %)	Aug 26	Yes	-1.61%	0.00%			-0.72%	-2.54%	1.11%	S	T	P
2	Adjusted Financial Performance (£m) - Variance to Plan	Aug 26	No	-1.2	0.0			0.3	-3.3	3.8	S	T	P
3	Cash (£m)	Aug 26	No	18.6	11.5			16.7	4.8	28.7	S	T	P
4	API Income (£m) - Variance to Plan	Aug 26	No	-0.3	0.0			-0.2	-1.8	1.4	S	T	P
5	Total Cost Improvement Programme (CIP) (£m) - Variance to Plan	Aug 26	No	-1.5	0.0	L		0.1	-1.5	1.7	S	T	P
6	Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan	Aug 26	No	-1.6	0.0			-0.5	-2.0	0.9	S	T	P
7	Implied Productivity	Aug 26	Yes	2.61%	5.50%		F	2.18%	-0.01%	4.36%	S	T	P
8	Agency Expenditure (£m)	Aug 26	No	0.5	0.3	L	F	0.7	0.5	0.9	S	T	P
9	Bank Expenditure (£m)	Aug 26	No	1.9	1.6			2.1	1.6	2.7	S	T	P
10	Capital Expenditure (£m) - Variance to Plan	Aug 26	No	3.0	2.1			0.6	-3.2	4.5	S	T	P
11	Better Payment Practice Code (BPPC)	Aug 26	No	90.4%	95.0%			93.3%	85.2%	101.4%	S	T	P

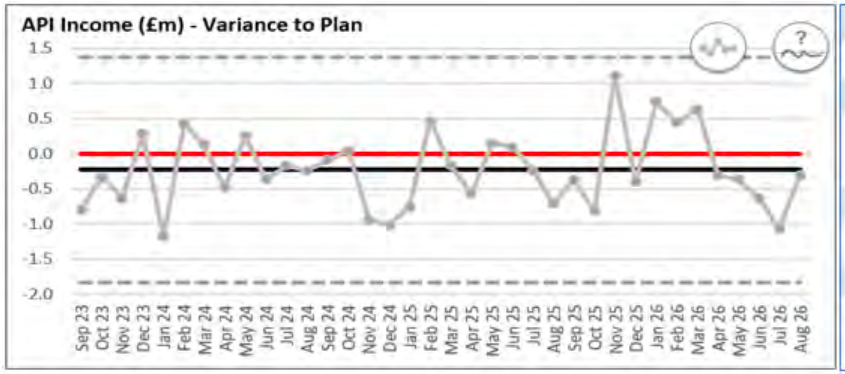
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The finance slides in the IPR should be viewed alongside the monthly finance report for wider context

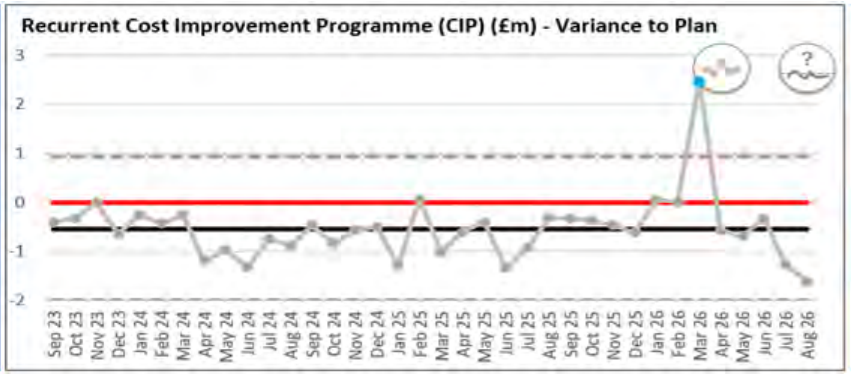
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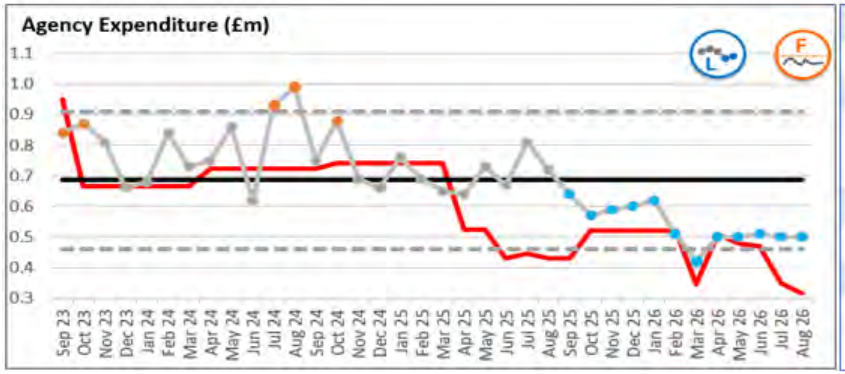
Performance Insight Report - Finance : M05 26/27



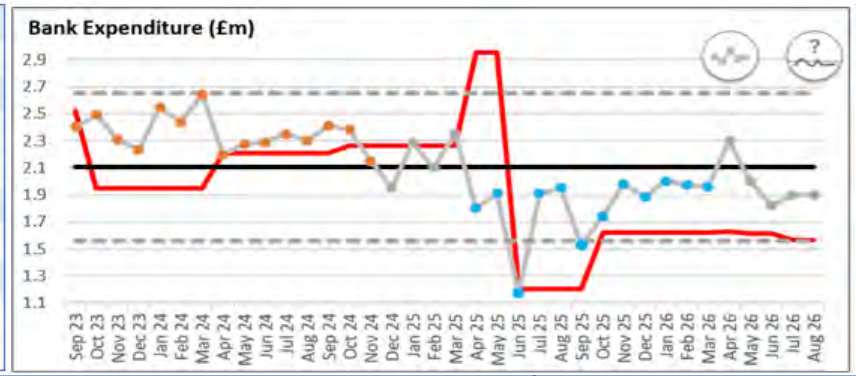
Aug-26
-0.31
Variance Type
Common cause variation
Target
0.0
Target achievement
Inconsistent performance compared to threshold/ target



Aug-26
-1.62
Variance Type
Common cause variation
Target
0.0
Target achievement
Inconsistent performance compared to threshold/ target



Aug-26
0.50
Variance Type
Special cause improving variation
Target
0.3167
Target achievement
Metric is consistently missing the threshold/ target



Aug-26
1.90
Variance Type
Common cause variation
Target
1.56
Target achievement
Inconsistent performance compared to threshold/ target

Summary:	Actions:	Assurance:
1. API Income: The Trust has underperformed against the elective API plan by £0.3m in month and £2.0m YTD. Gynaecology, ENT and Gastroenterology and Urology are the top 3 behind plan. **2. Recurrent CIP**: Recurrent CIP continues to be adverse to plan with £0.7m delivered against the target of £2.3m in month 6. Recurrent delivery in the year to date position is £4.5m behind plan. **3. Agency:** Agency spend is not achieving the 30% reduction target set by NHSE, when adjusted for industrial action costs. **4. Bank:** Bank spend is not achieving the 10% reduction target set by NHSE, when adjusted for industrial action costs.	**1. API Income:** Divisions are working to recover lost income and are in the process of fully developing their recovery plans. **2. Recurrent CIP**: Divisions are being tasked to review trackers in depth to validate delivery risk and mobilise work to mitigate both likely under delivery and remaining unidentified gaps to plan at pace. Divisions are also working on recovery plans and difficult decisions which would help to recover the year to date position. **3. Agency:** Reducing variable pay is being targeted critical to plan delivery in 2026/27. This is being led by the CFO with executive scrutiny at ETM and FIG with working groups set up with the medical nursing teams. Bank spend reduction links to CIP, recovery plan and control total delivery **4. Bank**: Reducing variable pay is being targeted critical to plan delivery in 2026/27. This is being led by the CFO with executive scrutiny at ETM and FIG with working groups set up with the medical nursing teams. Bank spend reduction links to CIP, recovery plan and control total delivery.	**1. API Income:** Updates provided at Divisional Performance Reviews and Elective Recovery Board. **2. Recurrent CIP**: Weekly CIP updates continue to be provided to GM via the CIP return. Robust governance processes and structures are in place within the Divisions to support and expedite development of schemes and governance documentation with a focus on those Divisions who are behind plan. Bi-weekly CIP huddles have been recommenced for the clinical divisions to provide a focus for gaining assurance; monitored by detailed action plans. **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

Performance Narrative – Finance : M05 26/27

Description	Performance Target	Performance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2026/27.	Red	The Trust reported a £7.4m deficit at Month 5, £3.9m adverse to plan. August was £1.8m adverse to plan and included £0.5m of non-recurrent support. The underlying run rate has not materially improved, with recurrent CIP delivery, pay expenditure and elective income remaining key pressures. Delivery of the 2026/27 financial plan is therefore at significant risk and requires accelerated recovery action.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber	Closing cash at the end of August was £18.6m, £7.0m lower than July's closing balance of £25.6m, due to the operating deficit and increased creditor payments. Cash is forecast to reduce towards year-end, although current projections indicate that cash support can be avoided during 2026/27. Operating cash days reduced from 16 days in July to 12 days in August.
API Income	Achieve the elective activity plan for 2026/27.	Red	The Trust underperformed against the elective API plan by £0.3m in August and £2.0m year to date. Live Well & Urgent Care was £49k behind plan in month, mainly due to Gastro and Cardiology, while Start Well & Planned Care was £264k behind plan, principally due to Gynaecology and T&O. The year-to-date position includes £280k of income delivered by Spire at additional cost.
Cost Improvement Programme (CIP)	Deliver Total CIP of £31.8m	Red	Total CIP delivery was £7.3m at Month 5, £2.3m below target. Only 33% of delivery was recurrent, with 67% delivered non-recurrently. Although the full £31.8m target has been identified, risk-adjusted delivery is £26.9m, leaving a £4.9m gap that requires accelerated scheme implementation.
	Deliver Recurrent CIP of £23.0m	Red	
Agency expenditure	30% reduction in agency spend.	Red	Agency expenditure was £0.5m in August, unchanged from July. Agency worked WTE reduced by three to 29 WTE, but expenditure remains above the NHS England target and is not achieving the required 30% reduction.
Bank expenditure	10% reduction in bank spend	Red	Bank expenditure was £1.9m in August, unchanged from July. Bank worked WTE increased by 10 to 344 WTE. Expenditure remains above the NHS England target and has not yet achieved the required 10% reduction.
Capital expenditure	Achieve capital plan for 2026/27.	Amber	Capital expenditure in Month 5 was £3.0m, £0.3m above the internal plan of £2.7m and £0.8m above the NHS England plan. Operational CDEL expenditure was £0.6m, below plan, principally due to the HIS upgrade scheme and VAT recovery, while expenditure on PDC-funded schemes was £1.8m.
Better Payment Practice Code (BPPC)	Pay 95% of invoices within 30 days.	Red	Year-to-date BPPC performance remains below the 95% target. August performance was 90.0% by volume, unchanged from July, and 86.7% by value, an improvement from 74.1% in July.

Eradication of corridor care

Board of Directors

7 October 2026

Kevin Parker-Evans
Chief Nursing Officer



The mission

0

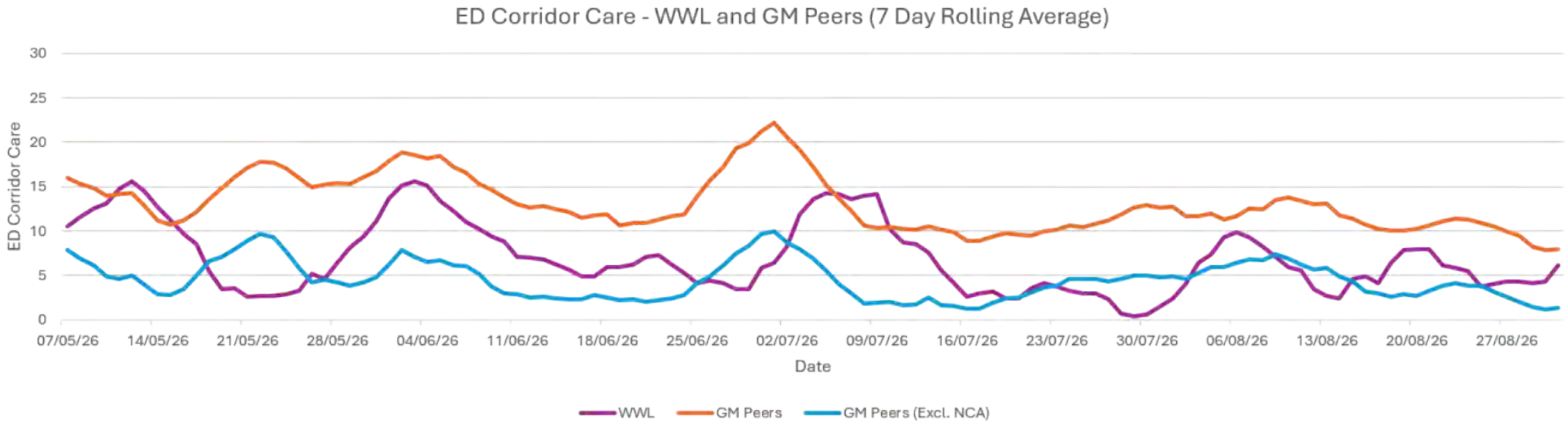
patients in corridors or temporary escalation spaces

Background

WWL received an invitation to a national event in London with 44 other trusts attended by CEO, CMO, COO, CNO

Corridor care remains a patient safety issue.

The aspiration has to be eradication



Corridor care and escalation spaces

Cause harm to

Patients and Staff



- Compromised emergency response
- Rapid deconditioning
- Increased length of stay
- Increased pressure ulcer damage
- Increased falls
- Medication errors
- Lack of privacy and dignity

Four executive pledges

01 Identify an Executive Lead

02 Enhance Board oversight and visibility of corridor care

03 Revisit Better Lives transformation workstreams

04 Collectively agree and formally set a final date after which no WWL patient will be cared for in a corridor or escalation space

Four immediate operational priorities

Priority	Executive lead	Next deliverable and target
Call-to-convey model	COO	Initial model within 6 weeks
Acute Medical Officer	CNO & CMO	Implementation plan within 4 weeks
Utilisation and intelligence of System Visibility	CNO & COO	Baseline within 2 weeks Dashboard within 6 weeks
Temporary Discharge Ready Ward	CNO	Options appraisal within 2 weeks Implementation date after approval

Call-to-convey: joint working with Bolton NHS Foundation Trust and NWAS, including a paramedic in the workforce model.

Our commitment

Through robust action, pathways and lasting change,

we will identify

the last day

we care for a patient in a corridor or escalation space at WWL.

Title of report:	Primary–Secondary Care Interface: Local Medical Committee (LMC) Presentation to Board
Presented to:	Board of Directors
On:	7th October 2026
Item purpose:	To note the approval to relaunch the Primary Secondary Care Interface document and the working group.
Presented by:	Sarah Brennan, Chief Operating Officer
Prepared by:	Sarah Brennan, Chief Operating Officer
Contact details:	Sarah.brennan@wwl.nhs.uk

Executive summary

Representatives from Wigan Local Medical Committee (LMC) attended the August Board Workshop to describe the importance of the primary–secondary care interface and to seek Board support for strengthening joint working between general practice, WWL and wider Wigan Place partners.

The presentation was intended to give the Board a direct clinical perspective on how communication, transfer of work and clarity of responsibility across organisational boundaries affect patient care, clinical capacity and relationships between teams. The GPs described examples including prescribing following outpatient or emergency care, requests for primary care to arrange specialist investigations, the quality and timeliness of correspondence, onward referrals, shared care and fit notes. They also acknowledged that interface improvement is reciprocal, including the need for clear, clinically focused GP referrals.

The presentation was set within the jointly developed Wigan Primary–Secondary care interface agreement. This sets out practical principles for both sectors, including that the clinician requesting a diagnostic test retains responsibility for it; unnecessary clinical and administrative transfers of care should be minimised; communication should be clear and timely; and work should be undertaken by the clinician or service best placed to do it. The agreement is intended to support high-quality care, efficient use of clinical time and reduced duplication rather than to constrain integrated working.

The GPs highlighted that progress has already been made, including access to GP practice bypass numbers to support urgent consultant-to-GP communication. However, they considered that momentum had reduced in other areas, particularly the clinical exchange programme and regular senior clinical participation in the Primary–Secondary Care Interface Group.

The Board was therefore asked to support restoration and strengthening of the interface arrangements, with greater clinician-to-clinician engagement and consistent implementation of the agreed principles across Trust services. The presentation also identified future opportunities for

joint work, including single point of access and pathway redesign, discharge communication and referral quality, care home admissions and readmissions, shared care, data and the appropriate alignment of resource where work moves between sectors.

Link to strategy and corporate objectives

This work supports WWL's strategic intent to deliver integrated, patient-centred care through stronger partnership working across organisational boundaries. It is directly relevant to improving patient flow, reducing avoidable duplication and hand-offs, making best use of clinical capacity, and supporting the Trust value of One Team across the wider Wigan system.

Risks associated with this report and proposed mitigations

The principal risks are inconsistent application of agreed interface principles, avoidable delay or duplication in patient pathways, unclear clinical responsibility, transfer of workload without appropriate capacity or resource, and deterioration in relationships between primary and secondary care. Mitigation is through a strengthened interface governance arrangement, senior clinical participation, clear escalation routes, consistent communication of the agreement and monitoring of agreed actions and themes.

Financial implications

No specific financial requirement is sought through this report at this stage. There may be resource implications associated with clinical participation, pathway redesign or future changes in where work is undertaken. The GP representatives specifically highlighted the importance of resource following work where pathway changes move activity between sectors. Any material financial consequences arising from agreed next steps should therefore be assessed through the appropriate business and governance processes.

Legal implications

The interface agreement reflects requirements and responsibilities arising from the NHS Standard Contract and locally agreed arrangements. Particular areas of relevance include responsibility for investigations and results, communication with patients and GPs, prescribing, shared care, fit notes and onward referrals. Consistent implementation is important in reducing clinical and medico-legal risk.

People implications

The presentation highlighted the impact that avoidable administrative transfer and unclear responsibilities can have on clinical time, workload and professional relationships in both primary and secondary care. Stronger clinician-to-clinician engagement, including the proposed clinical exchange approach, is intended to improve mutual understanding, relationships and the effective use of workforce capacity.

Equality, diversity and inclusion implications

Effective interface working should improve access and continuity for patients by reducing unnecessary hand-offs, delays and duplication. The interface agreement explicitly states that changes should not create or exacerbate inequalities, including through digital exclusion. Equality impacts should therefore be considered as individual pathways and workstreams are redesigned.

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

N/A

Recommendation(s)

The Board is asked to:

- Note the issues and opportunities described by GP/LMC representatives in relation to the primary–secondary care interface.
- Endorse the continued implementation of the Wigan Primary–Secondary Care Interface agreement across Trust services.
- Support regular senior clinical engagement from WWL in the Primary–Secondary Care Interface Group and stronger clinician-to-clinician working.
- Support appropriate clinical and operational capacity to progress agreed interface priorities. Agree that a clear set of next steps, owners, measures and reporting arrangements is developed and brought back through the appropriate governance route.









The interface between Primary and Secondary Care

Key messages for NHS clinicians and managers

(V10) January 2026

The National work towards the interface between primary and secondary care is supported by

Contents:

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Document Control:

Title	The Interface between Primary and Secondary Care V9 review of v8 draft
Supersedes	V8 March 2022
Minor Amendments	
Author	Wigan LMC ; WWL, ICB Place Wigan , PCSI ForuM Task and Finish Group Reference Docs BMA – Text taken from the document "The interface between primary and secondary care – Key Messages for NHS clinicians and managers. GM document "Primary and Secondary Care Interface Principles" details included. Wigan LMC: WWL : Wigan Place PCSCI Task and Finish group Acknowledement to Cheshire and Mersey ICB for permission to utlise and adopt some graphics and images in the C&M Consensus at the Interface.
Ratification	
Application	
Circulation	WWL – SLT, CLT, Clinical Governance: all clinicians Wigan LMC – all Gps and Practice Managers GM ICB PCSI Working Group GM ICB Place Wigan ICP
Review	July 2026 by Wigan LMC, WWL Teaching Hospitals and Wigan Place Task and Finish Group under the auspices of Wigan LMC; WWL: GM ICB Wigan Place, and GM Integrated Care System.

PART ONE: PURPOSE AND PRINCIPLES

1 Purpose

Within the Wigan borough locality there has been a long-standing relationship with Primary and Secondary Care clinicians who want to ensure that patients receive the best possible care in the right place at the right time to ensure that we achieve the optimum outcomes for our patients.

Over the past few years this has been strengthened through the integrated working through Healthier Wigan Partnership bringing together stakeholder organisations to work as a system to deliver a high standard of health and social care outcomes for our patients.

This document sets out the requirements of Primary and Secondary Care clinicians when referring a patient from one setting to another or discharging the care of the patient.

The document is not intended to hinder or limit our ability and ambitions as an integrated system to transform and reform our services.

2 Introduction

Good organisation of care across the interface between general practice and secondary care providers is crucial in ensuring that patients receive high-quality care and in making the best use of clinical time and NHS resources in both settings. This briefing document describes the key national requirements which clinicians and managers across the NHS need to be aware of. These are set out in the NHS Standard Contract for 2017, under which GM ICB and NHSE or successor bodies commission health services from providers, which came into effect on 1 April 2017 and has remained in place throughout subsequent contracts including the latest version of the contract dated March 2025.

This document has been cross checked with the Greater Manchester (GM) document “Primary and Secondary Care Interface Principles” to ensure alignment with the work in GM.

3 Principles and responsibilities

The following principles have been jointly produced with the overarching expectation that Clinicians and managers on either side of the Primary Secondary Care Interface should work together to do what is in the interest of Patients and within simplified and effective patient pathways with less silos and handoffs and by working positively at organisational interfaces.

No	Principles for all
1	The responsibility for diagnostics will remain with the requesting clinician. Treatment will be started and continued by receiving clinician unless part of a commissioned pathway.
2	If a request or referral is made to another part of the health care system, the requester should ensure all relevant information, based on an appropriate clinical assessment, has been shared with as much detail as possible, using agreed referral/request routes, in order to support the patient to best effect. Subsequent information required will be shared in a timely manner to prevent unnecessary delays in patient care, and to minimise bureaucracy or duplication.
3	Clinical and administrative transfers of care should be minimised between (or within) primary / community / secondary; facilitated through access to shared records and ensuring every contact counts.
4	Information sharing and other means of requests, are critical and should be digitally enabled and with appropriate information governance.

5	Standardised processes will be implemented for efficient and effective use of resources and to deliver the best possible patient care. Establishing a consistent approach to ensure that ways of working are embedded by staff and patients (including self-care).
6	Any actions to improve the interface between primary and secondary care will not create or exacerbate inequalities in any population including for example, through digital exclusion. This is an opportunity to improve the system for all, including the most vulnerable groups
7	All communication , exchanges and interactions between parties at the interface should be conducted in a professional and courteous manner at all times. Serious differences about how a matter should be handled across the interface will be resolved quick by adjudication via a panel convened by the LMC comprising a WWL MD and GPs not party to the difference

All communication, exchanges and interactions between parties at the interface should be conducted in a professional and courteous manner at all times. Serious differences about how a matter should be handled across the interface will be resolved quick by adjudication via a panel convened by the LMC comprising a WWL MD and GPs not party to the difference

Principles for Primary Care

- **When referring to secondary care please ensure you are clear in your 'ask' <u>see section 4</u>** of this document and below.
- Why are you referring this patient? Are you looking for advice, diagnosis, treatment?
- Please describe the reason for referral, and don't just put 'please see GP summary / consultation'
- Ensure an up-to-date medication list is available along with investigations to date.
- What are the patient expectations?
- If referring looking for a diagnostic procedure, please check local pathways for open access opportunities (this could include endoscopy, cardiology investigations or paediatric blood tests).
- Please avoid using abbreviations and acronyms. These may be commonplace within your team but may not be understood in Secondary Care.
- Place based systems should ensure that access to community. phlebotomy / diagnostics is available and understood by clinicians.

- **When referring to secondary care please ensure appropriate Primary Care assessments have been made;**
- Check local pathways for pre-referral criteria and potential investigations.
- Consider consultant advice and guidance.
- Consider other sources of help and guidance.
- Consider when face to face assessment may add value before referral (both elective and emergency).
- Remember, it can be helpful to have a face-to-face conversation with a patient who requires Rapid (2 week wait) referral to ensure understanding of the pathway being used and to record physical/frailty status of the patient.

- **When referring to secondary care please clearly communicate to the patient who you are referring them to, for what and what to expect (if known).**
- Please advise patients that waiting lists may be long and that first contact may be a remote consultation.
- Consider the use of Easy Read patient leaflets (where available) to inform about their condition.

- **When referring with the expectation that an operative procedure may ultimately be required, please consider optimising any Long-Term Conditions;**
- BP control for hypertensives, glycaemic control for those with diabetes etc.

- Please do empower patients to optimise their own health in the waiting period
- smoking cessation advice, weight advice etc.
- This will reduce the impact of last-minute cancellations in pre-op clinic

Principles for Secondary Care

- **Ensure clear and timely communication to the GP following patient contacts <u>see section 8 & 9 below</u>**
- This applies to both Outpatient episodes as well as on discharge from admission and A&E.
- Please highlight any changes in medication and reasons for any changes.
- Please avoid using abbreviations and acronyms. These may be commonplace within your team but may not be understood in Primary Care.
- Be clear about what follow up is required, how it will be provided and how any outstanding test results will be reviewed.
- Be explicitly clear about any requests/actions for the GP.
- If you want the GP to 'monitor' U&E for example, please say why, how often, for how long and what your expectations are if results are/remain abnormal.
- If you need a repeat test within a short period of time e.g., 2 weeks, please arrange this to avoid potential delays.
- The Trust should ensure fit notes are available for colleagues in Out-Patients.

- **Avoid asking General Practice to organise specialist tests - <u>see section 7 below.</u>**
- If you want the patient to have their blood test closer to home, then provide the blood form and enable community phlebotomy.
- Place based systems should ensure that access to community phlebotomy/diagnostics is available and understood by hospital colleagues.
- If a clinician wishes the patient to have further tests prior to next review they should look to undertake these investigations themselves.

- **If patients need a fit note (sick note) then please provide one - <u>see section 11 below.</u>**
- Provide Fit Notes for an appropriate period (if you know they need 3 months off work don't issue a 2 week note).
- Please issue fit notes from Out-Patients if these are required rather than sending back to the GP.

- **If immediate prescribing is required from Outpatients, Endoscopy, Procedure please prescribe - <u>see section 10 below.</u>**
- We would suggest work on ePrescribing for the Trust is accelerated.
- Prescribe an initial course of at least 14 days.

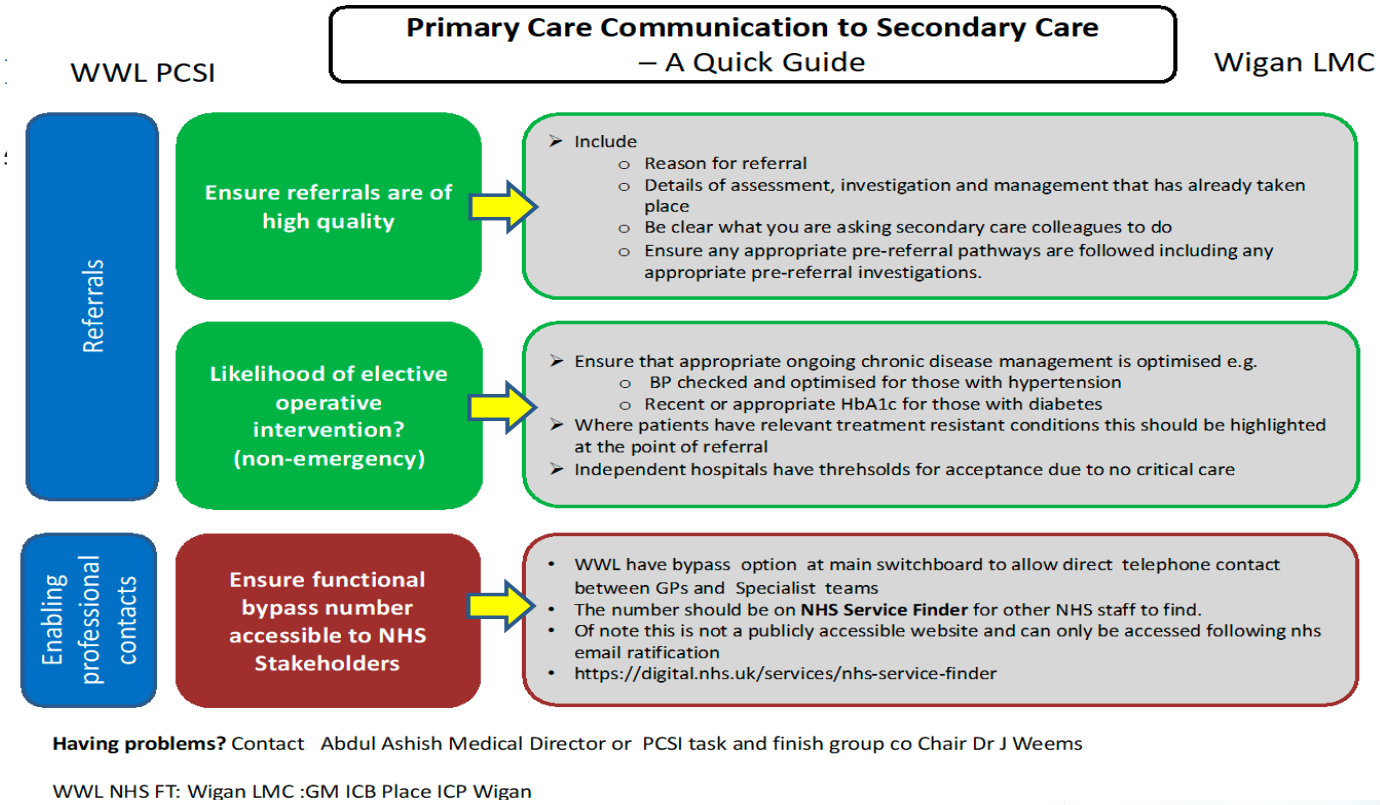
- **Discharge medications for longer term conditions should cover a period of between 14- 28 days or longer as agreed - <u>see section 10 below.</u>**
- When recommending ongoing prescribing from the GP please check the GMMMG agreed prescribing formulary first - **<u>HYPERLINK "https://www.greatermanchesterformulary.nhs.uk/default.asp" https://www.greatermanchesterformulary.nhs.uk/default.asp.</u>**
- It is important to check that the suggested medication is appropriate for the GP to prescribe.

- **Please put follow up plans in place for patients who self-discharge.**
- By definition these patients are thought to be unwell and vulnerable. They may have chosen to decline in-patient treatment, but they are still in need of our care; which may mean appropriate follow up in clinic is arranged.
- This also includes providing appropriate discharge care and medication.

- **Please ensure any DNAs are not automatically discharged without clinical review** **see section 5 below.**
- Also please ensure any discharge is communicated to patient and GP with reason why - see the specific agreement section 5 in this document.
- If patients are transferred to patient initiated follow up (PIFU) or seen on symptoms pathways, please ensure you clearly reference the criteria to access a further appointment.

- **Please arrange onward referral without referring back to the GP where appropriate - see section 6 below**
- A hospital clinician should be expected to arrange an onward referral if the problem relates to the original reason for referral e.g., patient referred to respiratory with breathlessness and respiratory consultant thinks it is a cardiac problem, the respiratory consultant should do the referral to cardiology.
- A serious and very urgent problem comes to light.

Section 4 Primary care communication to Secondary Care



It is important, in terms of patient experience and service efficiency, that Primary Care Clinician referrals to providers are clinically appropriate for the service referred to, are made in accordance with any agreed clinical pathways and referral protocols and include all the necessary clinical and administrative information. The contract requires Commissioner bodies to ensure that this is what happens in practice.

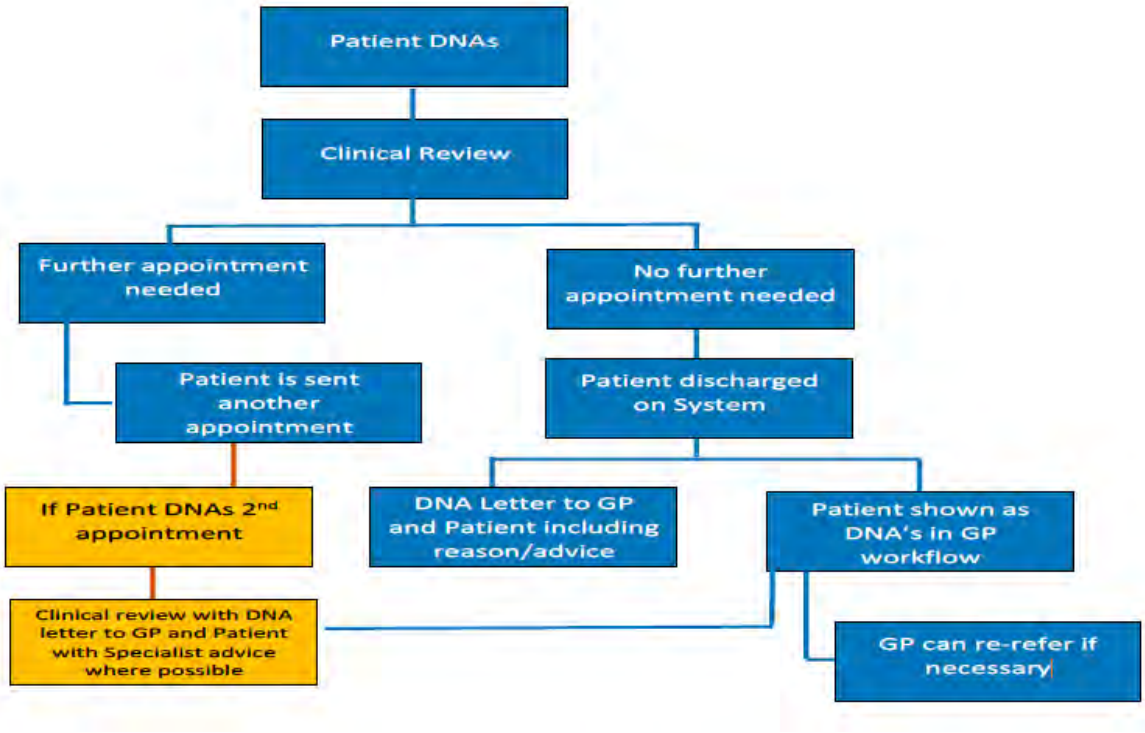
During and since the Covid-19 pandemic waiting lists have risen to unprecedented levels. It is important that patients are managed within primary care using existing pathways where appropriate. With the pandemic came new ways of working to ensure that patients could access services virtually.
Across the system, in addition to the conventional face to face appointments, clinical teams are using additional / alternative means of patient engagement e.g. Primary care using the Ask My GP app, digital appointments, telephone, and video consultations; secondary care utilising telephone, video appointments and patient initiated follow up (PIFU). The use of Advice and Guidance (A&G) has helped primary care teams to interact with secondary care teams in new ways than before and much quicker. GP Contract arrangements have been introduced to fund using A&G first if possible. Ensure that the patient is reviewed via face-to-face appointment where and when appropriate before a referral into secondary care takes place.

WWL/Wigan LMC/CCG representatives agreed:
That where appropriate, all existing pathways within primary care should be used in the first instance and where necessary and appropriate, advice and guidance should be used prior to a referral for an outpatient appointment.

Patients who are sent an appointment within 7 days in the post will also receive a telephone call to notify them (plus text reminder if a mobile number is held on the system).

5 Managing DNAs and re-referrals
When providers automatically discharge all patients, who do not attend a clinic appointment back to their Primary Care Clinician, this can create inconvenience and delays for patients and cause significant additional work for practices in simply re-referring many of the patients. The contract requires that a provider's local access policy must not involve blanket administrative policies under which all DNAs are automatically discharged; rather, any decisions to discharge are to be made by providers on the basis of clinical advice about the individual patient's circumstances.

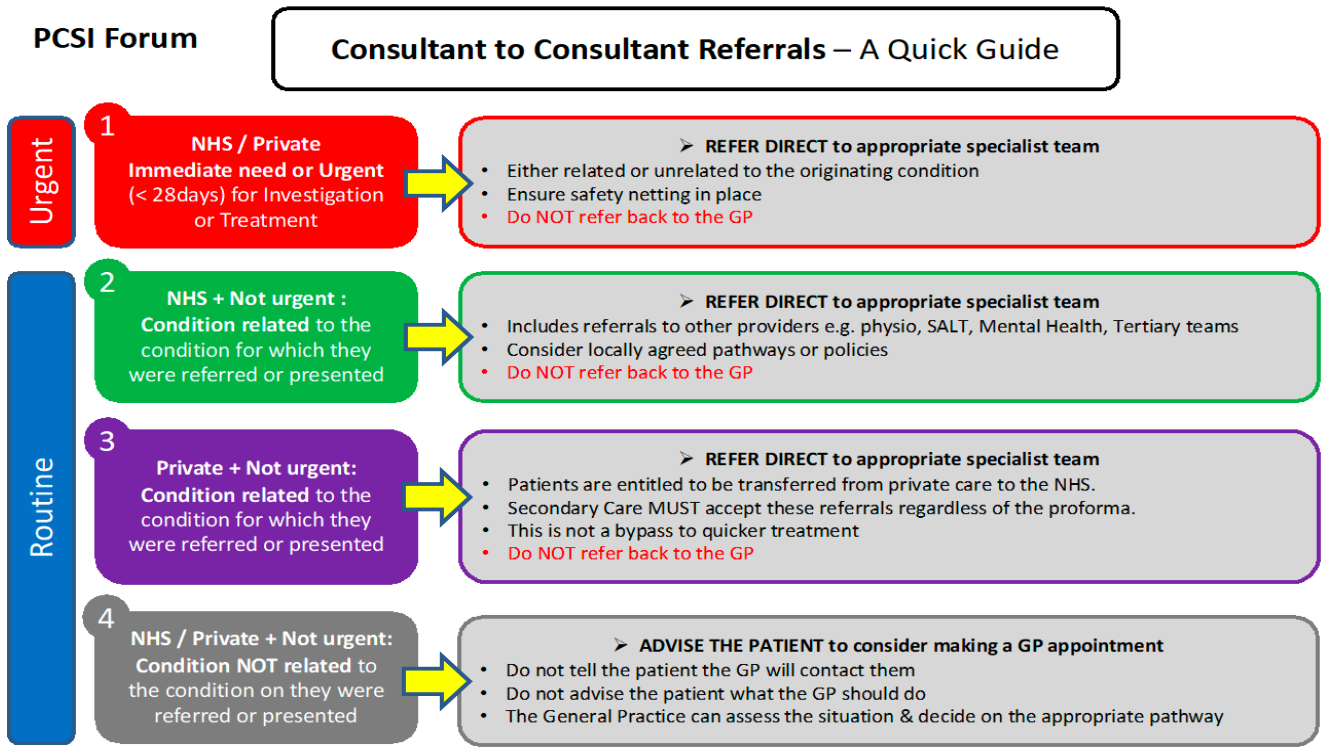
WWL/ Wigan LMC/GM ICB Place Wigan representatives agreed:



DNA letters to GPs directing that no further clinic appointment is necessary should contain an explanation of how this decision was reached and a confirmation that Patient has been advised that no further clinical appointments are deemed necessary.
DNA letters to patients and GPs should contain the Name and contact telephone numbers of the discharging Specialist

This process will be followed for both face to face and digital appointments. There will be no differentiation.

6 Managing onward referrals



It is important that there is clarity about situations in which provider clinicians may make onward referrals. Where a patient has been referred to one service within a provider by the Primary Care Clinician, or has presented as an emergency, the contract allows the provider clinician to make an onward outpatient referral to any other service, without the need for referral back to the Primary Care Clinician, where:

either the onward referral is directly related to the condition for which the original referral was made, or which caused the emergency presentation (unless there is a specific local ICB Place (or successor body) policy in place requiring a specific approach for a particular care pathway).

or the patient has an immediate need for investigation or treatment (suspected cancer, for instance). For clarity the Task and Finish Group view is that this includes cases in which the Specialist suspects that a detected condition, which is not directly related to the condition for which the patient was referred, would need immediate specialist diagnosis and treatment.

By contrast, the contract between GM ICB Wigan Place (formerly Wigan CCG) and Wrightington Wigan and Leigh NHS Teaching Foundation Trust, does not permit a hospital clinician to refer onwards where a patient's condition is non-urgent, and where the condition for which the referral would be made is not directly related to the condition which caused the original Primary Care Clinician referral or emergency presentation. In this situation, the contract requires the hospital clinician to refer back to the patient's Primary Care Clinician The onward referral can then be made by the Primary Care Clinician, who may instead choose to manage the patient's condition him/herself or to refer into a different service.

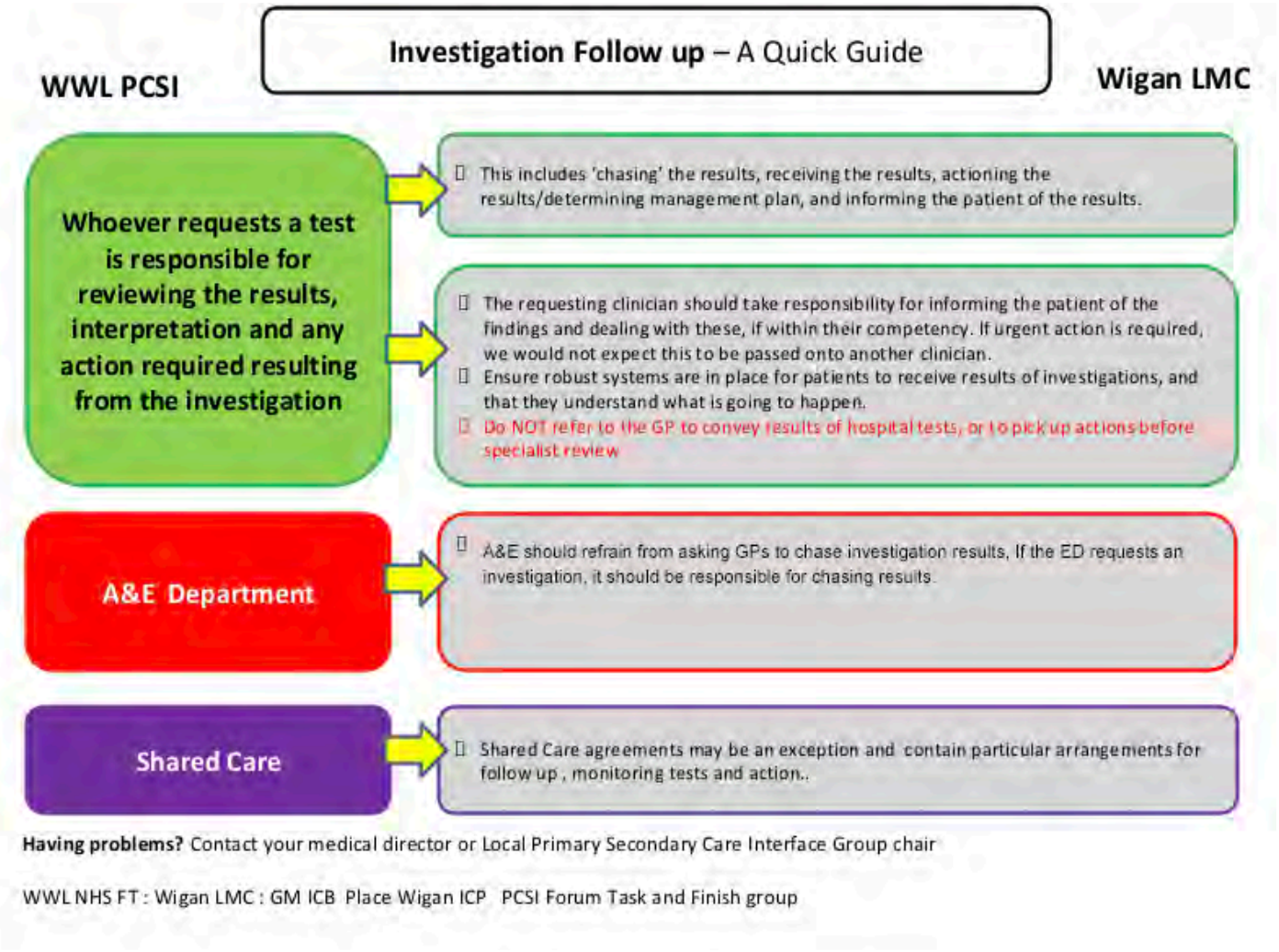
WWL/LMC/GM ICB Wigan Place representatives agreed:
Secondary Care Clinicians are required to operate the policy in the spirit in which it was intended See section 3 above. Primary Care clinicians will be asked to respect the clinical opinion of Secondary Care Clinicians but if specific issues arise these will be highlighted to the Trust for review. Baseline information

for Consultant to Consultant levels will be provided to allow monitoring.

Examples on ward referrals
Below are a few practical examples, but it must be realised that in clinical practice there will be "grey" areas, and at times there will be some variations of opinions.

A patient has been referred by the PRIMARY CARE CLINICIAN for investigation of breathlessness to respiratory department. The respiratory consultant has excluded respiratory causes but feels a cardiology opinion is needed to further the care of the patient. This referral SHOULD be made by the respiratory consultant to the cardiology department.
A patient has been referred to cardiology services to investigate "blackouts". The cardiology consultant feels that a neurological opinion is needed. This referral should be made by the cardiology consultant to neurology.
A patient is under haematology care with anaemia, and the consultant feels that it is necessary to investigate the gastrointestinal tract of the patient. This referral should be done by the consultant haematologist to the gastroenterologist.
A patient is under rheumatology or orthopaedic / MSK services with joint pains, and the clinician feels a pain clinic review is needed. This referral should be done by the consultant rheumatologist / orthopaedic surgeon to the pain service.
A patient is seen in cardiology clinic for review of heart failure. The patient mentions to the consultant that they have been experiencing diarrhoea. The consultant does not feel that there are any obvious cardiology reasons for this (i.e., no new medications have been started that could cause the symptom). The patient should be advised to consult their PRIMARY CARE CLINICIAN for further review.
A CT thorax and abdomen is performed for weight loss by a consultant. The CT shows no sinister abnormality (i.e., no cancer) BUT shows gallstones. The consultant should check the records that are available to see if the gallstones are known to be problematic (i.e., has the patient had admissions with biliary issues). The consultant is responsible for communicating this result to the patient. It would be acceptable to say something along the lines of "the scan also shows some gallstones. Please contact your Primary Care Clinician for further review.
A CT scan done by a specialist (any speciality) shows a lesion (a) which is suspicious of malignancy, the Secondary Care Clinician should make a referral to the appropriate specialty/MDT (b) non-malignant/ benign/incidental finding, the Secondary Care Clinician should refer back to the Primary Care Clinician for further review.

7 Managing patient care and investigations.



The GM ICB Place Wigan (or successor body) will have a key role in commissioning services and designing care pathways so that they operate in a clinically appropriate, efficient, and convenient way for patients. Depending on local commissioning arrangements, different secondary care providers and general practice may each have a role to play in delivering a particular care pathway. However, the contract makes clear that, within the context of the elements of the service which it has been commissioned to provide, a secondary care provider must itself arrange and carry out all of the necessary steps in a patient's care and treatment rather than, for instance, requesting the patient's Primary Care Clinician to undertake particular tests within the practice. (Please read in conjunction with section 5 above).

Surveillance investigations/procedures are the responsibility of secondary care, e.g., valve surveillance ECHO, endoscopy for Barrett's oesophagus, PSA/other blood tests before next appointment should be performed by secondary care clinicians. Blood test forms should be provided by specialist departments to patients in anticipation of the next secondary care appointment.

WWL/Wigan LMC/GM ICB Place Wigan representatives agreed:
Post diagnostic monitoring should be carried out in primary care where appropriate and when the patient is stable/or discharged. The initial diagnostic investigations/test will be carried out and acted upon by secondary care but as a general rule, post diagnosis monitoring should be carried out in primary care. There are, however, exceptions to this rule such as the ECHO example above. This applies to all forms of consultation i.e., face to face and digital. Surveillance of conditions e.g. PSA ,and related investigations and procedures are distinct from general post diagnosis referred above and will be subject to specific agreements and protocols.

Example managing patient case / investigations

Cardiology department advises an ECHO in 12 months' time: should the Primary Care Clinician do this, or should it be WWL? WWL should be responsible for arranging this investigation.
Similar to e-prescribing, WWL now has the facility to arrange requests for pathology tests and radiology investigations through the electronic HIS System.

8 Communicating with patients and responding to their queries.

It is important that providers take responsibility for managing and responding to queries received from patients. There are instances where providers simply refer questions about a patient's secondary care to the Primary Care Clinician, and the contract makes clear that this is not acceptable. It requires the provider to:

Put in place efficient arrangements for handling patient queries promptly and publicise these arrangements to patients and Primary Care Clinicians, on websites and appointment/admission/clinic/discharge letters and ensure that they respond properly to patient queries themselves, rather than simply passing them to practices to deal with.

Communicate the results of investigations and tests carried out by the provider to patients directly, rather than relying on the practice to do so (except in the case of Primary Care Clinician direct access diagnostic services). (Note that all clinicians, whether in primary or secondary care, retain clinical and medico-legal responsibility for the results of investigations which they personally request; sending a result on to another clinician does not absolve the original requester of that responsibility).

WWL/ Wigan LMC/ GM ICB Place Wigan representatives agreed:

The Provider Trust will ensure that all outpatient letters and discharge summaries are copied to patients (excluding agreed exceptions) and that a contact number for the Consultant managing the patient is provided. Patients should be advised in the letter that they should raise queries and concerns about the clinical condition and its management which gave rise to that secondary clinical episode with the Specialist on the number provided in the letter.

9 Discharge summaries and clinic letters.

Communication between the provider and the Primary Care Clinician should be clear and timely. Lack of clarity or delay may cause inconvenience to patients and create inefficiency in how staff time is used. It is obviously essential for good patient care that there is clear and prompt communication on discharge from hospital, and also at key stages during an outpatient pathway. For this reason, the contract between GM ICB Place Wigan and Wrightington Wigan and Leigh NHS Teaching Foundation Trust sets out clear requirements on providers in terms of the provision of discharge summaries and clinic letters to Primary Care Clinicians.

WWL/ Wigan LMC/GM ICB Wigan Place representatives agreed:

A clinic letter is not required after every single attendance but, as a minimum, one must be sent after any clinic attendance where the secondary care health professionals need to pass information to the Primary Care Clinician so that he/she can take action in relation to the patient's ongoing care. Where required, providers must send clinic letters within 7 days of the patient's attendance. (If the Primary Care Clinician does not receive a letter following an outpatient attendance, he/she will assume there is no action to be taken). It is good practice, though not a specific contract requirement, for a letter to be sent where there is a material change in the patient's condition or its management, even where there is no need for the Primary Care Clinician to take specific action as a result.

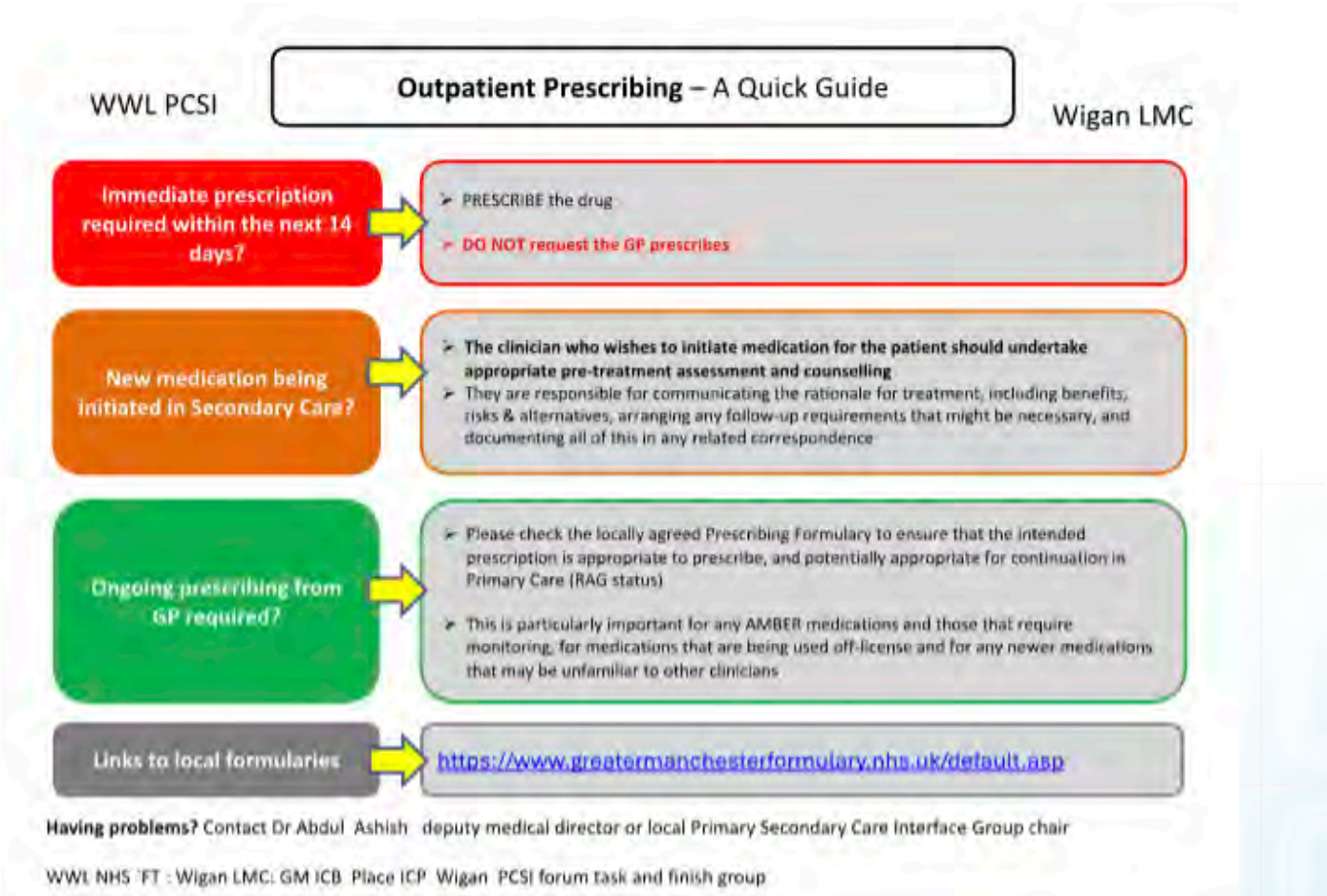
Discharge summaries following inpatient or day case admission must be sent electronically as structured messages of coded clinical information using standardised clinical headings. This requirement also applies to clinic letters and discharge summaries after A&E attendance.

As a matter of good practice, clinicians in both primary and secondary care should consider the content of communication carefully; a good way of assessing the quality of a letter/summary is to review it in the eyes of the recipient.

In accordance with the national requirement the Trust will aim to issue all discharge summaries electronically within 24 hours but in all cases within 2 working days. Outpatient letters will be issued within 7 working days.

It has been agreed that A&E should refer patients back to Primary Care Clinicians for further review unless there is a suspicion of malignancy or there are urgent findings on examination or investigation. However, the language used should be **"consider referring to…."**. The hospital clinician should give enough information for Primary Care colleagues to make the informed decision. Please note that there should not be postscript "PS" on discharge letters as it is too easy to miss.

10 Medication and shared care protocols



It is important that the responsibilities of providers and practices are clear, in terms of supply of medication to patients following hospital admission or attendance. Provision of insufficient quantity of medication from secondary care can mean that patients run out of medication, with adverse effects on their care, and have to make avoidable extra appointments with their Primary Care Clinician, and the Primary Care Clinician will not be able to prescribe appropriately if he/she has not received up-to-date information from the hospital about the patient's care.

The NHS Standard Contract allows the period for which the provider must supply medication to be determined in a local policy, but this must at least cover a minimum period.

WWL/Wigan LMC/GM ICB Wigan Place representatives agreed:
For medication on discharge following hospital admission, the minimum period of supply is 14 days (unless

a shorter period is clinically appropriate).
Where a patient has an immediate need for medication as a result of clinic attendance, Endoscopy procedure etc., the Provider must issue 28 days' supply (or as clinically appropriate).

Shared care protocols enable care to be provided more conveniently and closer to home for patients. Such protocols are agreed with the Greater Manchester Medicines Management Group in conjunction with the local Medicines Management Team. Introduction of a new protocol may sometimes require the Commissioner to commission a new local service from practices. However, the contract makes clear that the hospital must only initiate care for a particular patient under a shared care protocol where the individual Primary Care Clinician has confirmed willingness to accept clinical responsibility for the patient in question. Where this is not the case, the on-going prescribing and related monitoring will remain the responsibility of the secondary care team.

Hospital clinicians should issue prescriptions while doing remote clinics or reviewing investigation results. Prescriptions should be issued electronically when possible.

All patients are now able to collect prescriptions following their outpatient consultation whether this is digital or face to face, as the development of the electronic prescription facility allows hospital clinicians to prescribe online which saves delay and unnecessary workload for Primary Care.

11 Fit notes

It is important that Fit notes are issued to patients in a way which is convenient for them, and which is efficient in how clinical staff time is used. Where there is an appropriate opportunity (on discharge from hospital or clinic), provider clinicians must issue fit notes to appropriate patients, and their organisations must enable this, rather than expecting patients to make a separate appointment to see their Primary Care Clinician simply for this purpose. The contract includes a requirement to this effect.

The Standard NHS Contract also requires that fit notes cover an appropriate period, that is, until the patient is expected to be fit for work (following surgery, for example) or until a further clinical review will be required. (It is good practice for clinic or discharge letters to Primary Care clinicians to make clear where fit notes have been issued by the provider, the reasons given, and the exact dates covered).

WWL/ Wigan LMC/GM ICB Wigan Place representatives agreed:

If a patient needs to be certified as unfit for work following treatment by a specialist:

The specialist should issue a Fit Note.

The Fit Note should cover the period that the patient is expected to be unfit for work, or until the patient's next contact with the specialist.
A Primary Care Clinician should not need to issue a Fit Note following hospital treatment unless the patient's inability to work is unexpectedly prolonged.

Appendices

Appendix 1: The interface between primary and secondary care - key messages for NHS clinicians and managers.

AcroExch.Document.DC
https://www.england.nhs.uk/wp-content/uploads/2017/07/interface-between-primary-secondary-care.pdf

Appendix 2: The GM Primary Secondary Care Principles document
https://wiganlmc.org.uk/wp-content/uploads/2025/08/GM-PCSCP.pdf









Title of report:	Regional Mid-Year Review 2026/27: Board Self-Assessment and Certification
Presented to:	Board of Directors
On:	7 October 2026
Item purpose:	Endorsement of Submission (made 2 October 2026)
Presented by:	Director of Corporate Governance
Prepared by:	Director of Corporate Governance
Contact details:	Katharine.dowson@wwl.nhs.uk

Executive summary

As part of the NHS England regional mid-year review for 2026/27, all provider Boards are required to complete a standard self-assessment and return it to the regional team by Friday 2 October 2026 as per the letter received on 18 September 2026. The assessment provides a structured basis for the Board to review and confirm its confidence in delivery of the 2026/27 plan, preparedness for winter 2026/27 and the commencement of planning for 2027/28.

The exercise seeks explicit Board assurance across the key domains that underpin successful delivery of annual plans, including operational performance, financial sustainability, workforce, productivity, transformation, governance, risk management and winter preparedness. The attached assessment uses four ratings: Fully Assured; Assured with Managed Risks; Partially Assured; and Not Assured.

Due to the tight timescales the Executive Team were asked by NHS England to approve submission on 2 October 2026. The region agreed that Executive sign off was acceptable and if there were any changes made at the Board meeting these should be informed to the regional team as soon as possible. Executive Team were therefore asked to test the evidence, identify any material gaps or dependencies, agree the proposed ratings and commentary ensuring that any conclusions were evidence-based, candid and consistent with current performance, trajectories, recovery plans, risk registers and established assurance reporting.

Link to strategy and corporate objectives

The self-assessment supports delivery of the Trust's agreed 2026/27 organisational plan and provides assurance that operational, financial, workforce, productivity and transformation priorities remain aligned with the Trust's strategic objectives. It also reinforces effective governance, transparent risk management and system working.

Risks associated with this report and proposed mitigations
The principal risk is that the Board's stated level of assurance is not supported by sufficiently current, complete or triangulated evidence. Further risks include deterioration in operational or financial performance, workforce capacity constraints, slippage in productivity or transformation delivery, unresolved system dependencies and winter demand exceeding planned capacity. Mitigation is through executive validation of the ratings and narrative, use of current performance, finance, workforce and risk information, clear ownership and timescales for outstanding actions, continued oversight through established committees and prompt escalation of any material change before submission.

Financial implications
There is no direct additional financial commitment arising from completion of the self-assessment. However, the assessment must accurately reflect the Trust's financial position, delivery of efficiency and productivity plans, forecast risks and the adequacy of recovery actions. Any actions agreed to strengthen delivery will be managed through existing financial governance arrangements, with separate approval sought where additional resources are required.

Legal implications
No specific legal implications arise from completing the return. The Board should nevertheless ensure that its certification is accurate, properly evidenced and consistent with its statutory duties, regulatory obligations and approved governance arrangements.

People implications
Workforce capacity, capability, wellbeing, recruitment, retention and deployment are core dependencies for delivery of the 2026/27 plan and winter resilience. It is important that material workforce risks are reflected in the assessment and that mitigations have clear ownership, milestones and escalation routes.

Equality, diversity and inclusion implications
There are no direct equality, diversity and inclusion impacts arising from completion of the self-assessment. In reviewing delivery risks and mitigations, Executive Team should consider whether operational, workforce, financial or transformation actions could disproportionately affect groups protected under the Equality Act 2010, staff inclusion or access to services, and ensure that any required equality impact assessment is completed through the relevant decision-making process.

Which other groups have reviewed this report prior to its submission to the committee/board?
The supporting evidence is drawn from established Executive and Board assurance routes, including current integrated performance reporting, finance, workforce, transformation, risk and winter planning arrangements.

Executive Team reviewed this paper on 1 October and submission to NHS England was approved.

Recommendations
- Note the attached Board Self-Assessment and the proposed level of assurance against current evidence

- endorse the completed assessment which was approved by the Executive Team on 1 October ahead of submission to the NHS England Regional Team on Friday 2 October 2026.

Report

1. Purpose and regional requirement
NHS England has requested that all provider Boards complete the attached self-assessment as part of the regional mid-year review for 2026/27. The completed return was required by Friday 2 October 2026. Its purpose is to provide a consistent framework through which Boards can formally assess and confirm their confidence in delivery of agreed plans and identify where risks, dependencies or further action may affect delivery during the remainder of the financial year.

2. Scope of the assessment
The template requires a rating and supporting commentary in three areas: delivery of the 2026/27 plan; winter preparedness; and commencement of planning for 2027/28. In reaching its judgement, the Board is expected to consider operational performance, financial sustainability, workforce, productivity, transformation, governance, risk management and winter resilience. Commentary should identify the principal risks and dependencies, the mitigations in place, how these are being monitored and any further action needed.

3. Assurance ratings and implications
The available ratings are Fully Assured, Assured with Managed Risks, Partially Assured and Not Assured. A rating of Assured with Managed Risks may be followed up through routine regional oversight. A Partially Assured rating will prompt further engagement between the Regional Team and Executive Team. A Not Assured rating will lead to a formal Board-to-Board discussion. Ratings must therefore reflect the evidence available at the point of certification and should not understate known delivery risks or overstate the effectiveness of mitigating action.

4. Process of Review
Executive Team considered the assessment alongside the latest integrated performance report, financial, workforce, productivity, transformation and risk information, together with the winter assurance plan. For each section, confirmation was required as to whether the evidence supplied by individual Executive Leads supported the proposed rating, whether the commentary clearly described the current position, whether all material risks and system dependencies were included and whether mitigations are sufficiently specific, resourced, time-bound and subject to ensure appropriate oversight.

Where delivery is off trajectory the submission should include recovery actions underway, that there is an accountable Executive lead, agreed milestones and governance route through which progress will be monitored.

When the Executive Team reviewed the document they agreed to add in further detail in Section 1 due to the proposed rating of Partial Assurance. Further information on the actions in place was added for performance, finance and workforce.

5. Proposed assurance ratings and supporting evidence
The ratings below were submitted on 2 October in the submission document which is attached as Appendix 1.

5.1 Delivery of the 2026/27 plan – Proposed rating: Partially Assured

Supporting rationale and evidence.

The performance data as at 24 September provided evidence of established oversight and improvement activity but did not support full confidence that all annual commitments would be delivered without further material action. These actions have been outlined in the submission. The risks are being managed through fortnightly elective performance review, specialty recovery plans, independent-sector capacity, pathway validation, theatre optimisation, additional treatment capacity and diagnostic assurance arrangements.

Financial plan delivery was the most significant threat to plan delivery. Strengthening of Divisional Assurance meetings to hold divisions to account for these indicators and the delivery of recovery plans has taken place. If this is not evidenced by month 7 metrics then the Executive Team will need to take further action. The Board has reviewed the forecast financial risk and recovery framework, and controls include CFO/CPO/COO-led pay restraint, weekly CIP scrutiny, accelerated divisional turnaround, divisional recovery plans and committee oversight.

Several workforce indicators also remain off track. Further workforce mitigations are being developed and FTC reviews, cultural reviews to identify the root cause of sickness and an executive-led sickness absence panel with a workability ethos, underpinned by Healthy Working Lifecycle thinking.

The Board are asked to recognise that significant recovery actions and enhanced oversight arrangements are in place, however because performance remains below plan they cannot yet provide full confidence that all 2026/27 objectives will be achieved across several key operational, financial and workforce metrics. Material risks remain in relation to some areas.

5.2 Winter preparedness – Proposed rating: Assured with Managed Risks

Supporting rationale and evidence.

A current Winter Plan has been approved by the Executive Team and is awaiting Board approval. Existing operational governance includes integrated performance reports, divisional assurance meetings, escalation through Executive Team and Finance and Performance Committee, and EPRR self-assessment arrangements. Current performance demonstrates some positive assurance, including improving elements of urgent-care flow and established operational oversight; however, resilience remains dependent on sustained patient flow, discharge arrangements, capacity deployment and system coordination.

The principal risks are workforce availability and sickness, continued reliance on bank and agency staffing, urgent-care demand and flow, elective and cancer backlogs, infection prevention and control pressures, and the operational effect of constrained finances. September People Committee reporting confirms that sickness remains above target and appraisal compliance below target, although improvement plans, hotspot analysis, the absence-reduction programme and divisional oversight are in place. Quality governance has also provided assurance on the response to C. difficile, with robust improvement actions and no evidence of an outbreak. On balance, planning and governance arrangements are established and risks are understood and actively managed, but delivery remains exposed to known operational and workforce pressures. The final Winter Plan includes quantified capacity and workforce assumptions, escalation triggers, system dependencies and tested contingency arrangements. Assured with Managed Risks is therefore proposed.

5.3 Commencement of planning for 2027/28 – Proposed rating: Assured with Managed Risks

Supporting rationale and evidence. Forward planning has commenced with a paper taken to Executive Team Meeting on 1 October. The Strategy 2031 refresh and delivery ambition metrics have been considered by the Wider Leadership Team and Board, with final approval planned for October Board. The Trust also has established annual operational, capital, workforce, financial and committee planning arrangements, with five-year capital planning overseen through the Capital Strategy Group and Finance and Performance Committee.

The principal dependencies are receipt of national, regional and Greater Manchester planning requirements, translation of the refreshed strategy into measurable annual priorities, a credible financial trajectory, recurrent productivity and CIP opportunities, workforce affordability and capacity and alignment of service, digital and capital plans. Current-year financial and workforce performance increases the challenge of establishing a deliverable baseline for 2027/28. Nevertheless, governance and preparatory activity are demonstrably under way and there is a clear route to the detailed plan. Assured with Managed Risks is therefore proposed, with the expectation that milestones, responsibilities, assumptions and system dependencies are consolidated into an integrated planning timetable and reported through Executive Team and Board oversight.

6. Governance and next steps

The assessment was formally submitted to the NHS England Regional Team by the deadline of Friday 2 October 2026. Following Board review any material changes will be communicated to NHS England immediately. Actions arising from the review will continue to be monitored through the relevant Executive and Board Committees, with escalation where the risk profile or level of assurance changes.

Appendix 1 - NHS England Board Self-Assessment and Certification Template: Mid-Year Review 2026/27.

Board Self-Assessment and Certification Template

Mid-Year Review 2026/27

Purpose

As part of the Regional Mid-Year Review process, Boards are requested to undertake a self-assessment of their level of assurance against the statements below and provide supporting commentary where appropriate.

The purpose of this assessment is to enable the Regional Team to understand the Board's confidence in:

- Delivery of the 2026/27 plan.
- Preparedness for Winter 2026/27.
- Progress in commencing planning for 2027/28.

Assurance Ratings

Please select one rating for each statement.

□ Fully Assured

The Board has reviewed the available evidence and is fully confident that:

- Robust plans, governance and oversight arrangements are in place.
- Delivery is on track and within agreed tolerances.
- Risks have been identified and are being effectively managed.
- No material concerns exist that would significantly impact delivery of the stated objective.

Regional Response: No further action required beyond routine monitoring.

□□ Assured with Managed Risks

The Board is assured that delivery remains achievable; however:

- There are known risks, challenges or dependencies requiring active management.
- Appropriate mitigations are in place and are being monitored through established governance arrangements.
- The Board remains confident that the objective will be delivered notwithstanding these risks.
- No immediate regional intervention is required.

Regional Response: Risks and mitigations may be reviewed through routine assurance discussions and monitoring processes.

⚠ Partially Assured

The Board has identified concerns that require further attention and assurance because:

- Significant risks or dependencies remain unresolved.
- Additional mitigating actions are required to secure delivery.
- There is a risk to successful delivery if current issues are not addressed.
- The Board cannot yet provide full confidence that the objective will be achieved.

Regional Response: The Regional Team will seek further clarification through discussions with the Executive Team and review of supporting evidence. Additional actions may be agreed where required.

🔴 Not Assured

The Board does not currently have sufficient confidence that delivery can be achieved because:

- Material risks exist that threaten successful delivery.
- Mitigations are not fully developed, not operating effectively, or are unlikely to be sufficient.
- The Board has significant concerns regarding the organisation's ability to meet the stated objective.

Regional Response: A formal **Board-to-Board discussion** will be initiated to understand the issues, agree support requirements and determine any further actions necessary.

Board Self-Assessment and Certification

Mid-Year Review 2026/27

Organisation: Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Section 1: Delivery of the 2026/27 Plan

The Board confirms that it has reviewed progress against the 2026/27 organisational plan and is assured that appropriate governance, performance oversight, risk management and delivery arrangements are in place to support successful delivery of the agreed objectives.

Based on current performance, trajectories, recovery plans and mitigating actions, the Board is confident that the organisation has a credible and deliverable plan and that all reasonable actions are being taken to deliver the commitments set out within the 2026/27 plan.

Self-Assessment Rating

☐ Fully Assured

☐ Assured with Managed Risks

☒ Partially Assured

☐ Not Assured

Commentary (including key risks and mitigating actions where applicable)

The Board has reviewed delivery of the 2026/27 organisational plan across operational performance, quality, finance, workforce, productivity and transformation. Established governance arrangements provide visibility of the principal areas of underperformance and associated recovery actions through Divisional Assurance, Executive Team, Board Committees and onward reporting to the Board.

The Board is assured that the organisation understands the material risks to delivery, that Executive ownership is established and that mitigating and recovery actions are in place. The Trust recognises that it is not currently delivering the planned position therefore actions have been taken to address this which look to enhance and accelerate delivery to ensure that the Trust reaches its planned position by the end of 2026/27 rather than relying solely on existing assurance arrangements.

This includes mobilisation of an accelerated divisional turnaround programme, supported by a dedicated Turnaround Director, to provide additional delivery capacity, challenge and grip within the two operational divisional structures. The initial 10-week intervention is focused specifically on elective waiting-list recovery, activity and productivity, income improvement and acceleration of recurrent CIP delivery. It is being co-delivered with Trust teams, with an emphasis on measurable improvement, named Trust ownership and transfer of capability rather than operating as a

separate external review.

The intervention is integrated within existing Trust governance. A weekly Divisional Recovery Board will provide focused oversight of waiting-list and long-wait performance, elective activity and utilisation, income recovery, CIP milestones and realised benefits, workforce and quality risks and matters requiring Executive escalation. Trust leaders retain formal accountability, with the Turnaround Director providing hands-on delivery support, challenge and rapid escalation of barriers.

This is in addition to the actions that are already been taken in relation to financial and elective recovery plans which were agreed by the Board in September and the significant system wide transformation programme BetterLives to support delivery of the urgent and emergency care standards.

Elective performance remains below the required trajectory. At Month 5, 60.5% of incomplete pathways were within 18 weeks, with 52 patients remaining over 65 weeks. The current total waiting list is 46324, compared with the planned position of 39873. The latest number of patients waiting over 52 weeks is 1148 compared with a planned position of 353. The forecast March 2027 RTT position is 67%.

The rationale for the difference in the planned position compared to the actual is multifactorial and position reflects a combination of the closure of two key theatres on the Wigan site for 17 weeks, more patients converting to admitted pathway, increases in referrals in a small number of specialties and a reduction in validation activity. Further work is being undertaken to understand the contribution of hospital cancellations, patient cancellations, DNAs and workforce availability, including the extent to which nursing sickness contributes to theatre cancellations and lost activity.

The Trust has strengthened the recovery response through the accelerated divisional turnaround programme. This is establishing active patient-level control of the waiting list so that patients have a clear pathway status, clinical priority, next action, named owner and planned treatment date. Validation, stratification by clinical priority and forecast breach date, forward booking and earlier confirmation of diagnostics, pre-assessment and patient readiness are being strengthened. Daily patient-level tracking is supported by specialty assurance and escalation of patients without a safe and confirmed plan. A plan is in place to ensure that the Trust is back on plan against the 18 week standard by the end of November.

Urgent and Emergency Care is currently behind the forecasted position in relation to 4 hours and 12 hours. The Month 5, four-hour performance is 72.2%, compared with a trajectory of 79.7% with the percentage of 12-hour waits is 17.3 against a plan of 15.3%.

The Trust's recovery response is deliberately focused on the whole urgent-care pathway rather than Emergency Department performance in isolation and includes support from all system partners as part of the well-established BetterLives programme. This includes the development and enhancement of call before you convey, frailty pathways, development of the acute medical model, admission, in-hospital flow and all roads lead to home for complex discharges.

Cancer performance remains below trajectory; however, recovery plans are in place and the Trust expects performance to return to plan. Recovery is being managed through established Cancer governance, with tumour-site level trajectories, pathway tracking and escalation of capacity

constraints. The focus for the second half of the year is delivery of these recovery trajectories and securing the diagnostic and treatment capacity required to sustain performance against the Trust-level standards.

Diagnostic performance is currently below trajectory, however there has been a significant improvement over the last 12 months and recovery actions are in place.

The Trust is currently forecasting a range of potential year-end outcomes, from a worst case deficit of £21m and a mid case deficit of £15m to a best case delivery of the breakeven plan. This range reflects several material financial risks and uncertainties.

A significant unresolved risk relates to the funding of Specialist Commissioning activity. Discussions remain ongoing with GM ICB, NHS England North West and Specialist Commissioning colleagues to reach an agreed resolution.

The forecast also assumes full delivery of the Trust's CIP programme. This remains a material risk, particularly in relation to the transformation schemes across UEC, Outpatients and Digital. To mitigate this risk as outlined above the Trust is strengthening its governance and executive oversight. Where schemes are delayed or underperforming, corrective action and alternative recovery opportunities are being identified and progressed.

This provides the Board with assurance that the Trust is actively responding to areas of underperformance. It does not, however, remove the underlying delivery risk. At the mid-year point, performance is not sufficiently consistent across a number of key domains to provide confidence that all commitments within the 2026/27 plan will be achieved. In particular, there remain material and interdependent risks relating to elective, diagnostics and cancer recovery, urgent and emergency care, financial delivery, recurrent CIP, workforce trajectory and the pace at which transformation is converting into measurable operational and financial benefit.

Financial and workforce recovery is supported by a number of CFO/CPO/COO-led controls. This includes weekly CIP scrutiny and a divisional turnaround programme led by a turnaround director. Further workforce mitigations are being developed which include a mandatory and discretionary training freeze, a VR scheme and a non-clinical vacancy freeze on posts. FTC reviews, cultural reviews to identify the root cause of sickness and an executive-led sickness absence panel with a workability ethos, underpinned by Healthy Working Lifecycle thinking.

The Board recognises that significant recovery actions and enhanced oversight arrangements are in place, however because performance remains below plan the Board cannot yet provide full confidence that all 2026/27 objectives will be achieved across several key operational, financial and workforce metrics. Material risks remain in relation to some areas. Although mitigation plans are in place and are being accelerated, delivery remains dependent on demonstrable improvement during the second half of the year and therefore the Board cannot yet provide full confidence that all 2026/27 objectives will be achieved.

Section 2: Winter Preparedness

The Regional Team are aware that a separate winter assurance process is being completed; however this self-certification also seeks explicit assurance that winter planning, preparedness and resilience arrangements have been fully considered and that the organisation remains confident in its ability to deliver its 2026/27 operational, financial and strategic objectives throughout the winter period; therefore is included within this self-certification document.

The Board confirms that it has received assurance regarding the organisation's preparedness for Winter 2026/27.

The Board is satisfied that comprehensive winter planning arrangements are in place, including operational resilience measures, capacity planning, workforce preparations, escalation processes, system coordination arrangements and risk management processes. The Board is assured that identified risks are understood and that appropriate mitigations are being actively managed.

Accordingly, the Board is confident that the organisation is appropriately prepared to respond to anticipated winter pressures.

Self-Assessment Rating

☐ Fully Assured

☒ Assured with Managed Risks

☐ Partially Assured

☐ Not Assured

Commentary (including key risks and mitigating actions where applicable)

The Board is assured that comprehensive arrangements are in place to prepare for Winter 2026/27 and that these have been developed through established operational, workforce, quality, EPRR and system governance. The Winter Plan has been considered by Executive Team and Board and is supported by capacity, workforce, escalation and resilience arrangements. Winter preparedness is being managed as an organisational responsibility rather than solely as an urgent-care response, recognising the interdependency between emergency demand, elective and cancer delivery, workforce availability, community capacity, discharge, infection prevention and financial performance.
The operational model is supported by the Trust's Patient Flow and Escalation arrangements. These establish clear expectations for business-as-usual flow, Emergency Department escalation and Trust-wide escalation, aligned to OPEL status. Bed meetings provide structured oversight through the day, with increased frequency at OPEL 3 and 4 and defined attendance and accountability. Escalation arrangements include defined operational and Executive leadership, patient-safety red lines, dynamic risk assessment and explicit controls around the use of temporary escalation capacity.

A particular focus is reducing dependence upon escalation capacity by improving flow through the implementation of an enhanced call to convey offer, frailty pathways, an acute medical offer, in-

hospital flow programmes are intended collectively to reduce avoidable admissions and bed days. Delivery of these benefits is therefore a significant dependency within the winter plan.

Workforce remains one of the principal risks. Sickness remains above target, temporary staffing reductions remain challenging, and workforce availability may deteriorate during periods of increased respiratory illness. The Trust has workforce escalation processes, safe-staffing governance, flexible deployment arrangements, absence-reduction plans and wellbeing support in place. Workforce assumptions and actual deployment will require close monitoring throughout winter, particularly where staffing gaps have the potential to reduce available capacity or planned elective activity.

The Trust has also considered infection prevention, vaccination, operational resilience and EPRR arrangements. Infection-related bed closures or workforce absence could materially affect capacity during peak demand and are therefore incorporated into escalation and operational planning.

There remain important external dependencies. Sustainable flow depends upon community capacity, timely discharge, social care and wider Greater Manchester system response as well as actions within the Trust. These dependencies require continued system escalation where pressure cannot be resolved internally.

The Board recognises that winter will occur against a challenging baseline of high urgent-care demand, constrained hospital flow, workforce pressures and financial recovery requirements. However, the Trust has an established Winter Plan, clear escalation arrangements, defined governance and active mitigation of the principal risks.

Section 3: Commencement of Planning for 2027/28

The Board confirms that planning for 2027/28 has commenced.

The organisation has initiated the development of its strategic and operational planning approach for 2027/28, including consideration of future financial sustainability, service delivery priorities, productivity opportunities, workforce requirements and key strategic risks. Governance arrangements are in place to oversee the planning process and ensure alignment with national, regional and system priorities.

The Board is satisfied that early planning activity is underway and will support the development of a robust and deliverable plan for 2027/28.

Self-Assessment Rating

☐ Fully Assured

☒ Assured with Managed Risks

☐ Partially Assured

☐ Not Assured

Commentary (including key risks and mitigating actions where applicable)

- **Evidence and rationale:** Planning has commenced through the Strategy 2031 refresh, Executive Team planning preparation, five-year planning activity, the medium-term planning framework with established financial, workforce, operational and capital governance routes.

- **Key risks:** Outstanding national, regional and Greater Manchester requirements may delay assumptions; strategic priorities may not be translated into measurable plans; the financial baseline and CIP shortfall may constrain affordability; productivity opportunities may be insufficiently developed; workforce plans may not align with service need; and service, digital and capital plans may not be fully integrated.

- **Mitigations:** Progress planning discussions early with clear milestones, owners and decision points for planning; apply scenario planning pending guidance; reconcile finance, workforce, activity, productivity, digital and capital assumptions and report progress, risks and system dependencies through Executive Team and Board oversight.

Board Certification

On behalf of the Board, I certify that:

- The Board has reviewed the statements contained within this self-assessment.
- Appropriate evidence and assurance have been considered through the organisation's governance arrangements.
- The ratings provided accurately reflect the Board's current level of confidence and assurance.

The Board acknowledges that:

- A rating of **Assured with Managed Risks** may result in discussion as part of routine regional oversight and assurance processes.
- A rating of **Partially Assured** will prompt further engagement between the Regional Team and the Executive Team to understand outstanding risks, dependencies and mitigating actions.
- A rating of **Not Assured** will result in a formal **Board-to-Board discussion** with the Regional Team to review concerns, identify support requirements and agree next steps.

Organisation: Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Board Meeting Date: ____7 October 2026_____

Approved for Submission: Executive Team Meeting 1 October 2026 (subject to Board sign-off on 7 October)

Signed: 

Name: _____Dame Professor Robina Shah_____

Chair

Signed: 

Name: _____Mary Fleming_____

Chief Executive

Date of Submission: 2 October 2026

Regional Review (for completion by NHS England Regional Team)

Assessment Area	Board Rating	Regional Follow-up Required
Delivery of 2026/27 Plan		
Winter Preparedness		
Commencement of 2027/28 Planning		

Overall Regional Assessment:

☐ No Further Action

☐ Routine Monitoring

☐ Further Executive Discussion Required

☐ Board-to-Board Discussion Required

Regional Lead: _____

Date: _____

Title of report:	NHS EPRR Core Standards 2026
Presented to:	Trust Public Board
On:	7th October 2026
Item purpose:	Endorsement and Approval
Presented by:	Sarah Brennan, Chief Operating Officer
Prepared by:	Mark Taylor, Head of Resilience
Contact details:	Sarah.brennan@wwl.nhs.uk Mark.taylor1@wwl.nhs.uk

Executive summary

The Trust has completed its 2026 self-assessment against the 62 applicable NHS EPRR Core Standards and has assessed itself as Partially Compliant.

Of the 62 standards, 50 (80.6%) are fully compliant and 12 (19.4%) are partially compliant, with no standards assessed as non-compliant. This represents a reduction in assurance from the 2025 position, when the Trust was Substantially Compliant, with 58 (93.5%) standards fully compliant and four partially compliant.

The Trust remains fully compliant across eight of the ten EPRR domains, including Governance, Risk Assessment, Maintaining Plans, Command and Control, Training and Exercising, Response, Warning and Informing, and Cooperation.

The areas requiring improvement are Business Continuity and HazMat/CBRN. Business Continuity has reduced from seven to six fully compliant standards, reflecting gaps in Business Impact Analysis and Business Continuity Plans, alongside continuing partial compliance in BCMS monitoring and assurance of commissioned providers and suppliers.

HazMat/CBRN is the principal driver of the reduced overall assurance position, moving from 11 fully compliant standards in 2025 to four in 2026. The identified gaps relate to risk assessment, alignment with updated 2026 guidance, equipment and PPE assurance, preventative maintenance, staff training capacity and delivery, and exercising.

The overall position reflects a deterioration in assurance within two domains rather than a loss of EPRR capability across the organisation. A focused recovery programme is therefore proposed to address the identified gaps, with executive oversight and escalation where delivery or resource constraints place recovery at risk.

Link to strategy and corporate objectives
Supports the Trust's strategic objectives relating to the delivery of safe, effective and resilient services and robust organisational governance. Compliance with the NHS EPRR Core Standards provides assurance that the Trust has appropriate arrangements to anticipate, prepare for, respond to and recover from major incidents and business continuity events, maintaining delivery of critical services and protecting patients, staff and the wider health and care system.

Risks associated with this report and proposed mitigations
The 2026 self-assessment identifies a reduction in EPRR assurance, with 12 standards assessed as partially compliant compared with four in 2025. The principal risks relate to HazMat/CBRN operational readiness, Business Continuity maturity, assurance regarding critical suppliers and sufficient operational capacity to deliver the required improvements. In particular, gaps in CBRN training, exercising, PPE and equipment assurance and plan currency reduce the strength of assurance regarding sustained operational readiness.

Mitigation is through a time-bound recovery programme covering Business Impact Assessments, Business Continuity Plans, BCMS performance reporting, supplier resilience, CBRN plans and risk assessments, equipment assurance, training and exercising. Progress will be monitored through EPRR governance, with monthly exception reporting and escalation where milestones, resources or critical capabilities are at risk.

Financial implications
There are no specific additional financial requirements identified within the report at this stage. However, delivery of the recovery programme will require sufficient operational capacity across Resilience, Emergency Department and clinical services, Estates, Digital, Procurement and Education. Resource constraints have already contributed to some areas of partial compliance; therefore, there is a potential financial and opportunity-cost implication if additional capacity, training, equipment maintenance or exercising is required to achieve compliance. Any material additional resource requirement should be identified and managed through the Trust's established financial governance arrangements.

Legal implications
The EPRR Core Standards provide the framework through which NHS organisations demonstrate their preparedness and resilience arrangements. The identified areas of partial compliance require action to strengthen assurance that the Trust can maintain appropriate emergency preparedness, business continuity and response arrangements. Particular attention is required to maintaining current plans, risk assessments, training, equipment and exercising arrangements and to ensuring appropriate assurance over critical suppliers.

People implications
Delivery of the recovery programme will require coordinated input from a number of services and sufficient protected capacity to complete training, exercising, audits and plan development. Staff availability and resource constraints have contributed to the current CBRN assurance gaps, including the absence of training since 2025. A clear training trajectory, defined responsibilities and executive oversight will therefore be important to achieving and sustaining compliance.

Equality, diversity and inclusion implications
No specific adverse equality, diversity or inclusion impacts are identified within the report. However, EPRR and Business Continuity arrangements should ensure that the needs of patients, staff and communities with protected characteristics and additional communication, accessibility or support needs are appropriately considered within risk assessments, plans, response arrangements, training and exercises.

Implementation of the recovery programme should therefore continue to consider equality and accessibility requirements, particularly in relation to emergency communications, evacuation, access to services and maintaining continuity of care for vulnerable groups.

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

EPRR Group

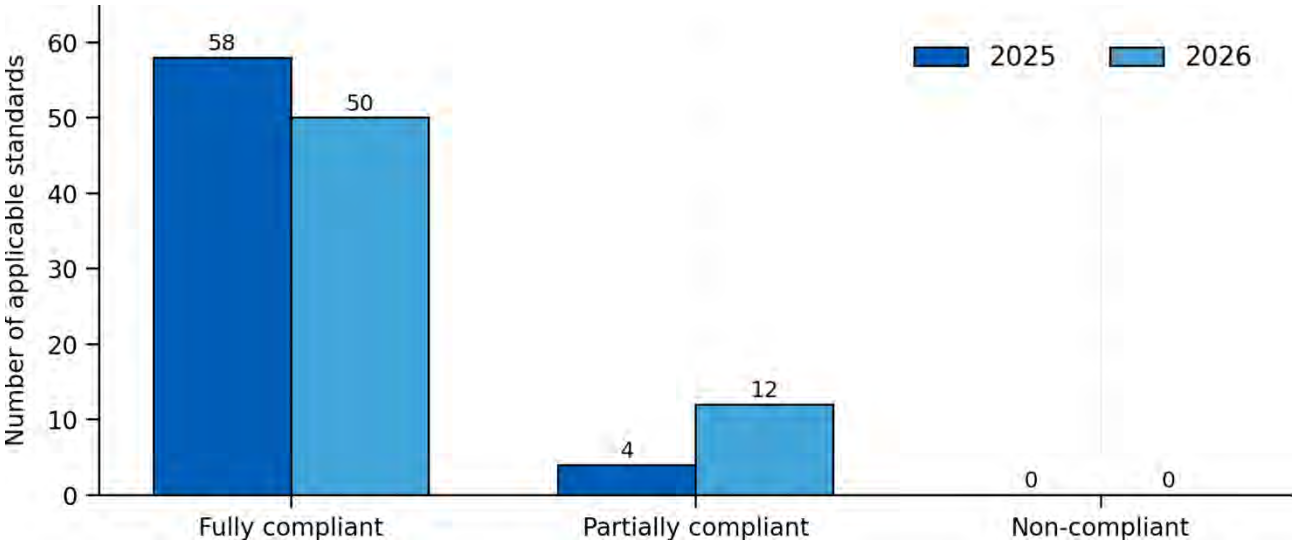
Recommendation(s)
This report presents the outcome of the Trust's 2026 self-assessment against the NHS Emergency Preparedness, Resilience and Response (EPRR) Core Standards and seeks Board endorsement of the proposed recovery priorities.

The Trust has assessed itself as Partially Compliant, with 50 of 62 standards fully compliant and 12 partially compliant. There are no non-compliant standards. The reduction in assurance is concentrated within Business Continuity and HazMat/CBRN, with the remaining eight EPRR domains continuing to be fully compliant.

The Board is asked to:

- Note the overall 2026 self-assessment rating of Partially Compliant.
- Note the movement from 58 to 50 fully compliant standards and from four to 12 partially compliant standards, with no standards assessed as non-compliant.
- Recognise that the deterioration is concentrated within two area Business Continuity and HazMat/CBRN.
- Approve the proposed time-bound recovery priorities to address the identified areas of partial compliance and receive an update in April 2027.

Overall assessment and year-on-year movement:



Measure	2025	2026	Change
Total applicable standards	62	62	No change
Fully compliant	58 (93.5%)	50 (80.6%)	-8; -12.9 percentage points
Partially compliant	4 (6.5%)	12 (19.4%)	+8; +12.9 percentage points
Non-compliant	0	0	No change
Overall rating	Substantially compliant	Partially compliant	Reduced assurance

The assurance thresholds shown in the workbooks classify 55 to 61 fully compliant standards as Substantially compliant, and 48 to 54 as Partially compliant. The 2026 result of 50 therefore falls within the Partially compliant band.

Domain-level Comparison

The NHSE EPRR Core Standards are set across 10 domains, the performance at this levels is:

Domain	2025 G/A/R	2026 G/A/R	Movement
Governance	6/0/0	6/0/0	Stable
Duty to risk assess	2/0/0	2/0/0	Stable
Duty to maintain plans	11/0/0	11/0/0	Stable
Command and control	2/0/0	2/0/0	Stable
Training and exercising	4/0/0	4/0/0	Stable
Response	7/0/0	7/0/0	Stable
Warning and informing	4/0/0	4/0/0	Stable
Cooperation	4/0/0	4/0/0	Stable
Business Continuity	7/3/0	6/4/0	Net -1 fully compliant
HazMat/CBRN	11/1/0	4/8/0	Net -7 fully compliant

Improvements Since 2025

Ref	Domain / standard	2025	2026	Evidence of change
49	Business Continuity: Data Protection and Security Toolkit	Partially compliant	Fully compliant	The 2026 workbook records full compliance supported by the IT annual DSPT report and toolkit evidence.

Reductions Since 2025

Ref	Domain	Standard	2026 recorded gap
46	Business Continuity	Business Impact Analysis/Assessment	New BIA under development; roll-out recorded as due by December 2026.
47	Business Continuity	Business Continuity Plans	New BCP template under development; roll-out recorded as due by December 2026.
56	HazMat/CBRN	Risk assessments	Plan requires estates and infrastructure risk assessment content.
58	HazMat/CBRN	Planning arrangements	Plans require updating to reflect new 2026 guidance.
60	HazMat/CBRN	Equipment and supplies	Inventory exists, but physical checks/audits have not been completed because of resource constraints.
61	HazMat/CBRN	Preventative programme of maintenance	Recorded as partially compliant; no specific action narrative is entered.
63	HazMat/CBRN	Training resource	Recorded gap refers to physical checks not undertaken because of resource constraints, with PPM in place.
65	HazMat/CBRN	PPE access	Recorded as partially compliant; Mask Fit testing rates to improve in 2026/27.
66	HazMat/CBRN	Exercising	No CBRN exercise recorded for 2026/27.

Standard 64, Staff training - recognition and decontamination, was partially compliant in both 2025 and 2026. The self-assessment captured that no training has been undertaken since 2025 because of staff availability and that a staff training plan is to be developed.

Continuing Partial Compliance

Ref	Domain / standard	Position and recorded requirement
50	Business Continuity: BCMS monitoring and evaluation	Partially compliant in both years. Performance reporting still needs to be added to the BCMS.
53	Business Continuity: assurance of commissioned providers / suppliers BCPs	Partially compliant in both years. The workbook identifies the requirement for a system and framework to assess supplier business continuity arrangements.
64	HazMat/CBRN: staff training - recognition and decontamination	Partially compliant in both years. No training since 2025 is recorded, and a staff training plan is required.

Principle Risks and Assurance Implications

Risk area	Board-level implication	Current judgement
CBRN operational readiness	Gaps in training, exercising, PPE assurance, equipment audit and plan currency reduce the strength of evidence that the full response capability is consistently ready and sustainable.	High assurance concern
Business continuity maturity	Incomplete BIA roll-out, BCP compliance and BCMS performance reporting limit the Trust's ability to evidence a complete, prioritised and measurable continuity system.	Moderate assurance concern
Supplier dependency assurance	Continuing partial compliance for supplier BCP assurance leaves a gap in evidence concerning the resilience and interoperability of critical commissioned services and suppliers.	Moderate assurance concern
Delivery capacity	The workbook explicitly links some CBRN checks and training gaps to resource constraints and staff availability, creating a risk to timely recovery.	High delivery concern
External moderation	The report is based on self-assessment. The final assurance position may be altered through regional review or challenge.	Assurance caveat

Proposed Recovery Plan and Oversight

The following time-bound recovery programme is proposed for Board endorsement. The programme addresses the areas of partial compliance identified through the 2026 self-assessment, with clear ownership, delivery milestones and evidence requirements. Progress will be monitored through the Trust's EPRR governance arrangements, with exceptions escalated where delivery is at risk.

#	Priority action	Proposed owner	Target	Evidence to Board
1	Complete and deploy the new BIA methodology, prioritising critical services and digital dependencies.	Head of Resilience	December 2026	BIA completion and improved conformance reported to Board.
2	Complete and deploy new BCP templates for Departmental BC plans.	Head of Resilience	December 2026	BCP completion and improved conformance reported to Board
3	Add agreed KPIs and routine performance reporting to the BCMS and report through EPRR governance.	Head of Resilience	December 2026	BCMS dashboard approved and reported.
4	Implement a risk-based supplier BCP assurance framework with Procurement.	Head of Resilience / Procurement	March 2027	Critical suppliers identified, assessed and actions tracked.
5	Update the HazMat/CBRN plan and associated risk assessments to 2026 guidance, including estates and infrastructure impacts.	Head of Resilience	March 2027	Approved plan and completed risk assessments.
6	Complete and evidence physical audit of CBRN equipment, PRPS/PPE and PPM records; resolve exceptions.	Head of Resilience / ED	March 2027	Signed audit, asset register and exception log.
7	Approve and deliver a CBRN training plan, including IOR, decontamination and PRPS competence for relevant staff.	Head of Resilience / ED	March 2027	Training trajectory, attendance and competency evidence.
8	Schedule and deliver a CBRN exercise, with debrief, action log and evidence of embedded learning.	Head of Resilience / ED	March 2027	Exercise report and closed action plan.

Governance and reporting

Progress against the recovery programme will be monitored through the Trust's established EPRR governance arrangements, supported by a single action and assurance log setting out actions, risks, issues, decisions, accountable owners and delivery milestones.

The Accountable Emergency Officer will retain executive oversight of the recovery programme. Delivery will require coordinated ownership across Resilience, Emergency Department and clinical services, Estates, Digital, Procurement, Education and divisional business continuity leads.

Progress will be reviewed routinely through the EPRR governance route, with particular focus on overdue actions, changes in RAG status, resource or capacity constraints and risks to achievement of the agreed recovery trajectory.

It is proposed that the Board receives a progress update on delivery in April 2027.

Appendix 1. Assessment basis and limitations

- The comparison uses the control totals and detailed RAG entries in the 2025 and 2026 WWL self-assessment workbooks.
- The assessment covers 62 standards applicable to an acute provider. Interoperable capability standards are shown in the workbooks as not started and are not included in the acute-provider core standards rating.
- The cyber security deep dive is not included within the organisation's overall EPRR assurance rating in the 2025 workbook and is not included in this year-on-year comparison.
- Where the 2026 workbook records a partially compliant rating without a completed action narrative, this report does not infer the missing cause or completion date. These items require confirmation through the action-planning process.
- Proposed owners, milestones and KPIs in section 7 are recommendations for governance purposes unless explicitly recorded in the workbook.

Please select type of organisation: Acute Providers

Click button to format the workbook Format Workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	4	8	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	50	12	0

Overall assessment:	Partially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 6: In the Action Plan tab, click on the 'Format Action Plan' button.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
Domain 1 - Governance				
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans				
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control				
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising				
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response				
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing				
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation				
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004
Domain 9 - Business Continuity				
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
Domain 10 - CBRN				
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance Domain 2 - Duty to risk assess Domain 3 - Duty to maintain Plans Domain 4 - Command and control Domain 5 - Training and exercising Domain 6 - Response Domain 7 - Warning and informing Domain 8 - Cooperation Domain 9 - Business Continuity										
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Corporate Businesss Continuity Plan 2.0 Business Continuity Management System V2 WWL Incident Response Plan v4.0 Examples of Departmental BCP's	Partially compliant	The current BIA uses an old methodology and is in the process of being updated. A new BIA is under development and due roll-out by December 2026. This new template will split the BIA from the BCP so that Teams will have a distinct stand-alone response plan for when things go wrong. MS Excel is also being used for the BIA to allow Trust-wide review of the data and feed into other areas such as disaster	Head of Resilience		46357
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Corporate Businesss Continuity Plan 2.0 Business Continuity Management System V2 WWL Incident Response Plan v4.0 Examples of Departmental BCP's	Partially compliant	WWL are in the process of developing a new BC Plan template to improve adherence to this standard. Current plans do not include all the requirements from ISO22301 as listed including: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation.	Head of Resilience	March '27	
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Corporate Businesss Continuity Plan 2.0 Business Continuity Management System V2 WWL Incident Response Plan v4.0 Examples of Departmental BCP's EPRR Group minutes EPRR Policy	Partially compliant	WWL currently don't have any Key Performance Indicators for the BCMS, this is something that needs to be developed with the internal EPRR Group.	Head of Resilience		46357

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	EPRR Policy EPRR Group minutes	Partially compliant	Ensure that suppliers have a duty in their standard terms and conditions to support WWL in adherence to the Civil Contingencies Act and that they hever BC plans in place. Also need to assess our suppliers for resilience and impact assessment should they cease supplying then develop BC plans for critical suppliers.	Head of Resilience	46447	
Domain 10 - CBRN										
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	CBRN and HazMat Plan v2.0	Partially compliant	WWL have not included impact to estates and infrastructure within plans. Plan needs updating to include risk assessments and impacts to estate and infrastructure into plan.	Head of Resilience	46447	
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions	CBRN and HazMat Plan v2.0 TW23-010 - PPE Policy GM Multi-agency CBRNe Tactical Annex - saved GM Multi-agency CBRNe Strategic Response Plan v3.01 - saved Lockdown Policy TW10-022 - Waste Management Policy	Partially compliant	Deployment of Decon tent not tested in 2026. Plans also doesn't include actions to ensure other patients can continue to be seen. Also need to include processes for accessing back-up / replacement PPE and PRPS Suits. New guidance has been released during 2026 which hasnt yet been back-fed into WWL plans. Plans need updating with new guidance.		46447	

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/epri-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/epri-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	CBRN and HazMat Plan v2.0 CBRN Decontamination Equipment Checklist	Partially compliant	No audits have been undertaken in 2026, also need to include a financial replacement plan. Equipment inventory held but physical checks/audits have not been completed due to constraints on available resources	Head of Resilience	46447	
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	CBRN and HazMat Plan v2.0 CBRN Decontamination Equipment Checklist	Partially compliant	Need to develop Planned Preventative Maintenance schedules for all equipment. Create a PPM schedule for the CBRN/HazMat equipment.	Head of Resilience	46447	
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	CBRN and HazMat Plan v2.0 EPRR Training Prospectus TNA Training Records	Partially compliant	ED need to have 2 or 3 staff trained as trainers in delivering the decontamination process and staff within ED need to have been trained. Train ED staff, put in place a training programme.	Head of Resilience / ED CBRN Lead	46447	

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Train the Trainer Training Records Train the Trainer Training Presentation Train the Trainer Training Certificates WWL CBRN Training Presentation & records EPRR Training Report	Partially compliant	As above, need to have trained trainers and then training delivered in ED and records kept of which staff have been trained. Train ED staff, put in place a training programme.	Head of Resilience / ED CBRN Lead	March '27	
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories, including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	PRPS Suit Audit Documentation Fit testing schedule & reports	Partially compliant	No CBRN exercise in 2026/27. Ensure that all staff within ED have been mask fit tested.	Health & Safety	March '27	
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	EPRR Exercise schedule report WWL CBRN Training	Partially compliant	No CBRN exercise in 2026/27. Arrange ED CBRN/HazMat exercise - normally done in June/July each year.		March '27	

Great Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2026-2027

STATEMENT OF COMPLIANCE

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

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

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

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

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

_____Sarah Brennan_____

Signed by the organisation's Accountable Emergency Officer

30/09/2026

Date signed

07/10/2026	07/10/2026	01/06/2027
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Title of report:	Financial reporting Month 5 - August 2026 - Trust Finance Report
Presented to:	Board of Directors
On:	7 October 2026
Item purpose:	Information
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Senior finance team
Contact details:	Ian.Roberts@wwl.nhs.uk

Executive summary

The Trust is reporting a £7.4m deficit at Month 5, £3.9m adverse to plan. August was £1.8m adverse to plan and the position was supported by £0.5m of non-recurrent items. The underlying run rate has not materially improved and delivery of the 2026/27 financial plan is at significant risk.

CIP delivery was £7.3m year to date, £2.3m below target, with only 33% delivered recurrently. Although the full £31.8m target has been identified, risk-adjusted delivery is £26.9m, leaving a £4.9m gap which requires accelerated scheme implementation.

Elective API income was £0.3m behind plan in August and £2.0m behind plan year to date. Live Well & Urgent Care was £49k adverse in month and Start Well & Planned Care was £264k adverse. Divisional elective recovery plans need to accelerate to prevent further deterioration.

The recovery plan is being finalised for implementation from Month 6. Immediate management action and enhanced oversight are required to address recurrent CIP, pay, elective income and cash pressures.

Closing cash at the end of August was £18.6m, £7.0m lower than July, reflecting the operating deficit and increased creditor payments. Operating cash days reduced from 16 to 12. Current projections indicate that cash support can be avoided during 2026/27, although balances are expected to decline towards year-end.

Worked WTE was 6,679 in August, 77 WTE above the vacancy-factor-adjusted establishment. Pay expenditure was £1.4m adverse in month and £3.4m adverse year to date, while variable pay remained at £3.3m in August.

Link to strategy

Whilst there are no direct links to strategy, delivery of a sustainable financial position is key to supporting the Trust's strategic aims.

Risks associated with this report and proposed mitigations

The principal risks are delivery of the financial plan and recovery plan; recurrent CIP; pay, workforce and variable-pay control; elective income; cash and liquidity; and unresolved funding for bespoke limb-salvage prostheses. Mitigation depends on rapid mobilisation of the recovery plan from Month 6, accelerated recurrent CIP delivery, delivery of divisional elective recovery plans and continued management oversight.

Financial implications

The Month 5 position is a £7.4m deficit, £3.9m adverse to plan, including an in-month adverse variance of £1.8m. The forecast ranges from delivery of plan in the best case to a £21.0m deficit in the worst case, with a £15.0m mid-case deficit. Delivery of plan is dependent on immediate recovery action, full CIP delivery and mitigation of the principal financial risks.

Legal implications

There are no direct legal implications in this report.

People implications

Worked WTE was 77 above the vacancy-factor-adjusted establishment at Month 5. Pay was £3.4m adverse year to date and the required reduction in workforce and variable-pay expenditure had not yet been achieved.

Equality, diversity and inclusion implications

There are no direct EDI implications in this report.

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

The Month 5 position is set out in the accompanying Trust Finance Report.

Wider implications

There are no wider implications identified beyond the financial, workforce and operational delivery risks described above.

Recommendation(s)

The Board of Directors is asked to note the Month 5 financial position, the significant risk to delivery of the 2026/27 financial plan, and the requirement for immediate and sustained recovery action.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Trust Finance Report - Board

Month 05 – August 2026

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Key Financial Messages



The Trust reported a £7.4m deficit at Month 5, £3.9m adverse to plan. August was £1.8m adverse to plan, with the position supported by £0.5m of non-recurrent items. The underlying run rate has not improved and delivery of the financial plan is at significant risk.



CIP delivery remains materially behind plan. £7.3m has been delivered year to date, £2.3m below target, with only 33% delivered recurrently. The £4.9m risk-adjusted gap requires accelerated scheme implementation.



Elective API income was £0.3m behind plan in August and £2.0m behind plan year to date. Live Well & Urgent Care was £49k adverse in month and Start Well &Planned Care was £264k adverse.



Immediate management action and enhanced oversight are required to address recurrent CIP, pay, elective income and cash pressures. The recovery plan is being finalised for implementation from Month 6.

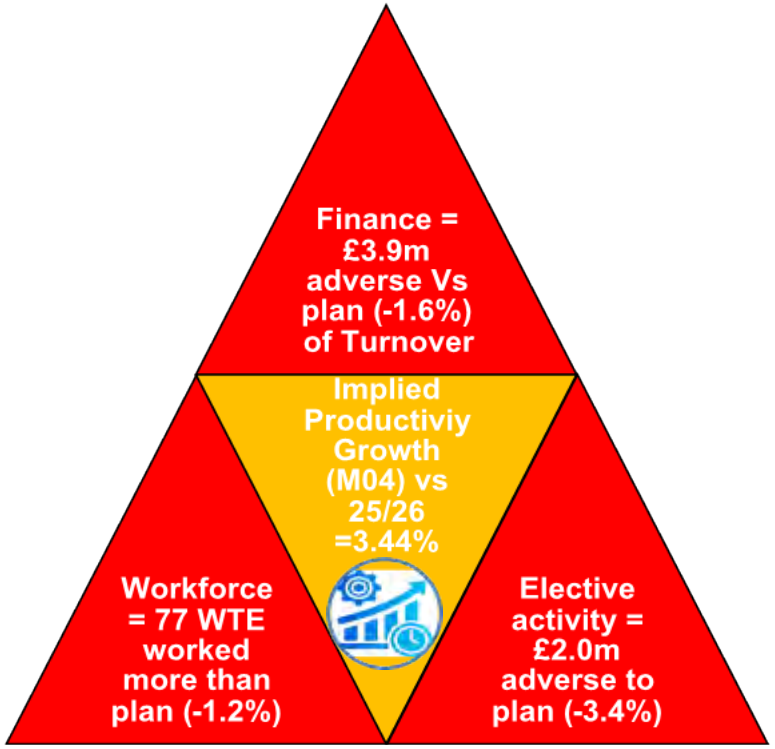


Closing cash at the end of August was £18.6m, £7.0m lower than the closing cash position at the end of July (£25.6m). The movement in cash is due to the operating deficit and an increase in creditor payments. At the current cash run rate cash balances are expected to significantly decline as we move into the end of the financial year however current forecasts indicate that cash support will not be required this financial year but will be required at the start of 2027/28. Current operating cash days at the end of August is 12.



Actual worked WTE was 6,679 WTE in August which is adverse to our budgeted establishment by 77 WTE. *NB we have moved to reporting worked vs establishment adjusted for vacancy factor, rather than NHSE staff in post methodology.

Drivers of The Position YTD



YTD deficit of £7.4m, adverse to plan by £3.9m

Drivers of Variance	M05 £m	YTD £m	RAG
CIP - Recurrent	(1.6)	(4.5)	
Elective Underperformance	(0.3)	(2.0)	
Bank and Agency	(0.8)	(3.5)	
Industrial action (Apr)	0.0	(0.4)	
MARS Costs	(0.4)	(0.4)	
CIP - Non Recurrent	0.1	2.2	
Technical - Non Recurrent	0.5	1.8	
Other run rate	0.8	2.9	
Reported Variance to Plan	**(1.8)**	**(3.9)**	

Financial Pressures

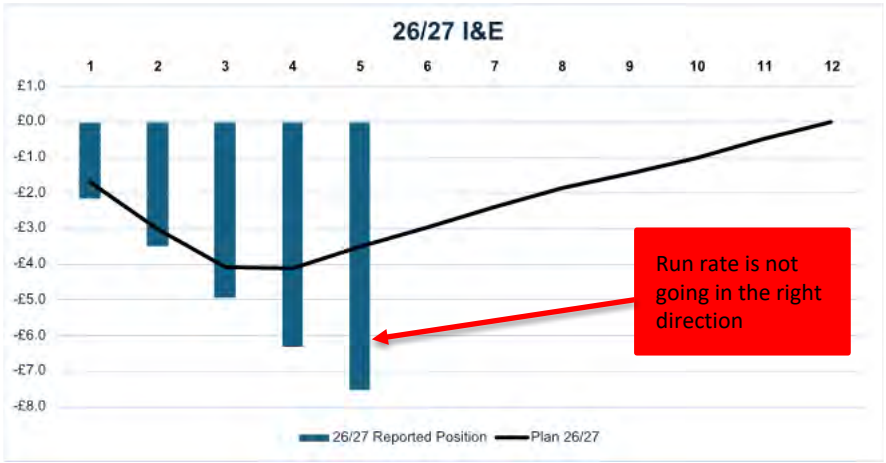
Mitigations - Non recurrent

Performance to August 2026

- The YTD position is away from plan due to elective activity being behind plan (£2.0m) and CIP underperformance (£2.3m) and bank and agency pay pressures. This is mitigated by Corporate and Estates doing better than plan and release of non recurrent technical items.
- Implied productivity has been on a steady increase for M1-5 but remains below the plan for M5 YTD.
- Workforce remains above Establishment (nett of vacancy factor), but below the Staff in Post plan by 77wte

I&E Summary YTD

	In Month £m			YTD £m		
I&E Category	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Clinical Income from Patient Care Activities	46.4	46.6	0.2	231.9	229.2	(2.8)
Other Operating Income	2.5	2.8	0.3	12.3	13.8	1.5
Total Income	**48.9**	**49.4**	**0.5**	**244.3**	**243.0**	**(1.3)**
Employee Expenses	(33.3)	(34.7)	(1.4)	(170.7)	(174.1)	(3.4)
Operating Expenses	(14.5)	(15.3)	(0.9)	(74.6)	(74.2)	0.4
Non Operating Expenses	(0.5)	(0.5)	0.0	(2.5)	(2.2)	0.4
Total Expenditure	**(48.3)**	**(50.6)**	**(2.3)**	**(247.9)**	**(250.5)**	**(2.6)**
Month 5 Surplus/Deficit	**0.6**	**(1.2)**	**(1.8)**	**(3.6)**	**(7.5)**	**(3.9)**
Month 5 Adjusted Financial Performance	**0.6**	**(1.2)**	**(1.8)**	**(3.5)**	**(7.4)**	**(3.9)**



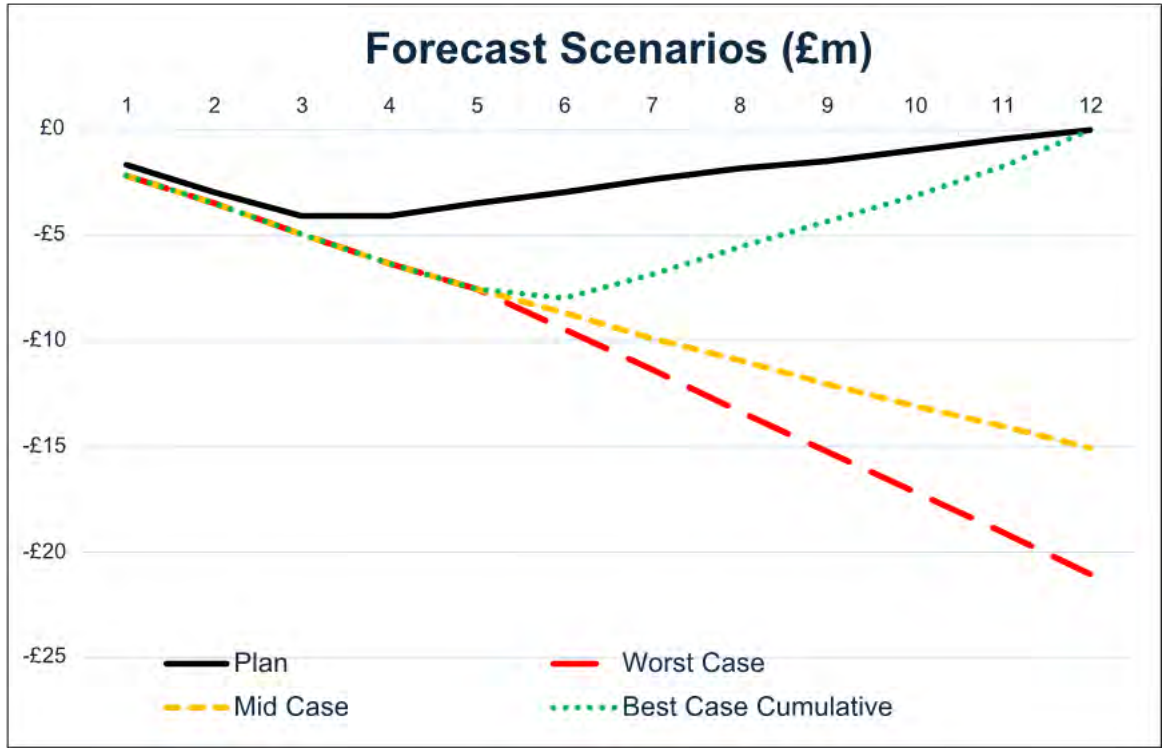
Performance to August 2026

The Trust's financial performance has continued to deteriorate during August, with the YTD deficit increasing to £7.4m (£3.9m adverse to plan). The in-month position for August is in line with the mid-case trajectory in the recovery plan, but relies on £0.5m in non-recurrent support. The underlying run rate has not materially improved, recurrent CIP delivery is materially behind target, and elective income underperformance continues. Without significant improvement in recurrent savings delivery and operational productivity over the remainder of 2026/27, achievement of the financial plan is at significant risk.

Headlines

- Our revenue plan for 2026/27 financial year is breakeven.
- In August (Month 5), we are £1.8m adverse to plan, and we are £3.9m adverse year to date. We have supported the position in M03 £0.5m, M04 £0.7m, M05 £0.5m
- Income is £49.4m, £0.5m favourable to plan in month and £1.3m adverse year to date due primarily to API Elective underperformance.
- Pay expenditure is £34.7m, £1.4m adverse to plan. This is predominantly due to recurrent pay CIP underperformance and temporary staffing costs. Year to date pay is £3.4m adverse to plan which includes £0.4m MARS costs and £0.4m of industrial action costs.
- Non pay expenditure is £15.3m, £0.9m adverse to plan. Year to date non pay is £0.4m favourable to plan.
- The Trust CIP target is £31.8m for 2026/27. Total CIP delivery was £7.3m YTD, £2.3m below target. Within this, recurrent CIP was £4.5m adverse to plan, with only 33% of YTD delivery achieved recurrently

Forecast Risk 26/27



Forecast Position

- The forecast ranges from a **worst case deficit of £21.0m**, a **mid case of £15.0m**, and a **best case delivering plan**.
- The table below highlights that the worst case is driven by extrapolated normalised Month 5 run-rate, return to plan requires immediate delivery of recovery actions, full CIP delivery and mitigation of key financial risks, funded IA costs and mitigation of limb salvage.

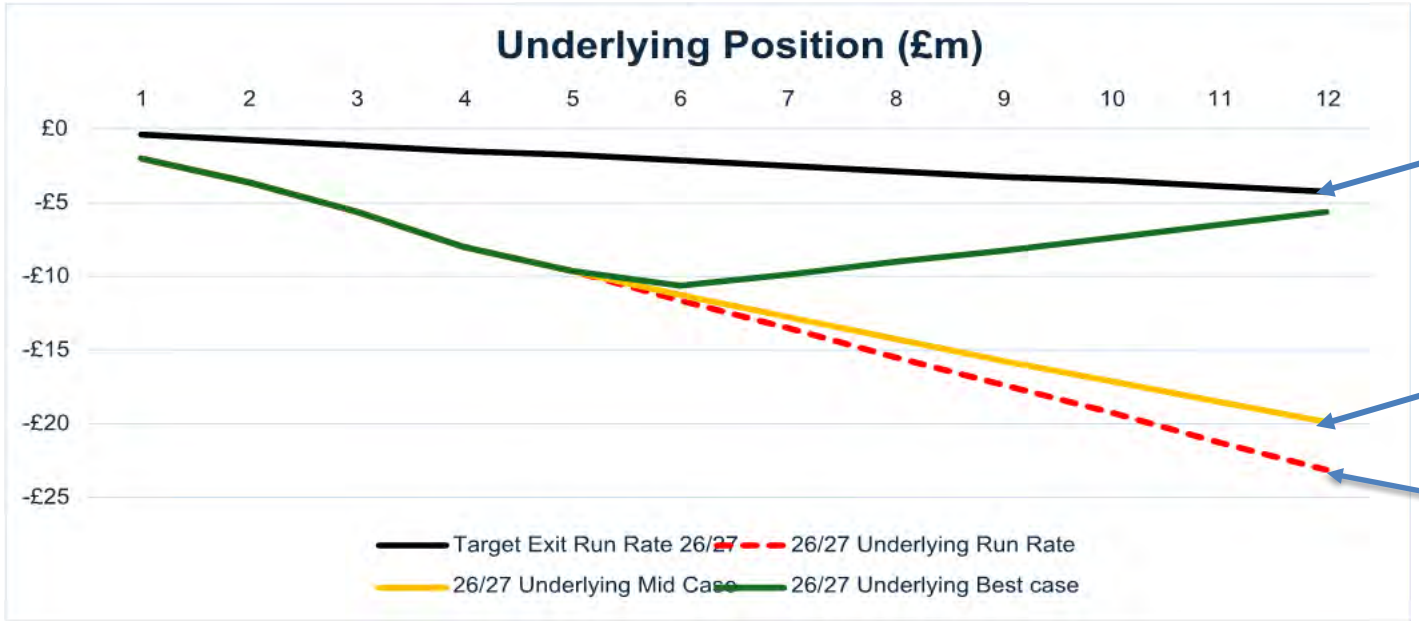
Worst Case (Normalised Extrapolation Month 5)	**-£21.0m**	
CIP Risk Adjusted	£10.3m	
Recover Elective Activity (net of costs)	£0.6m	
Seasonal Costs Patient Care & Energy	-£2.2m	
Bespoke Limb Salvage Risk	-£2.6m	
Small Items	-£0.1m	
Mid Case	**-£15.0m**	**RAG**
CIP Full Delivery	£5.0m	
IA Costs Funded	£0.4m	
Mitigate Bespoke Limb Salvage Risk	£2.6m	
Mitigate Christie Risk	£0.0m	
Recovery Plan	£7.0m	
Best Case = Plan	**£0.0m**	

Risks

Mitigations

The recovery plan is being finalised for implementation from Month 6, with delivery dependent on rapid mobilisation of recurrent actions.

Underlying Position Trajectory



26/27 Planned Exit Run Rate is £4.2m, best case is currently £5.6m deficit

Mid case Underlying Trajectory - £19.8m Deficit

Underlying Run Rate Trajectory - £23.1m deficit

Underlying Position

- WWL has a planned underlying exit position of a £4.2m deficit for 26/27.
- The current unmitigated underlying run-rate trajectory indicates a £23.1m full-year deficit, updated to reflect August position.
- The modelled underlying mid-case trajectory is a £19.8m deficit and the best case is a underlying £5.6m deficit, compared with the planned £4.2m underlying exit deficit.
- The recovery plan is being finalised for implementation from Month 6, with delivery dependent on rapid mobilisation of recurrent actions.

Income Analysis

Division	In Month (£000)			Year to Date (£000)		
	Plan	Actual	Variance	Plan	Actual	Variance
LIVE WELL & URGENT CARE	643	756	113	2,607	2,264	(343)
START WELL & PLANNED CARE	2,473	2,375	(98)	12,295	10,086	(2,209)
NON-DIVISIONAL INCOME	44,552	44,893	341	223,358	223,843	485
ESTATES & FACILITIES	558	563	4	2,792	2,608	(184)
GTEC	180	186	5	902	890	(12)
DIR OF STRAT & PLANNING	144	109	(35)	721	1,006	285
NURSE DIRECTOR	83	139	56	414	602	189
PEOPLE SERVICES	76	151	76	379	546	167
MEDICAL DIRECTOR	78	65	(14)	391	544	153
CORPORATE EXPENDITURE	67	119	52	336	474	138
FINANCE	6	24	18	47	90	44
DIGITAL SERVICES	3	3	0	17	17	1
Total	48,864	49,384	519	244,258	242,970	(1,288)

Headline

- Income is £0.5m favourable in month and £1.3m adverse YTD.

Clinical divisions

- **Live Well & Urgent Care**: Income is £0.1m favourable in-month, with over performance in UEC (£0.2m), CDC income (£0.1m) and other smaller balances (£0.1m) offsetting under performance in elective API activity (£0.05m) and Drugs & Devices (£0.2m). The budget relating to wound care has been transferred from Non-Divisional income in month resulting in a £0.1m adverse variance but is break even YTD.
- **Start Well & Planned Care**: Income is £0.1m adverse in month, driven by elective API underperformance (£0.2m) and a shortfall in Private Patient income (£0.2m). This was partly offset by drugs and devices over performance (£0.1m) and additional community funding (£0.05m).

Other

- **Non-Divisional Income**: Income is £0.3m favourable in-month, primarily due to Education income of £0.1m, Devices income of £0.1m and £0.1m relating to the budget transfer to Live well for wound care. There is £1.1m income included relating to Bespoke limb salvage in the Trust's year-to-date position. The Trust remains in dialogue with NHSE regarding the funding of this income, which therefore remains at risk.
- **People Services**: Income is £0.1m favourable in-month due to over performance on occupational health income.

Divisional Elective API Activity and Income v Internal Plan

Section 1 - Trust ERF 26/27 performance vs Internal Plan @ 26/27 Prices

Division	POD	In Month Activity			In Month (£000)			Year to Date Activity			Year to Date (£000)		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Live Well & Urgent Care	Day Cases	1,545	1,352	(193)	1,052	925	(127)	8,032	7,443	(589)	5,469	5,225	(244)
	Electives	48	266	218	87	333	247	248	829	581	450	1,100	650
	OP Proc New	947	709	(238)	175	133	(41)	4,926	3,619	(1,307)	908	649	(259)
	OP Proc FUP	1,276	1,657	381	221	288	67	6,633	8,992	2,359	1,151	1,490	340
	OPA New	3,217	2,522	(695)	899	704	(194)	16,730	13,159	(3,571)	4,674	3,632	(1,042)
	Advice & Guidance	608	837	229	132	132	0	3,164	3,910	746	684	684	0
Live Well & Urgent Care Total		**7,641**	**7,343**	**(298)**	**2,565**	**2,516**	**(49)**	**39,732**	**37,952**	**(1,780)**	**13,337**	**12,781**	**(556)**
Start Well & Planned Care	Day Cases	1,758	1,731	(27)	2,589	2,607	19	9,297	8,801	(496)	13,761	13,136	(625)
	Electives	495	467	(28)	3,173	2,941	(232)	2,665	2,493	(172)	17,209	16,300	(909)
	OP Proc New	2,279	2,011	(268)	499	453	(46)	11,851	10,363	(1,488)	2,597	2,299	(298)
	OP Proc FUP	3,765	5,407	1,642	776	1,061	285	19,578	28,168	8,590	4,037	5,636	1,598
	OPA New	7,196	5,878	(1,318)	1,548	1,260	(289)	37,419	31,672	(5,747)	8,051	6,806	(1,244)
	Advice & Guidance	197	342	145	43	43	0	1,026	1,720	694	222	222	0
Start Well & Planned Care Total		**15,690**	**15,836**	**146**	**8,628**	**8,365**	**(264)**	**81,837**	**83,217**	**1,380**	**45,876**	**44,397**	**(1,478)**
Divisional Elective API Totals		**23,331**	**23,179**	**(152)**	**11,193**	**10,881**	**(312)**	**121,569**	**121,169**	**(400)**	**59,212**	**57,178**	**(2,034)**

- Live Well & Urgent Care (£49k)
- Start Well & Planned Care (£264k)

Elective API Performance

- The Trust has underperformed against the elective API plan by (£0.3m) in month and (£2.0m) YTD.
- Live Well & Urgent Care are (£49k) adverse to plan in month predominantly due to Gastro (£227k) and Cardiology (£49k) which is partially offset by over achievement in General Medicine £250k.
- Start Well & Planned Care are (£264k) adverse to plan in month mainly due to Gynaecology (£134k) and T&O (£128k).
- *NB. The income on this slide includes £280k of income delivered by Spire YTD at additional cost.*

CIP Delivery

2026/27 CIP

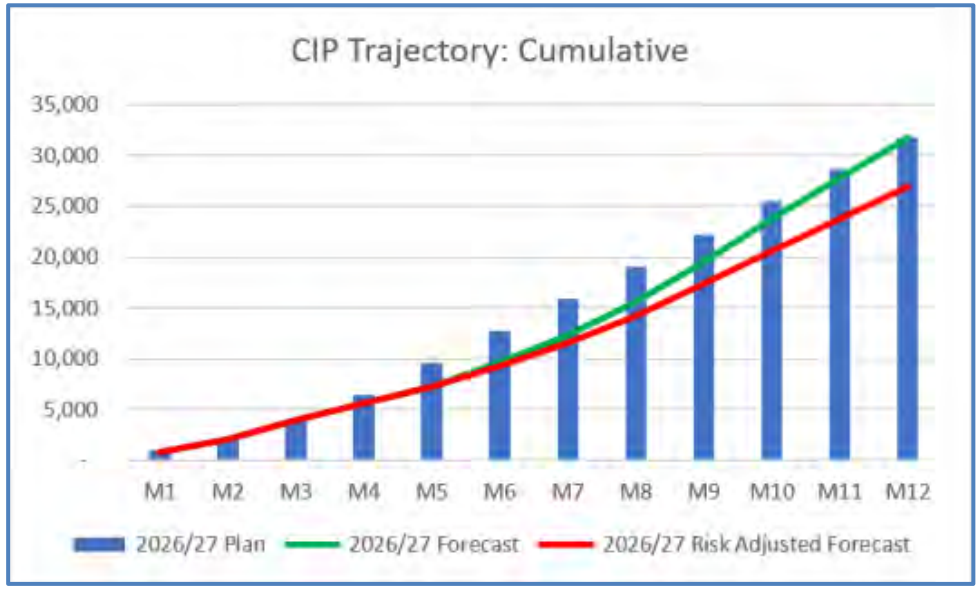
- Trust target = £31.8m
- Identified = £31.8m
- Risk adjusted = £26.9m
- Risk adjusted gap = £4.9m
- The current risk-adjusted gap of £4.9m represents a material risk to delivery of the financial plan and requires accelerated scheme implementation.

Month 5 YTD CIP

- £7.28m delivered YTD at month M5
- Below target by £2.26m
- 33% delivered recurrently and 67% delivered non-recurrently at Month 5.

WWL Trust Wide	2026/27
CIP Plan - (£)	31,800
Implemented	17,700
Fully Developed	9,607
Plans in Progress	3,521
Opportunity	972
Pre Pipeline	-
Total Identified	31,800
Unidentified	(0)
Unidentified (%)	0%

Risk Adjusted Forecast	26,909
Risk Adjusted Gap (£)	4,891
Risk Adjusted Gap (%)	15%



	£000's				
In Month	Target	Delivered	Variance	Delivered %	(Gap)/Over %
Recurrent CIP	2,300	681	(1,619)	30%	(70%)
Non Recurrent CIP	880	960	80	109%	9%
Total In Month CIP	**3,180**	**1,641**	**(1,539)**	**52%**	**(48%)**

	£000's				
Year to Date	Target	Delivered	Variance	Delivered %	(Gap)/Over %
Recurrent CIP	6,900	2,436	(4,464)	35%	(65%)
Non Recurrent CIP	2,640	4,845	2,205	184%	84%
Total YTD CIP	**9,540**	**7,282**	**(2,258)**	**76%**	**(24%)**

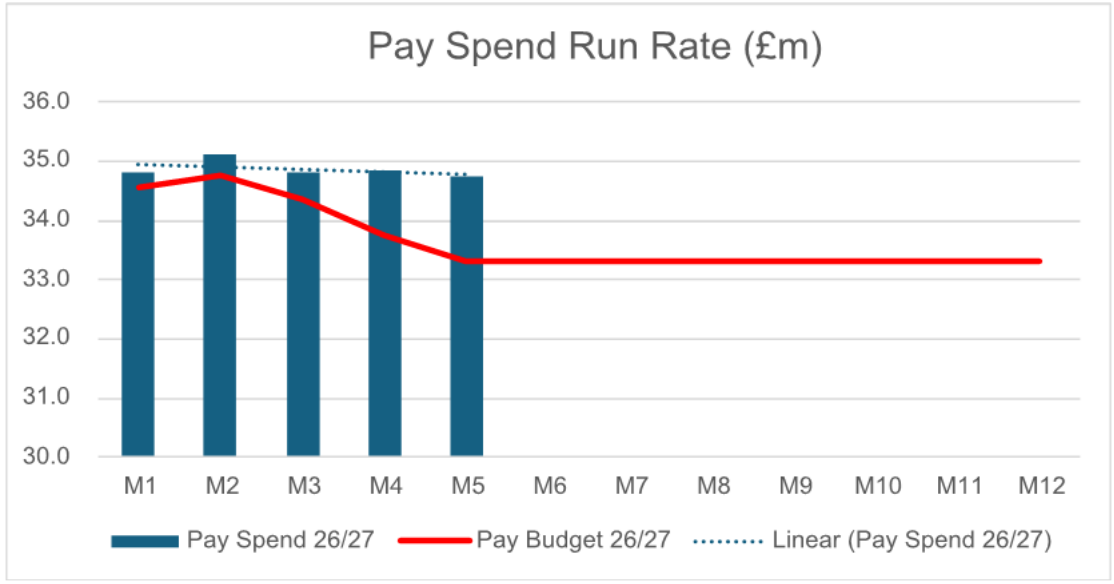
Workforce – Worked Vs Established WTE

Pay expenditure

- The in-month pay expenditure is £34.7m which is £1.4m above plan in month, with pay pressures in both Start Well and Live Well.
- The pay expenditure run rate is not reducing in line with plan driving a £3.4m overspend YTD.
- The current normalised pay is £34.6 m compared to the 2026/27 Q1 monthly average of £34.7m.

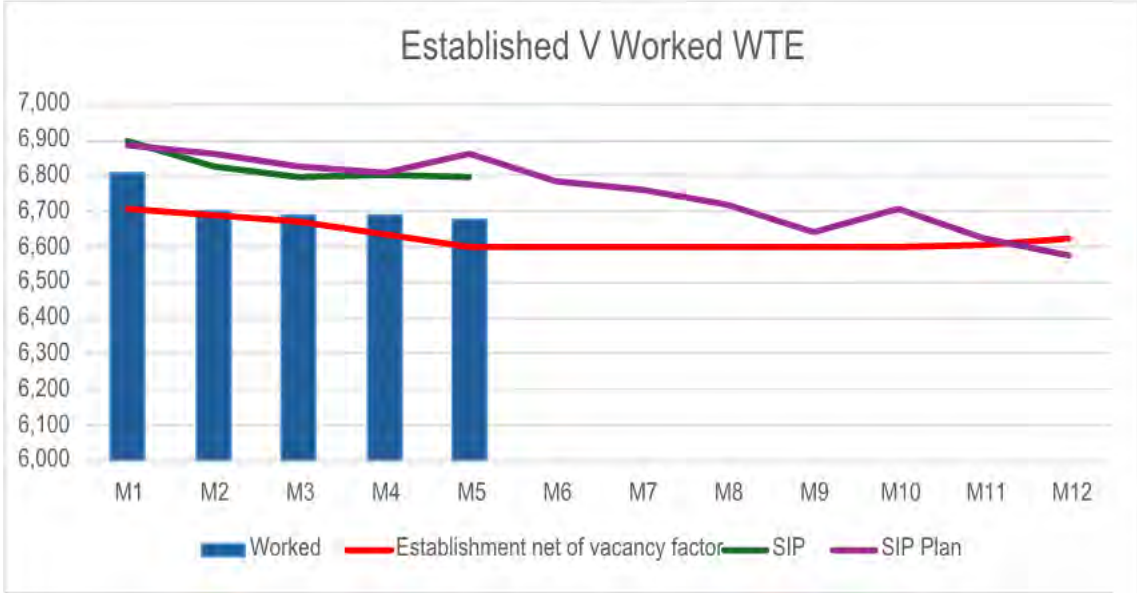
Normalised quarterly average

Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27
£33.7m	£34.5m	£33.7m	£33.8m	£34.1m	£34.1m	£34.6m

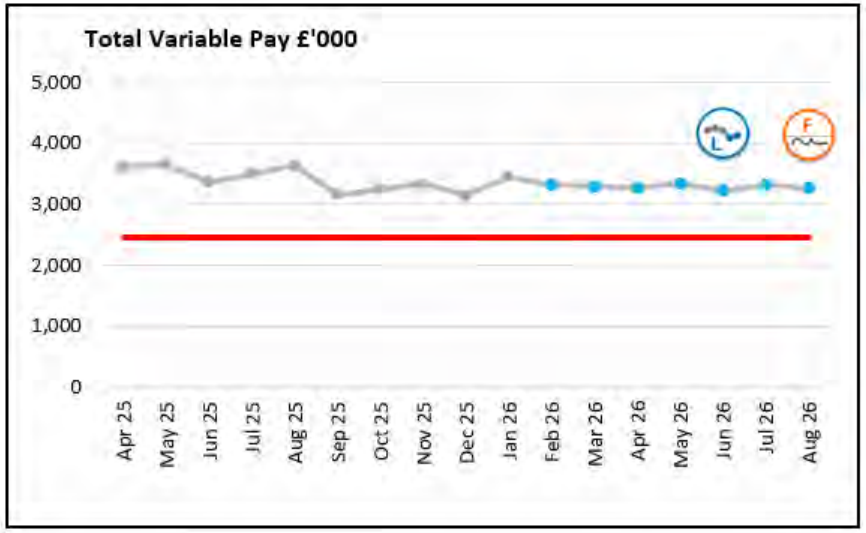


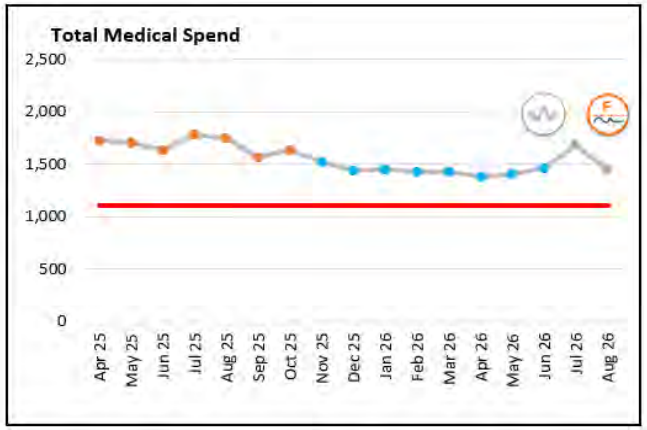
Worked WTE versus vacancy-factor-adjusted establishment

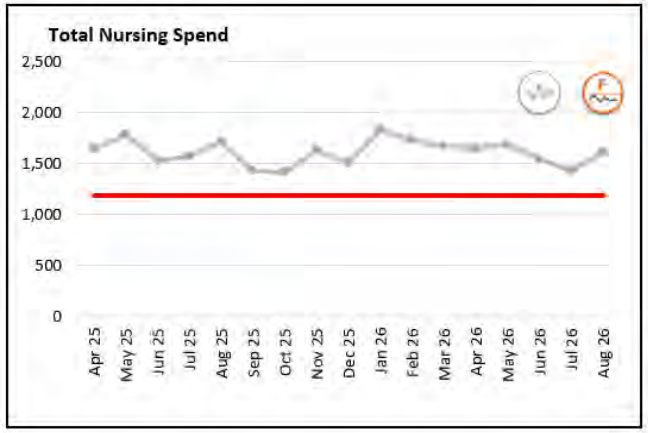
- Vacancy-factor-adjusted establishment WTE for August is 6,602, when adjusted for vacancy factor
- August worked WTE 6,679
  - Substantive worked 6,307
  - Bank worked 344
  - Agency worked 29
  - Overall WTE worked is 77 above establishment plan at month 5. WTE worked is currently below the Staff in Post (SIP) plan.
- Since March 2026, the worked WTE has decreased from 6,774 to 6,679 in M05, a reduction of 95 WTE.



Variable Pay







*The red plan line indicates the recovery target: a 25% reduction in the M1–5 run rate.

Key messages

- Overall variable pay remains above plan, and we are not yet seeing the step change required to reduce spend in this area.
- As part of the recovery plan, we need to identify a reduction in variable pay spend.

In month position

- Total variable pay is £3.3m in month.
- August saw no movement from July. Medical costs decreased and nursing costs increased.
- The in-month spend split by staffing group is Nursing £1.6m, Medical £1.5m, and Corporate £0.2m.

Notes

- Variable pay includes bank, agency, additional sessions, overtime, WOS, cost per reporting and local pay variations (LPVs). These are staffing costs that vary according to workforce requirements and service activity
- Variable pay oversight taking place via the divisional performance reviews and financial improvement group.
- Variable pay includes bank, agency, additional sessions, overtime, WOS, cost per reporting and LPVs.
- Prior year spend has been normalised for pay award and Industrial action costs have been removed.

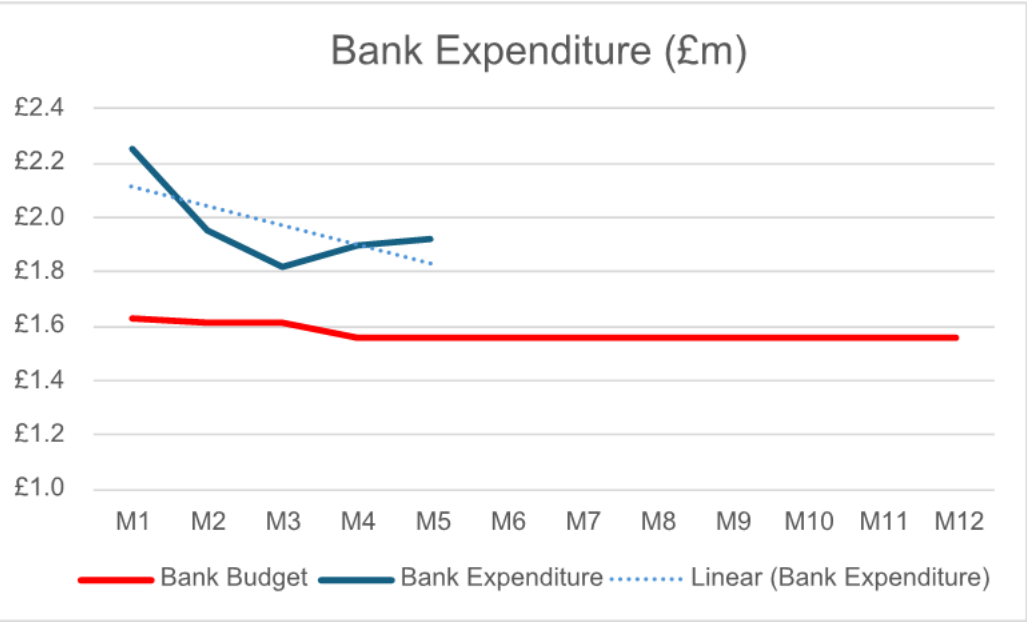
Bank & Agency Staffing

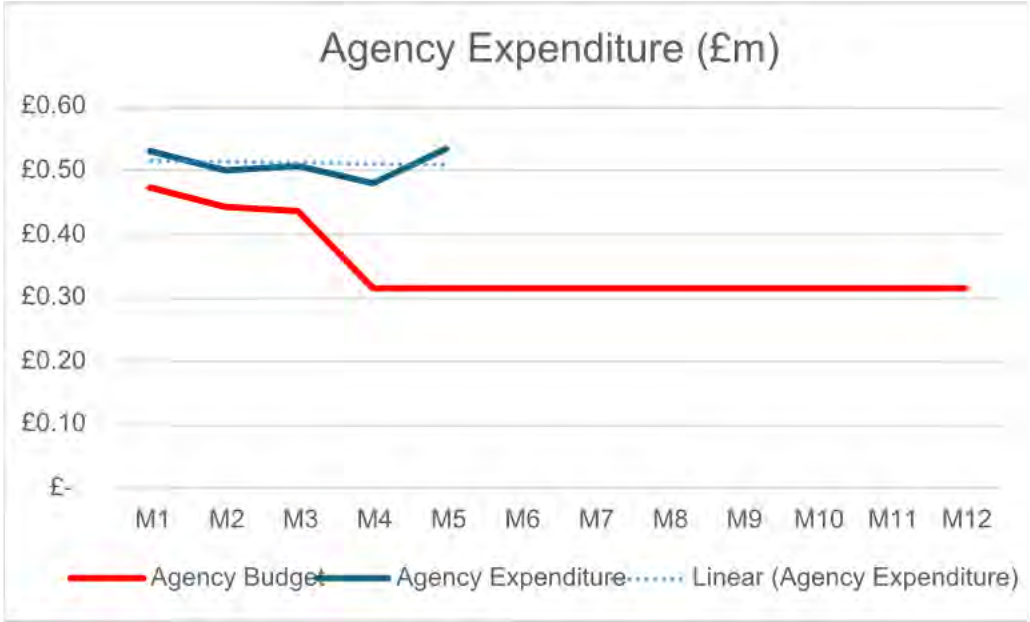
Bank expenditure

- Bank costs were £1.9m in August, the same as July.
- Bank WTE worked was 344 WTE, an increase of 10 since July.
- Bank spend is above the NHSE cap set during the planning round for 2026/27. This cap expects us to reduce our expenditure by 10%, shown by the red line.

Agency expenditure

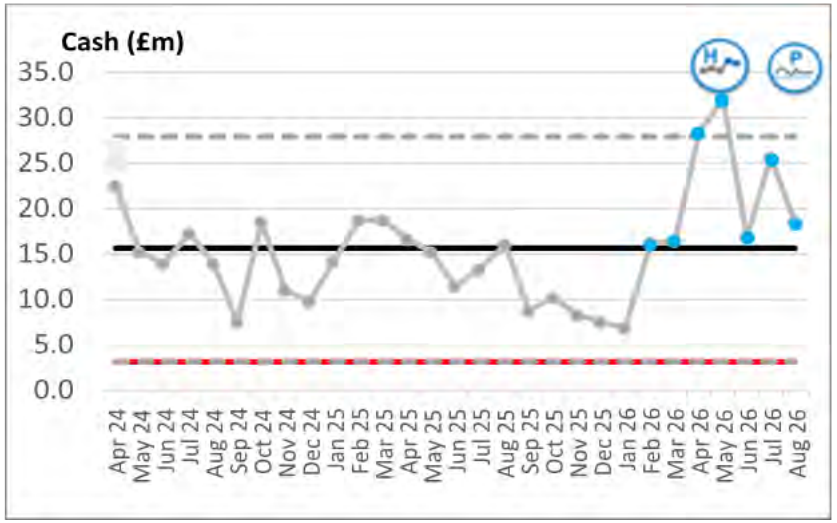
- Agency spend in month is £0.5m, in line with last month.
- Agency WTE worked is 29, a decrease of 3 WTE since July.
- Agency spend is above the NHSE cap set during the planning round for 2026/27. This cap expects us to reduce our expenditure by 30%, shown by the red line.

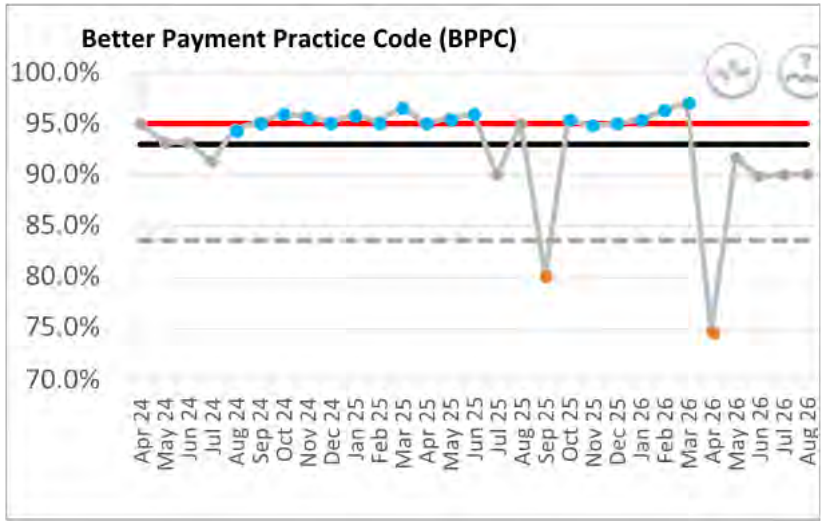




*The graphs have been represented from the SPC model to an in-year graph with different scales to help visualise the progress relative to the NHSE caps. (Budget & Cap are the same).

Cash and BPPC





Current cash position

- Closing cash at the end of August was £18.6m, £7.0m lower than the closing cash position at the end of July (£25.6m). The movement in cash is due to the operating deficit and an increase in creditor payments.
- Cash balances are forecast to reduce towards the end of the financial year; however, current projections indicate that cash resources can be managed to avoid the need for cash support during the year.
- Operating cash days at the end of August was 12 days a reduction of 4 days from July.

Better Payment Practice Code (BPPC)

- The year-to-date performance is below the target of 95.0%
- August performance is 90.0% by volume (90%, July) and 86.7% by value (74.1%, July).

Capital

Scheme	In Month (£000) Plan	Actual	Var	YTD (£000) Plan	Actual	Var	Full Year (£000) Plan
Operational capital programme	1,174	538	636	3,168	1,766	1,402	14,130
Over programming and over allocation			0			0	(673)
Operational capital (CDEL)	**1,174**	**538**	**636**	**3,168**	**1,766**	**1,402**	**13,457**
National funding (PDC)							
Estates Safety	357	731	(374)	1,631	2,041	(410)	4,083
Diagnostics	0	220	(220)	0	220	(220)	7,189
UEC Priorities	500	889	(389)	1,715	1,976	(261)	10,255
Sub total national funding	**857**	**1,840**	**(983)**	**3,346**	**4,237**	**-891**	**21,527**
Lease re-measurements	700	663	37	700	663	37	900
Total capital programme	**2,731**	**3,041**	**(310)**	**7,214**	**6,665**	**549**	**35,884**

Capital plan 2026/27

- Total capital plan submitted to NHSE was £29.5m made up of:
  - Operational CDEL: £14.1m.
  - PDC schemes: £14.4m.
  - Leases £0.9m
  - 5% planning tolerance £0.7m included within £14.1m to be managed in year.
  - Additional PDC funding of £7.0m has been approved in year to bring the total overall programme to £35.8m excluding over programming of £0.7m.
- Trust has also received notification of an increase in its CDEL allocation of £2.0m which is not cash backed. A decision is currently pending on whether to utilise this funding or defer to next financial year.

Month 5 Headlines

- Capital expenditure in month 5 is £3.0m which is £0.3m above the internal plan of £2.7m and £0.8m above the NHSE Plan.

Operational CDEL

- Capital expenditure in month 5 is £0.6m which is £0.6m below the internal plan of £1.2m and £0.3m below the NHSE Plan.
- The underspend in month is largely attributable to an underspend against the HIS upgrade scheme and VAT recovery in the month.
- In addition to expenditure against CDEL schemes, lease remeasurements of £0.7m have been transacted in month

PDC funded schemes

- Capital expenditure in month 5 is £1.8m which is £1.0m above the internal plan of £0.8m and £0.5m below the NHSE plan of £1.3m.

Key Risks



Financial plan delivery: The Trust reported a £7.4m deficit at Month 5, £3.9m adverse to plan, including an in-month adverse variance of £1.8m and £0.5m of non-recurrent support. The underlying run rate has not materially improved and delivery of the 2026/27 financial plan is at significant risk without accelerated recovery action.



Forecast and recovery delivery: The forecast range remains wide, from delivery of plan in the best case to a £21.0m deficit in the worst case, with a £15.0m mid-case deficit. Delivery is dependent on rapid mobilisation of the recovery plan, full CIP delivery and mitigation of the principal financial risks.



Pay and workforce: Pay expenditure was £1.4m adverse in August and £3.4m adverse year to date. Worked WTE was 77 above the vacancy-factor-adjusted establishment, while variable pay remained at £3.3m in month. The required reduction in workforce and variable-pay expenditure has not yet been achieved, creating a continuing risk to recovery-plan delivery.



Cash and liquidity: Closing cash reduced to £18.6m at the end of August, £7.0m below July, with operating cash days falling from 16 to 12 days. Current forecasts indicate that cash support can be avoided during 2026/27, but balances are expected to decline towards year-end and adverse movement against forecast could reduce available headroom.



CIP delivery: CIP delivery was £7.3m year to date, £2.26m below target in month, with only 33% delivered recurrently. Although the full £31.8m target has been identified, risk-adjusted delivery is £26.9m, leaving a £4.9m gap. Continued reliance on non-recurrent delivery presents a material risk to both the in-year position and the underlying run rate.



Elective income: Elective API income was £0.3m below plan in August and £2.0m below plan year to date. Delivery of divisional elective recovery plans will need to accelerate to prevent further income deterioration. The year-to-date position also includes £280k of income delivered through Spire at additional cost.



Bespoke limb-salvage funding: The full-year income plan assumes £3.1m of funding for bespoke limb-salvage prostheses. £1.1m is included in the year-to-date position and remains at risk while discussions with NHS England continue.

Title of report:	Resident Doctor Listening into Action: Progress Update and Improvement Programme
Presented to:	Board of Directors
On:	7th October 2026
Item purpose:	Information
Presented by:	Tracy Narot, Chief People Officer
Prepared by:	Tracy Narot, Chief People Officer
Contact details:	tracy.narot@wwl.nhs.uk

Executive summary

This paper provides Board with assurance on progress following the Resident Doctor Listening into Action session held on 29 July 2026. The full report was considered by People Committee on 15 September 2026, with resident doctor representation, and its recommendations were endorsed.

The Resident Doctor Listening into Action programme was established following direct feedback to Trust Board that WWL was not consistently experienced as a place resident doctors would recommend for education, learning or career development. The 29 July 2026 session secured strong engagement and identified two immediate priorities: improving rotas and day-to-day working conditions, and strengthening respectful, inclusive senior and team behaviours. The feedback highlights material implications for education, wellbeing, retention, patient safety and WWL's reputation as a teaching hospital.

Since the session, WWL has moved quickly from listening to visible action. Progress includes the soft launch of a local induction and welcome tool; Board representation at induction; establishment of the resident doctor Improving Working Lives Group; same-day escalation of patient safety concerns; additional microbiology cover; planned engagement with clinical supervisors; executive-sponsored culture check-ins; and development of a Quarter 4 digital bleep solution. Concerns relating to job swaps, rotation flexibility and enhanced track arrangements are being pursued internally, with the North West Foundation School and with NHS England. Further listening is also planned with IMGLED and locally employed doctors.

The People Committee assessment is partial assurance with a positive direction of travel. Early progress is encouraging, but substantial assurance cannot yet be given because several material issues remain unresolved, including rota and work schedule redesign, car parking, rotation flexibility, enhanced track arrangements, consistency of supervision and evidence of sustained cultural improvement. The next phase requires clear ownership, measurable outcomes, agreed timescales and regular "you said, we did, we are doing" updates. Trust Board is asked to note the progress and remaining gaps, support continued executive, operational, regional and national action, and receive a further update following the further engagement activity and development of the rota and work schedule proposals.

Link to strategy and corporate objectives
This work directly supports WWL's strategic commitment to be a great place to work and learn, and to provide safe, high-quality patient care. It links to the Trust's people, education, improvement and culture priorities by strengthening resident doctor experience, education, supervision, wellbeing, retention and advocacy. It also supports the Board's focus on listening to staff voice, improving psychological safety, and using workforce insight to inform quality, safety and productivity improvement.

Risks associated with this report and proposed mitigations
The principal risk is that unresolved rota and work-schedule design, bleep, parking, rotation flexibility, enhanced track arrangements, supervision and team culture issues continue to affect resident doctors' wellbeing, safety, learning and advocacy, undermining confidence in WWL as a supportive teaching hospital. Mitigation is being coordinated through the resident doctor improvement programme, with executive sponsorship, clinical supervisor engagement, appropriate professional governance, regular "you said, we did, we are doing" updates, and escalation through internal, regional and national routes where required.

Financial implications
No financial decision is requested. Any resource implications arising from specific improvement proposals will follow established operational, workforce and finance governance routes.

Legal implications
No direct legal decision is requested. Delivery will remain aligned with employment, education, equality, health and safety, and professional governance requirements.

People implications
The people implications are significant. Resident doctor experience affects education, supervision, wellbeing, advocacy, retention, patient safety and WWL's reputation as a teaching hospital and employer. The work is intended to improve belonging, respect, psychological safety, supervision quality and practical working conditions. It also supports clinical supervisors by listening to what helps or hinders good supervision and by identifying and spreading exemplar practice.

Equality, diversity and inclusion implications
Equality, diversity and inclusion implications are central to this work. Resident doctors raised concerns about respect, inclusion, sexism, misogyny, unequal treatment and culture. The improvement programme must therefore be explicitly aligned to dignity, fairness, respect, psychological safety and the Trust's equality duties. Planned listening events for IMGLED and locally employed doctors will provide further insight into the experience of groups who may face additional barriers and will help ensure improvement actions are inclusive and evidence-informed.

Which other groups have reviewed this report prior to its submission to the committee/board?
Executive Team received the report on 10 September 2026. People Committee considered the full report on 15 September 2026 and endorsed its recommendations.

Recommendation(s)

Board is asked to:

- Note the progress made and the assurance position of partial assurance with a positive direction of travel
- Note that People Committee considered the full report on 15 September 2026 and endorsed its recommendations
- Support continued delivery and monitoring of the resident doctor improvement programme, with a further assurance update through People Committee.

Title of report:	Speaking Up at WWL: Quarter 1 Assurance and Substantive FTSU Service Transition
Presented to:	Board of Directors
On:	7th October 2026
Item purpose:	Assurance
Presented by:	Director of Corporate Governance
Prepared by:	Tracy Narot, Chief People Officer Rachel Gleave, Associate Director of OD & Inclusion Q1 Data provided by FTSU Guardian from Manchester University NHS FT FTSU Guardian Service
Contact details:	Rachel.gleave@wwl.nhs.uk

Executive summary

This paper provides the Board with assurance on Freedom to Speak Up (FTSU) activity for Quarter 1, covering 1 April–30 June 2026, the continuity of interim arrangements and progress towards a substantive service with Manchester University NHS Foundation Trust (MFT).

Five formal FTSU concerns received and routed for action. The principal themes were worker safety and wellbeing (four), bullying and harassment (two), and patient safety and quality (two); a concern may carry more than one theme.

Partial Assurance judgement based on an independent route remained during Q1 available through MFT's interim goodwill arrangement and the Trust's FTSU Champion Network. With the Director of Corporate Governance now substantively in post, the transition of internal accountability from the interim arrangement held by the Associate Director of OD & Inclusion is being enabled. Locating substantive accountability with the Director of Corporate Governance provides a functionally and operationally independent route, separate from line management, HR case management and patient safety investigation processes, with direct access to the Chair where required. Concerns received were reviewed and escalated through the appropriate routes. The low reporting volume limits trend interpretation. The target is to establish the new contractual arrangement during Quarter 3 2026/27 and no later than 31 December 2026.

Key assurance gaps. Internal substantive accountability is identified with the Director of Corporate Governance and the handover from the Associate Director of OD & Inclusion is in progress. The new contractual arrangement is targeted for completion during Quarter 3 2026/27 and no later than 31 December 2026. The Board is not yet provided with evidence of contractual completion, documented transition milestones and completion of the accountability handover, service standards or key performance measures, comparative trend data, or outcomes and organisational learning from completed concerns.

Controls and follow-up. Interim MFT Guardian cover and the Champion Network remain in place. The Director of Corporate Governance is overseeing the transition of internal accountability from the

Associate Director of OD & Inclusion, establishing a functionally and operationally independent route, separate from line management, HR case management and patient safety investigation processes, with direct access to the Chair where required. Reporting volumes, access, themes, detriment and outcomes will continue to be monitored. A further assurance update will confirm completion of the accountability handover, delivery of the new contractual arrangement during Quarter 3 2026/27 and no later than 31 December 2026, the performance framework, communication plan and evidence that actions have been completed and embedded.

Link to strategy and corporate objectives
WWL's starting principle is that every colleague should feel safe and supported to raise a concern, ask a question or challenge practice. Speaking up helps colleagues support one another, put patient safety first, maintain public trust and uphold professional standards. Concerns should be heard and acted upon through the most appropriate route. Everyday conversations with line managers, clinical leaders and established safety, people and governance processes will often be the most direct route. Freedom to Speak Up and statutory whistleblowing protections are important parts of this wider toolkit, providing additional safeguards and independent routes where usual channels are not appropriate, have not worked or do not feel safe.

Risks associated with this report and proposed mitigations
Principal risks: reduced staff awareness or confidence during transition; delay in implementing the substantive service; insufficient visibility of outcomes and learning; and failure to identify or address detriment, cultural or patient safety concerns. Mitigation has continued with independent interim cover, Champion support, clear communications, routine monitoring and escalation through established people and quality governance routes.

Financial implications
The costs of the proposed substantive Freedom to Speak Up arrangements are contained within the Trust's approved financial envelope. No additional funding is requested through this paper.

Legal implications
The Trust's wider speaking-up arrangements support compliance with legal, professional and regulatory duties. Statutory whistleblowing protections apply where the relevant legal tests are met; FTSU provides an additional independent and confidential route. Neither replaces effective day-to-day management, clinical escalation, patient safety, people or governance processes. Clear signposting and appropriate onward referral are therefore essential so that concerns are handled under the correct framework and colleagues are protected from detriment.

People implications
A healthy speaking-up culture is one in which colleagues can raise questions, concerns and challenge through a range of accessible routes and can trust that they will be listened to, supported and not disadvantaged for doing so. FTSU adds an independent route and safety net where other channels are unsuitable or feel unsafe; it should complement, not replace, compassionate leadership, effective management and responsive clinical and people processes.

Equality, diversity and inclusion implications
A robust Freedom to Speak Up service supports an inclusive culture by ensuring all staff have access to a safe and confidential route to raise concerns, regardless of role, background or protected characteristic. Effective speaking up arrangements help identify potential inequalities, barriers to inclusion and concerns relating to fairness, supporting the Trust's commitment to equality, diversity and inclusion.

Which other groups have reviewed this report prior to its submission to the committee/board?
This report has been submitted directly to the Board because the current MFT Guardian support is operating as an interim goodwill arrangement rather than under a formal contracted provision. Direct Board consideration provides oversight during transition and enables the Board to confirm the required substantive accountability, contractual and assurance arrangements.

Recommendation(s)

The Board is asked to:

1. Note the Quarter 1 activity for 1 April to 30 June 2026, the themes identified and the limitations in interpreting the low reporting volume.
2. Receive partial assurance that an independent FTSU route remained available and concerns received were appropriately reviewed and escalated during the transition.
3. Note the Executive Team decision to appoint MFT as the substantive FTSU provider.
4. Note that the Director of Corporate Governance, now substantively in post, is enabling the transfer of internal accountability from the interim arrangement with the Associate Director of OD & Inclusion, providing a functionally and operationally independent route, separate from line management, HR case management and patient safety investigation processes, with direct access to the Chair where required.
5. Support the target to complete the new contractual arrangement during Quarter 3 2026/27 and no later than 31 December 2026, and require confirmation of contractual completion, the substantive service commencement date, transition milestones and completion of the accountability handover.
6. Require the next report to include comparative trend data, service performance measures, concern outcomes, evidence of learning and action completion, detriment monitoring, Champion Network coverage and staff awareness measures.

Freedom to Speak Up: Quarter 1 Assurance Report

WWL's speaking-up principle. All colleagues should feel safe and supported to raise concerns because listening and responding well enables us to support each other, put patient safety first, maintain trust and uphold professional standards. Speaking up is everyone's responsibility and is broader than any single service or process. Colleagues may raise matters through ordinary conversations and established management, clinical, patient safety, people or governance routes. FTSU and whistleblowing sit within this wider toolkit: they provide important additional safeguards and routes, particularly where usual channels are not appropriate, have not resolved the concern or do not feel safe. The emphasis should therefore be on responding well and ensuring the concern reaches the right route, rather than requiring colleagues to determine a technical label before they speak up.

During Quarter 1, 1 April–30 June 2026, the service received 32 contacts; five were progressed as formal FTSU concerns. Staff retained access to independent interim Guardian support from MFT and local FTSU Champions. All formal concerns were reviewed and directed to the appropriate management or governance route. The low number of formal concerns means trends should be interpreted cautiously and does not, on its own, demonstrate either improved culture or reduced access.

Published activity profile	Number
Formal FTSU concerns across multiple staff groups	5

Published characteristic	Position
Anonymous concerns	None reported
Reported detriment	One matter under review
Other reporting characteristics	Aggregated and suppressed in the published paper because of small numbers and the risk of indirect identification

Themes are not mutually exclusive. Of the five formal concerns, four included worker safety and wellbeing, two bullying and harassment, and two patient safety and quality. One concern described a lack of psychological safety. One matter included an allegation of detriment and remains under review. These issues require continued oversight because they may indicate local cultural, workforce and patient safety risks, although the small sample does not support wider conclusions.

Published location profile	Position
Formal concerns	Concerns arose across more than one Trust site. Individual site numbers are suppressed because of the small cohort and the risk of indirect identification.

All five formal concerns were shared with the appropriate management teams for investigation and response; patient safety issues were escalated through the relevant governance routes. Themes have been fed into existing people governance arrangements. One matter included an allegation of detriment and remains under review. The next report should provide assurance on investigation outcomes, completion dates, lessons implemented, impact, feedback to those speaking up and the outcome of the detriment review, in a form that protects confidentiality.

Substantive service implementation

A fair and safe procurement process, identified MFT as WWL's preferred supplier for the substantive FTSU service. The proposed model provides a dedicated Guardian for WWL with access to MFT's wider resilience, specialist expertise, governance and cover arrangements.

Contractual and operational arrangements for the substantive MFT Guardian service are being finalised and interim MFT cover remains in place. The target is to establish the new contractual arrangement during Quarter 3 2026/27 and no later than 31 December 2026. Separately, the Director of Corporate Governance is now substantively in post and is enabling the transfer of WWL's internal accountability from the interim arrangement held by the Associate Director of OD & Inclusion. This provides a functionally and operationally independent route, separate from line management, HR case management and patient safety investigation processes, with direct access to the Chair where

required. Completion of the internal handover and the precise substantive service commencement date will be confirmed to the Board. A signed contractual arrangements with MFT during Quarter 3 2026/27 and no later than 31 December 2026; a confirmed substantive service commencement date and transition milestones; documented completion of the internal accountability handover to the Director of Corporate Governance; clear role boundaries between the Guardian service and WWL's management, HR, patient safety and governance routes; continuity and escalation arrangements, including direct access to the Chair; staff communications; Champion engagement; data-sharing and confidentiality controls; performance measures; and a reporting route to the Board.

Champion Network

The Champion Network remained active during transition, supporting visibility, signposting and local access. Mapping has begun to identify representation and coverage gaps. The next report should quantify network coverage, vacancies, training compliance, engagement activity and action to improve access across sites, services, staff groups and protected characteristic communities.

Title of report:	NHS Staff Standards (Sexual Safety Charter) Progress and Assurance Update
Presented to:	Board of Directors
On:	7th October 2026
Item purpose:	Assurance and Oversight
Presented by:	Tracy Narot, Chief People Officer Prof Sanjay Arya, Chief Medical Officer & Responsible Officer
Prepared by:	Charlotte Wright, Deputy Chief People Officer Prof B Nirmal Kumar, Deputy Medical Director & Deputy Responsible Officer
Contact details:	tracy.narot@wwl.nhs.uk

Executive summary

This paper updates the Board on the Trust's response to an independent learning review of a historic sexual safety case and the wider learning tested through a comparator case and two current professional conduct matters. It confirms the action approved by People Committee on 15 September 2026, reports progress already made and sets out the remaining assurance gap.

Since the historic case, the Trust has strengthened executive and committee oversight, Doctors in Concern governance, case-management arrangements, role clarity, welfare expectations and the handling of sexual misconduct concerns. People Committee endorsed the Trust response and action plan, quarterly assurance reporting and addition of the residual risk to the Corporate Risk Register. Overall assurance remains limited until these controls are consistently embedded and their impact is evidenced. A fully redacted copy of the complete learning review is available to Board members on request through the Company Secretary function.

Limited assurance, noting governance and controls have strengthened, but consistent implementation and impact across all services have not yet been demonstrated.

Financial implications

There are no immediate direct financial implications arising from the review itself. Delivery may require investment in case management, investigation capacity, training, independent review and workforce intelligence. Failure to respond effectively may create future costs relating to litigation, regulatory intervention, turnover, sickness absence and reputational harm.

Legal implications

The review identifies potential risk relating to the Equality Act 2010, health and safety obligations, ACAS principles and NHS employment standards. It does not determine legal liability. Current improvement must also reflect the Worker Protection (Amendment of Equality Act 2010) Act 2023 proactive duty and NHS sexual safety expectations.

People & EDI Implications

The review highlights important People and EDI issues, including sexual safety, gender, workplace hierarchy, professional power, psychological safety and cultural awareness. The Trust's response must be fair, inclusive and sensitive to the different experiences of those involved. Complainants, witnesses and respondents should receive clear communication and appropriate support throughout. Evidence must be considered objectively, without assumptions, stereotypes or unfair blame, and colleagues must feel safe and confident to raise concerns.

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

Executive Team Meeting on 10 September 2026, for discussion; and People Committee on 15 September 2026, for scrutiny and endorsement of the Trust response, action plan, quarterly assurance route and addition of the residual risk to the Corporate Risk Register.

Recommendation(s)

- Receive the report and note the scope, limitations and organisational learning from the independent review and subsequent case learning.
- Note the progress made and the actions endorsed by People Committee on 15 September 2026, including the action plan, quarterly assurance reporting and addition of the residual risk to the Corporate Risk Register.
- Endorse the current limited-assurance judgement and the oversight arrangements, noting that People Committee will advise the Board when there is sufficient evidence to increase the assurance level.
- Require material delay, increased risk or deterioration in assurance to be escalated through the People Committee AAA report and Corporate Risk Register.

Assurance report

Following detailed scrutiny by People Committee in September 2026, this paper provides Board oversight of the Trust's response to serious organisational learning. The independent desktop review examined how concerns relating to a Specialty Doctor in Emergency Care were raised, managed, investigated and resolved between October 2019 and May 2022, using available documents, policies, correspondence and interview records. A later case was used as a comparator to test improvement.

The review was not a reinvestigation and did not determine disputed facts, individual culpability or legal liability. Evidence was provided in stages and some documents were unavailable; these limitations remain relevant when interpreting the findings. This paper therefore summarises the learning at Board level. A fully redacted copy of the complete review is available to Board members on request through the Company Secretary function.

A subsequent reflective discussion involving the Chief Medical Officer, Chief People Officer and Deputy Chief People Officer clarified the medical governance route used at the time. It did not alter the core organisational learning on People governance, role separation, documentation, timeliness and complainant welfare.

Taken together, the independent review, comparator case and two current professional conduct matters show stronger formal governance and executive intervention once concerns are escalated. They also show continuing variation in early recognition, ownership, escalation and timeliness. The current matters are referenced only to test the control environment; no view is expressed on the merits or outcome of any live process.

Strengths recognised and to build on:

- Prompt escalation once the 2021 formal complaints were raised, with working restrictions subsequently strengthened.
- Independent investigation arrangements, relevant clinical evidence and external participation in the fast-track hearing.
- Recognition of a pattern across known concerns.
- More structured documentation and welfare arrangements in the comparator case, providing evidence of improvement.

Significant learning and risk:

- Earlier concerns were not consistently investigated, documented or followed through, weakening pattern recognition and organisational grip.
- Case handling was prolonged and key decisions including risk assessment, reclassification, fast-track resolution and sanction were not always sufficiently clear or auditable.
- Advisory and decision-making roles were not adequately separated.
- Communication, welfare support and outcome processes did not consistently meet complainant, witness and respondent needs.
- Trauma-informed and culturally intelligent practice was not consistently applied, and material factual disputes were not always clearly resolved against the workplace standard of proof.

The learning is consistent with the direction of national expectations for fair, compassionate, transparent and well-governed employee relations. The Trust response aligns with:

- Dido Harding 2019 recommendations on improving how the NHS manages employee relations matters, including Board oversight, consistency, compassion, learning and use of data.
- NHS Sexual Safety Charter expectations and the Trust's wider sexual safety programme.
- NHS Staff Standards and National Oversight Framework workforce accountability.

- Be Fair and Just Culture principles.
- Freedom to Speak Up and psychologically safe practice.
- ACAS principles and the proactive duty to take reasonable steps to prevent sexual harassment.

Progress since the historic case

- Stronger executive oversight, improved Doctors in Concern governance and routine AAA reporting to People Committee.
- Implementation of an electronic employee relations case-management system to strengthen visibility, ownership and timeliness.
- A non-medical Staff Concern governance established from September 2026, chaired by the Chief Nurse.
- Removal of fast-track resolution for sexual misconduct cases and clearer separation between HR advice and accountable decision-making.
- Greater emphasis on documented risk assessment, complainant welfare, trauma-informed support and consistent investigation arrangements.

These changes demonstrate clear progress in governance, control design and executive oversight. The next phase is to evidence consistent application and sustained impact across services.

Current live-case learning and assurance judgement

People Committee has tested the learning against two current professional conduct matters. These examples are included solely to assess the present control environment; the underlying allegations remain subject to confidential and fair processes, and no view is expressed on their merits or outcome.

The current examples show a stronger formal response once matters reach executive oversight, including exclusion where appropriate, independent investigation, wider terms of reference and consideration of trauma-informed and cultural expertise. They also show improved documentation and a broader organisational-learning lens.

However, delays before formal escalation, incomplete informal resolution and uncertainty about early ownership remain evident. The position is therefore one of improved control and stronger executive grip, but not yet consistent or fully embedded practice.

Governance and response have strengthened materially, but current evidence does not yet demonstrate that early recognition, ownership, escalation, timeliness, welfare support and pattern identification are consistently effective across all services.

Following endorsement by People Committee on 15 September 2026, the Trust will add this residual organisational risk to the Corporate Risk Register. The risk reference, current and target scores, target date and review date will be confirmed through the established risk-management process when the entry is approved.

The entry will remain in place until the revised controls are demonstrably embedded and effective. The Board is asked to note the risk, the current limited-assurance judgement, executive ownership and the agreed oversight arrangements.

Risk	Employee relations governance, sexual safety and organisational learning: inconsistent identification, escalation, investigation or resolution of high-risk concerns may cause avoidable harm, reduce confidence in speaking up and expose the Trust to workforce, patient safety, legal, regulatory and reputational consequences.

Executive owner	The Chief People Officer is accountable for delivery of the action plan and assurance reporting. The Chief Medical Officer and Chief Nurse will provide assurance on the effectiveness of the relevant professional conduct routes.
Current assurance	Limited. Controls have strengthened but are not yet consistently embedded or independently tested across services.
Key gaps and actions	Priority gaps are early recognition and escalation, case timeliness, auditable decision-making, welfare support and pattern identification. The Committee-approved action plan addresses these through strengthened governance, case-management intelligence, quality audit, thematic sexual safety review and independent follow-up review of high-risk cases.
Oversight and escalation	Quarterly scrutiny by People Committee, with Board visibility through the Corporate Risk Register and People Committee AAA report. Material delay, increased risk or deterioration in assurance will be escalated to the Board.

The People Committee-endorsed action plan will be delivered through named executive accountability, defined milestones and exception-based escalation. The Chief People Officer will provide the first quarterly assurance update to People Committee following the October 2026 Board meeting. Reporting will focus on whether the changes are improving practice and outcomes, not only whether actions have been completed.

- delivery against milestones, overdue actions and recovery plans;
- case timeliness, aged cases and the quality of escalation and decision records;
- sexual safety and other high-risk themes, including repeated or linked concerns;
- evidence of effective welfare support and colleague experience; and
- case-audit and independent-review findings, with a clear recommendation on whether assurance should increase, remain unchanged or reduce.

The Board can take assurance that the learning has been independently identified, scrutinised by the Executive Team and People Committee, and translated into an endorsed improvement plan, strengthened controls and a Corporate Risk Register response.

Assurance nevertheless remains limited because consistent application and impact have not yet been demonstrated across all services. People Committee will maintain quarterly scrutiny, and material delay, increased risk or control failure will be escalated to the Board through the AAA report and Corporate Risk Register. Assurance will only increase when evidence shows timely case handling, sound and auditable decisions, reliable welfare support, effective pattern recognition and improved colleague experience.

Title of report:	Lord Mann Review: Assurance on Trust Response, Gaps and Priority Actions
Presented to:	Board of Directors
On:	7th October 2026
Item purpose:	Approval
Presented by:	Tracy Narot, Chief People Officer
Prepared by:	Tracy Narot, Chief People Officer
Contact details:	tracy.narot@wwl.nhs.uk

Executive summary

This paper provides the Board of Directors with assurance on the Trust's response to the Lord Mann Review on antisemitism and racism in the NHS. The Lord Mann Review set expectations for how NHS organisations recognise, report, investigate and respond to antisemitism as part of a wider anti-racism approach.

Following its review of the initial gap analysis, the People Committee assessed that partial assurance can be taken:

- key foundations are in place, but further work is required to establish a coherent, measurable and consistently governed anti-racism framework and achieve full assurance.

The Board is asked to agree the People Committee's assessment of partial assurance; note and endorse the Committee-endorsed priority action plan to achieve full assurance (set out at Appendix 1) and, as part of that plan, adopt the recognised anti-racism principles and the national definitions of antisemitism and anti-Muslim hostility as non-legally binding reference points (set out at Appendix 2)

Risks associated with this report and proposed mitigations

The principal risk is that staff and patients continue to experience racism, antisemitism, anti-Muslim hostility, bullying, harassment or inequitable treatment, resulting in harm, reduced confidence in speaking up, poorer staff experience and potential legal, regulatory and reputational exposure.

The priority action plan endorsed by the People Committee provides the route to strengthen control and assurance through clearer executive and Board oversight.

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

Executive Management Team, 20th August 2026, also, People Committee 15th September 2026.

Recommendation(s)

The Board is asked to:

- Agree the People Committee's assessment of partial assurance, noting that key foundations are in place.
- Note and endorse the priority action plan agreed by the People Committee to achieve full assurance (Appendix 1).
- As part of the priority action plan, adopt the recognised anti-racism principles and the national definitions of antisemitism and anti-Muslim hostility as non-legally binding reference points (Appendix 2).

Appendix 1: Priority action plan for assurance

Priority	Action	Assurance route
1. Board decision	Adopt recognised anti-racism principles and definitions as organisational reference points. (see appendix 2)	People Committee recommendation to Board.
2. Risk and assurance	Create one Tackling Racism delivery plan and dashboard, and formally review and score the associated Trust-wide risk for possible inclusion on the Corporate Risk Register.	Q4 2026/27 deep dive to People Committee, supported by risk escalation as required.
3. Protection and learning	Embed consistent investigation, staff support, patient/public escalation and organisational learning arrangements.	Exception reporting and impact review.
4. Q4 deep dive	Return to People Committee in Q4 2026/27 with progress against actions, WRES and WDES data, 2026 NHS Staff Survey feedback and qualitative insight from the FAME Staff Network Chair and Vice Chair and the Global Majority Professional Practice Nurse.	Committee to reassess the level of assurance and confirm any further controls, escalation or Board action required.

Appendix 2: Definitions and principles proposed for Board sign-off, 7th October 2026

This appendix is provided to support a specific Board decision. It sets out the recognised definitions and principles proposed for adoption as non-legally binding organisational reference points. Their adoption forms part of the priority action plan to strengthen the Trust's anti-racism arrangements and progress towards full assurance.

Adoption is intended to support consistent recognition, reporting, investigation, training, support and organisational learning in relation to antisemitism, anti-Muslim hostility and wider racism.

1. WWL definition of antisemitism

Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.

The definition is a non-legally binding working definition. It should be used as a practical reference point to support understanding, prevention, reporting and response, alongside existing legal duties and Trust policies.

2. WWL definition of anti-Muslim hostility

Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

The definition is non-statutory and does not change what is or is not a crime. It should be used as a reference point to improve consistency of understanding, recording, prevention, support and response.

3. NHS Race and Health Observatory seven anti-racism principles

- Name racism explicitly.
- Understand and acknowledge racism and its impacts.
- Meaningfully involve racially minoritised people and communities.
- Collect and publish data to support transparency and accountability.
- Identify and address racial bias.
- Apply a race-critical lens to policies, practices and decision-making.
- Evaluate progress and reflect on learning and impact.

The Board is asked to approve adoption of these definitions and principles as non-legally binding organisational reference points, to support a consistent Trust-wide approach to anti-racism, antisemitism, anti-Muslim hostility, staff and patient safety, reporting, investigation, support and learning. Adoption should be read alongside existing legal duties, Trust policies and professional standards.

Signed By the Chair……. Dated

On behalf of WWL Trust Board of Directors

Title of report:	Workforce Race Equality Standard and Workforce Disability Equality Standard 2025/26
Presented to:	Board of Directors
On:	7th October 2026
Item purpose:	Approval
Presented by:	Tracy Narot, Chief People Officer
Prepared by:	Tracy Narot, Chief People Officer in partnership with: Kev Parker Evans, Chief Nurse, Sanjay Arya, Chief Medical Officer, Anne-Marie Miller, Director of Communications and Stakeholder Engagement
Contact details:	tracy.narot@wwl.nhs.uk

Executive summary

This paper provides the Board with assurance on the Trust's 2025/26 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) position and seeks approval to publish the annual report and action plan. It draws on nationally mandated workforce metrics, the 2025 NHS Staff Survey and five-year trend evidence. The full annual report and the action plan provide the supporting evidence at Appendices 2 and 1 respectively.

Overall assurance: limited to moderate. The Board can take assurance that the statutory position is understood, the evidence has completed the agreed governance route and accountable leads are identified in the action plan. Positive movement is evident in representation, formal disciplinary and capability disparities, and reported reasonable adjustments. However, the Board cannot yet take full assurance that these actions are delivering sustained, organisation-wide improvement. Material inequalities remain in recruitment, discrimination, bullying and harassment, and in the workability, wellbeing, engagement and inclusion experienced by disabled colleagues. The principal assurance requirement is therefore evidence of implementation and measurable impact, not further activity alone.

Positive assurance

- Global Majority workforce representation has increased to **16.56%**.
- Global Majority Board representation has increased to **14.29%**.
- The relative likelihood of Black, Asian and Minority Ethnic staff entering a formal disciplinary process is **1.00**, indicating parity in the latest year. The five-year pattern has fluctuated, so this requires continued monitoring before it can be described as sustained improvement.
- Disability declaration has increased to **5.5%**. This provides a stronger evidence base and may indicate greater confidence in declaration, although other factors may also influence the result.
- The relative likelihood of disabled staff entering a formal capability process has reduced from **3.09 to 1.22**.
- **68.97%** of disabled staff report that the Trust has made reasonable adjustments, the strongest recorded position.

Principal inequalities and concerns

- White applicants remain **2.23 times more likely** to be appointed from shortlisting than Black, Asian and Minority Ethnic applicants.
- Harassment, bullying or abuse from staff reported by Black, Asian and Minority Ethnic colleagues reduced from **31.60% to 23.20%**. This is a significant single-year improvement, but remains above the White staff result of **18.10%** and requires confirmation over time.
- **15.73%** of Black, Asian and Minority Ethnic colleagues report personally experiencing discrimination from a manager, team leader or colleague, compared with **5.04%** of White colleagues.
- Disabled staff engagement has fallen to **6.31**, compared with **6.86** for non-disabled staff.
- Only **30.74%** of disabled staff report feeling valued, compared with **42.69%** of non-disabled staff.
- **26.99%** of disabled staff report pressure from their manager to attend work when unwell, compared with **16.42%** of non-disabled staff.
- No Board member has declared a disability across the five-year WDES series. This should prompt a careful review of data completeness, confidence in declaration and inclusive Board recruitment and appointment processes, without seeking disclosure from individuals.

Assurance interpretation**:** process and representation indicators are moving positively, but year-on-year variation means that single-year movement should not be treated as evidence of sustained change. Progress will therefore be assessed using Making Data Count principles, supported by trend evidence over three to five years and the delivery measures in Appendix 1.

Strategic risk: persistent inequalities may affect psychological safety, workforce supply, recruitment, retention, sickness absence, presenteeism, employee relations, legal compliance, organisational reputation, staff advocacy and, through workforce experience and engagement, the quality of care. Delivery will be monitored through the named Executive Sponsors and SROs in Appendix 1, with quarterly scrutiny by the EDI Strategy Group and People Committee and six-monthly assurance to the Board. Material deterioration missed critical milestones or inadequate ownership will be escalated earlier.

Finance implications

Poorer experience may contribute to attrition, sickness absence, reduced engagement and employee relations costs. Delivery should use existing resources wherever possible. Any additional investment or capacity requirement should be quantified through the agreed business planning route. The six-month report should include available evidence on retention, turnover, absence and associated workforce cost for the affected staff groups.

Legal implications

The Trust must meet its duties under the Equality Act 2010 and Public Sector Equality Duty to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. WRES and WDES also form part of national NHS contractual and reporting expectations.

Equality, Diversity and Inclusion implications

An equity-based approach is required. Different groups may need different support or intervention to achieve fair outcomes. Data must be interpreted carefully, with appropriate protection of confidentiality and no pressure on individuals to disclose a disability or other protected characteristic.

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

The EDI Strategy Group considered the performance on 8 September 2026 and People Committee considered the report on 15 September 2026. The governance sequence is complete. EDI Strategy Group members include the Executive Sponsors and SROs named in Appendix 1, providing a direct link between specialist oversight, accountable delivery and assurance to People Committee and the Board.

Recommendation(s)

The Board is asked to:

1. **Receive and note** the 2025/26 WRES and WDES results, including the areas of progress and persistent inequality.
2. **Take limited to moderate assurance** that the statutory position is understood, the governance route is complete and accountable delivery arrangements are in place, while noting that sustained organisation-wide impact is not yet evidenced.
3. **Approve publication** of the 2025/26 annual WRES and WDES report presented to People Committee at Appendix 2 and the associated action plan at Appendix 1.
4. **Require ongoing assurance** through quarterly People Committee scrutiny and a six-monthly Board update, with earlier escalation of material deterioration, significant delivery risk, missed critical milestones or inadequate ownership.

Post-approval control: before publication, the documents will undergo administrative checks for data reconciliation, accessibility, formatting and version control. No substantive change will be made without further approval through the appropriate governance route.

Appendix 1: 2025/26 WRES and WDES Action Plan and Delivery Tracker

Purpose: this action plan translates the principal WRES and WDES inequalities into four accountable improvement priorities. The Board is asked to approve its publication and will receive assurance on delivery through the reporting cycle shown below.

Priority	Baseline	Six-month deliverables	Outcome measure	Owner / RAG / escalation
1. Fair recruitment and progression	White applicants are 2.23 times more likely to be appointed from shortlisting.	Analyse each recruitment stage; identify hotspots by division, profession and band; agree corrective action; strengthen panel practice.	No deterioration; changed panel practice by 6–12 months; sustained narrowing of the gap over 12–24 months.	Executive Sponsor: Chief Nurse SRO: Global Majority Practice Nurse RAG: [ ] Escalate unexplained disparity, incomplete data or missed milestones.
2. Respect, safety and anti-discrimination	23.20% report harassment by staff; 15.73% report discrimination from a manager or colleague.	Standardise prevention, response and support; strengthen Red Card–Yellow Card, Active Bystander and Avoiding Harm delivery; review repeated themes.	Improved response and support within 6–12 months; reduced discrimination and harassment gaps over 18–24 months.	Executive Sponsor: Chief Medical Officer SROs: FAME Chair; Associate Director of Organisational Development & Inclusion RAG: [ ] Escalate hotspots, delayed response or unsafe reporting.
3. Disability inclusion and workability	68.97% report adjustments; engagement 6.31; 30.74% feel valued;	Set adjustment standards and escalation routes; monitor timeliness and completion; strengthen manager conversations and adviser support.	Improved adjustment delivery within 3–6 months; reduced presenteeism gap and improved experience over 12–24 months.	Executive Sponsor: TBC SROs: DaWN Chair; Associate

	26.99% report pressure to attend when unwell.			Director of Patient Experience & Engagement RAG: [ ] Escalate overdue adjustments, barriers or deterioration.
4. Inclusive leadership accountability	Improvement is not yet consistent or sustained; ownership and impact evidence require strengthening.	Agree divisional hotspot plans; embed indicators in assurance meetings; establish feedback loops and escalation arrangements.	All divisions reporting within six months; evidence of action and measurable cultural improvement over 18–36 months.	Executive Sponsor: Deputy CEO SRO: Deputy COO RAG: [ ] Escalate absent ownership, slippage or lack of impact.

RAG key: Green—on track with delivery and early impact; Amber—delivery risk or slippage requiring corrective action; Red—material deterioration or missed critical milestone requiring escalation.
Review: monthly operational review; quarterly EDI Strategy Group and People Committee scrutiny; six-monthly Board assurance, with earlier escalation where required.

Appendix 2: Annual WRES and WDES Report 2025/26

Title of report:	Board Diversity Policy Renewal
Presented to:	Board of Directors
On:	7 October 2026
Item purpose:	Approval
Presented by:	Director of Corporate Governance
Prepared by:	Director of Corporate Governance and Associate Director of Organisational Development and Inclusion
Contact details:	Company.secretary@wwl.nhs.uk

Executive summary

The Trust's Board Diversity Strategy was first published in 2020 in response to the Hampton-Alexander Review and Parker Reviews which both highlighted a lack of diversity at Board level in the UK.

Link to strategy and corporate objectives

Clear link to the people objective to ensure wellbeing and motivation and work and to minimise workplace stress by making WWL a great place to work, ensuring that our staff feel safe, engaged, empowered and valued.

Risks associated with this report and proposed mitigations

There could be a gap in policy between this policy being stepped down and a new trust wide EDI policy being approved. It will be essential to ensure that the existing board diversity commitments are explicitly carried forward into the new EDI policy and delivery plan.

There are a number of proposed actions which rely on the capacity of teams to develop a new strategy, policy and plan which may get delayed due to competing priorities and capacity of individuals. Progress against this plan should be monitored through established governance routes.

Financial implications

There are no immediate direct financial implications arising from the recommendation to step down the standalone Board Diversity Policy. Development of the Trust-wide EDI Policy, EDI Delivery Plan and associated talent management plan is expected to be delivered through existing corporate governance, organisational development and inclusion resources. Any future financial implications arising from specific initiatives within the EDI Delivery Plan will need to be identified and considered through the appropriate planning and approval routes.

Legal implications

There are legal and regulatory implications associated with ensuring the Trust continues to meet its duties under the Equality Act 2010, including the Public Sector Equality Duty. The proposed approach should support compliance by providing a clearer Trust-wide framework for advancing equality of opportunity, eliminating discrimination and encouraging greater diversity in senior roles. The Trust should ensure that the existing Board and senior leadership diversity commitments are retained within the new policy framework, and that equality impact considerations are embedded in the development of the EDI Policy and Delivery Plan.

People implications

There are positive people implications, as the proposal supports a more coherent Trust-wide approach to inclusion, fair recruitment, talent management, pay gaps and succession planning. It should help strengthen the Trust's focus on creating an inclusive culture in which staff feel safe, engaged, empowered and valued. There may also be capacity implications for the teams responsible for developing and implementing the new policy, delivery plan and talent management arrangements, which should be managed through clear ownership, prioritisation and governance oversight.

Equality, diversity and inclusion implications

The report has significant positive equality, diversity and inclusion implications. The proposed approach will broaden the current focus from Board diversity alone to a Trust-wide EDI framework, while retaining a specific focus on Board and senior leadership diversity, inclusive recruitment, talent management and succession planning. This will support delivery of national NHS EDI expectations and provide clearer governance and assurance arrangements for monitoring progress.

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

None

Recommendations

- Board Diversity Policy is closed as a first step, to be replaced with a Trust wide EDI policy and an EDI delivery plan which will bring together all the different elements of EDI work currently underway together into one framework.

- A talent management plan for senior managers which seeks to reflect local population demographics is to be developed and published.

Background

The Trust's Board Diversity Strategy was first published in 2020 in response to the **Hampton-Alexander Review and Parker Reviews (2020)** which both highlighted a lack of diversity at Board level in the UK. The policy was subsequently reviewed by the Board in 2024.

Since then the **Messenger Review (2022)** on NHS leadership has been published. This set out seven recommendations to strengthen leadership and management across health and social care including a call for 'Positive equality, diversity and inclusion (EDI) action'.

The recommendations from this were incorporated into the **NHS equality, diversity and inclusion improvement plan**[1] which was published in 2023. This includes six high impact actions:

1. **Chief executives, chairs and board members must have specific and measurable equality, diversity and inclusion (EDI) objectives to which they will be individually and collectively accountable.**
2. **Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity**.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce
5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

The first two recommendations in particular apply to the Board. The first recommendation has been implemented with all Board members having at least one EDI objective. The second recommendation specifically references the Board and the need for diversity, but it notes that any talent management strategy should recognise that these approaches should support the development and progression of all staff

In the NHS 2023 EDI plan there is a specific suggestion to create a diversity of executive and senior leadership teams by June 2024 and evidence implementation by June 2025. This reflects the reference in the Code of Governance for NHS Providers that there should be a published plan for improving the diversity for senior managers compared to local populations. This requirement is also reflected in the Provider Capability self-assessment for 2026.

As part of wider discussions regarding the future of the Board Diversity Strategy, it was recognised that whilst equality, diversity and inclusion is embedded throughout a range of Trust policies and strategies, the Trust does not currently have a standalone Equality, Diversity and Inclusion Policy. It was also noted that the Trust's **EDI Strategy** is due for review at the end of 2026.

In light of these developments, there is an opportunity to move from a standalone Board Diversity Policy towards a more comprehensive organisational approach that brings together all aspects of equality, diversity and inclusion, whilst maintaining a strong focus on leadership diversity, talent management and succession planning.

The proposed **Equality, Diversity and Inclusion Policy** would provide the Trust's overarching statement of commitment to promoting equality, diversity, inclusion and belonging for staff, patients and the communities it serves. It would establish the principles, responsibilities and standards

[1] NHS England » NHS equality, diversity, and inclusion improvement plan

expected across the organisation and set out the respective accountabilities of the Board, Executive Team, managers and staff in creating an inclusive culture.

The policy would provide a consistent framework for addressing discrimination, advancing equality of opportunity and ensuring that inclusion is embedded within leadership, workforce development, recruitment, service redesign, procurement, policy development and organisational decision-making. It would also establish the governance, reporting and assurance arrangements through which the Board receives oversight of progress against EDI objectives and statutory duties.

Supporting the policy, a Trust-wide **EDI Delivery Plan** would bring together the range of EDI activity currently underway across the organisation into a single coherent programme of work. This would include but not be limited to:

- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Gender/Disability and Race Pay Gap reporting
- NHS EDI Improvement Plan actions
- Anti-Racism Strategy and Lord Mann Review recommendations
- Staff Network development and support
- Inclusive recruitment and selection practices
- Talent management and succession planning
- Leadership development and positive action initiatives
- Staff health inequalities programmes
- Bullying, harassment and discrimination reduction initiatives
- International recruitment support and inclusion programmes
- Equality Impact Assessment processes and governance

The Delivery Plan would set out clear objectives, actions, milestones, measures of success and executive accountability arrangements. It would also include a specific section relating to Board and senior leadership diversity, covering inclusive recruitment, talent management and succession planning, ensuring continued compliance with national NHS expectations relating to leadership diversity.

This approach would provide a more comprehensive and sustainable mechanism for delivering the Trust's EDI ambitions than maintaining a standalone Board Diversity Strategy, whilst ensuring that Board and senior leadership diversity remains an important area of focus within a broader organisational commitment to inclusion.

A key enabler of the Trust's ambitions to improve diversity within senior leadership and Board-level roles is the effective use of talent management and succession planning. Responsibility for talent management and succession planning sits with the Executive Team, who oversee the identification, development and progression of future leaders across the organisation. Remuneration Committee have this responsibility for Board members. The proposed EDI Policy and Delivery Plan will support this approach by ensuring that inclusion and equality considerations are embedded within leadership development, talent reviews and succession planning processes.

To inform this work, the Trust participates annually in the NHS NorthWest Regional Talent and Succession Planning process. The intelligence generated through the regional exercise provides the Executive Team with valuable insight into the strength, readiness and diversity of the Trust's leadership pipeline, helping to identify succession risks, development priorities and opportunities to accelerate progression for aspiring Executive Directors and future Board-level leaders. The outputs from the regional process will be used alongside local talent reviews to inform the Trust's Talent Management and Succession Plans, ensuring a structured and evidence-based approach to developing a diverse and sustainable leadership pipeline.

Actions to be taken

Action	Responsible Lead	Completion Date
Agree to step down the Board Diversity Policy and incorporate this into a wider EDI Policy/ Delivery Plan	Director of Corporate Governance	7 October 2026
Review the EDI Strategy	AD of OD and Inclusion	November to December 2026
Develop a EDI Delivery Plan setting out all the EDI work underway at the Trust. This will include a section on inclusive recruitment with specific areas on senior managers and board level recruitment	AD of OD and Inclusion	December 2026 to March 2027
Develop a Trustwide EDI policy	AD of OD and Inclusion	January to March 2027
Diversity focused talent management plan for senior leaders to be published on the Trust Website	AD of OD and Inclusion	March 2027 onwards
NHS NorthWest Regional Talent and Succession Planning process, to support the identification, development and progression of aspiring Executive Directors and future Board-level leaders.	RemCom (with Chief People Officer as Executive Lead)	

Katharine Dowson, Director of Corporate Governance
Rachel Gleave, Associate Director of OD and Inclusion
September 2026

Three WISHES
DOING MORE FOR OUR PATIENTS
WWL'S HOSPITAL CHARITY

Charity Update



Emily Mundon, Charity Manager

7 October 2026

www.wwl.nhs.uk/threewishes

Three WISHES
DOING MORE FOR OUR PATIENTS
WWL'S HOSPITAL CHARITY

Vision: To make Three Wishes Charity the charity of choice for staff, patients, visitors, supporters and the local community, generating additional funds that enhance patient care, staff wellbeing and patient experience across WWL.

Mission: To further improve the quality of patient care, through staff training, purchasing medical equipment and enhancing the patient environment and experience.

Strategic Objective 1 - Patients

The Charity will support the Trust to deliver safe personalised and compassionate care leading to excellent outcomes and patient experience

The charity has continued to invest in projects that improve patient experience, enhance clinical environments and support staff in delivering high-quality care.













Strategic Objective 2 - People

The Charity will support the health and wellbeing of staff to minimise stress, enhance motivation and be the best they can to provide the best possible patient care.

The charity continues to support initiatives that enhance wellbeing and staff supporting their hospital charity.













Strategic Objective 3 - Performance

The Charity will manage financial resources and income streams to ensure contribution is maximised to support long term growth and resilience of the Charity.

The charity has strengthened engagement with supporters nd local communities through fundraising activity.













Strategic Objective 4 - Partnerships

The Charity will work to support fund managers effectively manage the funds they are responsible for.

The charity has rolled out Fund Manager Toolkit, training and furthe rgudiance to supprt Fubd Committees.













Looking Ahead 2026/2027

- Improve charity displays, branding and supporter engagement across Trust sites.
- Strengthen regular giving, fundraising events and grant funding opportunities.
- Build relationships with supporters, community organisations and charity partners.
- Ensure charitable funding continues to deliver meaningful impact for patients, families and staff.



DOING MORE
FOR OUR PATIENTS

WWL'S HOSPITAL CHARITY

Title of report:	Appraisal & Revalidation Report
Presented to:	Board of Directors
On:	7 October 2026
Item purpose:	Information
Presented by:	Professor Sanjay Arya – Responsible Officer
Prepared by:	Kathryn Heffernan, Appraisal & Revalidation Manager
Contact details:	T: 2637 E: kathryn.heffernan@wwl.nhs.uk

Executive summary

This report covers the appraisal cycle of 1 April 2025 – 31 March 2025.

The template format of the report has been provided by the NHS England Revalidation Team. All Trusts have been requested to use the template and submit the full report which includes the Compliance Statement to NHS England before 31 October 2026.

The purpose of this report is to provide assurance that appraisal systems are robust, support revalidation and are operating effectively, whilst acknowledging that there are further improvements to be made. The report forms part of the Medical Director's duties as Responsible Officer.

On 31 March 2026 there were a total of **515 doctors** who had a prescribed connection to Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust.

The Board of Directors are asked to note the contents of this paper and approve compliance in Section 4 of this report.

Link to strategy and corporate objectives

Patients – We continue to ensure our medical appraisal and revalidation process is a key part of assuring our patients of the safety and effectiveness of medical professionals. Whilst medical revalidation aims to give confidence to the public that doctors are well supported and monitored and that there is a system for responding to concerns about a doctor's practice.

People – to ensure that all doctors have an annual appraisal to ensure they are up to date and fit to practice.

Performance - Appraisal provides key information to the responsible officer on the fitness to practise of each doctor and their commitment to remaining up to date. The recommendations that responsible

officer make to the GMC on doctors' fitness to practise are made using outputs from appraisal and other information available to them from local clinical governance systems.

Partnerships – we continue to engage with all our partners associated with appraisal and revalidation our doctors, appraisers and associated departments within WWL; NHS England and GMC.

Risks associated with this report and proposed mitigations
None to report.

Financial implications
None to report.

Legal implications
Not applicable

People implications
None to report.

Wider implications
None to report

Recommendation(s)
The Board of Directors are asked to note the contents of this paper for approval of compliance in Section 4 of this report

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **30 October 2026**

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust
What type of services does your organisation provide?	Acute

	Name	**Email**
Responsible Officer	Prof Sanjay Arya	Sanjay.arya@wwl.nhs.uk
Medical Director	Prof Sanjay Arya	Sanjay.arya@wwl.nhs.uk
Medical Appraisal Lead	Dr Jenny Wiseman	Jenny.wiseman@wwl.nhs.uk
Appraisal and Revalidation Manager	Kathryn Heffernan	Kathryn.heffernan@wwl.nhs.uk
Additional Useful Contacts		
Deputy Medical Director/RO	Prof Nirmal Kumar	Nirmal.kumar@wwl.nhs.uk
Appraisal Lead MCh/MMed	Prof Raj Murali	Raj.murali@wwl.nhs.uk
Appraisal Admin Support Officer	Vacant	

Service Level Agreement
Do you have a service level agreement for Responsible Officer services?

NO

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:
Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust
can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	YES
Action from last year:	The Responsible Officer attends the NHSE NW RO Group meetings regularly and updates his knowledge where case studies are discussed as a group.
Comments:	He has regular meetings with GMC ELA and Chief People Officer through Doctors Concerns Meeting.
Action for next year:	Responsible Officer to continue regarding training.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	YES
Action from last year:	Continue to train Appraisal & Revalidation Admin Support Officer
Comments:	Postholder retired in May 2026, recruitment for replacement in progress.
Action for next year:	To recruit suitable Appraisal & Revalidation Admin Support Officer and train.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	YES
Action from last year:	As below.
Comments:	The Appraisal & Revalidation Manager monitors and updates the connection list with all starters and leavers and monitors all new connections. All inappropriate or incorrect connections are reviewed and where appropriate declined by the Appraisal & Revalidation Manager. Any issues identified are referred to the GMC Connect if clarification is required.
Action for next year:	As above.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	YES
Action from last year:	Due to changes in our appraisal reminder schedule, the A & R policy will be reviewed by amendments made to reflect new process and submit to LNC committee in Oct 2025 for approval.
Comments:	LNC approved updated policy in April 2026.
Action for next year	Following LNC approval, policy has been submitted to PARC for ratification in June 2026. Once approved by PARC updated policy to be circulated.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	NO
Action from last year:	Consider peer review with another NHS Trust Provider in the next 2-3 years.
Comments:	No current plans. Peer Review took place with Royal Bolton Hospital on 12 March 2024, followed by visit by Wigan Team to Royal Bolton on 14 May 2024. Responsible Officer attends NHSE RO Events and Appraisal & Revalidation Manager chairs regional peer group (x 4 meetings per year).
Action for next year:	Consider peer review with another NHS Trust Provider in the next 2 years.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	YES
Action from last year:	As below.
Comments:	When notified, the Appraisal & Revalidation Manager contacts all locum or short-term placement doctors to make sure they are aware of the appraisal process and requirements. All are invited to meet the Manager for training on appraisals (if required). For those with a prescribed connection to WWL as their designated body, the doctors will undertake an annual appraisal and be supported through revalidation by the Trust if required. For those doctors without a prescribed connection, we offer any support required for revalidation and this varies on a case-by-case basis. In-house locum bank system called TempRe has been set up. A & R Manager is emailed any new bank doctors from the TempRe admin team who then contacts the individual doctor to inform and train on the requirements of appraisal and revalidation.
Action for next year	A & R Manager to continue to ensure all bank doctors are aware of the requirements.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	YES
Action from last year:	Continue to ensure all doctors complete annual appraisal.
Comments:	All doctors' complete annual appraisal covering their whole scope of practice using our electronic appraisal system (Clarity). Appraiser Checklist helps the appraisers perform their role robustly.
Action for next year:	All doctors are reminded 5 months in advance when their appraisal is due and thereafter monthly reminders until deadline.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	YES
Action from last year:	Continue to document as below.
Comments:	If a doctor does not have annual appraisal the reason is documented on the master spreadsheet held by the Appraisal & Revalidation Manager and approved prior by the Responsible Officer. They are supported by the Appraisal Lead and Appraisal and Revalidation Manager in performing the appraisal.
Action for next year:	Continue as above.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	YES
Action from last year:	Further changes have been made to the A & R policy and submitted to LNC for approval in Oct 2025 then again in April 2026.
Comments:	A & R policy approved by LNC in April 2026 this has now been submitted to PARC for ratification in June 2026.
Action for next year:	Once approved by PARC, updated policy to be circulated to all doctors and updated on the intranet.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	YES
Action from last year:	Recruit new appraisers to all specialities over the 12 months due to the increase in number of doctors connected to WWL.
Comments:	1 appraiser recruited this past year. Currently 107 appraisers in total. 2 appraisers stopped appraising during this period.
Action for next year:	Continue to recruit new appraisers to all specialities.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	YES
Action from last year:	Sessions planned for May 2025 and Nov 2025.
Comments:	Above sessions took place in 2025. Session took place on 12 May 2026. This was a face-to-face session attended by 70 appraisers. Next face-to-face session will be November 2026 – date to be confirmed.
Action for next year:	Sessions to be arranged for May 2026 and November 2026.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	YES
Action from last year:	This report is submitted every year to the People's Committee then to the Trust Board.
Comments:	Every year the Appraisal Lead reviews two appraisals per appraisee using the PROGRESS Tool form. Feedback is sent to each appraiser at the end of the cycle. Every year the Appraisal Lead and Appraisal & Revalidation Manager runs two Appraiser Update Sessions which is monitored by the Responsible Officer. Attendance at these sessions is monitored. Each appraiser must attend one session per year to ensure they are up to date with their role. Appraisers who are unable to attend are provided with content of the presentation and encouraged to attend the next update.
Action for next year:	Continue as above.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	YES	
Action from last year:	Continue to process GMC recommendations timely.	
Comments:	This cycle 1 April 2025 – 31 March 2026. 56 recommendations this year, 42 positive and 14 deferrals made. Reasons for deferral are recorded on the Revalidation Checklist form.	
Action for next year:	Continue to process GMC recommendations timely.	

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	YES	
Action from last year:	Ensure all recommendations are made on time Amendments have been made to the Appraisal & Revalidation Policy which will help reduce deferral rates (through reminder process)..	
Comments:	New Appraisal timing reminder process introduced. 1 April 2025 - 31 March 2026 56 doctors due for revalidation, 42 positive recommendations, 14 deferred.	
Action for next year:	Ensure all recommendations made on time.	

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	YES	
Action from last year:	Continue process below.	
Comments:	Any concern or issue with a doctor is discussed at the quarterly Doctors Concerns Meeting with the Responsible Officer, Deputy RO; Chief People Officer; Deputy Chief People Officer and Appraisal & Revalidation Manager. Any complaints or never events are emailed to the appraisee and they are requested to include this in their next appraisal and discuss with their appraiser.	
Action for next year:	Continue above process.	

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	YES
Action from last year:	Continue with process below.
Comments:	Processes are in place ie: MHPS; Duty of Candour, Freedom to speak up Guardian. Medical Director/Responsible Officer, Associate Medical Director (RO) and the Appraisal & Revalidation Manager have regular meetings with the GMC ELA (every 4 months). If required, discussions are held with the Practitioner Professional Advise Services to discuss individual cases. All doctors are requested to add relevant information in their appraisal. In addition, the Responsible Officer, Appraisal & Revalidation Manager, Associate Medical Director (RO), Chief People Officer and Deputy Chief People Officer hold a Doctors Concerns Meeting every quarter to discuss and review any issues with our current doctors.
Action for next year:	Continue as above.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	YES
Action from last year:	All relevant organisational information is included in the portfolio or emailed by the Appraisal & Revalidation Manager.
Comments:	Doctors are provided with complaints, legal claims, clinical incidents and audit attendance. This is uploaded directly into their appraisal or emailed to them.
Action for next year:	Continue with above process.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	YES
Action from last year:	No change, continue with process.
Comments:	The Trust has a Maintaining High Professional Standards Policy (MHPS) which provides a process around all steps and considerations for when a concern arises in relation to a medical practitioner. Medical Director/Responsible Officer, Associate Medical Director (RO) and the Appraisal & Revalidation Manager have regular meetings with the GMC ELA (every 4 months). If required, discussions are held with the Practitioner Professional Advise Services to discuss individual cases. All doctors are requested to add relevant information in their appraisal. In addition, the Responsible Officer, Appraisal & Revalidation Manager, Associate Medical Director (RO), Chief People Officer and Deputy Chief People Officer hold a Doctors Concerns Meeting every two months to discuss and review any issues with our current doctors.
Action for next year:	Continue with above process. The MHPS Policy requires updating by HR.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	YES
Action from last year:	Continue with process.
Comments:	MHPS summary information is reported to the Board as per the annual reporting timeline. Minutes from Medical Director led Doctor Related Concerns meetings, held Bi-monthly are recorded for any audit purposes if required.
Action for next year:	Continue above process.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	YES	
Action from last year:	Continue with below process.	
Comments:	MHPS summary information is reported to the Board as per the annual reporting timeline. Minutes from Medical Director led Doctor Related Concerns meetings, held Bi-monthly are recorded for any audit purposes if required. MPiT transfer of information form or suitable alternative is used to receiving RO if any concerns about the doctor.	
Action for next year:	As above.	

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	As below.
Comments:	All cases where a concern has been raised by doctors practice are reviewed by the appropriate personnel. If a formal investigation is undertaken a case manager and independent case investigator with HR Support are appointed.
Action for next year:	Continue above process.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	YES
Action from last year:	Plan to hold Case Investigator and Case Manager Training from NHSR in early 2026. New Consultant Support Session scheduled for Dec 2025 for all new consultants to WWL in last 12 months
Comments:	Case Investigator and Case Manager Training from NHSR in early 2026 did not take place. New Consultant Support Session took place in Dec 2025 for all new consultants to WWL in last 12 months. All doctors are encouraged to attend their departmental/divisional meetings. All have allocated study leave. Mandatory training needs to be completed by all doctors and is updated, when necessary, eg: Oliver McGovern training must be completed by all staff.
Action for next year:	New Consultant Support Session scheduled for Dec 2026 for all new consultants to WWL in last 12 months

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Continue as below.
Comments:	Annual job planning Mandatory training Compliance adherence to Good Medical Practice (GMP) through appraisal process.
Action for next year:	Continue as above.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	YES	
Action from last year:	As below.	
Comments:	Pre-employment checks are carried out by the Medical HR Dept. All doctors who are recruited to the Trust (whether substantive or fixed term) are subject to the same pre-employment checks as defined by NHS Employment Check Standards. All references are reviewed by the Deputy Medical Director (RO). References for the MCh/ITF Doctors are reviewed by the GTEC Team.	
Action for next year:	No changes, continue as above.	

1F – **Organisational Culture**

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	YES
Action from last year:	Continue to promote our WWL values and vision.

Comments:	At WWL, we want to make sure that every member of staff feels valued and our vision is for WWL to be a provider of excellent health and care services, delivering safe and compassionate care to our patients, and being an inclusive and person-centered place to work, where everyone can flourish. Having shared core values is integral to creating a foundation of our culture at WWL, and how together, we will achieve our vision. 
Action for next year:	Continue to promote our WWL values and vision.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	YES
Action from last year:	Continue as below.
Comments:	The Trust has a Maintaining High Professional Standards Policy which provides a process around all steps and considerations for when a concern arises in relation to a medical practitioner. The Responsible Officer applies compassion when any staff is involved in an incident and ensures any action is fair and proportionate.
Action for next year:	Continue as above.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	YES
Action from last year:	As below
Comments:	FTSU Guardian of Safe Working Trust Values Steps for Wellness/Well-being Staff Engagement Reports for FTSU and GOSW are taken to People Committee.
Action for next year:	As above

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	YES
Action from last year:	Continue with below process.
Comments:	System for recording concerns is long established via excel tracker held confidentially within HR system – tracker is updated in line with updated requirements of Board, local and national reporting as required. Bi-monthly Doctor Related Concerns meetings take place to discuss all informal and formal concerns raised to Medical Director or HR to ensure consistency and appropriate advice sought to agree any action. Meeting attendees are Medical Director, Deputy Medical Director (RO), Chief People Officer & Deputy Chief People Officer.
Action for next year:	As above

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	YES
Action from last year:	No action.
Comments:	EDI data is held confidentially within HR systems and only used for demographic and governance processes, such as comparison and assurance reports for the Board or as part of national/local reporting requirements and Freedom of Information requests, that meet the legal criteria for disclosure.
Action for next year:	Continue as above.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	YES
Action from last year:	Continue to attend NHSE NW Network Meetings and all other appropriate meetings/conferences to ensure our knowledge is up to date.
Comments:	WWL is represented at all NHSE NW network meetings. Medical Director/Responsible Officer, Associate Medical Director (RO) and the Appraisal & Revalidation Manager have regular meetings with the GMC ELA (every 4 months). Chief Medical Officer/Responsible Officer, Deputy Medical Director, Appraisal Lead & Appraisal& Revalidation Manager attend NHSE North West Network Meetings.
Action for next year	Continue to attend all appropriate meetings/conferences to ensure our knowledge is up to date.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	515
Total number of appraisals completed	442
Total number of appraisals approved missed	68
Total number of unapproved missed All completed by 30 April 2026	5
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	56
Total number of late recommendations	0
Total number of positive recommendations	42
Total number of deferrals made	14
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	33
Total number of trained case managers	16
Total number of concerns received by the Responsible Officer[2] Managed through Doctors Concerns Meeting	10
Total number of concerns processes completed	5
Longest duration of concerns process of those open on 31 March (working days)	7 months
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	2

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	155
Total number of new employment checks completed before commencement of employment	155
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[3]	0

[3] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report			
	2025/2026	**2024/2025**	**2023/2024**
Number of Doctors	**515**	**496**	**471**
Completed Appraisals Consultants (substantive)	**216/225** **96%** **(99.5%)** With valid reasons	185/208 88.9% (90.3%) With valid reasons	178/202 (88.1%) (90.6%) With valid reasons
Completed Appraisals Staff Grade/ Associate Specialists/ Speciality Doctors	**66/74** **89.2** **(96%)** With valid reasons	56/68 82.3% (91.2%) With valid reasons	37/48 (77.1%) (94%) With valid reasons
Completed Appraisals All fixed term/locum doctors	**160/216** **74%** **(99.5%)** With valid reasons	138/220 62.7% (96%) With valid reasons	125/219 (57.1%) (96%) With valid reasons
Overall **Completed Appraisal Rate**	**85%** **(99%)** With valid reasons	76.4% (93.1%) With valid reasons	72.2% (93%) With valid reasons

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

There have been incremental improvements in the appraisal system including annual appraiser performance reports, and reduction of delays in appraisals.

Appraisers are remunerated specifically for their role to ensure quality and accountability. Appraisers receive additional supporting information for their own appraisals, including certification for attendance at Appraiser Update Meetings, and an annual feedback report which are added to their appraisals for them.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Wrightington, Wigan & Leigh Teaching Hospitals NHS FT

Name:	Mrs Mary Fleming
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Sanjay Arya
Email address:	Sanjay.arya@wwl.nhs.uk

Title of report:	Standing Financial Instructions
Presented to:	Board of Directors
On:	7th October 2026
Item purpose:	Approval
Presented by:	Consent agenda
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 approval from the Board of Directors for the proposed amendments to the Trust's Standing Financial Instructions (SFIs) and Budgetary Control and Delegation Arrangements, and to recommend these changes for adoption by the Board of Directors.

The SFIs are reviewed annually to ensure they remain aligned to current policies, procedures and practice. As part of this review, an additional section has been incorporated within SFI 12 covering redundancy, severance and other exit payments. This strengthens the governance framework by setting out the requirement for appropriate Finance and HR review, approval through the relevant governance route, and verification that all approvals are in place before any payment is made.

The proposed changes will be supported by a dedicated Exit Payments Standard Operating Procedure, which will provide further detail on roles, responsibilities and the process to be followed.

The proposed amendment was reviewed by Audit Committee at its meeting on 22 September 2026 and is now presented to the Board of Directors for approval and adoption.

Link to strategy and corporate objectives

None.

Risks associated with this report and proposed mitigations

The amendments reduce the risk of exit payments being processed without appropriate review, approval and verification.

Financial implications

The proposed amendments strengthen financial governance and control over redundancy, severance and other exit payments.

Legal implications

The proposed amendments support compliance with the Trust's legal, regulatory and governance obligations in relation to redundancy, severance and other exit payments. The inclusion of clearer approval and verification requirements provides additional assurance that payments are subject to appropriate review before being processed.

People implications

The proposed amendments do not alter employee terms and conditions but strengthen the governance process for managing redundancy, severance and other exit payments. The changes provide clearer roles and responsibilities for Finance and HR and support a consistent approach to the review and approval of such payments.

Equality, diversity and inclusion implications

There are no specific equality, diversity and inclusion implications arising directly from this paper.

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

Senior Finance Team.

Recommendation(s)

The Board of Directors is asked to approve the proposed amendments to the Standing Financial Instructions following review by Audit Committee, for adoption by the organisation.

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 SFIs is undertaken to ensure that the policy accurately reflects current policies, procedures, and practice.

Key changes

Following a review of the controls relating to employee exit payments, a new section titled Redundancy, Severance and Exit Payments has been added to SFI 12. The purpose of this amendment is to strengthen the governance and control framework for redundancy, severance and other exit payments. The updated section is included in Appendix 1.

The revised wording sets out the requirement for appropriate Finance and HR review, approval through the relevant governance route, and confirmation that all required approvals are in place before any payment is processed. This is intended to provide additional assurance that exit payments are subject to appropriate scrutiny and are managed consistently.

The changes will be supported by a dedicated Exit Payments Standard Operating Procedure, which will set out the detailed process, roles and responsibilities to be followed.

Appendix 1 of the SFIs has also been updated to include specific compliance monitoring arrangements for redundancy, severance and exit payments. Compliance will be monitored through periodic review of payroll and supporting approval documentation to ensure payments have been processed in accordance with the approved governance process.

Recommendation

The Board of Directors is asked to approve the proposed amendments to the Standing Financial Instructions and Budgetary Control and Delegation Arrangements, following review by Audit Committee, for adoption by the organisation.

Appendix 1

Redundancy, Severance and Exit Payments

SFI 12.10 All redundancy, severance and exit payments must be managed in accordance with the Trust's Organisational Change Policy, NHS Terms and Conditions of Service, applicable employment legislation and current NHS England, Department of Health and Social Care and HM Treasury guidance.

SFI 12.11 No employee, manager or officer of the Trust may commit to, offer, agree, authorise or otherwise create an expectation of a redundancy payment, severance payment, settlement agreement, mutually agreed resignation arrangement or any other exit package without prior approval through the Trust's approved governance arrangements.

SFI 12.12 Before any redundancy, severance or exit payment is approved, the following must be documented and retained for audit purposes:

a) the organisational rationale for the proposed exit;
b) confirmation that appropriate workforce consultation and organisational change processes have been completed where applicable;
c) the full financial implications of the proposal, including redundancy costs, pension strain costs, notice costs and any other associated liabilities;
d) confirmation of the source of funding;
e) confirmation that advice has been obtained from Human Resources and Financial Services; and
f) evidence that any required internal or external approvals have been received.

SFI 12.13 All proposed redundancy, severance and exit payments must be subject to review by the Chief People Officer and Chief Finance Officer, or their nominated deputies, prior to approval.

SFI 12.14 Any proposed payment that exceeds contractual entitlement, including special severance payments, settlement agreements or other non-contractual employment-related payments, shall be treated as a Special Payment and must be managed in accordance with SFI 14, Losses and Special Payments.

SFI 12.15 Where current NHS England, Department of Health and Social Care or HM Treasury guidance requires external approval, no commitment may be made and no payment may be processed until all necessary approvals have been obtained.

SFI 12.16 Payroll must not process any redundancy, severance or exit payment unless evidence of approval through the Trust's approved governance arrangements has been received and retained.

SFI 12.17 The Chief Finance Officer shall ensure that all redundancy, severance, settlement and other exit payments are appropriately recorded and reported in accordance with statutory reporting requirements and Trust governance arrangements.

Extract of Appendix 1 of SFI's (page 63)

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.
Terms of Service, Allowances Pay	• Processing a redundancy, severance or exit payment without approved governance, business case or required approval(11.3A)	Monitoring of payroll related information	All employees	Payroll	**Immediately**

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

Approved by the Board of Directors: 3rd June 2025
Review date: September 2027

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.

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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.

Redundancy, Severance and Exit Payments

SFI 12.10 All redundancy, severance and exit payments must be managed in accordance with the Trust's Organisational Change Policy, NHS Terms and Conditions of Service, applicable employment legislation and current NHS England, Department of Health and Social Care and HM Treasury guidance.

SFI 12.11 No employee, manager or officer of the Trust may commit to, offer, agree, authorise or otherwise create an expectation of a redundancy payment, severance payment, settlement agreement, mutually agreed resignation arrangement or any other exit package without prior approval through the Trust's approved governance arrangements.

SFI 12.12 Before any redundancy, severance or exit payment is approved, the following must be documented and retained for audit purposes:

a) the organisational rationale for the proposed exit;
b) confirmation that appropriate workforce consultation and organisational change processes have been completed where applicable;
c) the full financial implications of the proposal, including redundancy costs, pension strain costs, notice costs and any other associated liabilities;
d) confirmation of the source of funding;

e) confirmation that advice has been obtained from Human Resources and Financial Services; and
f) evidence that any required internal or external approvals have been received.

SFI 12.13 All proposed redundancy, severance and exit payments must be subject to review by the Chief People Officer and Chief Finance Officer, or their nominated deputies, prior to approval.

SFI 12.14 Any proposed payment that exceeds contractual entitlement, including special severance payments, settlement agreements or other non-contractual employment-related payments, shall be treated as a Special Payment and must be managed in accordance with SFI 14, Losses and Special Payments.

SFI 12.15 Where current NHS England, Department of Health and Social Care or HM Treasury guidance requires external approval, no commitment may be made and no payment may be processed until all necessary approvals have been obtained.

SFI 12.16 Payroll must not process any redundancy, severance or exit payment unless evidence of approval through the Trust's approved governance arrangements has been received and retained.

SFI 12.17 The Chief Finance Officer shall ensure that all redundancy, severance, settlement and other exit payments are appropriately recorded and reported in accordance with statutory reporting requirements and Trust governance arrangements.

Processing payroll

SFI 12.18 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 12.19 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 12.20 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 12.21 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 12.22 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 12.23 Expenses should only be reimbursed via payroll. There should be no reimbursement for Trust purchases via payroll.

Contracts of employment

SFI 12.24 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 12.25 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 Equipment and with no revenue implications.	£500k	N/A (CME cases over £500k still require ETM endorsement before going to F&P)	£1m	>£1m
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
	• 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)***					

						support on the financial position.
	• 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					**After 2nd notification**

	reimbursed through payroll without prior approval ***(6.4.5)***					
	• 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 notification 2nd**
	• Failure to involve procurement in the tender process ***(7.14.1)***	As and when the situation arises.				**After notification 2nd**
	• Unauthorised approval of NHS and Non NHS Contracts ***(7.14.3)***	As and when the situation arises.				**After notification 2nd**
	• Failing to ensure that all items received under a prepayment agreement have been received ***(8.3.4,d)***	As and when situation arises				**After notification 2nd**
	• 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 notification 2nd**
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 knowing the effective date of the an employee's resignation, termination or retirement ***(11.4.3, c)***					**After 2nd notification**
	• 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**.
Terms of Service, Allowances Pay	• Processing a redundancy, severance or exit payment without approved governance, business case or required approval(11.3A)	Monitoring of payroll related information	All employees		Payroll	**Immediately**
Disposals and condemnations, losses and	• Damage to premises, vehicles and equipment or	As and when the situation arises.	All employees		Financial Services	**After 2nd notification**

special payments	any of equipment stores or supplies must be reported. ***(13.3.5)***					
	• 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 notification** **1st**
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 notification** **1st**
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 notification** **2nd**
Intellectual property	• Selling, assign license or trade IP without approval ***(20.1.6)***	As and when the situation arises.	All employees		Financial Services	**After notification** **1st**
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 notification** **1st**

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**